Bridges Eligibility Policy Manuals
DEPARTMENT POLICY

MA Only

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

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

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

TARGETED GROUP

Waiver services are covered for MA recipients who:

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

WAIVER ADMINISTRATION

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

Assisting Participants

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

The waiver process includes:

Assessment

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

Plan of Service

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

At a minimum, the plan includes:

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

Supports Coordination

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

APPROVED FOR THE WAIVER

Approved for the waiver means:

- The agent conducted the assessment, and
- There is an available waiver slot for the individual’s placement and
- A person-centered plan of service has been developed and
- The participant has received services for more than 30 days or is currently receiving services that are expected to continue more than 30 days, or expects to receive supports coordination
services from the agent with appropriate waiver services for at least 30 consecutive days.

Approval and Termination Dates

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

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

MDHHS LOCAL OFFICE RESPONSIBILITIES

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

Waiver Participant Defined

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

Waiver Month Defined

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

Note: For purposes of MA eligibility, a month remains a waiver month even if the waiver participant enters a Long Term Care (LTC) facility and/or hospital (L/H) in the same calendar month. A waiver month does not become an L/H month; see Bridges Glossary.
NONFINANCIAL ELIGIBILITY FACTORS

The eligibility factors in the following items must be met.

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

FINANCIAL ELIGIBILITY FACTORS

Special MA policies are used in the MA eligibility determination:

- A waiver participant is a group of one even when he lives with his spouse; see BEM 211.

- The Special MA Asset Rules in BEM 402 apply when completing the Initial Asset Assessment. See *special initial asset assessment rules for waiver applicants* in this item for rules on determining the first period of continuous care.

- The MA divestment policy in BEM 405 applies to waiver participants.

- The extended-care category is available to waiver participants; see BEM 164.

- Income must be at or below 300 percent of the SSI Federal Benefit Rate. An individual cannot spenddown income to waiver eligibility.

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

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

Special Initial Asset Assessment Rules for Waiver Applicants

The first period of continuous care is a period of at least 30 consecutive days where the institutionalized spouse/applicant has been or is expected to be:

- In a hospital and/or LTC facility and/or
- Receiving appropriate home and community based services specified under the approved state waiver; see Exhibit I in this item. They do not have to receive these services from a waiver agent listed below, but the services must be received from a person or entity certified (or licensed) by the state to provide the services. See below for verification of services received.
- The period is no longer continuous when none of the above is true for 30 or more consecutive days; see BEM 402 for examples.
- The first period of continuous care may have occurred in the past, however the applicant must be currently receiving services in order to be eligible for the IAA.

Start of a Divestment Penalty Period

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

Notices

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

- A copy of the DHS-3503, Verification Checklist.
- A copy of the DHS-4588, Initial Asset Assessment Notice.
The original DHS-3503, and DHS-4588 must be sent to the participant or the guardian, court or agency that is legally responsible for the participant.

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

**HOSPICE SERVICES**

Waiver participants may receive hospice services and waiver services simultaneously.

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

**MANAGED CARE PLANS**

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

**Exhibit I Home And Community Based services Available thru the Approved state waiver**

- State Plan transition services.
- Community living supports.
- Nursing services (preventative nursing).
- Adult day health (adult day care).
- Environmental Accessibility Adaptations (home modifications).
- Community transportation (non-emergency transportation, medical or non-medical).
- Medical supplies and equipment not covered under the Medicaid State Plan.
- Chore services.
- Personal emergency response systems.
• Private duty nursing and respiratory care.
• Counseling.
• Home delivered meals.
• Training in independent living skills.
• Supports coordination.
• Fiscal intermediary.
• Goods and services.
• Community Health Worker.

VERIFICATION REQUIREMENTS

Home and Community based services (listed above) used to determine the first day of continuous care for the IAA must be verified.

Verification Sources

Sources to verify receipt of home and community based services listed in the approved waiver include:

• Bill from state certified medical provider with dates of provided services.
• Receipt from state certified medical provider with dates of provided services.
• Contact with medical provider or the provider's billing service.

EXHIBIT II- MSA WAIVER SERVICE AGENTS

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<thead>
<tr>
<th>WAIVER AGENCIES</th>
<th>COUNTIES SERVED</th>
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<tr>
<td>Detroit Area Agency on Aging</td>
<td>Cities of: Detroit, Hamtramck, Highland Park, Grosse</td>
</tr>
<tr>
<td>1333 Brewery Park Blvd, Suite 200</td>
<td>Pointe, Grosse Pointe Park, Grosse Pointe Shores,</td>
</tr>
<tr>
<td>Detroit, MI 48207</td>
<td>Grosse Pointe Woods, Grosse Pointe Farms, Harper</td>
</tr>
<tr>
<td>Phone: 313-446-4444</td>
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<tr>
<td>Fax: 313-446-4446</td>
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<tr>
<td>Web: www:daaa1a.org</td>
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<tr>
<td>The Senior Alliance</td>
<td>All of Wayne County excluding those areas</td>
</tr>
<tr>
<td>5454 Venoy Road</td>
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</tr>
<tr>
<td>Wayne, MI 48184</td>
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<tr>
<td>Phone: 734-722-2830 1-800-815-1112</td>
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<tr>
<td>Fax: 734-722-2836</td>
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<tr>
<td>The Information Center, Inc.</td>
<td>All of Wayne County excluding those areas</td>
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<tr>
<td>20400 Superior Road</td>
<td>served by the Detroit Area Agency on Aging</td>
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<tr>
<td>Taylor, MI 48180</td>
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<tr>
<td>Phone: 734-282-7171</td>
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<tr>
<td>Fax: 734-282-7105</td>
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<tr>
<td>Web: <a href="http://www.theinfocenter.info">www.theinfocenter.info</a></td>
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<tr>
<td>Area Agency on Aging 1B</td>
<td>Livingston, Macomb, Monroe, Oakland, St.</td>
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<tr>
<td>29100 Northwestern Hwy, Suite 400</td>
<td>Clair, Washtenaw</td>
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<tr>
<td>Southfield, MI 48034</td>
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<tr>
<td>Phone: 248-357-2255 1-800-852-7795</td>
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<td>Fax: 248-948-9691</td>
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<tr>
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<td>Macomb-Oakland Regional Center, Inc.</td>
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<tr>
<td>16200 Nineteen Mile Road</td>
<td>Clair, Washtenaw</td>
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<tr>
<td>PO Box 380710</td>
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<tr>
<td>Clinton Township, MI 48038-0070</td>
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<td>Phone:586-263-8700</td>
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<tr>
<td>Fax: 586-228-7029</td>
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<tr>
<td>Web: <a href="http://www.MORChomecare.org">www.MORChomecare.org</a></td>
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<tr>
<td>Region 2 Area Agency on Aging</td>
<td>Jackson</td>
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<tr>
<td>102 North Main Street</td>
<td>Hillsdale</td>
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<tr>
<td>PO Box 189</td>
<td>Lenawee</td>
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<tr>
<td>Brooklyn, MI 49230</td>
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<tr>
<td>Phone: 517-592-1974 Fax: 517-592-1975</td>
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<td>Web: <a href="http://www.r2aaa.net">www.r2aaa.net</a></td>
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| Senior Services, Inc.  
918 Jasper Street  
Kalamazoo, MI 49001  
Phone: 269-382-0515  
Fax: 269-382-3189  
Web: www.seniorservices1.org | Barry, Branch, Calhoun, Kalamazoo, St. Joseph |
| Region 3B Area Agency on Aging/Care Well Services  
200 West Michigan Avenue Suite 102  
Battle Creek, MI 49017  
Phone: 269-966-2450 1-800-626-6719  
Fax: 269-966-2493  
Web: www.region3b.org | Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren |
| Region IV Area Agency on Aging  
2900 Lakeview Avenue  
St. Joseph, MI 49085  
Phone: 269-983-0177 1-800-442-2803  
Fax: 269-983-5218  
Web: www.areaagencyonaging.org | Berrien  
Cass  
Van Buren |
| Valley Area Agency on Aging  
225 E. Fifth Street,  
Flint, MI 48502  
Phone: 810-239-7671 1-800-978-6275  
Fax: 810-239-8869  
Web: www.valleyaaa.org | Genesee  
Lapeer  
Shiawassee |
| Tri-County Office on Aging  
5303 South Cedar Street  
Lansing, MI 48911-3800  
Phone: 517-887-1440 1-800-405-9141  
Fax: 517-887-8071  
Web: www.tcoa.org | Clinton  
Eaton  
Ingham |
| Area Agency on Aging of Western Michigan, Inc.  
3215 Eaglecrest Dr. NE  
Grand Rapids, MI 49525  
Phone: 616-456-5664 1-888-456-5664  
Fax: 616-456-5692  
Web: www.aaawm.org | Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Newaygo, Osceola |
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<td>Reliance Community Care Partners</td>
<td>Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa</td>
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<tr>
<td>2100 Raybrook SE Suite 203</td>
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<tr>
<td>Grand Rapids, MI 49546</td>
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<tr>
<td>Phone: 616-956-9440 1-800-447-3007</td>
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<td>Fax: 616-954-1520</td>
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<tr>
<td>Web: <a href="http://www.relianceccp.org">www.relianceccp.org</a></td>
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<td>Region VII Area Agency on Aging</td>
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<tr>
<td>1615 S. Euclid Ave.</td>
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<tr>
<td>Bay City, MI 48706</td>
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<tr>
<td>Phone: 989-893-4506 1-800-858-1637</td>
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<td>Fax: 989-893-3770</td>
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<td>Web: <a href="http://www.region7aaa.org">www.region7aaa.org</a></td>
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<td>A&amp;D Home Health Care, Inc.</td>
<td>Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland, Saginaw, Sanilac, Tuscola</td>
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<tr>
<td>3150 Enterprise, Suite 200</td>
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<tr>
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<td>Phone: 989-249-0929 1-800-884-3335</td>
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<td>Fax: 989-249-1147</td>
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<td>Web: <a href="http://www.a-dhomecare.com">www.a-dhomecare.com</a></td>
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<td>Region IX Area Agency on Aging</td>
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<td>2375 Gordon Road</td>
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<tr>
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<tr>
<td>Phone: 989-356-3474 1-800-219-2273</td>
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<td>Fax: 517-354-5909</td>
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<td>Web: <a href="http://www.nemcsa.org">www.nemcsa.org</a></td>
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<tr>
<td>Area Agency on Aging of Northwest Michigan</td>
<td>Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford</td>
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<tr>
<td>1609 Park Drive</td>
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<tr>
<td>PO Box 5946</td>
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<tr>
<td>Traverse City, MI 49696-5946</td>
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<tr>
<td>Phone: 231-947-8920 1-800-442-1713</td>
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<td>Fax: 231-947-6401</td>
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<td>Web: <a href="http://www.aaanm.org">www.aaanm.org</a></td>
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<td>Northern Lakes Community Mental Health/</td>
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<td>Northern Health Care Management</td>
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<tr>
<td>105 Hall Street, Suite D</td>
<td></td>
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<tr>
<td>Traverse City, MI 49684</td>
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<tr>
<td>Phone: 231-933-4917 or 800-640-7478Fax: 231-995-7900</td>
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<tr>
<td>Web: <a href="http://www.northernlakescmh.org">www.northernlakescmh.org</a></td>
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<td>Senior Resources</td>
<td>Muskegon</td>
</tr>
<tr>
<td>560 Seminole Rd.</td>
<td>Oceana</td>
</tr>
<tr>
<td>Muskegon, MI 49444</td>
<td>Ottawa</td>
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<tr>
<td>Phone: 231-739-5858 1-800-442-0054</td>
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<tr>
<td>U.P. Area Agency on Aging (UPCAP)</td>
<td>Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft</td>
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<tr>
<td>2501 14th Avenue South</td>
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<tr>
<td>PO Box 606</td>
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<tr>
<td>Escanaba, MI 49829</td>
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<td>Phone: 906-786-4701 1-800-338-7227</td>
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<td>Fax: 906-786-5853</td>
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<td>Web: <a href="http://www.upcap.org">www.upcap.org</a></td>
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**LEGAL BASE**

**MA**

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

Medicaid Only

This is a MAGI related Medicaid category.

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

AUTOMATIC ELIGIBILITY

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

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

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

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

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

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

Do not delay authorizing MA for newborns.

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

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

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

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

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

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

Local Office Responsibilities

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

RENEWAL

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

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

LEGAL BASE

MA

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

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.
PHILOSOPHY OF FIP PROGRAM

FIP

The department goal is to assist families towards self-sufficiency. Self-sufficiency is best accomplished by:

- Adults being employed,
- Securing court-ordered child support for each child where appropriate,
- Providing life skills training for those needing it including minor and teen parents, and
- Ensuring that all children have access to medical care.

As families become self-sufficient, we will meet the legal mandates such as work participation rates, reducing subsequent out of wedlock pregnancies, ensuring that teens are completing secondary education, and ensuring that minor parents are living in appropriate settings.

Role of the FIS

The Family Independence Specialist (FIS) uses a Strength Based Solution Focused Approach and will:

- Identify goals with the client and develop plans for self-sufficiency, expressed in the client’s own words, when possible. This will occur through the interactive solution focused process. When setting goals with the client, keep in mind that the goals should be clear, simple, specific, measurable, realistic, positive and important to the client. Clients must see their role in these goals for themselves to change concrete behavior. Monitor progress toward meeting the goals identified in the Family Self Sufficiency Plan (FSSP).
- Modify or add to the plan, when there is a change in circumstances; or upon discovery of a challenge or concern.
- Determine eligibility for financial and medical programs.
- Identify and or authorize support services to help families carry out their plan.
• Provide direct services such as counseling and problem solving when needed. This is especially helpful for clients who are in noncompliance.

• Identify resources and initiate referrals for community services, including employment and training, and domestic violence counseling.

• Explore options and authorize child care.

Case managers should focus on building a trusting relationship with families using the solution-focused interviewing skills. This is best accomplished by doing an interview. Building trust requires accepting clients for who they are, and understanding they are key in identifying their own needs and strengths in moving toward self-sufficiency. Case managers will help clients discover their needs and build on their strengths, recognizing that open and frequent communication is necessary to build the family’s trust.

Use all available means in facilitating communications and trust. Such contact and communication are effective in developing and monitoring plans/contracts while reducing negative consequences. However, consequences will be used to reinforce the concept that clients are responsible for their own lives. Whenever possible, discretion has been left to staff to work with families. Discretion includes the frequency and types of contact beyond mandatory client contacts.

As the relationship with the client begins to build, the client may begin to disclose other barriers to self-sufficiency, such as domestic violence. The Michigan Department of Health and Human Services (MDHHS) believes all individuals have a right to be safe from violence. Domestic violence is a critical issue for many people. Victims of domestic violence need services that enhance their safety and self-sufficiency.

If there is a disclosure of domestic violence, and the client is not receiving services, the FIS must refer the family to the appropriate community services. Determine if domestic violence presents a barrier to cooperation with agency requirements, such as pursuit of child support (BEM 255), participation in employment and training activities (BEM 230A), and third-party liability (BEM 257).
Interviews

Interviews provide the best opportunity to interact with a client. Interviews help establish a trusting relationship which will open the door to an increased level of participation and willingness to discuss the family concerns.

While doing the interview, you can celebrate successes and identify challenges the family faces. Review and monitor the FSSP goals and activities and help the clients make a plan for removing any obstacles they perceive.

Topics for Discussion

When talking with a client, there are numerous topics for you to discuss, such as:

- The successes each adult has had since the previous contact for example, a plan for employment and, if they are employed, what progress have they made toward a raise, promotion, increased hours, or the results of any evaluations? This discussion will also give you an opportunity to make sure the correct earned income is in the benefit budgets.

- Any concerns or challenges that have come up which slowed down or hindered the family's movement to self-sufficiency. To meet those challenges, develop a plan. Compliment the family on any successes they had in dealing with the challenges or concerns. If a challenge or concern continues to exist, discuss and create a plan using the Solution Focused Approach to help the family meet these challenges.

- Discuss goals that the adults have for themselves which they believe will lead to self-sufficiency, what steps they need to take to achieve these goals, and how confident and motivated they are in achieving these goals (scaling questions).

- Involve the family in a discussion of the children and the importance of education. Ask the adult and the children, if present, how each child is doing in school, what their interests are and what extra-curricular activities they are participating in. Together with the family, talk about resources or opportunities for the children in their areas of interest.
This discussion will provide an opportunity for you to provide positive feedback and compliments. It will increase participation and involve the entire family in the plan to support each other. Inform them of the Tuition Incentive Program and other educational opportunities that are available for children to attend college if applicable.

- Ask what personal and community resources they know of that may be available to help the family remove their challenges and concerns, meet their goals, and move toward self-sufficiency. If the client does not know about community resources, help them develop a plan that will teach them to find these resources.

- Discuss child care arrangements that the parent has made for care of the children while the parent is employed, child care arrangements during school breaks, and back-up plans for child care if the provider is ill or otherwise unable to care for the children.

- Explain the Federal Earned Income Tax Credit and how receiving this credit throughout the year can increase monthly income. Help them find out how to apply for the credit.

- Discuss how to access the advanced education and training opportunities that are available for persons meeting the participation requirements.

- Discuss support services that are available while persons are participating in employment-related activities.

- Discuss the children and their adjustment to having the parent employed or otherwise out of the home and participating in employment-related activities.

- The children and their relationship to a stepparent or other adult living in the home can also be a topic of discussion and planning with the parent.

- Let clients know there are family and/or community support groups that are available in cases of emergencies.

**For ineligible grantee cases**, the focus of the interview should be a discussion about the children and resources that may be available to the family and/or the ineligible grantee, for example,
support groups that are available to grandparents who are raising grandchildren.

**In absent parent situations**, discuss the importance of parenting time and the involvement of both parents in a child's life. Discuss the relationship between the absent parent and child. Include steps in the plan to make it better. This discussion is also important for ineligible grantee cases. Does the child visit the parent? Are there custody issues? Is the relative interested in securing guardianship of the child, if appropriate?

In all interviews, including ineligible grantee situations, be alert to key indicators that signal problems in the home which may indicate a need for preventive services or require intervention by protective services. Be alert to situations of domestic violence, substance abuse by any family member, and behavioral problems of children or conflicts between family members.

Ask for the client’s explanation of events but if you believe that the home environment requires preventive or protective services involvement, a referral must be made.
DEPARTMENT PHILOSOPHY

Minor parents and their children should live under adult supervision to ensure that they are in a safe, nurturing environment. Adult parents should act as the caretakers of their minor children and provide maintenance, physical care, and guidance, even after a minor child has become a parent. When living with a parent, stepparent, or legal guardian is not possible, the minor parent and child should live in another adult-supervised living arrangement.

DEPARTMENT POLICY

FIP

All minor parents must live in an adult-supervised living arrangement as a condition of eligibility. A minor parent and the dependent child in his or her care must live with the minor parent's parent, stepparent, or legal guardian or have good cause to live elsewhere. A minor parent who has good cause for not living with a parent, stepparent, or legal guardian must live in an acceptable adult-supervised living arrangement.

A minor parent living in a parent's or stepparent's home may not receive assistance on his/her own behalf, but must be treated as the dependent child of the parent or stepparent. A minor parent living in an adult relative's or legal guardian's home must be included as a dependent child in the relative's/legal guardian's group if the relative/legal guardian also receives benefits under the Family Independence Program (FIP); see BEM 210, Multi-Generation and Combined Groups.

DEFINITIONS

Minor Parent: a person under age 18 who is not emancipated and is either the parent of a dependent child living with him/her or is pregnant.

A person under age 18 is emancipated if:

- Ever validly married.
- Emancipated by court order.
- On active duty with the Armed Forces of the United States.

Acceptable Adult-Supervised Living Arrangement: a Michigan Department of Health and Human Services (MDHHS) -approved
living arrangement, other than the home of the parent, stepparent, or legal guardian, in which the minor parent and child live with an adult who acts as a parent to the minor parent. See Acceptable Living Arrangements in this item for specific criteria.

**Adult Relative:** a person age 18 or over who is related to the minor parent as grandparent (including great and great-great), aunt or uncle (including great and great-great), sibling or stepsibling, nephew or niece, first cousin, first cousin once removed, or the parent of the putative (alleged) father.

**Supervising Adult:** a person who accepts responsibility for the supervision of a minor parent, and is an adult relative of the minor parent or is an unrelated person age 21 or over.

**INFORMING CLIENTS**

When a minor parent applies for assistance, inform them of all of the following:

- The requirement to live under adult supervision.
- The circumstances under which there is good cause for permitting the minor parent to live in an adult-supervised setting other than the home of a parent, stepparent, or legal guardian.
- The requirement to attend school if the minor parent has not completed high school.

When a minor parent who is not living with a parent, stepparent, or legal guardian applies for assistance, inform him/her that MDHHS will determine good cause. Do not approve assistance, except for MA and FAP.

**REFERRALS**

Record information about the minor parent’s circumstances in Bridges.

Bridges will generate a task/reminder when a CPS referral is needed. See the Administrative Policy Manual Human Resources (APR) - Mandated Reporters Child, for information regarding how to report suspected child abuse and neglect.
Protective Services Complaint

A complaint to Children's Protective Services (CPS) is required if any of the following are true:

- There is reason to suspect that either the minor parent or the child is endangered, abused, or neglected.
- The financial needs, safety, and security of the minor parent and child cannot be assured during the period of eligibility determination for FIP.
- The minor parent became pregnant when she was under the age of 12.
- The parent, stepparent, or legal guardian will not allow the minor parent to live in his/her home.

Law Enforcement

A referral to local law enforcement is required if:

The minor parent became pregnant when she was between the ages of 12 and 16. The purpose of this referral is so local law enforcement can determine if the situation should be investigated or referred to the prosecuting attorney if the minor parent is a victim of criminal sexual conduct. Local offices must develop guidelines for such referrals with the local prosecuting attorney. Use the DHS-1266, Law Enforcement Referral, form to initiate this referral.

Minor Parent Coordinator

Local offices must designate a minor parent coordinator to coordinate the delivery of services to minor parents. Refer all minor parents who refuse to comply with the requirements of this policy or withdraw their request for assistance to the minor parent coordinator. The department offers services to minor parents whether eligible for assistance benefits or not.
GOOD CAUSE REASONS - LIVING ARRANGEMENT

The good cause reasons for not requiring a minor parent and his/her child to live with a parent, stepparent, or legal guardian are:

- The minor parent is living with another adult relative with parental consent.

- The minor parent has no living parent, stepparent, or legal guardian whose whereabouts is known. At a minimum, do a Bridges Individual Inquiry on the parent's/stepparent's/legal guardian's name(s) to attempt to locate them.

- The parent, stepparent, or legal guardian will not allow the minor parent to live in his/her home. A CPS complaint is required because of neglect. Do not delay other actions or the eligibility determination awaiting the CPS determination.

- The physical or emotional health or safety of the minor parent or dependent child would be jeopardized if they lived with the minor parent's parent, stepparent, or legal guardian because:
  - An investigated CPS complaint (confirmed or unconfirmed) indicates that the minor parent or other children in the household did not receive adequate food, clothing, medical care or other necessities or were physically, emotionally, or sexually abused. An unconfirmed complaint must have indicated that there was risk to the children although the allegations could not be substantiated.
  - The return of the minor parent and child to the parent's, stepparent's, or legal guardian's home would result in violation of the terms of a lease or violation of local health or safety standards.
  - Law enforcement officers have verbally verified that there is probable cause to believe that the home of the parent, stepparent, or legal guardian is the scene of illegal activity.

- The minor parent is participating in a licensed substance abuse treatment program which would no longer be available if he/she returned to the parent's, stepparent's or legal guardian's home.
• The minor parent's parent, stepparent or legal guardian lives in another state.

Reevaluate good cause if it is discovered that circumstances regarding the good cause reason have changed.

Local Office Exception

The local office director may grant an exception to this policy and allow the minor parent to live independently when all of the following are true:

• Attending school full-time.
• Participating in a MDHHS or Teen Parent services plan.
• Moving would require the minor parent to change schools.
• The independent living arrangement will provide adequate structure and safety for the minor parent and child.

Follow local office procedure for requesting such exceptions. Local offices must maintain a record of these exceptions for annual reporting to the legislature.

DETERMINING GOOD CAUSE - LIVING ARRANGEMENT

The standard of promptness is 30 calendar days to determine if the minor parent has good cause for not living in the home of the parent, stepparent, or legal guardian. The client must move into the home of the parent, stepparent, or legal guardian unless he/she has good cause for refusing. Document good cause determinations in the case record.

At local office discretion, determinations of good cause and evaluations and supervision of acceptable living arrangements may be assigned to children's services staff instead of the specialist.

No Good Cause

If the minor parent does not have good cause, do all of the following:

• Record the fact that there is no good cause in Bridges.
• Run EDBC and certify the FIP denial in Bridges.
• Offer services to assist the minor parent to return home.
• Make a referral to a teen parent contractor or other community services to work with the minor parent, if appropriate.
• Make a referral to the local office minor parent coordinator if the client refuses to comply with the requirements.

**Good Cause Granted**

If the minor parent has good cause:

• Inform the minor parent that:
  - He/she must live in an adult-supervised living arrangement approved by the department.
  - The department will assist him/her in locating an acceptable adult-supervised arrangement if necessary.
  - FIP cannot be opened until the minor parent is living in an acceptable adult-supervised living arrangement.
• Determine if the minor parent's current living arrangement is acceptable.
• Help the minor parent to select an acceptable living arrangement, if necessary.

Minor parents age 16 and over have primary responsibility for finding and selecting an acceptable adult-supervised living arrangement. Assist the minor parent if necessary.

Notify your area service center if the minor parent, with the department's assistance, is unable to locate an acceptable adult-supervised living arrangement within 30 calendar days.

**ACCEPTABLE LIVING ARRANGEMENTS**

A minor parent cannot live with the child's other parent, regardless of the other parent’s age, unless both reside in an acceptable adult-supervised living arrangement. The child's adult parent may not function as the supervising adult to the minor parent.

Acceptable adult-supervised living arrangements are:
- The home of an adult relative.

- The home of an unrelated adult age 21 or over. These arrangements include private homes and cooperative and congregate living facilities.

- A licensed foster family home or foster family group home.
  
  Supervision of a minor parent in family foster care may be purchased from a licensed private child placing agency.

- A child welfare-licensed residential facility.

If placement in a foster home or residential facility is selected, a DHS-3813, Voluntary Placement Agreement, must be signed by the minor parent's parent or legal guardian. If the only acceptable living arrangement is in a foster home or residential facility and if the parent/legal guardian refuses to sign an agreement, make a referral to CPS for a petition for court jurisdiction.

DETERMINING ACCEPTABLE LIVING ARRANGEMENT

Determine if the minor parent's living arrangement is acceptable. The living arrangement must be one of those described in ACCEPTABLE LIVING ARRANGEMENTS in this item and must do all of the following:

- Support the minor parent's efforts to complete a high school education or participate in employment and training opportunities.

- Support the minor parent's efforts to learn parenting skills and enhance decision-making skills.

- Provide a safe environment which supports the minor parent's responsibilities to provide food, clothing, and medical care to the child.

Use the guidelines under Safety Assessment and Supportive Environment Assessment in this item to determine if the living arrangement meets the above criteria.
Safety Assessment

The living arrangement must not include individuals (other than parents, stepparents, or legal guardians when reunification is appropriate) who are listed as perpetrators on the CPS Central Registry. Request a check of all individuals over age 18 in the home against the CPS Central Registry.

If it is suspected at any time that either the minor parent or the child is endangered, abused, or neglected, make an immediate referral to CPS. Some indications that a CPS referral should be made are:

- The child or minor parent has marks or bruises which appear suspicious.
- The child is fearful of the parent or other people living in or having access to the home.
- The living conditions are hazardous or present a public health threat.
- The minor parent or child appear malnourished.
- The minor parent or another person living in or having access to the home exhibits violent behavior.
- The minor parent describes or acts toward the child in predominately negative terms or has unrealistic expectations, or the supervising adult or another person in the household exhibits similar behavior to the minor parent.
- Family members or household members refuse access to the minor parent or child, or there is reason to believe that the minor parent is about to flee, or the minor parent's child's whereabouts cannot be ascertained.
- The minor parent is unwilling or unable to meet his/her own or the child's needs for food, clothing, shelter, or medical care.
- The minor parent's use of alcohol or drugs seriously affects his/her ability to supervise, protect, or care for the child.
- The minor parent fails to protect himself/herself or the child from physical harm or threatened physical harm, neglect, or sexual abuse by other family or household members or others having access to the child.
• The minor parent does not provide the supervision needed to protect the child from potential harm:

  • The minor parent does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (for example, allows the child to wander outdoors alone, play with dangerous objects, or be exposed to other serious hazards).

  • The minor parent leaves the child alone in the home.

  • The minor parent makes inadequate/inappropriate child care arrangements or demonstrates very poor planning for the child's care.

• The minor parent has experienced incidents of domestic violence.

Supportive Environment Assessment

Determine if the living arrangement is a supportive environment for the minor parent. A supportive environment is one in which:

• The minor parent has a support person, such as the supervising adult, family members, neighbors, or other people in the community who are available to support and help the minor parent.

• The supervising adult discusses issues of concern with the minor parent and solutions are identified and pursued.

• The supervising adult does not take over parenting of the minor parent's child but demonstrates and discusses appropriate parenting techniques and skills.

• The supervising adult establishes reasonable house rules regarding visitors, curfews, phone usage, and care of the minor parent's child.

• The supervising adult is available to the minor parent when the minor parent experiences a problem.

• The minor parent has child care and transportation resources to enable attendance at school or work.
RESPONSIBILITIES OF THE SUPERVISING ADULT

By agreeing to be the supervising adult, a person assumes certain responsibilities. These must be explained to and accepted by the supervising adult. These responsibilities include:

- The supervising adult agrees to be the protective payee of the minor parent's FIP grant. As protective payee, the supervising adult must manage the minor parent's grant and help the minor parent learn to manage money.

- The supervising adult agrees to report any suspicion of abuse or neglect of the minor parent or his/her child to CPS.

- The supervising adult agrees to assist and facilitate the minor parent's school attendance and participation in other activities required by MDHHS. At a minimum, the supervising adult will not place any expectations on the minor parent which will impede attendance at school or negatively affect the minor parent's ability to care for his/her child.

- The supervising adult must acknowledge that the MDHHS is not responsible for any payments or expenses beyond those specifically included in the minor parent's FIP grant.

- The supervising adult has the authority and responsibility to set reasonable house rules regarding visitors, curfews, phone usage, and other issues necessary to maintain a safe and stable home. If the minor parent refuses to comply with the rules or if other disputes arise, the supervising adult or the minor parent may request the intervention of the specialist. If they are unable to resolve the issue, the supervising adult may request the minor parent to move to another appropriate setting.

- The supervising adult is not responsible for providing child care. The minor parent may be eligible for child care payments according to policies of the Child Development and Care program.

Obtain a signed, written agreement specifying the responsibilities and expectations for the minor parent, the supervising adult, and the department.
PAYMENTS

The minor parent’s FIP grant must be paid to a protective payee. The supervising adult should be the protective payee; see BAM 420.

SCHOOL ATTENDANCE

As a condition of eligibility, a minor parent must attend high school full-time. See BEM 245 for the definition of high school and full-time.

Minor parents who have graduated from high school must participate in Partnership. Accountability. Training. Hope. (PATH).

Failure to meet the above requirements causes ineligibility for the minor parent and his/her child. This requirement applies to all minor parents, including those who are living with a parent, stepparent, legal guardian, or other adult relative and are not the grantee.

If an applicant minor parent will not agree to attend school deny or close the FIP Eligibility Determination Group (EDG). A minor parent whose FIP is closed for this reason must reapply and enroll in school before assistance can be granted; see BEM 245, Regaining FIP Eligibility After Previously Failing Student Enrollment/Attendance Requirement.

VERIFICATION REQUIREMENTS

Verify good cause for living arrangement reasons as needed.

Verify school enrollment and attendance at application, redetermination, and at each birthday.

VERIFICATION SOURCES

- DHS-3380, Verification of Student Information.
- Telephone contact with the school.

School Attendance

See BEM 245.
LEGAL BASE

FIP

42 USC 608(a)(4)
42 USC 608(a)(5)
MCL 380.10
MCL 380.1561
MCL 400.57 et seq.
Mich Admin Code, R400.3112
45 CFR 233.107
DEPARTMENT PHILOSOPHY

The Michigan Department of Health and Human Services (MDHHS) believes that children are best served by living in supportive family settings. The mutual responsibility of family members for each other and their commitment to caring for each other are key to building strong families. Parents are responsible for the care and support of their minor children. In the absence of parents, children may be cared for by other adults having specific relationships to the children. Spouses are responsible for each other. All needy family members living together are expected to share income, assets, and expenses. The limited nature of the Family Independence Program is essential to meeting the goals of the program.

DEPARTMENT POLICY

FIP

Group composition is the determination of which individuals living together are included in the FIP eligibility determination group/program group and the FIP certified group. To be eligible for FIP both of the following must be true:

- The group must include a dependent child who lives with a legal parent, stepparent or other qualifying caretaker.

- The group cannot include an adult who has accumulated more than 60 TANF funded months, beginning October 1, 1996 or any other time limits in the Family Independence Program; see BEM 234.

DEFINITIONS

Caretaker

A caretaker is a legal parent or stepparent living in the home, or when no legal parent or stepparent lives in the home, another adult who acts as a parent to a dependent child by providing physical care and supervision. See Who May Be a FIP Caretaker? in this item.

Certified Group

The certified group means those individuals in the FIP EDG who meet all non-financial FIP eligibility factors. Countable income and
assets of certified group members are considered in determining FIP eligibility. Certified group members have a FIP EDG participation status of Eligible Child or Eligible Adult.

**Dependent Child**

A dependent child is an unemancipated child who lives with a caretaker and is one of the following:

- Under age 18.
- Age 18 and a full-time high school student. See BEM 245, for definition of high school.

**Note:** See definition of Emancipated, later in this item.

**Eligibility Determination Group (EDG)/Program Group**

The EDG means those individuals living together whose information is needed to determine FIP eligibility. Based on data entry, and rules programmed into the system, Bridges assigns an EDG participation status to each member of the household.

**EDG Participation Status**

The FIP EDG participation status explains the role the individual plays in the FIP eligibility determination. Individuals having a FIP EDG participation status other than Excluded Adult or Excluded Child, are included in the FIP EDG. The countable income and assets of individuals having an Eligible or Disqualified FIP EDG participation status are considered in determining FIP eligibility.

**Note:** The FIP payment standard is based on the grantee’s EDG participation status and the FIP certified group size; see RFT 210.

**Emancipated**

A child is emancipated if any of the following:

- Ever validly married.
- Emancipated by court order.
- On active duty with the armed forces of the United States.
Joint Physical Custody

Joint physical custody occurs when parents or other caretakers alternate taking responsibility for the child’s day-to-day care and supervision in separate homes. It may be included in a court order or may be an informal arrangement between parents or other caretakers.

Living Together

Living together means sharing a home where family members usually sleep except for temporary absences.

Primary Caretaker

The primary caretaker is the caretaker who is primarily responsible for the child’s day-to-day care and supervision in the home where the child sleeps more than half of the days in a month, when averaged over a twelve-month period. The twelve-month period begins at the time the determination is being made.

Absent Caretaker

Once a caretaker is determined to be the primary caretaker, the child’s other caretakers are considered absent caretakers.

Temporary Absence

A temporarily absent person is considered to be living in the home when all of the following are true:

- Individual’s location is known.
- There is a definite plan to return.
- The individual lived with the FIP EDG before the absence (newborns are considered to have lived with the FIP EDG).
- The absence has lasted or is expected to last 30 days or less.

*Exception:* An individual is still considered to be living in the home, even after 30 days if the absence reason is any of the following:

- In the hospital (including a psychiatric hospital).
In a residential substance abuse treatment center.

Absent for school or training.

Absent due solely to active duty in the uniformed services of the U.S.

A child who is living apart from a parent due solely to the parent residing in a domestic violence shelter.

**Note:** A dependent child who is temporarily absent, can be considered living with only one caretaker. When a child sleeps in the home of multiple caretakers who do not live together, Bridges makes a primary caretaker determination; see Determining Primary Caretaker in this item.

**Exception:** A court ward is under the care and supervision of the court. Even if they meet the temporary absence requirements above, the child is NOT considered to be living in the parent’s home.

### FAILURE TO REPORT CHILD’S ABSENCE

A parent or other FIP caretaker, must notify the department of a child’s absence from the home within five days of the date it becomes clear to the caretaker that the child will be absent for 30 days or more. If the child’s absence does not meet temporary absence requirements to be considered in the home, the caretaker who fails to notify the department within five days is disqualified for one month.

### WHO IS IN THE FIP EDG?

The FIP EDG includes all household members whose information is needed to determine FIP eligibility. Based on data entered in the system, Bridges determines all of the following:

- Each household member’s FIP EDG participation status.
- Which individuals’ income and assets are considered.
- Which individuals’ needs are considered.
- Which individuals’ relationship(s) to other members are considered.

These determinations are made based on the individual’s:
- Age.
- School attendance.
- Relationship(s) to other household members.
- Program Request status.
- Receipt of other program benefits such as SSI, child foster care payments or Independent Living Stipend.
- Criminal justice disqualifications.
- FIP time limit.

**Mandatory FIP EDG Members**

When cash assistance is requested for a dependent child, or a dependent child is a mandatory FIP EDG member, all of the following individuals who live together are in the FIP EDG:

- Dependent child.
- Child's legal parent(s).
- Child's legal siblings who meet the definition of a dependent child (siblings have at least one legal parent in common).
- Legal parent(s) of the child’s siblings.
- Child's legal stepparent, even after death of or divorce from the parent.
- Child's legal stepsiblings, who meet the definition of a dependent child, even after death of or divorce from the parent.
- Child's child.

**Example:** Sally is 18 and attends high school full-time. Sally and her one-year-old daughter live with her mother and 13-year-old brother. Sally applies for cash assistance for herself and her daughter. Everyone in the household is a mandatory FIP EDG member because Sally has requested cash for her dependent child, making Sally a mandatory EDG member; and Sally meets the definition of a dependent child, making her brother and mother mandatory FIP EDG members.
Refusal of any FIP EDG member to provide information needed to determine FIP eligibility causes ineligibility for the entire FIP EDG.

**Exception:** Failure to cooperate with the following eligibility requirements have specific penalties, not always FIP denial or closure:

- Employment and/or family self-sufficiency requirements.
- Social Security Numbers.
- Child Support.
- Third Party Liability.
- Caretaker’s failure to report a child’s absence timely.
- School attendance.
- Criminal justice requirements.

See Failure to Report Child’s Absence in this item and BEM 223, 228, 230A-233B, 255 and 257 for penalties for failure to meet these requirements.

There are circumstances in which a FIP certified group contains no dependent child; see FIP Certified Groups with No Child in this item.

**Who May be a FIP Caretaker?**

A legal parent or stepparent living with a dependent child is always the child’s caretaker, unless the parent is a minor. See Multi-Generation and Combined Groups in this item for exceptions regarding minor parents.

A person other than a legal parent or stepparent may be a caretaker only when the dependent child has no legal parent or stepparent in the home. A caretaker in the child’s home, other than a parent or stepparent must be one of the following:

1. A relative who is at least age 18 and legally related to the child by blood, marriage or adoption, as any of the following:

   - Grandparent (including great or great-great).
   - Aunt or uncle (including great or great-great).
   - Sibling.
   - Stepsibling.
• Nephew or niece.
• First cousin or first cousin once removed.
• The spouse of any of the above, even after the marriage is ended by death or divorce.
• The parent of the child’s putative (alleged) father.

Note: When a court order has terminated parental rights, the parent and child are no longer legally related. However, the child’s relationship to other relatives is not affected.

2. The child’s legal guardian(s).

3. An adult(s) who is at least age 21 and whose petition for legal guardianship of the child is pending.

4. An adult, having none of the qualifying relationships above, with whom MDHHS children’s services has placed a child, subsequent to a court order identifying MDHHS as responsible for the child’s care and supervision. This relationship is known as unrelated caregiver, formerly fictive kin. Occasionally, a child is included in a FIP EDG when there is not a qualifying relationship to the caretaker due to mandatory EDG member policy.

Example: Anthony applies for cash assistance for his son Tony and Tony’s half-sister Angela. Anthony was never married to Tony’s mother and she is not in the home. Because Tony and Angela are half siblings, Angela is a mandatory FIP EDG member, even though there is no qualifying relationship between Angela and Anthony.

Receipt of Other Program Benefits

Receipt of the following types of other program benefits or services affects an individual’s FIP EDG participation status.

• Children’s Services Independent Living Stipend.
• SSI.
• Child foster care payments.
• MDHHS children’s services for a child in an out-of-home foster care placement due to abuse or neglect, when there is a plan to return the child to the parent’s home.
Independent Living Stipend

A FIP EDG member who is a recipient of an Independent Living Stipend has an EDG participation status of Other Adult. The income, assets and needs of this individual are not considered in determining eligibility for FIP, however, their relationship to other FIP EDG members is considered.

Example: Linda, a former foster child, lives independently and receives an Independent Living Stipend. Linda has a baby daughter in the home. There is no allowance for the child in the Independent Living Stipend. Even though Linda cannot receive FIP for herself, she can receive ineligible grantee FIP for the child because she is the dependent child’s caretaker.

SSI Recipients

A FIP EDG member, who receives SSI, has a FIP EDG participation status of Other Adult or Other Child. The income, assets and needs of an SSI recipient are not considered in determining eligibility for the FIP EDG. However, their relationships to other EDG members are considered.

Example: An unmarried couple has one child in common. Paternity has been established. The child receives SSI. The child’s relationship to the parents forms a valid FIP EDG, even though the SSI recipient cannot be in the FIP certified group. The SSI recipient’s relationship to the parents makes them mandatory FIP EDG members.

Example: SSI recipient has one child. The SSI recipient cannot be in the FIP certified group; however, the SSI parent’s relationship to the dependent child forms a valid FIP EDG.

Note: Request cash assistance for the SSI child, even though the child will not be in the FIP certified group.

Children’s Foster Care Payment Recipient

A recipient of children’s foster care payments has a FIP EDG participation status of Excluded Child. The income, assets, needs and relationships to other household members are not considered. This child has no effect on FIP eligibility determination.
Parent of Child in
Out-of-Home
Foster Care
Placement

The legal parent and/or stepparent of a child in an out-of-home foster care placement due to abuse or neglect forms a valid FIP EDG, as long as there is a plan to return the child to the parent/stepparent’s home up to twelve months from the date of removal. When there is no basis for FIP eligibility except for the parent’s relationship to the child in out-of-home foster care placement, the child has a FIP EDG participation status of Other Child on the parent's case. If the foster care plan is to return the child to the parents' home, the parent/stepparent may be eligible for FIP based on the relationship to the child in foster care; see FIP Certified Groups with No Child in this item.

**Note:** Request cash assistance for the foster care child on the parent's case even though the child will not be in the FIP certified group.

Optional Certified Group Members

A needy caretaker other than a parent or stepparent may request cash assistance and be included in the FIP certified group. The caretaker’s spouse and dependent children living in the home must also be included in the FIP certified group when the caretaker is included. When FIP eligibility is based solely on the presence of a child placed in the home by children’s services, the adult is in the FIP EDG for relationship purposes, but cannot be in the FIP certified group. FIP for court-ordered unrelated caregivers is limited to the ineligible grantee payment standard. If there are other children in the home who have different relationships to this caretaker; see Multi-Generation and Combined Groups in this item.

DETERMINING PRIMARY CARETAKER

The primary caretaker is the person who is primarily responsible for the child’s day-to-day care and supervision in the home where the child sleeps more than half the days in a month, when averaged over a twelve-month period. The twelve-month period begins at the time the determination is being made.
When a child spends time in the home of multiple caretakers who do not live together (such as joint physical custody or parent/grandparent), Bridges determines the primary caretaker based on the number of days per month a child sleeps in the home.

Accept the client’s statement regarding number of days the child sleeps in the caretaker’s home unless questionable or disputed by another caretaker.

**Child’s Normal Sleep Time**

When a caretaker works during a child’s normal sleep hours, include the nights the child sleeps away from home when due solely to the caretaker’s employment, as nights slept in the home of the caretaker.

**Vacations/Other Absences**

Vacations or other time a child spends away from the primary caretaker does not change the result of the primary caretaker determination, unless the child is away, or expected to be away from the home for more than 30 consecutive days.

Once a caretaker is established as primary, the child’s other caretakers are considered absent caretakers.

Only the primary caretaker can receive FIP for a child.

**Absent Caretakers**

*Exception:* If otherwise eligible, an absent caretaker may receive FIP for a child when both of the following are true:

- The child lives with the absent caretaker for more than 30 consecutive days.
- The child does not meet temporary absent requirements to be considered living with the primary caretaker.

**Caretaking Time Shared Equally**

If the child sleeps in the home of multiple caretakers an equal number of days in a month, when averaged over a twelve-month period, such as every other week, the caretaker who applies and is certified eligible first is the primary caretaker for that program.
Note: It is possible to have a different primary caretaker for different programs

Caretaking Time Disputed

When the number of days per month a child sleeps in the home of multiple caretakers is questionable or disputed, give each caretaker the opportunity to provide evidence of their claim. Base primary caretaker determination upon best available information and evidence supplied by the caretakers; see Verification Sources in this item.

Example 1: Joey is seven years old and lives with Mom during the school year. He spends eight weeks each summer with Dad. Joey returns to Mom’s home two days per week during this time with Dad. Joey sleeps in Mom’s home more than half the days in a month, when averaged over the next twelve months. Mom is the primary caretaker and continues to receive assistance for Joey through the summer.

Note: If Joey does not return to Mom’s home at least once every 30 days, he is no longer considered to be living with Mom. If Joey is in Dad’s home for more than 30 consecutive days, Dad could apply and receive assistance for Joey.

Example 2: Eric is ten years old. His mom works during the week. Eric’s mom drops him off at his grandmother’s house on Sunday evening and picks him up on Friday evening. Eric’s grandmother is primarily responsible for his care and supervision in the home where he sleeps more than half the days in a month when averaged over the next twelve months. Eric’s grandmother is the primary caretaker. His mom is an absent caretaker.

Note: If Mom works during Eric’s normal sleep hours, and he is only at Grandma’s to sleep while mom works, he is not there all week. Mom is the primary caretaker. Grandma is providing child care.

Changes in Primary Caretaker

Re-evaluate primary caretaker status when any of the following occur:

- There is a change in the number of days per month the child sleeps in a caretaker’s home.
• A second caretaker disputes the first caretaker’s claim of the number of days the child sleeps in his/her home.

• A second caretaker applies for assistance for the same child.

**Example 1**: Tommy has lived in his Mom’s home except for weekends for the past several years. He is now fourteen and has become a discipline problem. Mom and Dad agree that it would be better for Tommy to live with Dad except weekends. Dad is now the primary caretaker. Mom is now an absent caretaker.

**Example 2**: Mom is receiving FIP for her six year old son, Austin. At application, Austin sleeps in her home more than half the days in a month, when averaged over the next twelve months. Dad is contacted by Friend of the Court regarding his ability to pay child support. Dad states that Austin sleeps in his home all week and spends weekends only with Mom. Determine the number of days per month Austin stays in each parent’s home based on best available information and evidence supplied by both parents.

**Legal Guardian**

Whenever a FIP Eligible Child has a legal guardian, the legal guardian must be the protective payee for the FIP grant; see BAM 420. This applies whether or not the guardian resides with the FIP group and continues until guardianship is terminated. Verify termination of legal guardianship prior to terminating the protective payee; see Verification Sources in this item.

**Note**: When a legal guardian is receiving FIP for a child, and the parent of the only eligible child returns to the home, enter the parent’s data on the legal guardian’s Bridges case and run eligibility. The legal guardian’s FIP will be terminated. If the parent applies and is found eligible for FIP, the legal guardian must be made the protective payee for the parent’s FIP.

**MULTI-GENERATION AND COMBINED GROUPS**

When an unemancipated minor parent and the parent’s child (see BEM 201) live with a legal parent(s) or stepparent, all three generations compose the group. The unemancipated minor parent may not be the grantee for FIP when living with a parent(s) or stepparent; the unemancipated minor parent is the dependent child of the parent(s) or stepparent.
When a minor parent lives with a qualifying FIP caretaker other than a parent or stepparent, and the caretaker requests cash assistance for themselves, the minor parent is a dependent child. If the minor parent’s non-parent caretaker does not request cash assistance, or is ineligible for FIP, the minor parent may apply, be treated as an adult and be the FIP grantee; see BEM 201.

When a person is caring for two or more dependent children who are not legally related to each other as siblings or stepsiblings, all children for whom the caretaker requests cash assistance are in a single FIP EDG and certified group. The caretaker, however, is not required to request assistance for all children who are not related to each other as siblings or stepsiblings.

FIP Certified Groups with No Child

A FIP certified group may be composed of only adults under specified circumstances. Groups with no eligible child may consist of the following:

- A pregnant woman and if married, her spouse.

  **Note:** If the pregnant woman is not a member of the certified group, such as an SSI recipient, there is no FIP eligibility based on the pregnancy.

- The caretaker(s) of a dependent child who would be eligible for FIP except for the child's receipt of SSI.

- A legal parent(s) and/or stepparent of a dependent child in an out-of-home foster care placement due to abuse and/or neglect when there is a plan to return the child to the parent's home. Eligibility based on this policy is allowed for up to 12 months from the date the child(ren) were removed.

Children’s services or the Services Inquiry screens will verify that there is a plan for reunification with the parent, at application and redetermination; see Verification Sources in this item.

**DETERMINING THE FIP CERTIFIED GROUP**

Bridges determines which members of the FIP EDG are included in the FIP certified group. A FIP EDG member, who does not meet a
nonfinancial eligibility factor or is disqualified for any reason, is not in the FIP certified group.

**Note:** An immunization penalty is not a disqualification.

### VERIFICATION REQUIREMENTS

#### Relationship

Relationship must be verified for each dependent child on the FIP EDG. Verification must establish the relationship of each dependent child to the child’s legal parent, step-parent or other qualifying caretaker.

When a child lives with the natural father, but paternity has not been legally established, the father may voluntarily complete the DHC-0682, Affidavit of Parentage; see BEM 255, Child Support, Voluntary Paternity Acknowledgement.

#### Primary Caretaker

Accept the client’s statement regarding the number of days per month a child sleeps in the home. If questionable or disputed by another caretaker, request verification from both caretakers.

#### Pregnancy

Verification of pregnancy is required when FIP eligibility is based solely on the pregnancy.

#### Guardianship Termination

Verify termination of legal guardianship before terminating the protective payee.

#### Reunification Plan

Verify at reported change, application and redetermination, that there is a plan for a child in foster care to be returned to a parent’s home.
Unrelated Caregiver Placement

Verify that a court has ordered MDHHS responsible for the care and supervision of a child(ren), and that MDHHS children’s services staff have placed the child(ren) with an unrelated caregiver at application and redetermination.

Emancipated

Verify emancipation of a child under age 18.

VERIFICATION SOURCES

Relationship

Verification must establish the relationship of each dependent child to the child's legal parent, step-parent or other qualifying caretaker. Verification sources include:

- Birth certificates.
- Michigan Birth Registry Inquiry.
- Adoption records.
- Marriage license/certificate.
- School records.
- Separation records.
- Divorce records.
- Hospital birth records.
- Affidavit of Parentage.
- Child support records.
- Court orders.
- Baptismal records.
- Immigration records.
• Any legal document that traces the child's relationship to the parent, stepparent or other qualifying caretaker.

• Other government or local agency records, newspaper records, or local histories that specify the relationship.

• Consecutively numbered I-94 cards do not prove relationship of a caregiver to a child.

Primary Caretaker

When caretaking time of a dependent child is disputed or questionable, examples of proof to consider include, but are not limited to:

• The most recent court order that addresses custody and/or visitation.

• School contact or records indicating who enrolled the child in school, first person called in case of emergency, and/or who arranges for the child's transportation to and from school.

• Child care provider contact or records showing who makes and pays for child care arrangements, and who drops off and picks up the child.

• Medical providers contact or records showing where the child lives and who usually brings the child to medical appointments.

• Other documents or collateral contacts that support/contradicts the caretaker’s claim.

Pregnancy

Statement, including expected date of delivery, from one of the following:

• Doctor of Medicine (MD).
• Doctor of Osteopathy (DO).
• Physician's Assistant (PA).
• Ob-gyn Nurse Practitioner (NP).
• Ob-gyn Clinical Nurse Specialist (NS).
• Certified Nurse-Midwife.
• Registered Nurse (RN).
• DHS-49, Medical Examination Report; DHS-54A, Medical Needs; DHS-54E, Medical Needs-PATH or other written statement may be used.
Guardianship Termination

Guardianship or other documents showing legal guardianship has been terminated.

Reunification Plan

Any document or collateral contact that verifies the services plan is to return the child to the parent’s home.

When a child in out-of-home foster care placement is active Children’s Protective Services only, assume there is a plan to return the child to the parent’s home when the field on the Services Inquiry screen Petition Filed for Termination of Parental Rights is not yes.

When the child in out-of-home foster care placement is active Children’s Foster Care, there is a plan to return the child to a parent’s home when the Services Inquiry screen shows ‘MI goal of return home’ and the ‘parent cooperation’ switch is not ‘no’.

Unrelated Placement

Verify that a court has ordered MDHHS responsible for the care and supervision of a child(ren), and that the child has been placed with the unrelated caregiver by MDHHS children’s services staff with one of the following:

- A DHS-498, Caregiver Assistance Application Cover Letter, completed by MDHHS children’s services staff.
- A copy of court documents.
- Contact with or statement from the MDHHS children’s services staff that provides the same information.

Emancipated

- Marriage certificate.
- Court order.
- Armed forces documentation.

LEGAL BASE

FIP

42 USC 608
42 USC 619
Mich Admin Code, R400.3112,.3114,.3122
MCL 400.57 *et seq.*
MCL 400.6(3) and (4)
MAGI-Related

Group composition for MAGI-related categories follows tax filer and tax dependent rules.

The MAGI related groups are:

- **Children (U19).** The income limit for children birth to age 1 is 195 percent of the federal poverty level (FPL). The income limit for a child age 1-19 is 160 percent FPL.

- **Pregnant Women (PW).** The income limit for pregnant women of any age is 195 percent FPL.

- **Parents and caretakers (PCR).** The income limit for parents and caretakers is 54 percent FPL.

- **Healthy Michigan Plan (HMP).** The income limit for adults age 19-64 is 133 percent FPL.

- **Former foster children (FCTM).** There is no income test for individuals' ages 18-26 who were in foster care in Michigan at age 18.

- **MOMS.** The income limit for pregnant women of any age is 195 percent FPL.

- **MIChild.** The income limit for children birth to age 19 is 212 percent FPL.

More information regarding income limits is available at [www.medicaid.gov](http://www.medicaid.gov).

FAMILY SIZE

The size of the household will be determined by the principles of tax dependency in the majority of cases. Parents, children and siblings are included in the same household. Parents and stepparents are treated the same. Individual family members may be eligible under different categories.
TAX FILERS AND NON-TAX FILERS

The household for a tax filer, who is not claimed as a tax dependent, consists of:

- Individual.
- Individual’s spouse.
- Tax dependents.

The household for a non-tax filer who is not claimed as a tax dependent, consists of the individual and, if living with the individual:

- Individual’s spouse.
- The individual's natural, adopted and step children under the age of 19 or under the age of 21 if a full time student.
- If the individual is under the age of 19 (or under 21 if a full time student), the group consists of individual's natural, adopted and step parents and natural, adoptive and step siblings under the age of 19 (or under 21 if a full time student).

The household for an individual who is a tax dependent of someone else, consists of:

- The household of the tax filer claiming the individual as a tax dependent, except that the individual’s group must be considered as non-filer/non-dependent if:
  - The individual is not the spouse or a biological, adopted, or step child of the taxpayer claiming them; or
  - The individual is under the age of 19 (or under 21 if a full time student) and expects to be claimed by one parent as a tax dependent and are living with both parents but the parents do not expect to file a joint tax return; or
  - The individual is under the age of 19 (or under 21 if a full time student) and expects to be claimed as a tax dependent by a non-custodial parent,
  - The individual’s group consists of the parent who has a court order or binding separation, divorce, or custody agreement establishing physical custody controls, or
• If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Core Relative

Core relatives include any of the following:

• Parent.
• Aunt or uncle.
• Niece or nephew.
• Any of the above relationships prefixed by grand, great or great-great.
• Stepparent.
• Sister or brother.
• Stepsister or stepbrother.
• First cousin.
• First cousin once removed (for example, a first cousin’s child).

A core relative may also include the spouse of any individual above, even after the marriage is ended by death or divorce. Core relatives include relationships established by adoption.

The individual’s statement regarding relationship, presence in the home and tax dependency is acceptable.

HOUSEHOLD COMPOSITION EXAMPLES

Kayla is a grandmother who claims her 20 year old daughter, Samantha and 2 year old granddaughter, Joy as tax dependents. Samantha is a full-time student. Kayla is the tax filer.

• Tax rules apply to all.
• Kayla’s group is 3. Kayla, Samantha and Joy.
• Samantha’s group is 3. Samantha, Kayla and Joy.
• Joy’s group is 2, Samantha and Joy.
Bob and Mary are married. Mary is the mother of Jane, age 22. Jane attends college in Ohio. Bob is the tax filer and claims Mary and Jane as tax dependents.

- Tax rules apply to all.
- Group is 3 for all individuals.

**SSI-Related Medicaid (MA), Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative**

Use fiscal groups and, for SSI-related MA, Group 2 Persons Under Age 21 and Group 2 Caretaker Relative, asset groups to determine the financial eligibility of a person who requests Medicaid and meets all the nonfinancial eligibility factors for an Medicaid category.

Individual family members may be eligible under different Medicaid categories.

All categories of Medicaid must be explored for each person who requests Medicaid; see *choice of category* in BEM 105.

**REFUSING INFORMATION**

**SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative**

A person about whom information necessary to determine eligibility is refused and that person's spouse and children, if living with the person, are not eligible for MA. Therefore, no fiscal or asset group is set up for them.

Failure to cooperate with SSN, support or third party resource liability requirements (BEM 223, 255, 256 and 257) may result in MA ineligibility for a person, but is not refusing information necessary to determine eligibility.

**DEFINITIONS**

**SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative**

*Child* means an unmarried person under age 18.

*Adult* means a person who is married or age 18 or older.
RULES FOR GROUPS

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

Determine the fiscal and asset groups separately for each person requesting MA. When referring to the group listings, remember:

- Only persons living with one another can be in the same group; see living with in this item.
- Certain persons cannot be fiscal or asset group members in SSI-related MA; see excluded persons in this item.
- There is no asset test for Group 2 Pregnant Women.

For all Group 2 MA categories, when a child lives with both parents who do not live with each other (for example, child lives with his mother two weeks each month and his father the other two weeks), only one parent, the primary caretaker, is in the fiscal group. Determine a primary caretaker.

The primary caretaker is the parent who is primarily responsible for the child’s day-to-day care and supervision in the home where the child sleeps more than half the days in a month, when averaged over a twelve month period. The twelve month period begins at the time the determination is being made. Vacations and visitation with the absent parent do not interrupt primary caretaker status.

Joint physical custody occurs when parents alternate taking responsibility for the child’s day-to-day care and supervision. It may be included in a court order or may be an informal arrangement between parents. A child is considered to be living with only one parent in a joint custody arrangement. This parent is the primary caretaker.

Pregnancy

Count a pregnant woman as at least two members. If multiples are expected count the woman as three, etc.
LIVING WITH

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

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

Temporary Absence

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

A person’s absence is temporary if for the month being tested:

- His/her location is known; and
- There is a definite plan for him/her to return home; and
- He/she lived with the group before the absence (Note: newborns and unborns are considered to have lived with their mothers); and
- The absence did not last, or is not expected to last, the entire month being tested unless the absence is for education, training, or active duty in the uniformed services of the U.S.

Exception: An absence is never temporary when:

- The month being tested is an L/H month (see BPG) for the absent person; or
- The absent person is in one of the following on the last day of a past month or on the processing date for current and future months:
  - Long-term care (LTC) facility.
  - Adult foster care facility.
  - Home for the aged.
  - Licensed child foster care home.
  - Child caring institution.

Therefore, the above persons (including spouses residing in the same facility) are never considered to be living with others. A child who has resided in a hospital for 30 or more days is not considered
to be living with others and is a fiscal group of one. Certify for 12 months before re-determining eligibility for the child.

**RULES FOR DEPENDENT CHILDREN**

A dependent child can be temporarily absent from only one home. When a child spends time with two parents who do not live together, a primary caretaker must be determined. Scheduled vacations and visitation do not interrupt primary caretaker status.

**EXCLUDED PERSONS FOR SSI-RELATED SSI-Related MA**

The following cannot be fiscal or asset group members:

- FIP recipients.
- SSI recipients.
- Title IV-E recipients.
- Department wards.
- A person about whom information necessary to determine eligibility is refused.

**SSI-RELATED FISCAL GROUPS**

**SSI-Related MA**

Determine the fiscal group for each person who is requesting MA. The fiscal group must be determined separately for each person.

**SSI-Related Child**

**SSI-Related MA**

A child is a fiscal and asset group of one.

For a child living with his parent(s), BEM 400 and 540 explain whether the parent(s) must deem assets or income to the child. Also, see BEM 540 to determine budgetable income for the fiscal group.
SSI-Related Adult

SSI-Related MA

When an adult is applying for L/H, waivers (BEM 106 and 167) or FTW (BEM 174) the fiscal and asset group is the adult, even if the individual lives with a spouse, and the spouse is not also an L/H, waiver, or Freedom to Work client.

When the adult is applying for any other program (including the Medicare Savings Program) the fiscal and asset group is the adult applicant and the spouse.

See BEM 400 to determine the asset group’s countable assets and BEM 541 to determine budgetable income for each person in the fiscal group.

Exception: When BEM 402 instructs you to determine a couple’s countable assets for an INITIAL ASSET ASSESSMENT or Initial Eligibility, the L/H or waiver patient and the community spouse are considered an asset group.

Note: Transfers of income and/or assets are allowed between spouses regardless of each’s eligibility for program benefits. Transfers between spouses may cause program ineligibility for one or both spouses. This includes transfers of income from an L/H spouse to the spouse in the home who may be a waiver client.

Group 2 Fiscal Groups

Determine the fiscal and asset groups separately for each person requesting Medicaid. The fiscal group must be determined separately for each person. In determining a person’s eligibility, the only income that may be considered is the person’s own income and the income of the following persons who live with the individual:

- The individual’s spouse, and
- The individual’s parent(s) if the individual is a child.

Group 2 Under Age 21

A child's fiscal group is the child and the child's parents.
Group 2 Caretaker Relative

An adult's fiscal group is the adult and the adult's spouse.

VERIFICATION REQUIREMENTS

Group 2 Medicaid

Verify the primary caretaker when questioned or disputed.

Verification Sources

Primary Caretaker

Court order that addresses custody or visitation.

School records indicating who enrolled the child and who is called in an emergency situation.

Medical records stating where the child lives, who is responsible for the child’s medical care.

Child care records showing where the child lives and who makes and pays for the child care arrangements.

LEGAL BASE

MA

Social Security Act, Sections 1902(a) (10), (17) MCL 400.106

The Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).
DEPARTMENT POLICY

Bridges will help determine who must be included in the Food Assistance Program (FAP) group prior to evaluating the non financial and financial eligibility of everyone in the group.

Food Assistance Program group composition is established by determining all of the following:

1. Who lives together.
2. The relationship(s) of the people who live together.
3. Whether the people living together purchase and prepare food together or separately.
4. Whether the person(s) resides in an eligible living situation; see LIVING SITUATIONS in this item.

RELATIONSHIPS

The relationship(s) of the people who live together affects whether they must be included or excluded from the group. First, determine if they must be included in the group. If they are not mandatory group members, then determine if they purchase and prepare food together or separately.

Spouses

Spouses who are legally married and live together must be in the same group.

Parents and Children

Children include natural, step and adopted children.

Parents and their children under 22 years of age who live together must be in the same group regardless of whether the child(ren) have their own spouse or child who lives with the group.

Note: For ongoing and intake applications where the child(ren) are not yet 22, they are potentially eligible for their own case, the month after turning 22.
Primary Caretaker

The primary caretaker is the person who is primarily responsible for the child’s day-to-day care and supervision in the home where the child sleeps more than half of the days in a calendar month, on average, in a twelve-month period.

Caretaker

A caretaker is a related or unrelated person who provides care or supervision to a child(ren) under 18 who lives with the caretaker but who is not a natural, step or adopted child. This policy does not apply to foster children (see below). A person acting as a parent and the child(ren) for whom he acts as a parent who live with him must be in the same group.

Example: Emma’s grandson Pete (age 15) lives with her and she receives FIP for him as an ineligible grantee. She provides for his care by giving him a place to live, clothing, etc. Emma and Pete must be in the same group.

Example: Polly’s niece Peggy (age 17) lives with her. Peggy has a full-time job, pays room rent and buys her own food. Polly states that she has just provided a place to live in exchange for the room rent; she does not supervise Peggy’s activities. Polly and Peggy are separate groups. Either may apply with separate group status.

Foster Children

The FAP group may choose to include or exclude a foster child whose foster parent is a group member. If excluded, the foster child is not eligible for FAP as a separate group, and the foster care payment is not income to the group.

Foster Adults

The FAP group may choose to include or exclude a foster adult who lives with the group. If excluded, the foster adult is not eligible for FAP as a separate group, and the foster care payment is not income to the group.

Exception: This policy does not apply to residents of Adult Foster Care (AFC)/Community Living Facility (CLF) homes which are nonprofit and licensed for 16 or fewer residents. Policy in Bridges Eligibility Manual (BEM) 615, Group Living Facilities and BEM 617, FAP in Nonprofit Group Living Facilities applies to these residents.
LIVING WITH

**Living with** means sharing a home where family members usually sleep and share any common living quarters such as a kitchen, bathroom, bedroom or living room. Persons who share only an access area such as an entrance or hallway or non-living area such as a laundry room are not considered living together.

For policy regarding persons in other group living situations; see BEM 617.

Temporary Absence

A person who is temporarily absent from the group is considered living with the group.

A person's absence is temporary if all of the following are true:

- The person’s location is known.
- The person lived with the group before an absence (newborns are considered to have lived with the group).
- There is a definite plan for return.
- The absence has lasted or is expected to last 30 days or less.

**Exception:** The absence may last longer than 30 days if the absent person is in a hospital and there is a plan for him to return to the home.

DETERMINING PRIMARY CARETAKER

When a child spends time with multiple caretakers who do not live together such as joint physical custody, parent/grandparent, etc., determine a primary caretaker. Only one person can be the primary caretaker and the other caretaker(s) is considered the absent caretaker(s). The child is always in the FAP group of the primary caretaker. If the child’s parent(s) is living in the home, he/she must be included in the FAP group.

**Exception:** If otherwise eligible, the absent caretaker may receive FAP benefits for the child when the child is visiting the absent
caretaker for more than 30 days (not temporarily absent from the primary caretaker’s home.)

Determine primary caretaker by using a twelve-month period. The twelve-month period begins when a primary caretaker determination is made. To determine the primary caretaker:

- Ask the client how many days the child sleeps at his/her home in a calendar month.

- Accept the client’s statement unless questionable or disputed by another caretaker.

  **Note:** When a caretaker works during a child’s normal sleep hours, include the nights the child sleeps away from home when due solely to the caretaker’s employment as nights slept in the home of the caretaker; see Example 3.

- If primary caretaker status is questionable or disputed, verification is needed.

- Allow both caretakers to provide evidence supporting his/her claim.

- Base your determination on the evidence provided by the caretakers; see **verification sources**.

- Document who the primary caretaker is in the case.

If the child spends virtually half of the days in each month, averaged over a twelve-month period with each caretaker, the caretaker who applies and is found eligible first, is the primary caretaker. The other caretaker(s) is considered the absent caretaker(s).

**Example 1:** Patty normally lives with Mom and they receive FAP benefits. Dad has scheduled visitation every other weekend, two weeks at Christmas, two weeks at Easter and eight weeks in the summer. When Patty is gone for the eight weeks in the summer, Dad (absent caretaker) could apply and receive FAP benefits with Patty in his group, if otherwise eligible. Patty would have to be removed from Mom’s case because she no longer meets the definition of temporary absence.

**Note:** If in the example above, Patty returns every other weekend to visit with Mom during the summer visitation with Dad, she remains on Mom’s case (she is temporarily absent).
Example 2: Eric is ten years old. His mom works during the week. Eric’s mom drops him off at his grandmother’s house on Sunday evening and picks him up on Friday evening. Eric’s grandmother is primarily responsible for his care and supervision in the home where he sleeps more than half the days in a month when averaged over the next twelve months. Eric’s grandmother is the primary caretaker. His mom is considered an absent caretaker.

Example 3: Mom works during Eric's normal sleep hours, and Eric is only at Grandma’s house to sleep while mom works (he is not there all week). Mom is the primary caretaker. Grandma is providing child care.

Changes in Primary Caretaker

Re-evaluate primary caretaker status when any of the following occur:

- A new or revised court order changing custody or visitation is provided.

- There is a change in the number of days the child sleeps in another caretaker’s home and the change is expected to continue, on average, for the next twelve months.

- A second caretaker disputes the first caretaker’s claim that the child(ren) sleeps in their home more than half the nights in a month, when averaged over the next 12 months.

- A second caretaker applies for assistance for the same child.

Example: Martin has lived in Mom’s home more than half the days in a month on average over the past several years. He is now a teenager and becoming a problem for Mom. There is a change in the custody arrangement. Mom and Dad agree that it would be better for Martin to live with Dad. They now expect him to stay at Dad’s home more than half the days in a month, when averaged over the next twelve months. Dad is now the primary caretaker. Mom is considered the absent caretaker.

FOOD PURCHASE AND PREPARATION

The phrase, purchase and prepare together, is meant to describe persons who usually share food in common.
Persons usually share food in common if any of the following conditions exist:

- They each contribute to the purchase of food.
- They share the preparation of food, regardless of who paid for it.
- They eat from the same food supply, regardless of who paid for it.

In general, persons who live together and purchase and prepare food together are members of the FAP group.

**Example:** Sue, age 26 and her sister Mary, age 29 live in the same home. They purchase and prepare their food together. They are one FAP group.

**Example:** Betty and her two children move in with Sara, Betty's friend. Sara purchases and prepares food separately from Betty and her two children. They are two groups for FAP purposes.

Persons who normally purchase and prepare separately maintain that distinction even when they are temporarily sharing food with others.

Persons are temporarily sharing food if both of the following are true:

- They had previously purchased and prepared separately.
- Others are sharing their food until the person:
  - Is approved for FAP.
  - Qualifies for other cash assistance.
  - Secures some other source of income.

The purchase and prepare question on the MDHHS-1171, Assistance Application, is addressed as buy and fix food together.

**Senior Impaired Group**

A person at least 60 years old, his spouse and their children under 22 years of age may choose to be a separate group from those they live with, even if they purchase and prepare together if both of the following are true:
• The person cannot purchase and prepare meals due to a permanent disability as determined by Social Security Administration (SSA) or a non-disease-related permanent, severe disability.

• The countable income of all the other people the senior impaired group lives with does not exceed 165 percent of the poverty level; see Reference Tables Manuals (RFT) 250.

LIVING SITUATIONS

The following policies describe living situations which create ineligibility for FAP or which must meet specific requirements to allow eligibility.

Boarder

A boarder is a person residing in either of the following:

• In a commercial boarding house.
• With the FAP group and paying reasonable monthly compensation for meals.

A commercial boarding house is an establishment which provides room and board for compensation. It may or may not be licensed; it is not IRS tax exempt.

Persons residing in a commercial boarding house are not eligible for FAP.

Reasonable monthly compensation is:

• The amount of the maximum monthly FAP benefits for the number of persons making the board payment if the payment is for at least three meals a day.
• Two-thirds of the maximum monthly FAP benefits for the number of persons making the board payment if the payment is for less than three meals per day.

Note: Spouses, parents and children, and children under parental control of a person acting as a parent living together are never boarders, regardless of any payments made to one another.

The group providing the board in a noncommercial board situation may choose to include or exclude the boarder(s) from the group. If excluded, the boarder is not eligible for FAP.
Persons paying less than reasonable monthly compensation for board **must** be included in the group providing the board.

**Residents of Institutions**

A person is a resident of an institution when the institution provides the majority of his meals as part of its normal services.

Residents of institutions are **not** eligible for FAP unless one of the following is true:

- The facility is authorized by the Food and Nutrition Service (FNS) to accept FAP benefits.
- The facility is an eligible group living facility; see BEM 615.
- The facility is a medical hospital and there is a plan for the person's return home; see **Temporary Absence** in this item.

**DISQUALIFIED PERSONS**

A disqualified person is one who is ineligible for FAP because the person refuses or fails to cooperate in meeting an eligibility factor.

Disqualified members are determined based on questions in Bridges.

Individuals are disqualified for the following reasons:

- Failure to meet citizenship/alien status; see BEM 225.
- Failure to provide a social security number; see BEM 223.
- Failure to comply with employment-related activities; see BEM 233B.
- Intentional program violation; see Bridges Administrative Manual (BAM) 720.
- Voluntary quit; see BEM 233B.
- Failure to comply with a Quality Control review; see BAM 105.
- Child Support noncooperation; see BEM 255.
- Traffickers; see BEM 203.
• Parole and Probation Violators; see BEM 203.
• Drug-related felony, 2nd offense; see BEM 203.
• Divestment; see BEM 406.
• Time Limited; see BEM 620.

**MEMBER ADDS/DELETES**

A member add that increases benefits is effective the month after it is reported or, if the new member left another group, the month after the member delete. In determining the potential FAP benefit increase, Bridges assumes the FIP/SDA supplement and new grant amount have been authorized.

When a member leaves a group to apply on his own or to join another group, a member delete should be completed in the month the local office learns of the application/member add. Initiate recoupment if necessary. If the member delete decreases benefits, adequate notice is allowed.

**NON-GROUP MEMBERS**

Persons might live with the FAP group or applicant group who are not group members. Do not consider their income and assets when determining the group’s eligibility.

**Furloughed Prisoner**

A furloughed prisoner is a person on leave from a correctional institution. The Department of Corrections provides meals or meal money to such persons.

A furloughed prisoner is not eligible.

**Ineligible Student**

A person who is in student status and does not meet the criteria in BEM 245 is a non-group member.

**Live-in Attendant**

A live-in attendant lives in the group's home to provide housekeeping, medical or child care, or similar personal services. Persons
who take someone into their own home to provide such services are not live-in attendants.

The live-in attendant may apply for FAP as a separate group.

**Note:** Spouses, parents and children, and persons acting as a parent and the children they care for cannot be live-in attendants for one another, regardless of the actual situation.

**Roomer**

A roomer is a person to whom the group furnishes lodging, but not meals, for compensation.

The roomer(s) may apply for FAP as a separate group.

**Persons Who Have Already Received FAP Benefits**

A person must not participate as a member of more than one FAP group in any given month; see BEM 222.

**Exception:** Residents of shelters for battered women and children; see BEM 617.

If the person is a mandatory group member, action must be taken as soon as possible to remove him from his former group and add him to the new group.

**CATEGORICALLY ELIGIBLE GROUP**

After determining who is in the FAP group, Bridges determines if this group is categorically eligible for FAP benefits; see BEM 213.

**VERIFICATION REQUIREMENTS**

Verify group composition factors if the information given is questionable. Such factors might include boarder status, age or senior members, and inability to purchase and prepare meals separately.
Primary Caretaker

Accept the client’s statement regarding the number of days per month (on average) a child sleeps in their home. Verify only if questionable or disputed by the other parent.

Senior Impaired Status

A person's impaired status must be verified if it is not obvious and it affects the FAP group composition.

VERIFICATION SOURCES

Verify the factors below using one of the listed sources.

Boarder Status

Written statement from the board provider that indicates the amount paid for board.

Impaired (Disability Considered Permanent Under SSA)

The following is a partial list of disabilities considered permanent under the SSA:

- Permanent loss of the use of both hands, both feet, or one hand and one foot.
- Amputation of a leg at the hip.
- Amputation of a leg or foot because of diabetes mellitus or a peripheral vascular disease.
- Total deafness, not correctable by surgery or a hearing aid.
- Statutory (legal) blindness, except if due to cataracts or a detached retina.
- IQ of 59 or less, established after age 16.
- Paraplegia or quadriplegia.
- Multiple sclerosis that is severe, recurring, and includes muscle weakness, paralysis, or interference of vision or speech.
- Muscular dystrophy with a significant effect on the use of the arms or legs.
- Chronic renal disease (documented by persistent, adverse objective findings) resulting in severely reduced kidney function.

Age

Birth Certificate.

Hospital certificate of birth.

Other official records containing birth information such as school records, medical records, baptismal record, marriage certificate, or insurance policy.

Identification containing birth information such as driver’s license or state-issued ID.

Newspaper clipping containing the date of birth.

Written statements from two or more individuals who know the person’s age.

Inability to Purchase and Prepare Meals

Statement from physician or psychologist.

Primary Caretaker

When primary caretaker status is questionable or disputed, base the determination on the evidence provided by the caretakers. Give each caretaker the opportunity to provide evidence supporting his/her claim. Suggested verifications include:

- The most recent court order that addresses custody and/or visitation.
- School records indicating who enrolled the child in school, first person contacted in case of emergency, and/or who arranges for child’s transportation to and from school.
• Child care records showing who makes and pays for child care arrangements, and who drops off and picks up the child(ren).

• Medical providers’ records showing where the child lives and who generally takes the child to medical appointments.

LEGAL BASE

7 CFR 273.1
7 CFR 273.8(h)
Mich Admin Code, R 400.3006
FAP Only

Traditional categorically eligible groups automatically meet the asset and income limits for the Food Assistance Program (FAP).

Applicants and recipients are eligible for enhanced authorization for Domestic Violence Prevention Services (DVPS). If their gross income is at or below 200 percent of the federal poverty level and they meet the asset test, they are also categorically eligible.

Categorical eligibility applies to groups, not individuals. Bridges determines group composition prior to determining categorical eligibility. Determination of categorical eligibility will be made at application, reported change and redetermination.

**Note:** Categorical eligibility does not mean applicants automatically receive FAP as clients must still meet all of the other program requirements.

**ASSET TESTS**

**Traditional Categorical Groups**

FAP groups whose members are all FIP and/or SDA and/or SSI are categorically eligible and do not require an asset test. Their asset test requirements are met by the FIP/SDA/SSI program.

A recipient is a person who is one of the following:

- Receiving FIP and/or SDA and/or SSI.
- Authorized for such benefits but who has not yet received payments.
- Eligible for such benefits however, benefits are suspended or recouped.
DVPS Categorical Groups

FAP groups whose members are not all FIP and/or SDA and/or SSI are categorically eligible based on DVPS and do require an income and asset test.

DVPS Non-Categorical Groups

The following households are not categorically eligible but are authorized to receive DVPS. They must meet income, asset and all other program requirements to receive FAP benefits.

Senior/Disabled/Disabled Veteran (SDV)

Households which contain an SDV member and whose gross income is above 200 percent are not categorically eligible but they may still be eligible for benefits if their net income is below 100 percent of the poverty level and they meet the asset limit; see BEM 400 and BEM 550.

Disqualified Member

A group is not categorically eligible for FAP if any member of the group is FAP disqualified for:

- Intentional program violation (IPV).
- Employment-related activity only when the disqualified person is the head of household.
- Drug-related felony.

APPLICATION PROCESSING

Verification

If questionable, verify that the group:

- Meets all of the group composition requirements; see BEM 212.
- Includes all persons who purchase and prepare food together in one FAP group, and
- Includes no persons who have been FAP disqualified for IPV, employment-related activity (only when the disqualified person is the head of household) and/or drug-related felony.

If categorically eligible, do not verify for FAP purposes:

- That the group's income is within gross and 100 percent net income limits.
- Social Security numbers.
- Sponsored alien information.
- Residency.

**Note:** Although the above eligibility factors are not verified for categorically eligible households, they must be verified if they are not verified by another program.

**Postponing Denial**

Postpone the denial of benefits for a potential categorically eligible group that does not require an asset test until the 30th day if it is likely that the group will be categorically eligible.

**Benefits for Previously Denied Group**

If the group meets FAP categorical eligibility within 30 days of application, FAP eligibility is effective the date of application. Household applies for FIP and FAP or SDA and FAP on June 23. FAP is denied due to excess assets. FIP or SDA is approved on July 8. FAP eligibility begins on June 23.

If the group meets FAP categorical eligibility criteria after 30 days, the FAP eligibility is effective on the date FIP or SDA is approved.

**Example:** Same household applies on June 23 and is approved for FIP or SDA on August 3. FAP eligibility begins on August 3.

Update the original application from available information or through mail or phone contact with the group or authorized representative and document the case.

**ISSUING BENEFITS**

Bridges will compute net income for all categorically eligible groups.
One and two member categorical FAP groups that exceed the gross and/or 100 percent net income limit, but whose gross income is at or below 200 percent of the poverty level, and who meet the asset limit and all other FAP eligibility requirements are automatically eligible for the minimum benefit amount.

Three or more member categorical FAP groups that exceed the gross and/or 100 percent net income limit, but whose gross income is at or below 200 percent of the poverty level and who meet the asset limit and all other FAP eligibility requirements may be eligible for benefits as low as $1 as determined by the Food Assistance Issuance Tables; see RFT 260.

**Exception:** Benefits are prorated in the initial month of application and benefits will not be issued if the issuance is less than $10.

A case with zero benefits won't be opened on Bridges. Therefore, three or more member categorical FAP groups will be denied or closed if net income results in a zero benefit amount based on the Food Assistance Issuance Tables.

**TERMINATION OF CATEGORICAL ELIGIBILITY**

When the group is no longer categorically eligible due to imposing a FAP disqualification for IPV, employment-related activity (only when the disqualified person is the head or household) and/or drug-related felony, all FAP eligibility requirements are reviewed to determine whether the group remains eligible. Bridges will send a DHS-1605 to inform the client of any change in eligibility or benefit level.

**LEGAL BASE**

**FAP**

7 CFR 273.2(j)

7 CFR 273.8

Food and Nutrition Act of 2008, as amended
DEPARTMENT PHILOSOPHY

Spouses are responsible for each other. Needy spouses living together are expected to share income, assets, and expenses.

DEPARTMENT POLICY

SDA

SDA is a cash program for individuals who are not eligible for FIP and are disabled or the caretaker of a disabled person. An SDA eligibility determination group (EDG) consists of either a single adult or adult and spouses living together. See BEM 261 for disability criteria.

DEFINITIONS

Adult

An individual is considered an adult for SDA when he or she is age 18 or older or has been emancipated.

Emancipated

An individual under the age of 18 is emancipated if any of the following:

- Ever validly married.
- Emancipated by court order.
- On active duty with the armed forces of the United States.

An emancipated individual is considered an adult.

Eligibility Determination Group

The eligibility determination group (EDG) means those adults living together whose information is needed to determine SDA Eligibility. Only an adult individual and his or her spouse who live together are included in an SDA EDG.
Certified Group

The **certified group (CG)** means those persons in the EDG who meet all non-financial SDA eligibility factors. Countable income and assets of CG members are always considered in determining SDA eligibility.

Living Together

Living together means sharing a home except for temporary absences.

Temporary Absence

A temporarily absent person is considered to be living in the home when all of the following are true:

- His location is known.
- He plans to return.
- He lived with the group before the absence.
- The absence has lasted or is expected to last 30 days or less.

**Exception:** A person is considered living in the home, even after 30 days, when absence is due to hospitalization, education or training.

DETERMINING THE ELIGIBILITY DETERMINATION GROUP

SDA

The EDG consists of both:

- The individual.

The individual's spouse who lives with the individual and does not receive FIP, Refugee Cash Assistance, or a refugee matching grant.

Bridges determines the members of the SDA EDG based on information reported by the individual and entered in the system.
DETERMINING THE CERTIFIED GROUP

The CG includes only the eligible members of the SDA EDG. A spouse in the home may fail eligibility and be excluded from the CG but remains a mandatory EDG member. A spouse who fails to meet a nonfinancial eligibility factor or is disqualified for any reason is excluded from the CG.

Bridges determines the members of the SDA CG based on information reported by the individual and entered in the system.

LEGAL BASE

SDA

Annual Appropriations Act
Michigan Administrative Code R 400.3151 - 400.3180
DEPARTMENT PHILOSOPHY

Michigan Department of Health and Human Services (MDHHS) requires participation in employment and/or self-sufficiency-related activities associated with the Family Independence Program (FIP) or Refugee Cash Assistance (RCA). Applicants or recipients of Food Assistance Program (FAP) only must accept and maintain employment. There are consequences for a client who refuses to participate in FIP/RCA employment and/or self-sufficiency-related activities or refuses to accept or maintain employment without good cause.

DEPARTMENT POLICY

The policies in this item apply to all FAP applicants and recipients age 16 to 59. Noncompliance without good cause, with employment requirements for FIP/RCA may affect FAP if both programs were active on the date of the FIP noncompliance; see BEM 233A.

Exception: See BEM 233C for FAILURE TO MEET EMPLOYMENT REQUIREMENTS: RCA. RCA clients do not have the Last RCA budgeted on their FAP benefits, but can be disqualified from FAP.

Michigan’s FAP Employment and Training program is voluntary and penalties for noncompliance may only apply in the following two situations:

- Client is active FIP/RCA and FAP and becomes noncompliant with a cash program requirement without good cause
- Client is active RCA and becomes noncompliant with a RCA program requirement
- Client is pending or active FAP only and refuses employment (voluntarily quits a job or voluntarily reduces hours of employment) without good cause

At no other time is a client considered noncompliant with employment or self-sufficiency related requirements for FAP.
When a recipient of FIP/RCA and FAP is noncompliant, the following will occur:

- On the night that the One-Stop Service Center case manager places the participant into triage activity, the One-Stop Management Information System (OSMIS) will interface to Bridges a noncooperation notice. Bridges will generate a triage appointment at the local office as well as generating the DHS-2444, Notice of Employment And/Or Self-Sufficiency Related Noncompliance, which is sent to the client.

- For manually entered noncooperations, the DHS-2444 will be generated upon the next EDBC run, which will schedule the triage appointment and place the case into case closure pending the negative action period.

- If a participant is active FIP and FAP at the time of FIP noncompliance, determination of FAP good cause is based on the FIP good cause reasons outlined in BEM 233A. For the FAP determination, if the client does not meet one of the FIP good cause reasons, determine the FAP disqualification based on FIP deferral criteria only as outlined in BEM 230A, or the FAP deferral reason of care of a child under 6 or education. No other deferral reasons apply for participants active FIP and FAP.

- Determine good cause during triage appointment/phone conference and prior to the negative action period. Good cause must be provided prior to the end of the negative action period. Document the good cause determination on the noncooperation detail screen within 24 hours of determination. If the client does not participate in the triage meeting, determine good cause for FAP based on information known at the time of the determination. Good cause may be verified by information already on file with MDHHS, the Refugee Contractor (RC), or the Partnership. Accountability. Training. Hope. (PATH)

- Determine FAP good cause separately from the FIP/RCA based on FAP good cause reasons defined later in this item. If a good cause reason is selected for FIP/RCA it also applies to FAP. If the client does not meet one of the FIP/RCA good
cause reasons in the drop down list, but does meet one of the FAP only good cause reasons, select the FAP only good cause reason to avoid client disqualification on FAP. Bridges makes both determinations simultaneously.

When To Disqualify

Disqualify a FAP group member for noncompliance when all the following exist:

- The client was active both FIP/RCA and FAP on the date of the FIP/RCA noncompliance
- The client did not comply with FIP/RCA employment requirements
- The client is subject to a penalty on the FIP/RCA program
- The client is not deferred from FAP work requirements; see DEFERRALS in BEM 230B
- The client did not have good cause for the noncompliance.

See member disqualification in this item.

Budgeting Last FIP

Bridges applies policies associated with a FIP related noncompliance and budgets the Last FIP grant amount into the FAP budget. The FIP grant is removed from the FAP budget at the end of the FIP penalty period. For individuals serving a lifetime sanction, Bridges will remove the FIP income from the FAP budget once the individual reaches their FIP lifetime time limit.

In instances in which the individual serving a FIP sanction leaves the group, the sanction follows that individual. When the client reapplies for FIP, Bridges will remove the FIP income from the FAP budget.

**Note:** When the individual with the lifetime sanction enters a different FIP group, Bridges will close the FIP case for the lifetime sanction and budget the last FIP, for that sanctioned individual, into the FAP budget for the new group.

Bridges will not budget the Last RCA grant when imposing Refugee Assistance Program penalties. See BEM 233C for RCA penalties.
Overlapping Negative Actions

When a client is active both FIP and FAP on the date of a FIP non-compliance and FIP is closing for a reason unrelated to noncompliance (for example client request) take one of the following actions:

- If the client requests closure of both FIP and FAP during the good cause determination and before case closure, act on the unrelated FAP closure. Do not proceed with the FAP noncompliance penalties

- If the client requests closure of FIP benefits only, but not FAP, any time during the penalty process and after the noncompliance occurred, continue to process the FAP disqualification. A minimum one or six month penalty applies. If the FIP closure is not employment and/or self-sufficiency-related, Bridges will not budget the Last FIP grant amount

FAP ONLY NONCOMPLIANCE

Refusing Employment

Non-deferred adult members of FAP households must follow certain work-related requirements in order to receive food assistance program benefits.

Working

Disqualify non-deferred adults who were working when the person:

- Voluntarily quits a job of 30 hours (weekly earnings equal to or in excess of 30 hours times federal minimum wage) or more per week without good cause, or

- Voluntarily reduces hours of employment below 30 hours per week without good cause, and after the reduction, earnings are less than 30 hours times the federal minimum wage

Note: If the job quit or reduction in hours occurred more than 30 days prior to the application date, no penalty applies.
Not Working

Non-deferred adults who are not working or are working less than 30 hours per week must:

- Accept a valid offer of employment  
  **Note:** A valid offer of employment means a definite offer paying wages of at least the applicable state minimum wage

- Follow through and participate in activities required to receive unemployment benefits (UB) if the client has applied for or is receiving UB

**Note:** Determine good cause before implementing a disqualification.

FAP ONLY
PENALTIES FOR REFUSING SUITABLE EMPLOYMENT

When a client has refused suitable employment as described above, do the following:

- Complete the noncompliance record by either completing the *Loss of Employment screen* for job quit or voluntary reduction of hours below 30 hours or by entering a noncooperation for refusal of employment on the *Noncooperation Summary screen*. The DHS-2444, Notice of Employment And/Or Self-Sufficiency Related Noncompliance will be generated upon the next run of EDBC, which will also schedule the triage appointment at the local office and place the individual into disqualification pending the negative action period

- The following information will be populated on the DHS-2444:
  - The name of the noncompliant individual
  - The date of noncompliance
  - All the dates, if addressing more than one incident of noncompliance
  - The reason the client was determined to be noncompliant
  - The disqualification that may be imposed
• The scheduled triage appointment, to be held in person or by phone, within the negative action period

• Hold the triage appointment/phone conference to determine good cause prior to the negative action period. Good cause must be verified and provided prior to the end of the negative action period and can be based on information already on file with MDHHS. Document good cause determination on the Noncooperation Detail screen within 24 hours of determination.

• If the client does not participate in the triage meeting, determine good cause for FAP based on information known at the time of the determination.

• An in-person meeting is not required for FAP only. A phone conference to determine good cause is acceptable.

• Determine FAP good cause based on FAP good cause reasons defined later in this item.

WIOA AND OTHER EMPLOYMENT & TRAINING PROGRAMS

Do not disqualify FAP applicants or recipients for failing to comply with Workforce Innovation Opportunity Act (WIOA) services or any other FAP employment and training components.

MEMBER DISQUALIFICATION

Disqualifications for failure to comply without good cause are the same for FAP applicants, recipients and member adds. Evaluate each client’s work requirement before imposing a disqualification; see BEM 230B DEFERRALS.

• For the first occurrence, disqualify the person for one month or until compliance, whichever is longer.

• For a second or subsequent occurrence, disqualify the person for six months or until compliance, whichever is longer.

Bridges counts any previous FIP or RCA-related FAP penalty as a first or subsequent occurrence.
Applicants

For applicants, begin the disqualification the month after application, even if the failure occurred within the 30 days before the application. Bridges sends a client notice to inform the client.

Member Add

For a member add, the disqualification must begin the month after the new member was reported.

Recipients

For recipients, begin the disqualification the first month possible after determination or notification of the failure to comply. Provide the group timely notice.

Disqualification Begin Date

Begin the disqualification the first month after the negative action period ends. If the notice is not sent timely, impose the full disqualification period beginning the first month possible after discovering the error.

Once begun, the month(s) of disqualification proceed consecutively and cannot be interrupted, even if the noncompliant person or the group becomes ineligible for another reason.

**Note:** When a member in a FAP group becomes disqualified, Bridges budgets the member’s income and expenses as they count toward the remaining eligible group members. See BEM 550 for budgeting instructions.

GOOD CAUSE FOR NONCOMPLIANCE

Good cause is a valid reason for failing to participate in employment and/or self-sufficiency-related activities or refusing suitable employment. Investigate and determine good cause before deciding whether to imposing a disqualification. Good cause includes the following:

Deferred

- The person meets one of the deferral criteria; see DEFERRALS in BEM 230B
**Meets Participation Requirements**

- The person meets participation requirements; see DEFERRALS in BEM 230B

**Wage Under Minimum**

- Except for sheltered workshops, the wage offered, including tips, is less than the applicable state minimum wage

**Client Unfit**

- The client is physically or mentally unfit for the job, as shown by medical evidence or other reliable information

**Health or Safety Risk**

- The degree of risk to health or safety is unreasonable

**Illness or Injury**

- The client has a debilitating illness or injury, or an immediate family member’s illness or injury requires in-home care by the client

**Religion**

- The working hours or nature of the employment interferes with the client’s religious observances, convictions or beliefs

**Net Income Loss**

- The employment causes the family a net loss of cash income

**No Child Care**

- Child Development and Care (CDC) is needed for a CDC-eligible child, but none is adequate, suitable, affordable and within reasonable distance of the client’s home or work site; see BEM 703

**No Transportation**

- Reasonably priced transportation is not available to the client
Illegal Activities

- The employment involves illegal activities

Discrimination

- The client experiences discrimination on the basis of age, race, disability, gender, color, national origin or religious beliefs

Unplanned Event or Factor

- Credible information indicates an unplanned event or factor which likely prevents or significantly interferes with employment and/or self-sufficiency-related activities

Comparable Work, Job Quits

- The client obtains comparable employment in salary or hours to the job that was lost

**Note:** When a client quits a job and during the negative action period secures employment, the penalty still applies unless the new job meets the definition of comparable work above.

Education or Training

- The employment interferes with enrollment at least half time in a recognized education or job training program

Long Commute

- Total commuting time exceeds either:
  - Two hours per day, not including time to and from child care facilities
  - Three hours per day, including time to and from child care facilities

Unreasonable Conditions

- The employer makes unreasonable demands or conditions (for example, working without being paid on schedule)
Forced Move

- The person must quit a job and move out of the county due to another group member’s:
  - Employment
  - Employment and/or self-sufficiency-related activities
  - Enrollment at least half time in a recognized education or job training program

Retirement

- The employer recognizes the person’s resignation as retirement

Unkept Promise of Work

- For reasons beyond the person’s control, promised employment of at least 30 hours per week (or the state minimum wage times 30 hours) does not materialize or results in less than that minimum

Union Involvement

- The person must join, resign from, or refrain from joining a labor organization as an employment condition

Strike or Lockout

- The work is at a site subject to a strike or lockout (not enjoined by federal law) at the time of the offer

Work Not Familiar

- In the first 30 days after determined a mandatory FAP participant, the only employment offered is outside the person’s major field of experience

REESTABLISHING FAP ELIGIBILITY

A noncompliant person must serve a minimum one-month or six-month disqualification period unless one of the criteria for ending a disqualification early exists.

End the disqualification early if the noncompliant person either:

- Complies with work assignments for a cash program
• Obtains comparable employment in salary or hours to the job which was lost

• Meets a deferral reason other than unemployment benefit (UB) application/recipient; see DEFERRALS in BEM 230B

• Leaves the group

If the person has met any of the criteria above after a disqualification has actually taken effect, restore benefits beginning the month after the noncompliant person reports meeting the criteria.

**Example:** A mandatory FAP recipient reports a job quit on March 28 without good cause. The adverse action to disqualify the noncompliant person takes effect on April 13. The noncompliant person reports getting a comparable job on April 25. Since the disqualification doesn't actually take effect until May 1, and the client has met one of the criteria for ending a disqualification early, she/he should receive FAP benefits for May. If the noncompliant person did not report a new job until May 1, the FAP benefits could not be restored until the 1st of June.

If the noncompliant person does not meet the criteria above for ending a disqualification early, a compliance test must be completed before eligibility is regained. In addition, the minimum disqualification period must be served.

If the disqualification caused FAP closure, and all eligibility criteria for FAP eligibility are met, open the case effective the latter of:

- The date the person agreed to comply
- The day after the disqualification ended
- The date of application

### Compliance Test

After a one-month or six-month disqualification, the noncompliant person must complete a compliance test to become eligible for FAP, unless:

- Working 20 hours or more per week
- Meets FAP deferral criteria; see DEFERRALS in BEM 230B

When a disqualified client indicates a willingness to comply, provide an opportunity to test his/her compliance, provided it is no earlier than one month before a minimum disqualification period ends.
The test may consist of any of these activities for a total of 20 hours:

- Community Service - verify participation with community service agency
- Work Experience - verify participation with work experience site
- Applying for three jobs within 10 days. Use the DHS-402, FAP Compliance Letter, and Job Application Log or other acceptable verification
- Other employment and/or self-sufficiency-related activities for a total of 20 hours

If the person completes the test, recalculate the group’s FAP benefit amount with him/her included.

LEGAL BASE

Food and Nutrition Act of 2008 (7 USC 2011 et seq.)
Mich Admin Code, R 400.3610
7CFR 272 and 273.7
Social Welfare Act
DEPARTMENT PHILOSOPHY

Families are strengthened when children’s needs are met. Parents have a responsibility to meet their children's needs by providing support and/or cooperating with the department, including the Office of Child Support (OCS), the Friend of the Court (FOC) and the prosecuting attorney to establish paternity and/or obtain support from an absent parent.

DEPARTMENT POLICY

Family Independence Program (FIP), Child Development and Care (CDC) Income Eligible, Medicaid (MA) and Food Assistance Program (FAP)

The custodial parent or alternative caretaker of children must comply with all requests for action or information needed to establish paternity and/or obtain child support on behalf of children for whom they receive assistance, unless a claim of good cause for not cooperating has been granted or is pending.

Absent parents are required to support their children. Support includes all of the following:

- Child support.
- Medical support.
- Payment for medical care from any third party.

Note: For purposes of this item, a parent who does not live with the child due solely to the parent's active duty in a uniformed service of the U.S. is considered to be living in the child’s home.

Complete the Absent Parent Logical Unit of Work and trio for any group member who has been or is currently a recipient of public assistance as a dependent child and had an absent parent.

Complete a new trio when the custodial parent/caretaker changes.

The summary will include all trios created for individuals who had an absent parent during an episode of assistance. This may include parents who were previously absent for a period of time an individual received assistance. This may include individuals who are now adults but the history of having an absent parent is
necessary for the OCS to determine disbursement of arrearage payments that may be received.

Failure to cooperate without good cause results in disqualification. Disqualification includes member removal, as well as denial or closure of program benefits, depending on the type of assistance (TOA); see Support Disqualification in this item.

Note: When OCS, FOC or a prosecuting attorney determines a client is in cooperation or noncooperation the determination is entered in Bridges via a systems interface. When the client is in noncooperation, Bridges will generate a notice closing the affected program(s) or reduce the client benefit amount in response to the determination. A copy of the details regarding the cooperation or noncooperation can be requested by contacting the primary worker noted in the Child Support (CS) icon on the Absent Parent Child Link page.

Note: A pregnant woman who fails to cooperate may still be eligible for MA; see MA Member Disqualification in this item.

FIP

All rights to current and future court-ordered child support paid for a period of time a child receives FIP must be assigned to the state as a condition of FIP eligibility. See Assignment in this item for the types of child support payments that a FIP recipient is entitled to keep.

Note: Custodial parents cannot waive family owed arrears while receiving FIP.

Spousal support included in a child support order must also be assigned; see Support Assignment and Certification in this item.

GOOD CAUSE FOR NOT COOPERATING

FIP, CDC Income Eligible, MA and FAP

Exceptions to the cooperation requirement are allowed for all child support actions except when the recipient fails to return assigned child support payments received after the support certification effective date; see Support Certification Effective Date in this item.
Informing Families about Good Cause

FIP, CDC Income Eligible, MA and FAP

Inform the individual of the right to claim good cause by giving them a DHS-2168, Claim of Good Cause - Child Support, at application, before adding a member and when a client claims good cause. The DHS-2168 explains all of the following:

- The department’s mandate to seek child support.
- Cooperation requirements.
- The positive benefits of establishing paternity and obtaining support.
- Procedures for claiming and documenting good cause.
- Good cause reasons.
- Penalties for noncooperation.
- The right to a hearing.

Grant good cause only when both of the following are true:

- Requiring cooperation/support action is against the child’s best interests.
- There is a specific good cause reason.

See the Good Cause Reasons in this item.

Good Cause Reasons

FIP, CDC Income Eligible, MA and FAP

There are two types of good cause:

1. Cases in which establishing paternity/securing support would harm the child. Do not require cooperation/support action in any of the following circumstances:

   • The child was conceived due to incest or forcible rape.
• Legal proceedings for the adoption of the child are pending before a court.

• The individual is currently receiving counseling from a licensed social agency to decide if the child should be released for adoption, and the counseling has not gone on for more than three months.

2. Cases in which there is danger of physical or emotional harm to the child or client. Physical or emotional harm may result if the client or child has been subject to or is in danger of:

• Physical acts that resulted in, or threatened to result in, physical injury.

• Sexual abuse.

• Sexual activity involving a dependent child.

• Being forced as the caretaker relative of a dependent child to engage in non-consensual sexual acts or activities.

• Threats of, or attempts at, physical or sexual abuse.

• Mental abuse.

• Neglect or deprivation of medical care.

Note: This second type of good cause may include instances where pursuit of child support may result in physical or emotional harm for a refugee family, or the absent parent of a refugee family, when the family separation was the result of traumatic or dangerous circumstances. This may also apply to individuals who are treated to the same extent as a refugee, including asylees and victims of trafficking.

Claiming Good Cause

FIP, CDC Income Eligible, MA and FAP

If a client claims good cause, both the specialist and the client must sign the DHS-2168. The client must complete Section 2, specifying the type of good cause and the individual(s) affected. Give the client a copy of the completed DHS-2168.
To prevent any support action while the good cause claim is pending, enter good cause status and claim date in the absent parent logical unit of work and file the DHS-2168 in the case **within two working days of completion**. A claim may be made at any time. The FIS/ES specialist is responsible for determining if good cause exists. Do **not** deny an application or delay program benefits just because a good cause claim is pending.

A good cause claim must do all of the following:

- Specify the reason for good cause.
- Specify the individuals covered by it.
- Be supported by written evidence or documented as credible.

**Evidence and Credibility of Good Cause**

Request the client provide evidence of good cause within 20 calendar days of claim. Allow an extension of up to 25 calendar days if the client has difficulty obtaining the evidence.

**Note:** Change the Verification Check List (VCL) due date in Bridges manually, to extend the due date of verification.

Assist clients in obtaining written evidence if needed. Place any evidence in the case record. See Verification Sources in this item for examples of acceptable evidence.

If written evidence does **not** exist, document why none is available and determine if the claim is credible. Base credibility determination on available information, including client statement and/or collateral contacts with individuals who have direct knowledge of the client’s situation.

Verification of good cause due to domestic violence is required only when questionable.

**Determining Good Cause**

**FIP, CDC Income Eligible, MA and FAP**

Make a good cause determination within 45 calendar days of receiving a signed DHS-2168 claiming good cause. The OCS can review and offer comment on the good cause claim before you
make your determination. Exceed the 45-day limit **only if** all of the following apply:

- The client was already granted an additional 25-day extension to the original 20-day limit.
- More information is needed that **cannot** be obtained within the 45-day limit.
- Supervisory approval is needed.

Document extensions in the case record.

One of three findings is possible when making a determination:

- **Approved** - Continue with Child Support Action.

**Example:** Court order is already established and client participation is no longer necessary to pursue support.

- **Approved** - Discontinue or do not initiate Child Support Action; this applies when there is a risk to the child or custodial parent/caretaker or there is an existing child support order.
- **Denied** - Good cause does not exist; this applies if the family does not present criteria that meets good cause or there was no convincing evidence of risk.

All good cause determinations must be:

- Approved by a specialist's supervisor.
- Reviewed at every redetermination if subject to change.
- Documented on the DHS-2169, Notice of Good Cause Finding - Child Support/Third Party Resources and a copy must be placed in the case record.
- Entered in the absent parent logical unit of work to include status, claim date, and begin date when approved. End date is entered when applicable.
ROLE OF THE SUPPORT SPECIALIST

FIP, CDC Income Eligible, MA and FAP

Support Specialists work for the OCS to support families by:

- Accepting referrals/applications for child support services on behalf of public assistance recipients, as well as from the general public.
- Obtaining absent parent information from clients.
- Reviewing and offering comment on good cause claims.
- Attending pre-hearing conferences and administrative hearings in support of OCS actions.
- Determining cooperation and non-cooperation (entered in Bridges via the systems interface).
- Referring appropriate cases to the local prosecutor or the FOC.

Support Specialist Role in Good Cause

FIP, CDC Income Eligible, MA and FAP

Enter the good cause claim within two workdays of the individual’s claim. No support action or contact with the client will be initiated while the good cause claim is pending.

Provide the support specialist with information if submitted when a recommendation is needed. Consider the OCS recommendation even though it is not binding. Consider the recommendation especially when determining if support action can proceed without the client’s cooperation and without resulting in physical/emotional harm to the child or client.
FIP, CDC Income Eligible, MA, and FAP

Refer unmarried children who have no legal father or who have a legal parent absent from the home to the OCS for child support action by completing the Absent Parent Logical Unit of Work and certifying eligibility of benefits.

**Exception:** The following children are not referred to OCS:

- Children whose absent parent is deceased.
- Children adopted by a single parent only.
- Teen and minor parents with an adult Eligibility Determination Group (EDG) participation status.

**MA Only**

The support specialist will **not** take action on deductible cases until after certification of the first period of MA coverage.

Children not living with a specified relative, as defined in BEM 135, are not referred to the OCS.

REPORTING CHANGES TO OCS

FIP, CDC Income Eligible, MA and FAP

Enter new information about the absent parent in the absent parent logical unit of work within two workdays of learning the following changes when there is an active EDG:

- Changes affecting cooperation or a good cause claim.
- New information about an absent parent.

Contact the primary worker noted in the Child Support (CS) icon on the Absent Parent Child Link page to resolve case-specific questions regarding collection action.

**Note:** The primary child support worker can be the support specialist or the prosecutor’s office, which also determines cooperation and non-cooperation.
Voluntary Paternity Acknowledgement

FIP, CDC Income Eligible, MA and FAP

Parents who wish to voluntarily establish paternity must complete form DCH-0682, Affidavit of Parentage. Give these clients the DCH-0682. Clients may complete the affidavit in the local office, may take it with them for completion, and/or may seek assistance from the support specialist.

It is critical that parents are provided with sufficient information on the paternity acknowledgement process. If assisting clients in completing the affidavit, be sure to review the consequences, rights and responsibilities of acknowledging paternity that are listed on the DCH-0682.

Refer parents with questions about paternity or child support to the support specialist (1-866-540-0008).

Signatures of both parents on the affidavit must be notarized.

Provide each parent with a copy of the completed form.

A copy of the form is available to the public at https://www.michigan.gov/documents/Parentage_10872_7.pdf.

COOPERATION

FIP, CDC Income Eligible, MA and FAP

Cooperation is a condition of eligibility. The following individuals who receive assistance on behalf of a child are required to cooperate in establishing paternity and obtaining support, unless good cause has been granted or is pending:

- Grantee (head of household) and spouse.
- Specified relative/individual acting as a parent and spouse.
- Parent of the child for whom paternity and/or support action is required.
Cooperation is required in all phases of the process to establish paternity and obtain support. It includes all of the following:

- Contacting the support specialist when requested.
- Providing all known information about the absent parent.
- Appearing at the office of the prosecuting attorney when requested.
- Taking any actions needed to establish paternity and obtain child support (including but not limited to testifying at hearings or obtaining genetic tests).

**FIP Only**

Cooperation includes repaying to the department any assigned support payments received on or after the support certification effective date.

**Exception:** The following child support payment types should not be returned. The FIP recipient is entitled to keep:

- Child support collections attributed to a time period during which the child was not on FIP, when initial FIP eligibility was certified on or after October 1, 2009.
- Child support refunds.
- Child support reimbursements.

**MA**

The support specialist will not take action on deductible cases until after authorization of the first period of MA coverage in Bridges.

Cooperation is required for an active deductible EDG once the first period of MA coverage is authorized. This requirement continues as long as the EDG is active and includes periods for which MA coverage is not authorized.
Support Specialist Determines Cooperation

**FIP, CDC Income Eligible, MA and FAP**

The support specialist determines cooperation for required support actions. The date client fails to cooperate will be populated in the absent parent logical unit of work and negative action is applied the same night automatically; see Support Disqualification.

**Exception:** Determine non-cooperation for failure to return assigned support payments received after the support certification effective date; see **FIS Determines Cooperation** in this item.

Cooperation is assumed until negative action is applied as a result of non-cooperation being entered. The non-cooperation continues until a comply date is entered by the primary support specialist or cooperation is no longer an eligibility factor. The comply date will be populated in the absent parent logical unit of work and the mandatory member will be added to active MA and FAP EDG the same night automatically; see **Removing A Support Disqualification** in this item.

**FIS Determines Cooperation**

**FIP Only**

Determine non-cooperation for failure to return assigned support payments received after the support certification effective date; see **Support Certification Effective Date** in this item.

The individual is considered non-cooperative when they have received assigned support payments directly for a second calendar month after the certification effective date and failed to return them to the department.

**Note:** The two calendar months need not be consecutive.

Start the disqualification procedure; see **Support Disqualification** in this item.

Cooperation exists when the client returns subsequent assigned support payments or an over issuance claim has been established.
and certification of support has occurred; see Removing a Support Disqualification in this item.

SUPPORT DISQUALIFICATION

FIP, CDC Income Eligible, MA and FAP

Bridges applies the support disqualification when a begin date of non-cooperation is entered and there is no pending or approved good cause. The disqualification is not imposed if any of the following occur on or before the timely hearing request date; see BAM 600, Hearings:

- OCS records the comply date.
- The case closes for another reason.
- The non-cooperative client leaves the group.
- Support/paternity action is no longer a factor in the child’s eligibility (for example, the child leaves the group).
- Client cooperates with the requirement to return assigned support payments to DHS and the support is certified.
- Client requests administrative hearing.

Note: Reinstatement of FIP and income-eligible CDC is necessary to prevent the disqualification from being applied when an administrative hearing is requested timely.

Support Disqualification At Application

FIP, CDC Income Eligible, MA and FAP

At application, client has 10 days to cooperate with the OCS. Bridges informs the client to contact the OCS in the verification check list (VCL). The disqualification is imposed if client fails to cooperate on or before the VCL due date when all of the following are true:

- There is a begin date of non-cooperation in the absent parent logical unit of work.
• There is **not** a subsequent comply date.

• Support/paternity action is still a factor in the child’s eligibility.

• Good cause has not been granted nor is a claim pending; see **Good Cause For Not Cooperating** in this item.

**Note:** If the client is cooperating at reapplication, but has not served the minimum one-month penalty for FIP or FAP, Bridges determines eligibility for the month following the penalty month; see **FIP Disqualification** in this item.

Do all of the following at the application interview:

• Inform the applicant that the disqualification will be imposed unless a comply date is received from the support specialist.

• Encourage the applicant to cooperate with the support specialist and discuss the consequences of the non-cooperation.

• Promptly refer persons who indicate a willingness to cooperate to the primary worker from the CS icon. A support specialist can be reached at 1-866-540-0008 or 1-866-661-0005 to re-evaluate the individual’s cooperation status; see **Removing a Support Disqualification** in this item.

### FIP Disqualification

**FIP**

Any individual required to cooperate who fails to cooperate without good cause causes group ineligibility for a minimum of one month.

Bridges will close FIP for a minimum of one calendar month when any member required to cooperate has been determined non-cooperative with child support. The disqualification is effective the first day of a month.

### CDC Disqualification

**CDC Income Eligible**

Failure to cooperate without good cause, with Office of Child Support requirements for a child requesting or receiving benefits
will result in group ineligibility for CDC. Bridges will close or deny the CDC EDG when a child support non-cooperation record exists and there is no corresponding comply date.

**MA Member Disqualification**

**MA**

Failure to cooperate without good cause results in member disqualification. The adult member who fails to cooperate is **not** eligible for MA when both of the following are true:

- The child for whom support/paternity action is required receives MA.
- The individual and child live together.

**Exception:** Bridges will not begin or continue a disqualification for failure to cooperate when any of the following are true:

- During pregnancy when a woman meets all other eligibility factors.
- Up to two months after the month the pregnancy ends.

**Note:** The child’s MA eligibility is not affected by the adult member’s disqualification. The adult member’s MA must have an ex-parte review before closure because of a failure to cooperate.

**FAP Member Disqualification**

**FAP**

Failure to cooperate without good cause results in disqualification of the individual who failed to cooperate. The individual and his/her needs are removed from the FAP EDG for a minimum of one month. The remaining eligible group members will receive benefits.

**Budgeting Last FIP Grant on FAP When FIP Closes**

When FIP closes due to child support non-cooperation and the non-cooperating individual has a FAP EDG participation status of eligible or disqualified, Bridges counts the last FIP grant amount in the FAP budget for **one month**.
Note: The last FIP grant amount is the monthly grant amount the individual received immediately before FIP closed.

Bridges removes the last FIP grant amount from the FAP budget after it has been budgeted for one month.

Hearings

Notify the primary worker from the Child Support (CS) icon of hearing requests involving child support actions. Attempt to resolve the issue without going to a hearing. Involve the primary worker noted in the CS icon on the Absent Parent Child Link page in the pre-hearing conference.

REMOVING A SUPPORT DISQUALIFICATION

FIP, CDC Income Eligible, MA and FAP

Ask a disqualified client at application, redetermination or reinstatement if they are willing to cooperate. A disqualified member may indicate willingness to cooperate at any time. Immediately inform clients willing to cooperate to contact the primary worker from the CS icon or a support specialist can be reached by calling 1-866-540-0008 or 1-866-661-0005.

Bridges will **not** restore or reopen benefits for a disqualified member until the client cooperates (as recorded on the child support non-cooperation record) or support/paternity action is no longer needed. Bridges will end the non-cooperation record if any of the following exist:

- OCS records the comply date.
- Support/paternity action is no longer a factor in the client’s eligibility (for example, child leaves the group).
- For **FIP only**, the client cooperates with the requirement to return assigned support payments, or an over issuance is established and the support is certified.
- For **FIP and FAP only**, a one-month disqualification is served when conditions (mentioned above) to end the disqualification are not met prior to the negative action effective date.
FIP and CDC Income Eligible

Client must reapply for program eligibility when the above did not exist before the negative action effective date of the closure.

MA only

Disqualified member is returned to the eligible group active for program in the month of cooperation.

FAP only

Disqualified member is returned to the eligible group the month after cooperation or after serving the one-month disqualification, whichever is later.

SUPPORT ASSIGNMENT AND CERTIFICATION

Assignment

FIP

Assignment is the agreement of the head of household and parent to give to the state all rights to current and future court-ordered child support paid on behalf of a FIP recipient for the same time period. Assignment occurs when the individual completes and signs a DHS-1171, Assistance Application.

Note: Minor parents must also sign the DHS-1171 to confirm their understanding of the assignment of child support.

Exception: The following child support payment types are not assigned and should not be returned. The FIP recipient is entitled to keep:

- Child support collections attributed to a time period during which the client was not receiving FIP, when initial FIP eligibility is certified on or after October 1, 2009.
- Child support refunds.
- Child support reimbursements.

FIP recipients also assign their spousal support if it is included in the same order as the child support.
Certification

FIP and MA

Child support is certified (sent to the state) when it is paid for a period of time an individual was a dependent receiving FIP or MA. This is reimbursement for the FIP or MA expenditures.

Support certification occurs automatically based on completion of an Absent Parent Logical Unit of Work for each child requiring a referral to the OCS when initial FIP and/or MA eligibility is certified in Bridges.

FIP recipients’ spousal support that is included in the same order as child support is also certified.

Support Certification

Effective Date

The support certification effective date is based on the initial FIP eligibility date and if direct child support was included in the initial eligibility determination in Bridges. When direct child support is not included in the initial eligibility determination, the certification is effective when eligibility begins. When direct child support is included in the initial eligibility determination, certification is effective the first of the original ongoing month.

Original Ongoing Month

FIP

The original ongoing month displayed in the FIP EDG summary is the date that child support will begin to be assigned to the state by OCS for the current episode of FIP. The original ongoing month is in the future, as indicated below.

When the initial FIP eligibility date is the first of a month, the original ongoing month is the first day of the month following the day initial FIP eligibility is certified in Bridges.

When the initial eligibility date is the 16th day of a month, the original ongoing month is the later of:

- The first day of the month following the initial eligibility date.
CHILD SUPPORT

INCOME TEST

The child support income test compares the amount of child support collected by OCS with the FIP grant. This process is automatically applied each month to FIP cases that have certified support. FIP is closed when collected child support exceeds the grant by $50 in two consecutive months; see BEM 518. This test does not include support that has been collected for MA purposes.

Support Received by FIP Recipient

FIP

A FIP recipient may receive assigned support payments after the support certification effective date because of:

- Delays in processing the certification.
- Delays in processing out-of-state orders.
- An incomplete Absent Parent logical unit of work.

If one of these types of child support is paid to the FIP client, a task/reminder is received by the specialist.

The recipient must return or forward assigned support payments received after the support certification effective date to the local MDHHS fiscal unit. Accounting Manual item ACM 462 gives fiscal unit instructions for handling client-returned child support warrants.

Inform all clients of this requirement, whether support is established or pending, when FIP is approved or a member is added to a FIP EDG. See Assignment section in this item for the types of child support payments the FIP recipient is entitled to keep.

See BEM 500 and BEM 518 for budgeting policies/procedures for support payments received after the support certification date that are retained by the FIP recipient.
Child Support Warrants Addressed to the Local Office

Child support warrants are mailed to the client’s mailing address in Bridges. To minimize the number of warrants received in the local office, avoid entering the local office address as the client’s mailing address in Bridges.

When the Local Office Liaison receives a child support warrant addressed to the client at the local office address, a DHS-2362, State Treasurer’s Warrants, Rewrite/Disposition Request, will also be received. Determine and notify the Local Office Liaison if the warrant should be returned to MiSDU or forwarded to the individual by completing the DHS-2362.

**Note:** The client need not return all child support payment types. See Assignment section in this item for types of payments that FIP recipients are entitled to keep while receiving FIP.

**VERIFICATION REQUIREMENTS**

**Good Cause**

**FIP, CDC Income Eligible, MA and FAP**

A claim of good cause must be supported by written evidence or documented as credible. Assist clients in obtaining evidence if needed. See Verification Sources in this item for examples of acceptable evidence.

Verification of good cause due to domestic violence is required only when questionable.

**VERIFICATION SOURCES**

**Good Cause**

**Pending Adoption**

Court documents or records indicating that legal proceedings for adoption are pending.
Adoption Counseling

Written statement from a licensed social agency indicating both of the following:

- The individual is receiving counseling to decide whether the child should be released for adoption.
- The counseling has not gone on for more than three months.

Domestic Violence

- Documented receipt of domestic violence counseling or client is residing in a domestic violence shelter.
- Medical records.
- Court records (for example, personal protection order or petition).
- Police records (for example, domestic disturbance response).
- Other case record information (including Children’s Services).

LEGAL BASE

FIP

42 USC 608, Social Security Act, Section 408
45 CFR 303.11(b)(9)
MCL 400.1 et seq.
MCL 552.23(2)
MCL 722.718

CDC

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

MA

42 USC 1386(K)
Social Security Act, Section 1912
42 CFR 433.146, .147
MCL 400.106

**FAP**

7 USC 2015(l)
Mich Admin Code, R 400.3007, .3009, .3010
OVERVIEW

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance (RCA), Group 2 Persons Under Age 21 (G2U), Group 2 Caretaker Relative (G2C), Refugee Medical Assistance (RMA), SSI-Related MA, Child Development and Care (CDC) and Food Assistance Program (FAP)

Consider assets in determining eligibility for FIP, SDA, RCA, G2U, G2C, RMA, SSI-related MA categories, CDC and FAP.

FIP, SDA, RCA, G2U, G2C, CDC and RMA consider only the following types of assets:

- Cash (which includes savings and checking accounts).
- Investments (which includes 401(k), Roth IRA etc.).
- Retirement Plans.
- Trusts.

FIP, SDA, RCA and CDC only

Homes and Real Property.

G2U, G2C, RMA and SSI-Related Medicaid

The department will utilize an asset verification program to electronically detect unreported assets belonging to applicants and beneficiaries.

Asset detection may include the following sources at financial institutions: checking, savings, and investment accounts, IRAs, treasury notes, certificates of deposit (CDs), annuities and any other asset that may be held or managed by a financial institution.

Asset detection will be requested by sending the required fields, name, Social Security number, and address, to the asset detection program. This request may occur at any day and time during the month.

Assets Defined

Assets mean:

- Cash (see Cash in this item).
- Personal property. **Personal property** is any item subject to ownership that is not real property (examples: currency, savings accounts and vehicles).

- Real property. **Real property** is land and objects affixed to the land such as buildings, trees and fences. Condominiums are real property.

**Overview of Asset Policy**

Countable assets **cannot** exceed the applicable asset limit. Not all assets are counted. Some assets are counted for one program, but not for another program. Some programs do **not** count assets; see **Programs With No Asset Test** in this item.

Consider both of the following to determine if an asset is countable, and how much to count:

- **Availability:**
  - See **Available in this item.**
  - See **Jointly Owned Assets** in this item.
  - See **Non-Salable Assets** in this item.

- See **Exclusions** in this item.

An asset is countable if it meets the availability tests and is **not** excluded.

**Note:** Only certain types of assets are considered by FIP, RCA, SDA, G2U, G2C, RMA, CDC and FAP. See the list in this section. FIP asset rules apply to RCA.

Consider the assets of each person in the asset group; see the **Program’s Asset Group** policy in this item.

An asset converted from one form to another (example: an item sold for cash) is still an asset.

**Exception:** See Bridges Eligibility Manual (BEM) 503, **SALE OF PROPERTY IN INSTALLMENTS.**

**FIP, SDA, RCA, G2U, G2C, RMA and CDC Only**

The following types of assets are the only types considered for FIP, SDA, RCA, G2U, G2C, CDC and RMA:
• Cash (which includes savings and checking accounts).
• Investments (which includes 401(k), Roth IRA etc.).
• Retirement plans.
• Trusts.

**FIP, SDA, RCA and CDC only**

Homes and Real Property.

**SSI-Related MA Only**

All types of assets are considered for SSI-related MA categories.

**PROGRAMS WITH NO ASSET TEST**

**MAGI-Related MA**

There is no asset test for MAGI-related Medicaid categories.

Do **not** deny or terminate those benefits because of a refusal to provide asset information or asset verification requested for purposes of determining eligibility for a category or program that has an asset test, such as FIP.

**FAP Only**

There is a FAP asset test for all FAP groups.

**Exception:** When all FAP members are receiving FIP and/or SDA and/or SSI, they do not have a FAP asset test because their asset requirements are met by the FIP/SDA/SSI program; see BEM 213, CATEGORICAL ELIGIBILITY, Asset Tests.

**FIP, RCA, SDA, CDC AND FAP ASSET ELIGIBILITY**

**FIP, RCA, SDA and FAP**

**Policy Overview**

Determine asset eligibility prospectively using the asset group's assets from the benefit month. Asset eligibility exists when the group’s countable assets are less than, or equal to, the applicable asset limit at least one day during the month being tested.
Note: For FAP, Bridges budgets all countable assets for ineligible and/or disqualified individuals. All assets of non-group members such as ineligible students, furloughed prisoners, etc., will be excluded by Bridges.

CDC Only

For asset eligibility a program group's assets may not exceed the asset limit, as confirmed through self-certification.

Application

At application, do not authorize FIP, RCA, SDA, CDC or FAP for future months if the person has excess assets on the processing date.

Exception: If the FAP group meets categorical eligibility within 30 days of application, FAP eligibility is effective the date of application. If the FAP group meets categorical eligibility criteria after 30 days, FAP eligibility is effective on the date FIP or SDA is approved.

Pending Application Months

For pending FIP, RCA, SDA, CDC and FAP applications, use asset policy that is in effect for the month for which eligibility is being determined.

Ongoing

If an ongoing FIP, RCA, CDC or SDA recipient has excess assets, initiate closure. However, reinstate the program if it is verified that the excess assets are under the limit on or before the timely hearing request date.

FIP, RCA, SDA, CDC and FAP Only

Bridges produces an overissuance referral for benefits issued after the last month of eligibility only if a closure delay was caused by the group’s failure to report the asset change timely. Bridges Administrative Manual (BEM) 700, BENEFIT OVERISSUANCES and BAM 705, AGENCY OVERISSUANCES explain overissuance and recoupment policies and procedures.

RCA Only
Do not consider the assets of a refugee's sponsor in determining the refugee's eligibility.

Exclude as an asset any cash assistance given to a refugee from a resettlement agency.

Evaluate and treat other assets as they are evaluated and treated for FIP.

**FIP/RCA/SDA/CDC Asset Group**

**FIP, RCA, SDA Only**

The asset group includes individuals with an EDG participation status of eligible or disqualified; see BEM 210, FIP GROUP COMPOSITION, 214, SDA GROUP COMPOSITION and 215, RCA GROUP COMPOSITION.

**CDC ONLY**

The CDC asset group includes those individuals that would be included in the CDC program group; see BEM 205, CDC Group Composition.

**FIP, RCA and SDA Asset Limit**

**FIP, RCA and SDA Only**

$3,000 for cash, investments and retirement plans.

$200,000 for real property assets.

**CDC Asset Limit**

The total countable assets for the CDC program group cannot exceed $1 million.

**FAP Asset Limits**

**FAP**

$5,000 or less.
Non-Categorically Eligible Groups:

$5,000 or less for SDV groups who have income over 200 percent of the poverty level and certain disqualified household members; see BEM 213, CATEGORICAL ELIGIBILITY.

FAP Asset Group

The asset group is:

- FAP eligible members; see BEM 212, FOOD ASSISTANCE PROGRAM GROUP COMPOSITION.
- All disqualified members; see BEM 550, FAP INCOME BUDGETING.
- Alien sponsors; see BEM 226, SPONSORED ALIENS.

FAP Divestment

Divestment occurs if a FAP group transfers assets for less than the fair market value for any of the following reasons:

- To qualify for program benefits.
- To remain eligible for program benefits.

See BEM 406, FAP DIVESTMENT.

MA ASSET ELIGIBILITY

G2U, G2C, RMA, and SSI-Related MA Only

Asset eligibility is required for G2U, G2C, RMA, and SSI-related MA categories.

Note: Do not deny or terminate Group 2 Pregnant Women because of a refusal to provide asset information or asset verification requested for purposes of determining G2U, G2C, RMA or SSI-related MA eligibility.

Use the special asset rules in BEM 402, SPECIAL MA ASSET RULES, for certain married L/H and waiver patients. See BPG Glossary, for the definition of L/H patient and BEM 106, MA WAIVER FOR ELDERLY AND DISABLED, for the definition of waiver patient.
Asset eligibility exists when the asset group's countable assets are less than, or equal to, the applicable asset limit at least one day during the month being tested.

At application, do not authorize MA for future months if the person has excess assets on the processing date.

If an ongoing MA recipient or active deductible client has excess assets, initiate closure. However, delete the pending negative action if it is verified that the excess assets were disposed of. Payment of medical expenses, living costs and other debts are examples of ways to dispose of excess assets without divestment. LTC and waiver patients will be penalized for divestment; see BEM 405, MA DIVESTMENT.

G2U, G2C and RMA Asset Group

G2U, G2C and RMA

See BEM 211, MA GROUP COMPOSITION.

G2U, G2C and RMA Asset Limit

G2U, G2C and RMA

$3,000.

SSI-Related MA Asset Group

SSI-Related MA Only

See BEM 211, MA GROUP COMPOSITION.

SSI-Related MA Asset Limit

SSI-Related MA Only

For Freedom to Work (BEM 174) The asset limit for the initial eligibility determination is set to the current asset limit for a group of one in the Medicare Savings Program (listed below). Once eligibility for FTW has been established the countable asset limit increases to $75,000 for ongoing Medicaid. IRS recognized retirement accounts (including IRAs and 401(k)s) may be of unlimited value. These retirement accounts may continue to be
excluded as assets from future MA eligibility determinations; see BEM 174.

For Medicare Savings Programs (BEM 165) the asset limit is:

- For an asset group of one:
  - $7,730 effective April 1, 2019.
  - $7,560 effective January 1, 2018.
  - $7,390 effective January 1, 2017.
  - $7,280 effective January 1, 2016.
  - $7,280 effective January 1, 2015.
  - $7,080 effective January 1, 2013.
  - $6,940 effective January 1, 2012.
  - $6,680 effective January 1, 2011.

- For an asset group of two:
  - $11,600 effective April 1, 2019.
  - $11,340 effective January 1, 2018.
  - $11,090 effective January 1, 2017.
  - $10,930 effective January 1, 2016.
  - $10,930 effective January 1, 2015.
  - $10,750 effective January 1, 2014.
  - $10,620 effective January 1, 2013.
  - $10,410 effective January 1, 2012.
  - $10,020 effective January 1, 2011.

  - For QDWI (BEM 169) the asset limit is: $4000 for an asset group of one.

  - $6000 for an asset group of two.

For all other SSI-related MA categories, the asset limit is:

- $2,000 for an asset group of one.
- $3,000 for an asset group of two.

DEEMING OF PARENTAL ASSETS

SSI-Related MA Only

Deeming means counting a portion of parents' assets as their child's assets. Do not deem when:
- Any parent living with the child is an SSI or FIP recipient; see BEM 211, MA GROUP COMPOSITION.

- When determining a child's eligibility under BEM 170, HOME CARE CHILDREN.

- When determining a child's eligibility under BEM 171, CHILDREN’S WAIVER.

- When determining a child's eligibility under BEM 172, Children with Serious Emotional Disturbance (SED) Waiver.

**Deeming Calculation**

**SSI-Related MA Only**

Use the following to calculate the deemed amount.

1. Determine the total value of the parents’ countable assets, as if they were an asset group, even if they are not married.

   **Note:** The child is not eligible for SSI-related MA if the parents refuse to provide asset information or a required verification.

2. Subtract $2,000 for one parent ($3,000 for two parents) from the amount of the parents' countable assets (step 1). The result is the deemable asset amount.

3. Divide the deemable asset amount (step 2) by the number of the parents' unmarried children under age 18 in the parents' home who are:

   - SSI recipients.
   - Applicants for, or recipients of, MA based on blindness or disability, who also meet both:

     - The nonfinancial eligibility factors in BEM 155, 503 INDIVIDUALS or BEM 166, GROUP 2 AGED, BLIND AND DISABLED.

     - Are not Home Care Children (BEM 170), Children’s Waiver (BEM 171), or SED Waiver (BEM 172).

   The result is the amount of assets deemed to the child whose eligibility is being determined.
ALIEN SPONSOR ASSET DEEMING

FAP

An alien’s assets might include assets deemed from the alien’s sponsor; see BEM 226, SPONSORED ALIENS, Definitions.

AVAILABLE

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

An asset must be available to be countable. Available means that someone in the asset group has the legal right to use or dispose of the asset.

Exception: This does not apply to trusts. There are special rules about trusts. See Trusts in this item for FIP, RCA, SDA, CDC and FAP. See BEM 401, MA-TRUST policy.

Assume an asset is available unless evidence shows it is not available.

An asset remains available during periods in which a guardian or conservator is being sought. This includes situations such as:

- A person’s guardian dies, and a new guardian has not been appointed yet.
- A court decides a person needs a guardian, but has not appointed one yet.
- A person is unconscious, and his family asks the court to appoint a guardian.

Availability might also be affected by joint ownership and efforts to sell or the possibility of domestic violence. See Jointly Owned Assets, Non-Salable Assets and Victims of Domestic Violence in this item.

SSI-Related MA Only

A person’s death and probating his estate does not make his assets unavailable for purposes of determining his eligibility. Determine asset eligibility for the days of the month the person was alive.
ESTATE RECOVERY

MA Only

The federal government requires Medicaid to recover money that it paid for services from the estates of Medicaid beneficiaries who have died. Medicaid will only recover the amount Medicaid paid for a beneficiary. This is estate recovery. The state will not seek recovery of certain Medicare cost-sharing benefits; see BAM 120, MSA/MDHHS Coordination.

Victims of Domestic Violence

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA, CDC and FAP

Assets owned by victims of domestic violence may be unavailable due to domestic violence. These assets do not have to be jointly owned but accessing them could put the client in danger. Exempt these assets for a maximum of three months. With FIM approval one three-month extension is permitted. Document in the case record the reasons for the temporary exclusion, and, if any extension is requested, document what steps have been taken to secure the asset. Clients should be advised at the time of the exemption that they are required to report any changes in the status of the asset within 10 days.

Exception: For FAP, there is no time limit for the length of the exemption.

JOINTLY OWNED ASSETS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Jointly owned assets are assets that have more than one owner.

Note: For Freedom To Work determinations, jointly owned assets are considered to belong to the initial person.

An asset is unavailable if all the following are true, and an owner cannot sell or spend his share of an asset:

• Without another owner’s consent.
• The other owner is not in the asset group.
• The other owner refuses consent.

Exception 1: In SSI-related MA, when ownership is shared by an SSI-related child and his parent(s) and parental asset deeming applies, refusal to sell by either the child or the parent(s) does not make an asset unavailable; see Deeming of Parental Assets in this item, see definition of SSI-related child in BEM 211.

Exception 2: For FAP, the value of a vehicle is available even if a joint owner refuses to sell.

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only and CDC

Jointly owned real property is only excludable if it creates a hardship for the other owners.

Note: In SSI-related MA a divestment has occurred if joint owners are added during the five year look back period. See BEM 405, MA DIVESTMENT for determination of a divestment penalty.

Ownership documents for jointly owned real property commonly use one of four phrases:

• Joint Tenancy: no owner can sell unless all owners agree.

• Joint Tenancy with Right of Survivorship: no owner can sell unless all owners agree.

• Tenancy by the Entirety: same as joint tenancy except the owners are husband and wife. Neither owner can sell unless both owners agree.

• Tenancy-in-Common: each owner can sell their share without the other owner’s agreement.

Note: For jointly owned real property count the individual’s share unless sale of the property would cause undue hardship. Undue hardship for this item is defined as: a co-owner uses the property as his or her principal place of residence and they would have to move if the property were sold and there is no other readily available housing.
Joint Cash and Retirement Plans

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section applies to the types of assets listed under CASH and RETIREMENT PLANS in this item.

Count the entire amount unless the person claims and verifies a different ownership. Then, each owner’s share is the amount they own.

SSI-Related MA Only

Exception: Apply the following when an L/H or waiver patient (see BPG, Glossary, and BEM 106, MA WAIVER FOR ELDERLY AND DISABLED) and his spouse jointly own the asset:

- Consider the client the sole owner in determining the community spouse resource allowance (CSRA). BEM 402, SPECIAL MA ASSET RULES, describes the CSRA.

- Proceed as follows for all other purposes:

  - If the spouse is an MA-only client or receives FIP or SSI, each spouse owns an equal share unless otherwise claimed and verified.
    
  - If the spouse is not an MA-only client and does not receive FIP or SSI, consider the asset totally available unless otherwise claimed and verified.

Exception: Count equal shares of an asset owned by more than one SSI-related MA child unless the person claims and verifies a different ownership.

Exception: If the owners are an SSI-related MA child and their parent(s) and asset deeming applies, count the total amount as the child's unless the person claims and verifies a different ownership.

Other Joint Assets

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA, CDC and FAP

This applies to all assets that are not included under Cash or Retirement Plans.
Count an equal share for each owner.

**Note:** If specified otherwise by the ownership document, each owner's share is the amount specified.

**Residents of Domestic Violence Shelters**

**FAP**

Assets owned by residents of domestic violence shelters are unavailable when the assets cannot be accessed without agreement of a joint owner residing in the former household.

**NON-SALABLE ASSETS**

**SSI-Related MA Non-Salable Assets**

**SSI-Related MA Only**

Give the asset a $0 countable value when it has no current market value as shown by one of the following:

- Two knowledgeable appropriate sources (example: realtor, banker, stockbroker) in the owner's geographic area state that the asset is not salable due to a specific condition (for example, the property is contaminated with heavy metals). This applies to any assets listed under:
  - Investments.
  - Vehicles.
  - Livestock.
  - Burial Space Defined.
  - Employment and Training Assets.
  - Homes and Real Property (see below).

In addition, for homes, life leases, land contracts, mortgages, and any other real property, an actual sale attempt at or below fair market value in the owner's geographic area results in no reasonable offer to purchase. Count an asset that no longer meets these conditions. The asset becomes countable when a reasonable offer is received.
For applicants, an actual sale attempt to sell must have started at least 90 days prior to application and must continue until the property is sold. For recipients, the asset must have been up for sale at least 30 days prior to redetermination and must continue until the property is sold. An actual sale attempt to sell means the seller has a set price for fair market value, is actively advertising the sale in publications such as local newspaper and is currently listed with a licensed realtor. The definition of fair market value can be found in the glossary. If after a length of time has passed without a sale, the sale price may need to be evaluated against the definition of fair market value.

**Note:** The non-salable asset policy does not apply to the Initial Asset Assessment.

**FAP Non-Salable Assets**

**FAP**

Do not count **real property** that the FAP group is making a **good-faith effort** to sell. All the following must be met for the real property to be excluded:

- No reasonable purchase offer has been made.
- For active cases, the property is continuously up for sale by a real estate company, by owner, etc.
- An actual attempt has been made to sell it at a price not higher than the fair market value.

**CASH**

**FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP**

This section is about the following types of assets:

- Money/currency.
- Uncashed checks, drafts and warrants.
- Checking and draft accounts.
- Savings and share accounts.
• Money market accounts.

• LTC patient trust fund and all other money held by the facility for the patient. **Example:** Patient has prepaid in advance for the nursing home stay.

• Money held by others. **Example:** Sally does **not** have a bank account. She puts money in her mother’s checking account, but it is **not** a joint account.

• Time deposits. A **time deposit** is a contract between a person and a financial institution whereby the person agrees to leave funds on deposit for a specified period in return for a specified interest rate. Common time deposits are certificates of deposit (CDs) and savings certificates.

**Note:** For FAP, use the lowest checking, savings or money market balance in the month when determining asset eligibility.

**Note:** Determining the cash value of investment instruments, such as stocks, bonds and mutual funds, is found in the INVESTMENT section of this item.

**Crowdfunding Account**

**FIP, RCA, SDA, CDC and FAP**

Funds that are available to the household in a crowdfunding account (such as, but not limited to, GoFundMe, Kickstarter) are considered a cash asset.

**Lump Sums and Accumulated Benefits**

Lump sums and accumulated benefits are defined in the BPG, Glossary.

**FIP, RCA, SDA, CDC and FAP**

Lump sums and accumulated benefits are assets starting the month received.

A person might receive a single payment that includes both accumulated benefits and benefits intended as a payment for the
current month. Treat the portion intended for the current month as income.

**G2U, G2C, RMA, SSI-Related MA Only**

Lump sums and accumulated benefits are income in the month received. See BEM 500, INCOME OVERVIEW, about countable income policy.

**Exception:** The following are assets:

- Income tax refunds; see Tax Refund & Tax Credit Exclusions in this item.
- Nonrecurring proceeds from the sale of assets.
- Payments that are excluded assets.
- Medical Loss Ratio Rebate.

**Retroactive SSI Benefits**

**FIP, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP**

Retroactive SSI benefits may be paid as a one-time payment or in installments over several months. The Social Security Administration determines how payment will be made.

Retroactive SSI benefits are treated as accumulated benefits (see above) even when paid in installments. See Retroactive RSDI and SSI Exclusion in this item for SSI-related MA determinations.

**Note:** For FAP households where all members receive FIP and/or SDA and/or SSI, retroactive SSI benefits are excluded in Bridges.

**Value of Cash**

**FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP**

The value of the types of assets described above is the amount of the:

- Money/currency.
- Uncashed check, draft or warrant.
- Money in the account or on deposit.
- Money held by others.
• Money held by nursing facilities for residents.
• Money in a vendor pre-paid debit card (for example, Direct Express, ReliaCard, etc.).

**Exception:** Reduce the value of a time deposit by the amount of any early withdrawal penalty, but not the amount of any taxes due.

### CASH EXCLUSIONS

#### Homestead-Loss Funds Exclusion

**FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only and CDC**

Use this exclusion only if the funds are not commingled with countable assets and not in time deposits.

Exclude funds an owner received for repairs or replacement of a damaged or destroyed homestead (example: insurance settlement) if both of the following are true:

- The owner intends to reoccupy the home.
- There is a written repair/replacement agreement.

The client must declare an estimated completion date. The exclusion lasts until that date. The local office may grant extensions.

Exclude funds for temporary housing while the homestead is being repaired or replaced.

Also see Homestead-Loss Land Exclusion in this item regarding the land the home was on.

**FAP**

Exclude any governmental payments which are designated for the restoration of a home damaged in a disaster if the household is subject to a legal sanction if the funds are not used as intended. Examples include, but are not limited to, payments made by the Department of Housing and Urban Development through the individual and family grant program or disaster loans or grants made by the Small Business Administration.
Homestead Sale Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, CDC and FAP

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

Exclude funds received from the sale of a homestead, or the land the home was on, for 12 months if there is a written agreement to purchase another homestead. The 12-month period starts the month the funds are received.

Note: See homestead land retained exclusion in this item if ownership of the land was retained.

SSI-Related MA Only

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

When an individual sells an excluded home, the proceeds (the net amount the seller receives at settlement) of the sale are excluded resources if the individual:

- Plans to use them to buy another excluded home and,
- Does so within three full calendar months of receiving the proceeds.

If the individual received the proceeds under an installment contract, the contract is an excluded resource for as long as the individual:

- Plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home and,
- Does so within three calendar months of receiving such down payment or installment payment.

Health Reimbursement Accounts

SSI-Related MA only

Health Reimbursement Account Plans (HRAs) are group health plans and need to be reported to Third Party Liability.
Health Savings Accounts and Medical Savings Accounts

MA programs, excluding MAGI-Related

Health savings accounts are countable resources. The value is the amount available for withdrawal minus any penalties but not taxes. Count amounts withdrawn as an asset in the month received.

Medicare Set-Aside Account

All Programs

Medicare Set-Aside Accounts are limited to payment of qualified medical expenses as determined by the Social Security Administration. They are created when a Medicare recipient has a workers’ compensation settlement. They are excluded as income and as an asset.

Non-Homestead Loss Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

Exclude funds received for the planned repair or replacement of a non-homestead exempt item (example: furniture, clothing, vehicle) that was lost, stolen or destroyed. Exclude the funds until the item is repaired or replaced.

Loan Exclusion

FIP, RCA and CDC

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

Exclude funds a person has borrowed provided it is a bona fide loan. This includes a loan by oral agreement if it is made a bona fide loan.

Bona fide loan means all the following are present:
• A loan contract or the lender's written statement clearly indicating the borrower's indebtedness.

• An acknowledgment from the borrower of the loan obligation.

• The borrower's expressed intent to repay the loan by pledging real or personal property or anticipated income.

This exclusion does not apply to:

• Interest earned on borrowed money.
• Purchases made with borrowed money.

Note: When a client has loaned money to another person please refer to the policy in Promissory Notes/Land Contracts/Mortgages/Loans.

Reverse Mortgage Exclusion

FIP, RCA, SDA, CDC and FAP

Use this exclusion only if the funds are not commingled with countable assets and not in time deposits.

A reverse mortgage allows a homeowner to borrow some percentage of the value of his home via a mortgage. The homeowner receives periodic payments (or a line of credit) that does not have to be repaid while the homeowner lives in the home. Exclude these payments. They are loans.

SSI Related MA Only

Payments that a homeowner receives from a reverse mortgage are loan proceeds. The loan proceeds are an excluded resource in the month received, but are a countable resource if retained in the month following the month of receipt. A transfer of reverse mortgage proceeds is subject to review for a divestment determination when the client is in a penalty situation; see BEM 405, MA Divestment.

Tax Refund and Tax Credit Exclusion

FIP, RCA, CDC and FAP

All state and local earned income tax credits and refunds are excluded, including home heating credits.
Note: Federal income tax refunds are excluded for 12 months from the month of receipt. The refund amount is subtracted from the household's total assets to determine if they meet the asset limit.

Note: This exclusion continues even if the client has already spent the refund.

Example: Clara applies for FAP in November and her total countable assets are $6,000. During the interview ask her if anyone in the household received a Federal income tax refund in the past 12 months. Her tax refund of $2,000 was received in January and she used it to pay bills. The $2,000 is still subtracted from the $6,000 resulting in countable assets of $4,000.

SDA

Exclude tax refunds and credits.

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

G2U, G2C, RMA, SSI-Related MA Only

Exclude tax credits for nine months after the month of receipt. Tax credits include credits such as Earned Income Tax Credit and Child Tax Credit.

Note: Federal income tax refunds are excluded for 12 months from the month of receipt. The refund amount is subtracted from the household's total assets to determine if they meet the asset limit.

Note: This exclusion continues even if the client has already spent the refund.

Excluded Income Under BEM 500 Series

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

BEM 500, INCOME OVERVIEW, 501, INCOME FROM EMPLOYMENT, 502, INCOME FROM SELF-EMPLOYMENT, 503, INCOME UNEARNED and 504, INCOME FROM RENTAL/ROOM AND BOARD, identify certain sources of funds that are excluded as
both income and assets. Time limits and other conditions applicable to the income exclusion also apply to the asset exclusion.

**Note:** For FAP, see *Excluded Assets* in this item.

### Current Income Exclusion

**FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP**

Do not count funds treated as income by a program as an asset for the same month for the same program.

When income must be prorated or averaged (example: self-employment), exclude the resulting assets for the months of proration.

### Business Account Exclusion

**FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP**

Use this exclusion only if the funds are **not** commingled with countable assets and **not** in time deposits.

Exclude a savings, share, checking or draft account used **solely** for the expenses of a business. Continue the exclusion while the business is not operating, provided the person intends to return to the business.

### SSI Dedicated Account

**FAP**

Exclude an SSI Dedicated Account. These accounts are mandated if a child under 18 is approved for SSI and receives a lump-sum payment.

### Retroactive RSDI and SSI Exclusion

**SSI-Related MA Only**

Exclude retroactive RSDI and SSA-issued SSI benefits for nine calendar months beginning the month after payment is received. Do
not exclude purchases made with such funds including CDs and other time deposits.

This exclusion applies only to any unspent portion of the retroactive payment from RSDI or SSI. Once the money from the retroactive payment has been spent, this exclusion does not apply to the items purchased with the money, even if the nine month period has not expired.

The money may be commingled with other funds but, if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit.

Use the following to separate countable and excluded funds that are commingled:

- Assume that countable funds are withdrawn first, leaving as much of the excluded funds as possible.

- Excluded funds withdrawn are not excluded if redeposited. The excluded amount can be increased only by deposits of subsequently received excluded payments.

- Count any interest paid to the account.

**Example:** A person received a $1,000 retroactive RSDI payment on December 3 via direct deposit. The account already contained $1,800.

<table>
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<th>DEPOSIT</th>
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Funds for Burial Arrangements

SSI-Related MA Only

Money set aside for burial expenses might be excludable. See Burial Fund Exclusion in this item.

Retroactive Tax and Utility Cost Subsidy Payments

FAP

Use this exclusion only if the funds are **not** commingled with countable assets and are **not** in time deposits.

Exclude retroactive tax and utility cost subsidy payments in the month received and the following month.

Student Savings Exclusion

FIP, RCA, G2U, G2C, CDC and RMA

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

Exclude funds in a separate account under a student's name and accrued solely from a student's earnings; see STUDENT EARNINGS DISREGARD in BEM 501, INCOME FROM EMPLOYMENT.
INVESTMENTS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section is about the following types of assets:

- U.S. Savings bonds.
- Securities such as:
  - Stocks.
  - Bonds.
  - Mutual funds.

Value of Investments

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

The value of a U.S. Savings bond is the amount the owner could get if the bond were cashed in.

G2U, G2C, RMA, SSI-Related MA Only

U.S. Savings bonds cannot be cashed in until 12 months after the date of issuance. However, if bonds are in this waiting period and the value of the bond(s) and other assets is over the client’s asset limit, the client must seek a waiver of the waiting period.

The waiver is a written request from the bond holder or representative to the United States Department of Treasury outlining why a waiver of the waiting period is necessary. If the waiver is granted the value of the U.S. Savings bond is considered available. If the waiver is denied the bond becomes available at the expiration of the waiting period.

G2U, G2C, RMA, SSI-Related MA Only, and FAP

The value of other investments is the amount the asset is selling for:

- Use the closing price for publicly traded stocks.
- Use the bid price or net asset value (NAV) for mutual funds.
- Use the bid price for bonds.

If a security was not paid for in full at the time of purchase (bought on margin), the securities firm has made a loan to the buyer.
Deduct the balance owed from the price if there is written proof that the balance owed must be repaid when the security is sold.

INVESTMENT EXCLUSION

SSI-Related MA Only

Investments set aside for burial expenses might be excludable; see Burial Fund Exclusion in this item.

RETIREMENT PLANS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section is about the following types of assets:

- Individual retirement accounts (IRAs).
- Keogh plans (also called H.R. 10 plans).
- 401k plans.
- Deferred compensation.
- Pension plans.
- Annuities-- An annuity is a written contract establishing a right to receive specified, periodic payments for life or for a term of years.

FAP

The following retirement accounts are excluded:

- Traditional Defined-Benefit Plan.
- Cash Balance PlanEmployee Stock Ownership Plan.
- Keogh Plan.
- Money Purchase Pension Plan.
- Profit-sharing Plan.
- Simple 401(k).
- 401(k).
- 403(a) and (b).
- IRA.
- Simple Retirement Account IRA.
- Simplified Employee Pension Plan (SEP).
- Roth IRA.
- myRA.
- Eligible 457(b) Plan.
- 501(c)18 Plan.
• Federal Thrift Savings Plan.
• Employer-Sponsored Annuities.

**Exception:** For annuities which are **not** employer-sponsored; see **Annuity** in this item.

### Retirement Plan Value

**FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only and CDC**

The value of these plans is the amount of money the person can currently withdraw from the plan. Deduct any early withdrawal penalty, but not the amount of any taxes due.

Funds in a plan are **not** available if the person must quit his job to withdraw any money.

**Freedom to Work (FTW) only**

The value of funds in retirement accounts and individual retirement accounts may be excluded, see BEM 174.

### Annuity

**G2U, G2C, RMA, SSI-Related MA Only and FAP**

Annuities are similar legal devices to trusts. Annuities are a written contract with a commercial insurance company, establishing a right to receive specified, periodic payments for life or for a term of years. They are usually designed to be a source of retirement income; see BEM 503, Annuity Income policy. Policy in BEM 401 Trusts applies, including referring annuities to the Trust and Annuities Unit; see **FAP Trusts** below.

### TRUSTS

**FIP, RCA, SDA and CDC**

A **trust** is a right of property created by one person for the benefit of himself or another.

### Trust Definitions

**FIP, RCA, SDA and CDC**

**Beneficiary** - the person for whose benefit a trust is created.
**Grantor or settlor** - the person who established the trust. It includes anyone who furnishes real or personal property for the creation of the trust.

**Principal (or corpus)** - the assets in the trust. The assets may be real property (example: house, land) or personal property (example: stocks, bonds, life insurance policies, saving accounts).

**Trustee** - the person who has legal title to the assets and income of a trust and the duty to manage the trust for the benefit of the beneficiary.

### FIP/SDA/CDC Trust Policy

**FIP, RCA, SDA and CDC**

The Probate Court decides availability of the trusts it administers. A grantor must petition the Probate Court to make the principal available.

For other trusts, the principal is an available asset of the person who is legally able to:

- Direct use of the principal for his or her needs.
- Direct that ownership of the principal reverts to himself or herself.

### MA Trust Policy

**G2U, G2C, RMA, and SSI-Related MA Only**

See BEM 401, TRUSTS-MA.

### FAP Trust Policy

**FAP**

The trust principal and any income retained by the trust are considered unavailable if all the following conditions apply:

- The trust arrangement is **not** likely to end during the benefit period.
- No asset group member has the power to revoke the trust or change the name of the beneficiary during the benefit period.
- The trustee administering the trust is one of the following:
• A court or an institution, corporation or organization **not** under the direction of ownership of any asset group member.

• An individual appointed by the court who is restricted by the court to use the funds solely for the benefit of the beneficiary.

• Investments made on behalf of the trust do **not** directly involve or benefit any business or corporation under the control or direction of an asset group member.

• The funds in the irrevocable trust are one of the following:
  - Established from the asset group’s own funds and the trustee uses the funds solely to make investments on behalf of the trust or to pay the educational or medical expenses of the beneficiary.
  - Established from funds of a person who is **not** a member of the asset group.

**Referrals to Trust and Annuities Unit**

All trusts and annuities must be evaluated by the Trust and Annuities Unit. Send a completed DHS-1517, Request for Trust/Annuity Evaluation, to the following email box:

Email address boxes for requests or inquiries to Legal Affairs Administration can be found on the MDHHS-Net at: [http://inside.michigan.gov/dhs/DeptSites/CentOff/olsp/Pages/default.aspx](http://inside.michigan.gov/dhs/DeptSites/CentOff/olsp/Pages/default.aspx)

Please see the EDM business process on Trust & Annuity Review for information on how to complete the referral process.

Advice is only available to local offices and only for purposes of determining eligibility when a trust actually exists. Advice is **not** available for purposes of estate planning, including advice on proposed trusts or proposed trust amendments.
HOME CARETAKER AND PERSONAL CARE CONTRACTS

A contract that prospectively pays for expenses such as repairs, maintenance, property taxes, homeowner’s insurance, heat and utilities for real property/homestead, or that provide for monitoring health care, securing hospitalization, medical treatment, visitation, entertainment, travel and/or transportation, financial management or shopping, etc., would be considered a divestment. Consider all payments for care and services which the client made during the look-back period as divestment; see BEM 405, MA DIVESTMENT.

Note: The preceding examples should not be considered an all-inclusive or exhaustive list.

Assets transferred in exchange for a contract/agreement for a personal services/assistance or expenses of real property/homestead provided by another person after the date of application are considered an available and countable asset even if the contract is irrevocable.

INDIVIDUAL DEVELOPMENT ACCOUNTS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Individual Development Accounts (IDA) are established pursuant to Michigan Public Act 361 of 1998 and section 404(h) of the Social Security Act or Public Law 105-285. IDAs allow low-income families to promote their economic independence by saving for:

- Post-secondary educational expenses.
- First home purchase.
- Business capitalization.

IDAs are funded by periodic contributions from the family’s earnings and matching contributions by or through a nonprofit organization. The IDA must be a trust or a joint account that requires the signatures of both the nonprofit organization and a family member to authorize withdrawals.

An IDA is excluded as an asset.
A 529 college savings plan is similar to an IDA. See **Education and Training Exclusion** in this item for FIP, RCA, SDA, G2U, G2C and RMA.

**MIABLE/ABLE (529A) ACCOUNTS**

**FIP, SDA, RCA, G2U, G2C, RMA, SSI Related MA Only, CDC and FAP**

The Internal Revenue Code section 529A establishes ABLE (Achieving a Better Life Experience) accounts entitles a MiABLE account in Michigan. The account beneficiary must be an individual who lives with a disability. Disregard funds on deposit in an ABLE account, interest earned on the account, and any matching funds deposited in an ABLE account. Disregard distributions from the account for qualified expenses.

The Michigan Department of Treasury administers ABLE accounts in Michigan.

**HOMES AND REAL PROPERTY**

**FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP**

This section is about the following types of assets:

- Real property.
- Mobile homes.
- Life estates and life leases.

**Real Property Definition**

**FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP**

**Real property** is land and objects affixed to the land such as buildings, trees and fences. Condominiums are real property.

**Real Property and Mobile Home Value**

**FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP**

To determine the fair market value of real property and mobile homes use:

- Deed, mortgage, purchase agreement or contract.
- State Equalized Value (SEV) on current property tax records multiplied by two.
- Statement of real estate agent or financial institution.
- Attorney or court records.
- County records.

**FIP, SDA, RCA**

Use the fair market value.

**SSI-Related MA Only, CDC and FAP**

The value is the equity value. Equity value is the fair market value minus the amount legally owed in a written lien provision.

Deeds are considered legal if they are signed and notarized. It does not have to be registered with the registrar of deeds to be a legal document.

**Note:** In Michigan, a lien on a mobile home is on record with the Secretary of State. If the mobile home is on land the person owns, the lien may also be recorded with the land deed.

**Life Estate/Life Lease Definition**

**FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP**

A life estate or life lease gives the person who holds it certain rights to property during the person’s lifetime. Usually, the right is the right to live on the property. The person holding the life estate or life lease can sell it, but does not own the actual property and normally cannot sell the actual property.

**Life Estate/Life Lease Value**

**FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP**

Use the life estate factors in Exhibit II to compute the value of a life estate or life lease. Choose the life estate factor that corresponds to the person’s age. Multiply the fair market value of the actual property by the appropriate life estate factor. The result is the value of the life estate or life lease.
**SSI-Related MA Only**

Use the value of the life estate to determine if the purchase price was for fair market value when a person purchases a life estate in another individual's home.

When a person purchases a life estate in another individual's home, they must actually reside there for at least one year after the date of purchase to qualify for the homestead exclusion. If the person resides in the home for less than one year, treat the transaction as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. See BEM 405, MA DIVESTMENT to determine the penalty period.

**FAP Only**

*Exception:* Use a lower amount if verified. Verified means statements from two financial institutions or real estate firms with a lower value and the reason for it (example: terminal illness). Use the lowest amount if the statements have different values.

**HOMES AND REAL PROPERTY EXCLUSIONS**

**Homestead Definition and Exclusion**

**FAP**

A homestead is where a person lives (unless absent; see absent from homestead, in this item) that they own, is buying or holds through a life estate or life lease. It includes the home, all adjoining land and any other buildings on the land. Adjoining land means land which is not completely separated from the home by land owned by someone else. Adjoining land may be separated by rivers, easements and public rights-of-way (example: utility lines and roads).

Exclude only one homestead for an asset group. If a migrant claims two homesteads, exclude the homestead of the migrant's choice.
**SSI-Related MA Only**

A homestead is where a person lives that they own, is buying or holds through a life estate or life lease. It includes the home in which they live, the land on which the home is located, and any other related buildings on the adjoining land. Adjoining land means land which is not completely separated from the home by land owned by someone else. Adjoining land may be separated by rivers, easements, and public rights-of-way (example: utility lines and roads). A homestead does not include income producing property located on the homestead property.

Exclude only one homestead for an asset group. If an individual claims two homesteads, exclude the homestead of the individual’s choice.

BEM 402, Special MA Asset Rules, describes when both a client’s and community spouse’s assets are counted. If a client and community spouse own two homes, or they are separated, and each owns a homestead, exclude the homestead with:

- The lower equity value for purposes of the initial asset assessment, and
- The higher equity value for purposes of determining initial eligibility.

See policy in this item about exempting a homestead when the owner is *absent from homestead*.

**Home Equity Limit for Long Term Care Costs**

Determine the equity value of the homestead; see *real property and mobile home value* in this item.

MA will not pay the client’s cost for:

- Home health services.
- Home and community-based services (MIChoice Waiver/PACE).
- LTC services.
- Home Help.
When the equity in the client’s homestead exceeds:

- $500,000 in 2010.
- $506,000 starting in January 2011.
- $525,000 starting January 1, 2012.
- $536,000 starting January 1, 2013.
- $543,000 starting January 1, 2014.
- $552,000 starting January 1, 2015.
- $560,000 starting January 1, 2017.
- $572,000 starting January 1, 2018.
- $585,000 starting January 1, 2018.

Do not apply the home equity limit to the client if the spouse, child under 21, or the client’s blind or disabled child is residing in the homestead.

**Absent from Homestead**

**SSI-Related MA Only**

Exclude the homestead (see definition in this item) that an owner lived in prior to the time the individual left the property if any of the following are true:

- The owner intends to return to the homestead.
- The owner is in an LTC facility, a hospital, an adult foster care (AFC) home or a home for the aged.
- A co-owner of the homestead uses the property as his home.

**Relative Occupied.** Exclude a homestead provided both of the following are true:

- The owner is in an institution; see BPG Glossary.
- The owner’s spouse or relative (see below) lives there.

Relative for this purpose means a person dependent in any way (financial, medical, etc.,) on the owner and related to the owner as any of the following:

- Child, stepchild or grandchild.
- Parent, stepparent or grandparent.
- Aunt, uncle, niece or nephew.
- Cousin.
- In-law.
- Brother, sister, stepbrother, stepsister, half-brother or half-sister.

**FAP**

Exclude the homestead the owner formerly lived in if the owner intends to return and is absent for one of the following reasons:

- Vocational rehabilitation training.
- Inability to live at home due to a verified health condition.
- Migratory farm work.
- Care in a hospital.
- Temporary absence due to employment, training for future employment, illness, or a casualty (example: fire) or natural disaster.

### Homestead Land Retained Exclusion

**SSI-Related MA Only**

If an owner sells a homestead (example: mobile home), but retains ownership of the land it was on, exclude the land for three months. The first month is the month the owner receives any payment from the sale. Also, exclude the land for the time between the sale and the receipt of such payment.

### Homestead-Loss Land Exclusion

**SSI-Related MA Only**

Exclude the land of a damaged, destroyed or condemned homestead if both of the following are true:

- The owner intends to reoccupy it.
- There is a written repair or replacement agreement.

The client must declare an estimated completion date. The exclusion lasts until that date. The local office may grant extensions.
Real Property and Employment Assets

SSI-Related MA Only and FAP

Employment-related assets such as farmland and the building where a business is located might be excluded; see Employment Asset Exclusions in this item.

Future Home Exclusion

FAP

Exclude a lot (including a partially built home) if the owner intends it to become the fiscal group’s homestead and has no other homestead.

Real Property and Burial Arrangements

SSI-Related MA Only

Property intended as burial space might be excludable; see Burial Space Exclusion in this item.

FAP

Exclude burial plots and any burial and funeral arrangements purchased by members of the FAP group.

Income-Producing Real Property

SSI-Related MA Only

Exclude up to $6,000 of equity in income-producing real property if it produces annual countable income equal to at least 6 percent of the asset group’s equity in the asset. Countable income is total proceeds minus actual operating expenses.

(Exception: Use the Employment Asset Exclusions in this item for property used in a business or trade.)
FAP Only

Exclude rental and vacation properties owned by the group if they are renting it to produce income.

Note: Time-share properties are excluded.

HOUSEHOLD AND PERSONAL GOODS DEFINED

FAP

Household Goods - those items customarily found in the home and used in connection with the maintenance, use and occupancy of the premises. This includes items necessary for an adequate standard of sustenance, accommodation, comfort, information and entertainment of occupants and guests. Examples are appliances, furniture, television sets, carpets, cooking utensils, eating utensils and dishes.

Personal Goods - items of personal property that are worn or carried by a person or that have intimate relationship to him. Examples are personal clothing and jewelry, personal care items, and educational or recreational items such as books, musical instruments or hobby material.

SSI-Related MA Only

Household Goods - those items of personal property found in or near the home. Household goods are needed for maintenance, use, and occupancy of the premises as a home. Examples include furniture, carpets, and dishes.

Personal Effects - those items of personal property which are ordinarily worn or carried by the individual, or items which have an intimate relation to the individual. Examples include wedding and engagement rings, pets, books.

HOUSEHOLD AND PERSONAL GOODS EXCLUSION

SSI-Related MA Only and FAP

Exclude household and personal goods.
VEHICLES

SSI-Related MA Only and FAP

A vehicle is a device used to transport people or goods. Vehicle includes passenger cars, trucks, motorcycles, motorbikes, trailers, campers, motor homes, boats and all-terrain vehicles.

Note: See Homes and Real Property about mobile homes.

Vehicle Value

SSI-Related MA Only

The value of a vehicle is its equity value. Equity value is the fair market value minus the amount legally owed in a written lien provision.

Liens must be on record with the Secretary of State or other appropriate agency.

FAP

There is a $15,000 limit on countable vehicles owned by the FAP group. Enter the fair market value of all licensed and unlicensed vehicles and the mileage. Do not allow for options such as low mileage, automatic transmission, power windows and power locks.

Bridges adds together the fair market value of all licensed and unlicensed vehicles which are not excluded and subtracts $15,000 to determine the countable value; see FAP Vehicle Exclusions. If the countable value exceeds $15,000 the excess is applied towards the $5,000 asset limit. For instance, the value of the client’s countable vehicles equals $17,000. The remaining amount of $2,000 is counted towards the $5,000 asset limit.

Exception: Count the equity value of an unlicensed vehicle driven by tribal members on a Native American Reservation unless they meet one of the FAP Vehicle Exclusions below. Verify if the vehicle is licensed using the Secretary of State clearance.
VEHICLE EXCLUSIONS

SSI-Related MA Vehicle Exclusion

SSI-Related MA Only

Exclude one motorized vehicle owned by the asset group. If the asset group owns multiple motorized vehicles:

- Use the Employment Asset Exclusions first, then
- From any remaining motorized vehicles, exclude the one with the highest equity value.

FAP Vehicle Exclusions

Highest Fair Market Value Exclusion

FAP

Exclude one vehicle with the highest fair market value per household. This exclusion occurs after all other vehicle exclusions are applied.

Example: A client has three vehicles with fair market values of $1,500, $19,000 and $25,000. The vehicle worth $1,500 is excluded because the fair market value is $1,500 or less. Of the remaining fair market values, the vehicle worth $25,000 is excluded because it is the one with the highest fair market value. Based on the fair market value of the third vehicle, Bridges will count $4,000 ($19,000 - $15,000) towards the $5,000 asset limit.

Fair Market Value Exclusion

FAP

Exclude vehicles with a fair market value of $1,500 or less if currently licensed/registered by the state.

Vehicle as Home Exclusion

FAP

Exclude vehicles that serve as the owner’s home if currently licensed/registered by the state.
**Disability Exclusion**

**FAP**

Exclude one vehicle to transport each physically disabled group member. It does **not** have to be used primarily for that purpose. It must be currently licensed/registered by the state.

**Fuel/Water Exclusion**

**FAP**

Exclude vehicles necessary to carry heating fuel or water for home use when such transported fuel/water is the primary source for the group. The vehicle must be currently licensed/registered by the state.

**Employment Exclusion**

**FAP**

Exclude the following vehicles during periods of employment and temporary unemployment. The vehicle must be currently licensed/registered by the state.

- Vehicles used for income-producing purposes such as but not limited to a taxi, truck, fishing boat or vehicles used for deliveries.

  **Note**: Licensed vehicles previously used by a self-employed household member engaged in farming but no longer used because they quit their self-employment are excluded for one year from the date farming ended.

- Vehicles producing income consistent with their trade-in value even if used on only a seasonal basis.

- Vehicles used on long-distance travel other than daily commuting that are essential to the employment of an asset group member. Examples include migrant worker and traveling salesperson.

**Leased Exclusion**

Exclude vehicles which are leased because the individual has no equity value, cannot sell the vehicle and generally does not have title to the vehicle.
**Exception:** During or at the end of the lease agreement if the individual chooses the purchase option, the vehicle is included in the vehicle asset limit.

**PROMISSORY NOTES/LAND CONTRACTS/MORTGAGES LOANS**

**Land Contracts**

**SSI-Related MA Only**

A land contract is a form of seller financing. It is similar to a mortgage, but the buyer makes payments to the real estate owner (seller) until the purchase price is paid in full. A homeowner might also sell their home via a sale-leaseback agreement; see definition in this item. A land contract does not have to be recorded in Michigan.

The person who sold the property is the holder of the note. The note is the holder's asset.

**Example:** John sells land to Irma on a land contract. John is the land contract holder. The land contract is John's asset. The land is Irma's asset.

The value of a land contract is the amount it can be sold for in the holder's geographic area on short notice (usually at a commercial discount rate) minus any lien on the property the holder must repay.

A land contract may be treated as a transfer of assets unless all the following are true:

- The repayment schedule is actuarially sound; and
- The payments are made in equal monthly amounts during the term of the agreement with no deferral of payments and no balloon payments; and
- The contract must prohibit the cancellation of the balance upon the death of the lender.
See BEM 405, Uncompensated Value, to determine the value of any land contract which does not meet all of the bullets listed in this policy.

**Note:** The payments from a land contract are countable unearned income.

### Mortgages

A mortgage is a loan that a bank or mortgage lender gives to a buyer to finance the purchase of a house. Mortgages are usually recorded to notify the public that the lender has a lien against the property.

The value of a mortgage is the amount it can be sold for in the holder's geographic area on short notice (usually at a commercial discount rate) minus any lien on the property.

A mortgage may be treated as a transfer of assets unless all the following are true:

- The payment schedule is actuarially sound; and
- The payments are made in equal monthly amounts during the term of the agreement with no deferral of payments and no balloon payments; and
- The mortgage contract must prohibit the cancellation of the balance upon the death of the lender.

See BEM 405 Uncompensated Value to determine the value of any mortgage which does not meet all of the bullets in this policy.

### Promissory Notes/Loans

A promissory note is a written promise to pay a certain sum of money to another person at a specified time. Promissory notes are loans. The promissory note may call for installment payments over a period of time (installment note) or a single payment on a specified date. The note is an asset to the lender. The value of the note is the outstanding balance due as of the date of application for long term care, home help, waiver services, or home health services.
All money used to purchase a promissory note or loan, are transfers of assets. They are a transfer of assets for less than fair market value unless the following are also true:

- The repayment schedule is actuarially sound; and
- The payments are made in equal monthly amounts during the term of the agreement with no deferral of payments and no balloon payments; and
- The note must prohibit the cancellation of the balance upon the death of the lender.

See BEM 405, Uncompensated Value to determine the value of any promissory note or loan as a transfer for less than fair market value.

**Bona Fide Loans**

A loan is bona fide if it meets all the following requirements:

- It is enforceable under state law.
- The loan agreement is in effect at the time of the transaction.
- The borrower acknowledges an obligation to repay.
- The loan document includes a plan for repayment.
- The repayment plan is feasible.

**Note:** Count principal payments from a bona fide loan or promissory note are the return of the principal as an asset in the month received. Payment of interest on a bona fide loan and all payments from a loan or promissory note which is not bona fide is countable unearned income.

The estate recovery program needs to know about a promissory note for the state to recover Medicaid expenses. Please send a copy of the promissory note to the estate recovery unit at: MDHHS-EstateRecovery@michigan.gov.

**Sale-Leaseback Agreement Defined**

**SSI-Related MA Only**

In a sale-leaseback agreement, a homeowner sells his home on an installment note and receives monthly payments from the buyer. The buyer allows the former homeowner to live in the home in exchange for rent. The difference between the buyer’s payment and
the rent is money the former homeowner can use for current expenses. Sometimes the arrangement involves purchase of an annuity that pays money to the former homeowner.

**Sale-Leaseback Asset Value**

**SSI-Related MA Only**

The note held by the former homeowner is an asset. The value is the amount the note can be sold for in the holder’s geographic area on short notice (usually at a commercial discount rate) minus any liens on the property the former homeowner must repay.

The sale might also create income for the note holder; see BEM 503, Sale-Leaseback Income.

**LIFE INSURANCE**

**SSI-Related MA Only**

A life insurance policy is a contract between the policy owner and the company that provides the insurance. The company agrees to pay money to a designated beneficiary upon the death of the insured. Pure Endowment Life Insurance Contracts pay out on a specific date in the future, not just when the beneficiary dies, and does not meet the definition of life insurance for Medicaid.

**Life Insurance Definitions**

**SSI-Related MA Only**

**Cash surrender value (CSV)** - the amount of money the policy owner can get by canceling the policy before it matures or before the insured dies. It may be titled the cash surrender value or the cash value.

**Face value (FV)** - the amount of the basic death benefit contracted for at the time the policy is purchased. It might be titled the face value, face amount, amount of insurance, amount of policy or sum insured. It does not include dividends or additional amounts payable because of accidental death or other special circumstances.

**Insured** - the person whose life the policy insures.

**Insurer** - the company that contracts with the policy owner.
Policy owner - the person who has the right to change the policy. This is usually the person who pays the premiums. The policy owner and the insured can be different people.

Life Insurance Value

SSI-Related MA Only

A life insurance policy is an asset if it can generate a CSV. A policy is the policy owner's asset.

- A policy's value is its CSV. A policy can generate a CSV but have a CSV of zero. Such a policy is an asset with zero value.

- Generally, term insurance does not have a CSV. Whole or straight life policies generate a CSV. Policies called graded term or level term may have a CSV and must be verified and counted as an asset.

- The CSV usually increases over time. A loan against a policy reduces its CSV. A pre-death payment of the death benefit might reduce the CSV. See *Accelerated Life Insurance Payments* in BEM 500 about the payments received.

- CSV and FV are not the same thing.

- Tables included with a life insurance policy are not considered accurate. Verification of the CSV should be either a current notice (within the year) from the company or by contacting the company for the current value.

LIFE INSURANCE EXCLUSIONS

Life Insurance for Funeral

SSI-Related MA Only

In addition to the general exclusion below, some or all of the value of insurance might be excluded to pay for funeral expenses; see *Funeral Plans* in this item.
General SSI-Related MA Life Insurance Exclusion

**SSI-Related MA Only**

Look at each policy owner's life insurance separately.

Exclude the entire cash surrender value when the total **face values** of all policies a policy owner has for the **same insured** are $1,500 or less.

See the example and exceptions below.

**Example:**

Mr. and Mrs. Smith own the following policies:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Owner</th>
<th>FV</th>
<th>Insured</th>
<th>CSV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mr.</td>
<td>$1,000</td>
<td>Mrs.</td>
<td>$500</td>
</tr>
<tr>
<td>2</td>
<td>Mr.</td>
<td>$800</td>
<td>Mrs.</td>
<td>$300</td>
</tr>
<tr>
<td>3</td>
<td>Mr.</td>
<td>$1,500</td>
<td>Mr.</td>
<td>$1,000</td>
</tr>
<tr>
<td>4</td>
<td>Mr.</td>
<td>$2,000</td>
<td>Son</td>
<td>$1,000</td>
</tr>
<tr>
<td>5</td>
<td>Mrs.</td>
<td>$1,500</td>
<td>Mr.</td>
<td>$500</td>
</tr>
<tr>
<td>6</td>
<td>Mrs.</td>
<td>$2,000</td>
<td>Mrs.</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

CSVs for policies 1 and 2 are **not** excludable under this policy for Mr. Smith. He owns both policies. They insure the same person. The combined FVs exceed $1,500.

CSV for policy 4 is **not** excludable under this policy for Mr. Smith. The FV exceeds $1,500.

CSV for policy 6 is **not** excludable under this policy for Mrs. Smith. The FV exceeds $1,500.

**Exceptions:** Do **not** count the face value of:

- Term insurance that does **not** generate a CSV.
• Burial insurance. Burial insurance is an insurance policy whose terms prevent the use of its proceeds for anything other than payment of the insured's burial expenses. A policy is not burial insurance if the policy has a CSV the owner can access. A policy used for a Life Insurance Funded Funeral below is not burial insurance. Michigan does not have burial insurance, but a person from another state could have such insurance.

• Endowment policies. An endowment policy is a policy which enables the insured to accumulate a sum of money payable to him at a date named in the policy (the maturity date). The policy states whether the money is paid over time or all at once. The policy matures on the maturity date. An endowment policy is not life insurance. Because the applicant gives up the rights to control the money until the maturity date, a non-matured endowment policy must be considered a divestment; see BEM 405, MA Divestment.

LONG TERM CARE INSURANCE PARTNERSHIP POLICIES

SSI-Related MA Only

Long term care insurance partnership policies are health insurance and are not countable as assets. However, there are special asset rules for individuals who use long term care insurance partnership policies to pay for long term care.

At the initial eligibility determination there is an asset disregard (starting with countable assets first) equal to the amount that the long-term care policy has paid to, or on the behalf of, the applicant. The asset disregard can increase at redetermination or case closure. The countable asset limit for Extended Care category remains the same. Assets of any type can receive the disregard. These disregarded assets are also disregarded (protected from) estate recovery.

FUNERAL PLANS

SSI-Related MA Only

Funeral plan refers to the prearrangement for cemetery and/or funeral goods and services. Normally, the plan is established using one or more of the following:
Burial Fund Exclusion

SSI-Related MA Only

A limited amount of certain types of assets a person has clearly designated to pay for burial expenses is excluded as a burial fund. See below for information about:

- Types of assets.
- Burial expenses.
- Clearly designated.
- Not commingled.
- Amount excluded.
- Misuse of funds.

See Exhibit I of this item for examples of this exclusion.

Types of Assets

Assets under the following headings in this item can be a burial fund:

- Cash.
- Investments.
- Life insurance.
- Prepaid funeral contract.

Other types of assets (example: real property, vehicles, livestock) may not be a burial fund.

Burial Expenses

Expenses that qualify for the burial fund exclusion are generally those related to preparing a body for burial and any services prior to burial. Examples are:

- Services of funeral director and staff.
- Transportation of the body.
- Embalming.
- Cremation.
- Clothing.
• Cost of guest registry book.
• Cost of obituary.
• Flowers not displayed at gravesite.
• Cleric’s honorarium if no services at gravesite.
• Burial space items that do not meet the held for test described in SSI-Related MA Burial Space Exclusion in this item.

Note: A Luncheon or similar service does not meet the definition of a burial expense as it is not related to the preparation of the body for burial. Do not certify a DHS-8A with such an expense and do not consider it as an allowable burial expense item.

Clearly Designated
The asset must be clearly designated. The designation can be on the asset (example: title on a bank account, prepaid funeral contract) or on a signed statement from the client. The designation must include the following information:

• Value and owner of the asset.
• Whose burial the fund is for.
• Date the funds were set aside for the person’s burial.
• Form in which the asset is held (example: bank account, life insurance).

Not Commingled
Burial funds may not be commingled with any assets except excluded burial space assets; see SSI-Related MA Burial Space Exclusion in this item.

Amount Excluded
Exclude up to $1,500 for each qualified fiscal group member and/or spouse. In addition, exclude accumulated interest and dividends.

Reduce the $1,500 per person maximum by the following:

• The face value of excluded life insurance policies (including term insurance) when the person is the insured and:
  • If an adult, the policy is owned by the person or the person’s spouse.
  • If a child, the policy is owned by the child, the child’s parent or the parent’s spouse.
• The principal amount (not accumulated interest or dividends) held in an irrevocable prepaid funeral contract for the person’s burial expenses (see above). Do not count the identifiable cost of burial space assets; see Burial Space Defined in this item.

• The cost of burial expenses (see above) identifiable in a life insurance funded funeral plan that was irrevocably transferred (see Life Insurance Funded Funeral and Life Insurance Irrevocably Transferred in this item.

• The face value of burial insurance on the person. See Life Insurance in this item for the definition of burial insurance.

Count only the original principal amount and any additions to the principal to determine if the maximum limit has been reached. Do not count accumulated interest and dividends.

Note: The principal amount of a life insurance policy is the cash surrender value (CSV) of the policy, not the face value. Increases in the CSV count against the limit. Increases in the CSV above the person’s burial fund limit are countable as the policy owner’s assets.

Misuse of Fund

Count the amount of an excluded burial fund used for another purpose while the person was an MA recipient as unearned income for one month. The month must be far enough in the future so that any negative action pend period would end before the month begins.

Exception: Do not do this if the value of countable assets plus the misused funds were within the asset limit for the month the misuse occurred.

Burial Space Defined

SSI-Related MA Only

A burial space is a(n):

• Burial plot, gravesite.
• Crypt, mausoleum.
• Casket, urn, niche.
• Some other type of repository customarily and traditionally used for the deceased's bodily remains.

• **Necessary** and **reasonable** improvements or additions to or upon such spaces including:
  - Vaults.
  - Headstones, markers or plaques.
  - Burial containers.
  - Opening and closing of the gravesite.
  - Contracts for care and maintenance of the gravesite.

**Note:** **Reasonable** and **necessary** are those items required by the cemetery.

• Flowers if displayed at gravesite.
• Cleric’s honorarium for service at gravesite.

**Note:** Of the items that serve the same purpose, exclude only one item per person.

**Example:** Exclude a cemetery lot and casket for the same person, but not a casket and an urn.

**Value of Burial Space**

**SSI-Related MA Only**

The value of a burial space item is its equity value. Equity value is fair market value minus the amount legally owed in a written lien provision.

**SSI-Related MA Burial Space Exclusion**

**SSI-Related MA Only**

Exclude one burial space held for (see below) each of the following:

• Each qualified fiscal group member.
• Whether by blood, adoption or marriage, the member's:
  - Parents.
  - Minor and adult children.
  - Siblings.
- The spouse of each person listed above.

For a member’s relatives only by marriage, apply the exclusion only if the marriage has not ended by death or divorce.

Burial space items in a prepaid funeral contract must be identified and valued separately from non-burial space items to be excluded.

If the contract shows the purchase of a specified burial space at a specified price, determine whether such space is held for the client or member of the client’s immediate family. If the space is held for the individual, determine if the contract is irrevocable or revocable. If irrevocable, it is not a resource. If the contract is revocable, it is an excludable resource. The burial space must continue to meet the held for criteria to be excluded. If a space is transferred to another individual (even if listed above) it no longer meets the held for criteria and needs to be evaluated for divestment.

**Held For.** A burial space is held for an individual when someone currently has:

- Title to and/or possesses a burial space intended for the individual's use (example: has title to a burial plot, owns a burial urn stored in the basement for his own use).

- A contract with a funeral service company for specified burial spaces for the individual's burial (that is, an agreement that represents the individual's current right to the use of the items at the amount shown).

A burial space does not meet the definition of held for an individual under an installment sales contract or similar device if the purchase price is not paid in full and any of the following are true:

- The individual does not currently own the space.

- The individual does not currently have the right to use the space.

- The seller is not currently obligated to provide the space.

Until all payments are made on the contract, the amounts paid might be considered burial funds; see **Burial Fund Exclusion** in this item.
Prepaid Funeral Contract

**SSI-Related MA Only**

A prepaid funeral contract means a contract requiring payment in advance for funeral goods or services. Contracts may be revocable or irrevocable.

- See **Revocable Prepaid Funeral Contract Exclusions and Value** below if the contract is revocable.
- See **Irrevocable Prepaid Funeral Contracts** below if the contract is irrevocable.
- See **BAM 805, PREPAID FUNERAL CONTRACTS**, about making Michigan contracts irrevocable.

**Revocable Prepaid Funeral Contract Exclusions and Value**

**SSI-Related MA Only**

Funds in a revocable prepaid funeral contract might be excludable using the **Burial Fund Exclusion** and/or the **SSI-Related MA Burial Space Exclusion** above.

The countable amount of the contract is the amount remaining on deposit after deducting those exclusions and any commissions or fees that would be charged upon withdrawal. There is no burial funds exclusion.

**Irrevocable Prepaid Funeral Contracts**

**G2U, G2C, RMA, SSI-Related MA Only**

Funds in an **irrevocable** prepaid funeral contract are unavailable and thus are **not** counted.

Funds in a Michigan contract (DHS-8A, Irrevocable Funeral Contract Certification) certified irrevocable are excluded.
Note: Prior to 1986 Michigan law allowed a pre-paid funeral contract to be funded with a Certificate of Deposit (CD). These contracts may be certified as irrevocable.

Life Insurance Funded Funeral

SSI-Related MA Only

A funeral plan can be funded using life insurance. A person purchases a life insurance policy and directs the proceeds to be used to pay for his funeral. In addition, the person might irrevocably/permanently transfer ownership of the policy to either:

- A trust.
- A funeral director who then transfers ownership to a trust.

Note: An annuity can be used in the same way to fund a funeral plan.

Proceeds of a life insurance policy means the face value of the policy plus any additions payable at maturity or death. Proceeds are reduced by the amount of outstanding loans against the policy and Accelerated Life Insurance Payments; see BEM 500.

A funeral plan funded with life insurance is not a prepaid funeral contract per BAM 805, PREPAID FUNERAL CONTRACTS.

Life Insurance Funded Funeral Trusts

SSI-Related MA Only

Life insurance funded trusts, regardless of including specific goods or services, or naming a funeral provider, are countable if revocable and a divestment if irrevocable. Send a life insurance funded trust to the Trust and Annuity Evaluation Unit.

Other Funded Funeral Trusts

Other funded funeral trusts, regardless of including specific goods or services, or naming a funeral provider, are countable assets if revocable and divestment if irrevocable. These trusts are not prepaid funeral agreements and do not qualify for any funeral
exemptions. A DHS-8A cannot be used to certify a revocable trust as irrevocable for purposes of exclusion.

**Life Insurance NOT Irrevocably Transferred**

**SSI-Related MA Only**

If a person has directed the proceeds of a life insurance policy be used to pay for his/her funeral, but has **not** irrevocably transferred ownership, the policy is treated as life insurance. See **Life Insurance and Burial Fund Exclusion** in this item.

**Life Insurance Irrevocably Transferred**

**SSI-Related MA Only**

Use the following when a person directs that the proceeds of a life insurance policy be used for his funeral and has **irrevocably** transferred ownership of the policy. Do this even if the person retains the right to change funeral providers, items or services.

- Do **not** count the cash surrender value of the policy as an asset effective the month of transfer.
- Do not count the funeral contract as an asset.
- Do not apply policy in BEM 401, TRUSTS-MA.
- Do not consider the ownership transfer as divestment when all of the following are true:
  - The proceeds are still to be used to pay the insured’s funeral expenses.
  - The value of the goods and contracted services at least equals the cash surrender value of the insurance.
  - The new owner **cannot** use the cash surrender value of the insurance policy for themselves.

**Note:** If the value of the goods and services contracted for is less than cash surrender value of the insurance, the difference is transferred for less than fair market value.
Limited Liability Companies

SSI-Related MA Only

Count any assets in a Limited Liability Company (LLC).

LIVESTOCK

SSI-Related MA Only and FAP

Exclude farm animals used for personal consumption. Exclude family pets.

Other livestock might be excluded as an employment asset; see Employment Asset Exclusions in this item.

EMPLOYMENT AND TRAINING ASSETS

SSI-Related MA Only and FAP

Employment assets are those assets commonly used in a business, a trade or other employment. Examples:

- Farmland.
- Tools, equipment and machinery.
- Inventory, livestock.
- Savings or checking account used solely for a business.
- The building a business is located in.
- Vehicles used in business such as a farm tractor or delivery truck. It does not include vehicles used solely for transportation to and from work.

Such assets might also be used in education or job training.

Employment or Training Asset Value

See the appropriate sections above regarding the value of vehicles, real property and savings or checking accounts. The value of other employment or training assets is their equity value. Equity value is fair market value minus the amount legally owed in a written lien provision.
Payment-In-Kind (PIK) Program

A PIK commodity or commodity certificate may be an asset; see BEM 502, INCOME FROM SELF-EMPLOYMENT and 503 (for MA), PAYMENT-IN-KIND (PIK) PROGRAM.

EMPLOYMENT ASSET EXCLUSIONS

General Employment Exclusion

SSI-Related MA Only and FAP

Exclude employment assets (see above) that:

- Are required by a person's employer.
- Produce income directly through their use.

Such assets remain excluded when a person is unemployed only if the person intends to return to that type of work.

Exception: For FAP, exclude assets essential to self-employment farming for one year after the person quits the farming activity, even if they have no intent to resume.

Lien Exclusion

FAP Only

Exclude a non-liquid asset against which a lien has been placed as a result of taking out a business loan and the household is prohibited by the security or lien agreement with the creditor from selling the asset(s). This asset is considered not accessible.

Education and Training Exclusion

FIP, RCA, SDA, G2U, G2C, RMA and CDC

529 college savings plans are designed to allow individuals to make after-tax deposits for their children’s future higher education expenses. In Michigan, these plans are administered by the Department of Treasury and are known as Michigan Education Savings Accounts.
Plans. Funds deposited into these accounts may qualify for matching funds. After a child reaches age 18, the funds may be used for post-secondary education or a certified training program.

Disregard funds on deposit in a 529 college savings plan, interest earned on a 529 plan, and any matching funds deposited in a 529 plan.

**SSI-Related MA Only**

Exclude assets directly related to a person's current education or job training program. Directly related means the asset is necessary for the major program of study or related occupation. Current means ongoing participation except for school breaks.

**Example:** Exclude tools the person needs for his ongoing auto mechanics program.

Continue this exclusion for six calendar months following the month the program is completed if the person intends to seek employment in that occupation.

**Note:** This exclusion does not apply to real property, life estates and life leases.

**Health Profession Opportunity Grant**

**All Types of Assistance**

These payments are issued to provide education and training in the health care field to Temporary Assistance to Needy Families recipients and other low-income individuals.

Bridges excludes as income and assets.

**EXCLUDED ASSETS**

**FAP**

Exclude Native American lands held jointly with the Tribe, or land that can be sold only with the approval of the Department of the Interior’s Bureau of Indian Affairs.

Public Law 79-396, Section 12(e) of the National School Lunch Act, as amended by Section 9(d) of Public Law 94-105, excludes assistance provided to children rather than that paid to providers. The programs include:
• School Lunch Program.
• Summer Food Service Program.
• Child and Adult Care Food Program.
• Commodity Distribution Program.

Public Law 89-642, the Child Nutrition Act of 1966, Section 11(b). The programs include but are not limited to:

• Special Milk Program.
• School Breakfast Program.
• Special Supplemental Food Program for Women Infants and Children (WIC).

Public Law 93-531, Section 22, 10/17/75 - Relocation assistance payments to members of the Navajo and Hopi tribes.

Public Law 97-403 - Payments to the Turtle Mountain Band of Chippewas and Arizona.

Public Law 97-408 - Payments to the Blackfeet, Grosventre and Assiniboine tribes, Montana, and the Papago, Arizona.

Public Law 97-458.

Public Law 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act, provides that funds made to heirs of deceased Indians under this Act should not be considered as assets nor otherwise used to reduce or deny food stamp benefits except for per capita shares in excess of $2,000.

Public Law 99-146, Section 6(b), 11/11/1985 - Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior. Judgments were awarded in Dockets Numbered 18-S, 18-U, 18-C and 18-T.

Public Law 99-377, Section 4(b), 8/8/86, - Funds distributed per capita to the Chippewas of the Mississippi or held in trust under this Act are excluded. The judgments were awarded in Docket Number 18-S.

Public Law 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73,151 and 73-A of the Indian Claims Commission.

Public Law 103-436, 11/02/94, Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act, Section 7(b), provides that payments made pursuant to this Act are totally excluded.
Public Law 111-291, Section 107(f)(2) of the Claims Resolution Act of 2010 - Payments received from the Cobell vs. Salazar Settlement.

**VERIFICATION REQUIREMENTS**

**FIP, SDA, RCA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP**

Do not require verification when countable assets exceed the limit based on a person’s own statement of value.

**FIP, SDA, RCA, G2U, G2C, RMA, SSI-Related MA Only, and FAP**

Verify the value of countable assets at application, redetermination and when a change is reported.

**Note:** For FAP, verify assets at semi-annual and mid-certification contacts only if a change is reported.

Verify joint ownership and that the countable amount is less than that presumed by policy at application and when a change is reported.

Verify the following factors affecting exclusion of an asset at application, redetermination, and when a change is reported:

- An asset is not available.
- Joint ownership prevents sale (other owner refuses to sell). Note: this does not apply to MA policy; see Jointly Owned Assets in this item.
- There is a written agreement to repair/replace a damaged or destroyed homestead (cash exclusion for FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only; land exclusion for SSI-related MA).

**FAP Only**

Do not require verification of a vehicle when the client claims to own only one vehicle. Verify only if questionable.
CDC ONLY

Do not verify countable assets.

SSI-Related MA Only

- An asset is non-salable.
- The equity value in income-producing real property.
- Any transfer of ownership of life insurance to fund a funeral.

VERIFICATION SOURCES

FIP, SDA, RCA, G2U, G2C, RMA, SSI-Related MA Only, and FAP

The following prove ownership and/or value of assets. Use the DHS-20, Verification of Assets, the DHS-27, Release of Information, or other specified form as appropriate, when helping a person verify assets.

Document information verified by telephone contact in the case or on a DHS-223, Documentation Record.

Other sources of verification are listed by asset type.

Note: For FAP the following are examples of acceptable verification sources and not an all-inclusive list.

Checking or Draft Account

- Telephone contact with financial institution.
- Written statement from financial institution.
- Monthly statement (Examination of checkbook is not sufficient.)

Crowdfunding Account

- Copy of Account site.
- Bank statement showing deposits from a crowdfunding account.

Federal Tax Refund

Proof of tax refund amount and date received.
Individual Development Account

- Copy of documents establishing the IDA.
- Statement from the trustee or custodian of the account.

Note: Documentation must specify the purpose for which the trust or account is established, that the trust or account will receive matching funds, and that withdrawals must be authorized by the trustee or custodian.

Irrevocable Funeral Contract

Copy of DHS-8A, Irrevocable Funeral Contract Certification, certifying contract irrevocable.

Loan

- Lien Exclusion.
- Letter from creditor.
- Telephone contact with creditor. Copy of financial institution loan contract.
- Lender's financial statement showing withdrawal of borrowed amount.

Life Insurance

- DHS-4786, Life Insurance Verification, completed by agent or company.
- Statement from insurance company or agent.

LTC Patient Trust Fund

Written statement from LTC facility.

Money Held By Other

Written statement from person holding the money.
Native American Land
- Letter from the tribe.
- Telephone contact with the tribe.

Prepaid Funeral Contract
- Statement of funeral home or contract seller.
- Copy of contract.

Real Property
- Deed, mortgage, purchase agreement or contract.
- State Equalized Value (SEV) on current property tax records multiplied by two.
- Attorney or court records.
- County records.
- Statement of real estate agent or financial institution.

Retirement Plan
- Written statement from plan administrator.
- Current plan statement.

Savings or Share Account
- Monthly statement.
- Written statement from financial institution.
- Telephone contact with financial institution.

Savings Certificate
- Written statement from financial institution.
- Certificate itself.

SSI Dedicated Account
- Letter from Social Security Administration.
- Telephone contact with Social Security Administration.

Stocks and Bonds
- Written statement from broker or company.
- Listing in current newspaper.

Trust
- Copy of trust document.
- Copy of documents transferring ownership of assets to the trust.
• Appropriate source for the asset types owned by the trust.

**U.S. Savings Bond**

• Statement from financial institution.
• Bond itself.

**Vehicles**

• Title, registration or proof of insurance.
• Loan statement or payment book.
• Secretary of State (SOS) inquiry. This inquiry needs to be done only if no other verification source is available or if the client requests assistance.

**Exception:** This is the only acceptable verification source for unlicensed vehicles driven by tribal members on Native American reservations. The SOS clearance must be completed by a local office.

To determine value of the vehicle, do the following:

• Use Kelley Blue Book fair condition option at (www.kbb.com) or NADA Book at (www.nadaguides.com) wholesale (rough trade-in) value. When comparing the value between the two sources, use the lowest value.

• Do **not** add the value of optional equipment, special equipment or low mileage when determining value.

• Enter the greater of actual mileage or 12,000 per year.

**Note:** For FAP, accept the client’s statement on the actual mileage.

• Enter the client’s ZIP code.

• Do **not** change the preset typical equipment.

• Enter “fair” as the condition.

• Use the lowest trade-in value.

Statement of vehicle dealer or junk dealer, as appropriate.

Allow the person to verify a claim that the vehicle is worth less (example: due to damage) than wholesale book value. If the vehicle is no longer listed, accept the person’s statement of value.
**Exception:** Verify the value of antique, classic or custom vehicles. For the definition of antique and classic vehicles; see BPG Glossary.

**Note:** For FAP, if the client disputes the fair market value of a vehicle, verification of the value from a reliable source is required.

**Vendor Pre-Paid Debit Cards**

- Statement from the vendor or online printout which reflects the current account balance, (for example, Direct Express, ReliaCard, etc.).

  **Note:** The client may have to pay for the statement.

- ATM balance inquiry with sufficient information to support a match to the account. For example, the card number matches the printed digits on the ATM slip.

  **Note:** For MA an ATM slip sets the day of the month to determine countable assets. If the slip balance causes the client to exceed the asset limit the client must be given the opportunity to supply sufficient information to determine a calendar day in the month when they may be asset eligible.
**EXHIBIT I - BURIAL FUNDS EXAMPLES: SSI-RELATED MA CATEGORIES ONLY**

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<thead>
<tr>
<th>EXAMPLE 1:</th>
<th>EXAMPLE 2:</th>
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<td><strong>Client has:</strong></td>
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<td>$2,500 SSI-Related MA Categories Only</td>
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<tr>
<td><strong>BURIAL FUNDS MAXIMUM:</strong></td>
<td><strong>Principal Sum of Irrevocable Funeral Contract - No Burial Space Items</strong></td>
</tr>
<tr>
<td>$1,500 - MAXIMUM</td>
<td>$1,500</td>
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<tr>
<td></td>
<td>- $2,000</td>
</tr>
<tr>
<td><strong>Client may:</strong></td>
<td><strong>Client may not designate any assets as excludable burial funds. However, the client could use savings to purchase burial space items.</strong></td>
</tr>
<tr>
<td>Designate up to $1,500 for self as excludable burial funds.</td>
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<td><strong>Client must:</strong></td>
<td><strong>Establish a separate account for the amount designated.</strong></td>
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<table>
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<td>Irrevocable Funeral Contract as follows:</td>
<td><strong>Face Value of Excludable Life Insurance</strong></td>
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<td>- $1,000 Casket</td>
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<td>- $600 Headstone</td>
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<td>- $400 Assorted Professional Services</td>
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<td><strong>Principal Amount of Irrevocable Funeral Contract for Non-Burial Space Items</strong></td>
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<td><strong>Client may:</strong></td>
<td><strong>Client may:</strong></td>
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<tr>
<td>Designate up to $1,100 excludable burial funds or buy more burial space.</td>
<td>Designate up to $500 as excludable burial funds or buy burial space items.</td>
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<tr>
<td><strong>Client must:</strong></td>
<td><strong>Establish a separate account for the amount designated.</strong></td>
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<td>Establish a separate account for the amount designated.</td>
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Client has: | Couple has:  
---|---  
$2,500 | $2,800  
$400 | $1,300  
$500 | $1,600
Savings Account | Savings Account (Joint)  
Irrevocable Funeral Contract for Professional Services | Common Stock Account (Husband)  
Face Value of Excludable Life Insurance | Face Value Life Insurance - CSV=$300 (Wife)

**BURIAL FUNDS MAXIMUM:**  
$1,500 - MAXIMUM PER PERSON  
- $400 | Principal Amount of Irrevocable Funeral Contract  
$1,100 |  
- $500 | Face Value of Excludable Life Insurance  
$600 | MAXIMUM

Client may: | Designate up to $1,500 per person as excludable burial funds. One way to do this is:  
---|---  
Designate up to $600 as excludable burial funds or buy burial space items. |  
**HUSBAND** | **WIFE**  
$200 | Savings Account $1,200  
$1,300 | Common Stock 0  
$0 | Life Insurance $300  
$1,500 | $1,500

Client must: Establish a separate savings account for the amount designated. | Client must: Establish a separate savings account for any amounts designated from savings.

**EXHIBIT II - LIFE ESTATE AND LIFE LEASE FACTOR TABLE**

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MCL 400.10d
Annual Appropriations Act
26 USC 6409

MA
Social Security Act title XX
Social Security Act, Sections 1902(a)(10); (r)(2)
Deficit Reduction Act of 2005
26 USC 6409
42 CFR 435.840 -.845
MCL 400.106,112g
The Patient Protection and Affordable Care Act (Pub. L. 111-148
and the Health Care and Education Reconciliation Act (Pub. L.111-
152).

RMA
26 USC 6409
45 CFR 400.101-102
Annual Appropriations Act

RCA
26 USC 6409
45 CFR 400.66

SDA
Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

FAP
Food and Nutrition Act of 2008, as amended, Sec. 5. 7 U.S.C. 2014
7 CFR 273.8
7 CFR 273.8(h)
7 CFR 273.9
25 USCS 640d-22 (P.L. 93-531, Section 22, dated 12/22/74).


26 USC 6409

Public Law 79-396, Section 12(e) of the National School Lunch Act, as amended by Section 9(d) of Public Law 94-105.

Public Law 89-642, the Child Nutrition Act of 1966, Section 11(b)

Public Law 91-646, Section 216 Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970.

Public Law 92-203, Section 29, dated 1/2/76, the Alaska Native Claims Settlement Act and Section 15 of Public Law 100-241, 2/3/88 the Alaska Native Claims Settlement Act Amendments of 1987.

Public Law 93-113, the Domestic Volunteer Services Act of 1972, Title I and II Payments

Public Law 93-288, Section 312(d), the Disaster Relief Act of 1974, as amended by P. L. 100-707, Section 105(i) the Disaster Relief and Emergency Assistance Amendments of 1988.

Public Law 93-531, Section 22,10/17/75.

Public Law 94-114, Section 6,10/17/75.

Public Law 94-540.

Public Law 95-433, Section 2.

Public Law 96-420, Section 9(c),10/10/80.

Public Law 97-300.

Public Law 97-403.

Public Law 97-408.

Public Law 98-123.

Public Law 98-124 Section 5.

Public Law 98-500, Section 8, 10/17/84.
Public Law 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act.


Public Law 99-346, Section 6(b)(2).

Public Law 99-377, Section 4(b), 8/8/86.

Public Law 99-425.

Public Law 99-498.

Public Law 100-175.

Public Law 100-383, Section 105(f)(2).

Public Law 100-435, Section 501.

Public Law 101-201.

Public Law 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73,151 and 73-A of the Indian Claims Commission.

Public Law 101-426.

Public Law 101-508.

Public Law 101-610.

Public Law 102-325.

Public Law 103-286.

Public Law 103-322.

Public Law 103-436, 11/02/94, Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act, Section 7(b).

Public Law 104-193.

Public Law 104-204.
Public Law 105-143, 12/15/97, Michigan Indian Land Claims Settlement Act, Section 111.

MCL 400.10d

**CDC**

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).

45 CFR Parts 98 and 99

Social Security Act, as amended 2016

**All Programs**

Public Law 111-291, Section 107(f)(2) of the Claims Resolution Act of 2010 - Payments received from the Cobell vs. Salazar Settlement.

Affordable Care Act, Public Law 111-148.
DEPARTMENT POLICY

MA Only

This item contains Medicaid policy for trusts. The item is divided into three parts:

- Medicaid trusts.
- Medicaid qualifying trusts (MQTs).
- Other trusts.

Which policy applies depends on the terms of the trust and when the trust was established.

Use policy in Bridges Eligibility Manual (BEM) 400 and Bridges Administrative Manual (BAM) 805 for prepaid funeral contracts and life insurance funded funerals.

MAGI-related MA

For MAGI related programs there is no asset test. However, disbursements from annuities are generally countable as income in the month that they are received. In some cases, such as structured annuities that result from lawsuit settlements, this annuity income may not be taxable. Therefore, part or all of the annuity payments may not be countable toward an individual’s MAGI income. In order to determine what parts of an annuity payment may or may not be countable toward an individual’s income please follow the process for referrals to the Trusts and Annuities Unit outlined in this item to have the annuity evaluated. In the case of MAGI-related annuity evaluations, a copy of the lawsuit settlement agreement must be submitted to the Trusts and Annuities Unit in order to make the determination.

GENERAL DEFINITIONS

MA Only

These definitions apply to all trust policy. There are special definitions for Medicaid trusts.

Beneficiary - the person for whose benefit a trust is created.

Grantor or settlor - the person who established the trust. Any person who contributes to a trust is considered a grantor.
Principal or corpus - the assets in the trust. The assets may be real property (house, land) or personal property (for example, stocks, bonds, life insurance policies, savings accounts).

Trust - a right of property created by one person for the benefit of himself or another. It includes any legal instrument or device that exhibits the general characteristics of a trust but is not called a trust or does not qualify as a trust under state law. Examples of such devices might be annuities, escrow accounts, pension funds and investment accounts managed by someone with fiduciary obligations.

Trustee - the person who has legal title to the assets and income of a trust and the duty to manage the trust for the benefit of the beneficiary.

REFERRALS TO TRUSTS AND ANNUITIES UNIT

A completed DHS-1517, Request for Trust/Annuity Evaluation, must accompany all trusts/annuities requests. Send all trusts and annuities to the Trusts and Annuities Unit for evaluation. The evaluation request must be sent to the following email box:

MDHHS-MA-FAP-Trusts_Annuities@michigan.gov

Email is the preferred method for submitting evaluation requests; however, if necessary, requests may also be sent via ID mail to:

Michigan Department of Health and Human Services
Legal Affairs Administration
Attn: Trust & Annuities
333 S Grand Avenue
P.O. Box 30195
Lansing, MI 48909

Email address boxes for requests or inquiries to the Legal Affairs Administration can be found on the MDHHS-Net at:

This does not apply to the following:

- Prepaid funeral contracts.
- Life insurance funded funerals.
- Limited Liability Companies (LLC).
- S-Corporations.

Once a trust has been evaluated, a re-evaluation is not required unless the local office believes a change has occurred affecting availability of the trust principal or income, including a change in department policy.

An evaluation of a trust advises local offices on:

- Whether a trust is revocable or irrevocable, and
- Whether any trust income or principal is available.

Advice is only available to local offices for purposes of determining eligibility or an initial assessment when a trust actually exists. Advice is not available for purposes of estate planning, including advice on proposed trusts or proposed trust amendments.

Send the referral as soon as possible so that everyone can complete their tasks timely. The referral must be in writing and include:

- Referring specialist’s name, email address, phone number and local office.
- What advice is being requested.
- What programs are involved.
- Whether the grantor is living or dead.
- Whether the person is an applicant or recipient.
- Source of the assets used to establish the trust (for example money from the grantor's lawsuit settlement).
- The MA client’s name and, if applicable, their spouse’s name.
- The grantor's relationship to the MA client or spouse.
- The name of the person(s) who contributed to the trust and their relationship to the MA client and spouse.
- Legible copies of the complete trust document, all amendments to the trust, addenda, correspondence and other pertinent information.

**Note:** Do not send asset and/or income verifications to the Trust and Annuities Unit.
EVALUATING TRUSTS

Determine if a trust established on or after August 11, 1993, is a Medicaid trust using:

- *Medicaid trust definitions* and
- *Medicaid trust criteria*.

Use the following policies if the trust is a Medicaid trust:

- *Countable assets from Medicaid trusts*.
- *Countable income from Medicaid trusts*.
- *Transfers for less than FMV*.

Determine if a trust established before August 11, 1993, is a Medicaid Qualifying Trust (MQT). Use the following policies if the trust is an MQT.

- *Countable MQT assets*.
- *Countable MQT income*.

Use *other trust policy* when a trust is not:

- An MQT.
- A Medicaid trust.

MEDICAID TRUST DEFINITIONS

Use the *general definitions* and these definitions when determining:

- Whether a trust is a Medicaid trust, and
- What is available from and transferred for a Medicaid trust.

**Irrevocable Trust** - a trust that is not a revocable trust; see *revocable trust* in this item.

**Resources** - all income and assets of a person and the person's spouse. It includes any income and assets the person or spouse is entitled to but does not receive because of action:

- By the person or spouse.
- By someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or spouse.
• By someone else (including a court or administrative body) acting at the direction or upon the request of the person or spouse.

**Revocable trust** - a trust which can be revoked or modified by:

- The grantor.
- A court.
- The trustee.
- Any other person or entity.

This includes a trust which allows for revocation or modification only when a change occurs, such as the grantor leaves the LTC facility or the beneficiary becomes competent.

Modify means changing the beneficiaries or the availability of principal or income.

**ANNUITY DEFINED**

**Annuity** - A written contract, with a commercial insurance company, establishing a right to receive specified, periodic payments for life or for a term of years. They are usually designed to be a source of retirement income.

**TRANSFERS TO AN ANNUITY EFFECTIVE 9/1/05**

Converting countable resources to income through the purchase of an annuity or the amendment of an existing annuity by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services on or after 09/01/05, is considered a transfer for less than fair market value unless the annuity meets the conditions listed below:

- Is commercially issued by a company licensed in the United States and issued by a licensed producer (a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance), and
- Is irrevocable, and
- Is purchased by an applicant or recipient for Medicaid or their spouse and solely for the benefit of the applicant or recipient or their spouse, and
- Is actuarially sound and returns the principal and interest within the annuitant’s life expectancy, and

- Payments must be in substantially equal monthly payments (starting with the first payment) and continue for the term of the payout (no balloon or lump sum payments) and

If the annuity was purchased or amended by, or on behalf of, the applicant or recipient on or after February 8, 2006 the State of Michigan must be named as the remainder beneficiary in the first position, or as the second remainder beneficiary after the community spouse or minor or disabled child, for an amount at least equal to the amount of the Medicaid benefits paid on behalf of the institutionalized individual. The naming of the state in the first or second position must be verified at application or redetermination. If the State of Michigan is not named as a beneficiary as required in this paragraph, the total purchase price of the annuity will be considered to be the amount transferred for less than fair market value.

If an annuity is actuarially sound and provides for payment only to the community spouse during his/her lifetime then the annuity is considered to be for the sole benefit of the applicant's spouse, and it is not a transfer for less than fair market value and does not have to name the State of Michigan as a remainder beneficiary.

**Annuities Funded With Certain Retirement Resources**

An annuity purchased by or on behalf of an annuitant who has applied for Medical assistance with respect to nursing facility services or other long-term care services on or after 2/8/2006 is **not** a transfer for less than fair market value if it is funded with certain retirement resources and established under any of the following sections of the Internal Revenue Code (IRC)

1. The annuity is considered either:
   - An individual retirement annuity under section 408(b) of the IRC; or
   - A deemed Individual Retirement Account under a qualified employer plan under section 408(q) of the IRC; or
2. The annuity is purchased with proceeds from one of the following:

- A traditional individual retirement account (IRA) under section 408(a) of the IRC; or
- Certain accounts or trusts which are established by employers or certain associations of employees under section 408(c) of the IRC; or
- A simple retirement account under section 408(p) of the IRC; or
- A simplified employee pension under section 408(k) of the IRC; or
- A Roth IRA under section 408A of the IRC

Annuities established under any sections of the Internal Revenue Code referenced above do not have to be irrevocable or actuarially sound, and do not have to provide for equal monthly payments.

**MEDICAID TRUST CRITERIA**

A Medicaid trust is a trust that meets conditions 1 through 5 below:

1. The person whose resources were transferred to the trust is someone whose assets or income must be counted to determine MA eligibility, an MA post-eligibility patient-pay amount, a divestment penalty or an initial asset assessment (IAA) amount. A person's resources include his spouse's resources (see definition).

2. The trust was established by:

- The person.
- The person's spouse.
- Someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or the person's spouse, or an attorney, or adult child.
3. The trust was established on or after August 11, 1993.
4. The trust was not established by a will.
5. The trust is not described in *Exception A, Special Needs Trust, or Exception B, Pooled Trust* in this item.

**Exception A, Special Needs Trust**

A trust is not a Medicaid trust if it meets all the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an *Exception A, Special Needs Trust*. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies; it must be irrevocable.

- The trust contains the resources of a person who is under age 65 and is disabled (not blind) per BEM 260. See *Continuing Exception A* when the person has attained age 65.

- The trust was established for the person described above. This means that the trust must ensure that none of the principal or income can be used for someone else during the person's lifetime, except for trustee fees per BEM 405.

- The trust was established by a court, by the person described above, or by the person's:
  - Parent.
  - Grandparent.
  - Legal guardian/conservator.

- The trust imposes on the trustee an automatic duty to repay Medicaid upon the person's death up to an amount equal to the total Medical Assistance paid on behalf of the person.

When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on
the state's proportionate share of the total amount of Medicaid benefits paid by all of the states on the person's behalf.

Examples of circumstances under which a trust **fails** this repay condition are:

- Requiring a trustee to reimburse Medicaid only if Medicaid first submits a claim.
- Failing to provide that repaying Medicaid has priority over all debts and expenses except those given higher priority by law.

**Transfers to Exception A Trust**

Treat assets and income transferred into an *Exception A, Special Needs Trust* as part of the trust for the entire month of transfer.

**Continuing Exception A**

A trust that is an *Exception A, Special Needs Trust* when the person was under age 65 continues being an *Exception A, Special Needs Trust* after the person attains age 65. However, any additions or augmentations to the trust after the person attains age 65 are not protected by the exception. The additions/augmentations are subject to trust and divestment policies without regard to *Exception A, Special Needs Trust*.

**Countable Exception A Payments**

Count as a person's unearned income any payment received from the trust.

**Exception B, Pooled Trust**

A trust is **not** a Medicaid trust if it meets all of the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an *Exception B, Pooled Trust*. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies.
• The trust contains the resources of a person who is disabled (not blind), per BEM 260; see Transfers to an Exception B trust in this item.

• The trust is established and managed by a nonprofit association.

• A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.

• Accounts in the trust are established for the benefit of persons who are disabled (not blind) per BEM 260. This means the trust must ensure that none of the principal or income attributable to a person’s account can be used for someone else during the person’s lifetime, except for trustee fees per BEM 405.

• Accounts in the trust are established by the disabled person, the courts, or by the disabled person’s:
  • Parents.
  • Grandparents.
  • Legal guardians/conservators.

• The trust provides that to the extent any amounts remaining in the beneficiary’s account upon the death of the beneficiary are not retained by the trust, the trust will pay to the state the amount remaining up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under a state Medicaid plan.

When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on the state’s proportionate share of the total amount of Medicaid benefits paid by all of the states on the person’s behalf.

Examples of circumstances under which a trust fails this repay condition are:
  • Requiring a trustee to reimburse Medicaid only if Medicaid first submits a claim.
  • Failing to provide that repaying Medicaid has priority over all debts and expenses except those given higher priority by law.
Transfers to
Exception B Trust

Treat assets and income transferred into an Exception B, Pooled Trust as part of the trust for the entire month of transfer.

Transfers to an Exception B, Pooled Trust by a person age 65 or older are subject to divestment analysis. Do a complete divestment determination if the person is in a Penalty Situation per BEM 405.

Countable
Exception B
Payments

Count any payment received from the trust by the client as unearned income in the month received.

Multiple
Contributors

When someone other than the person or the person's spouse has contributed to the principal of a trust, do not count as the person's assets or transferred assets an amount proportional to that other person's contributions to the principal.

Example: The Lang family contributed assets to the Lang Trust as follows:

John (MA applicant) $50,000
Sally (John’s daughter) $10,000
Total Contributions $60,000

Sally has contributed 1/6 of the total contributions. The value of the entire principal is currently $102,000. Therefore, $17,000.00 (one-sixth) of the current value cannot be counted as John's assets. Do not count the contributor's share as an asset.

REPAYMENT
INQUIRIES

Refer trustees seeking to repay Medicaid to the following:

Michigan Department of Health and Human Services
Court Originated Liability Section
PO Box 30435
Lansing, Michigan 48909
COUNTABLE ASSETS FROM MEDICAID TRUSTS

How much of the principal of a trust is a countable asset depends on:

- The terms of the trust, and
- Whether any of the principal consists of countable assets or countable income.

Countable Assets

The following are countable assets.

- Assets that are countable using SSI-related MA policy in BEM 400. Do not consider an asset unavailable because it is owned by the trust rather than the person.

- The homestead of an L/H or waiver patient or the patient's spouse even if the home was transferred before the patient was institutionalized or approved for the waiver.

Countable Income

Countable income from a trust is income that is countable using SSI-related MA policy in BEM 500. Income from a Medicaid trust that is not to or for the benefit of the person or their spouse is considered a divestment of income; see BEM 405.

Revocable Trust

Count as the person's countable asset the value of the countable assets and countable income in the principal of a revocable trust.

Exceptions:

- Reduce the countable amount when there are Multiple Contributors.

- Do not count the amount if it creates an Undue Hardship.

Example: The trustee of the Lang Trust can cancel the trust, but must pay the entire principal to Sally if the trust is cancelled. Therefore, none of the principal is John's countable asset.
Irrevocable Trust

Count as the person's countable asset the value of the countable assets in the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust.

Count as the person's countable asset the value of the trust's countable income if there is any condition under which the income could be paid to or on behalf of the person. Individuals can keep income made off of property and the money goes to the individual not the trust.

Exceptions:

- Reduce the countable asset amount by the amount of principal or income actually paid to or on behalf of the person during the month.
- Reduce the countable amount for multiple contributors.
- A trust may allow use of one portion of the principal, but not another portion. Count only the usable portion.
- Do not count the amount if it creates an undue hardship; see BEM 405.

Example: The principal of the Lang Trust consists of stocks, bonds, CD's and a life insurance policy with a face value of $5,000 and cash surrender value of $2,000. The trustee is prohibited from using the life insurance policy in any way. The trustee can pay from the remaining portion of the trust principal enough to maintain John in the style to which he is accustomed. The trustee must pay the trust income to John. John wants MA for May. In May, the entire principal was worth $102,000. However, the usable portion of the trust principal (the stocks, bonds and CD's) was worth $100,000. The trustee used $300 to buy a TV for John and gave John $50 from the principal in May.

\[
\begin{align*}
\text{usable principal} & = 100,000 \\
\text{one-sixth reduction for multiple contributors from first example} & = 16,666 \\
\text{actually paid} & = 350 \\
\text{John's countable asset amount} & = 82,984
\end{align*}
\]
Any portion of the principal or income that could never be paid to or on behalf of the person is transferred for less than fair market value. The look-back period is 60 months; see BEM 405. Reduce the transferred amount to account for multiple contributors and assets and income that are not countable assets or countable income.

**Undue Hardship**

Assume there is no undue hardship unless there is evidence to the contrary. Undue hardship exists when the person’s physician (M.D. or D.O.) says:

- Necessary medical care is not being provided, and
- The person needs treatment for an emergency condition.

A medical emergency exists when a delay in treatment may result in the person’s death or permanent impairment of the person’s health.

A psychiatric emergency exists when immediate treatment is required to prevent serious injury to the person or others.

Payments actually made by a trustee to or on behalf of a beneficiary do not create an undue hardship.

See BEM 100, Policy Exception Request Procedure.

**COUNTABLE INCOME FROM MEDICAID TRUSTS**

Count as a person's unearned income any payment from a Medicaid Trust that is made to the person or his legal representative.

**Example:** In the preceding example for the Lang Trust, the $50 paid to John from the principal is countable unearned income. The trust income is also countable unearned income when paid to John.

**TRANSFERS FOR LESS THAN FMV**

**Revocable Trust**

Count payments from a revocable Medicaid trust to or on behalf of someone other than the person as follows:
• If the other person never contributed to the principal — any payment of countable assets or countable income is a resource transfer for less than fair market value for purposes of BEM 405.

• If the other person contributed to the principal — any payment of countable assets or countable income exceeding the other person's proportional contribution to the principal is a resource transfer for less than fair market value for purposes of BEM 405.

The look-back period for such transfers is 60 months; see BEM 405.

**Example:** The Lang Trust pays Sally $300 per month from the trust's $600 per month income. Sally contributed only 1/6 of the trust principal. Therefore, $200 (1/6 of 600 = $100. $300 - 100 = $200) is a resource transferred for less than fair market value.

---

**Irrevocable Trust**

Count any portion of a trust's principal or income that is countable assets or countable income which cannot be paid to or on behalf of the person as transferred for less than fair market value for purposes of BEM 405.

**Note:** Be sure to adjust the transferred amount to account for multiple contributors.

The look-back period for such transfers is 60 months.

The date of transfer is the date payment is prohibited. The amount transferred is the amount which cannot be used as of that date plus any countable resources added by the person after that date.

**Example:** On 8/12/07 Ms. Thomas established an irrevocable Medicaid trust. Ms. Thomas transferred $50,000 cash to the trust on that date and $10,000 cash on 9/9/07. The trustee may pay all of the trust income to Ms. Thomas but cannot use any of the principal for Ms. Thomas. Ms. Thomas has transferred $60,000 for less than fair market value: $50,000 on 8/12/07 and $10,000 on 9/9/07.

**Example:** On 10/1/07 Mr. Lewis established an irrevocable Medicaid trust with $100,000 cash. The trustee has discretion to pay Mr. Lewis as much of the trust income and principal as Mr. Lewis may direct as long as Mr. Lewis is not in a nursing home.
Once Mr. Lewis enters a nursing home, the trustee may only pay the trust income to Mr. Lewis. Mr. Lewis enters a nursing home on 12/12/07. The trust principal on 12/12/07 has a value of $101,250. On 12/14/07 Mrs. Lewis transfers $10,000 cash to the trust. The Lewis's have transferred $111,250 for less than fair market value; $101,250 on 12/12/07 and $10,000 on 12/14/07.

Count payments from an irrevocable Medicaid trust to or on behalf of someone other than the person as follows:

- If the other person never contributed to the principal - any payment of countable assets or countable income is a resource transfer for less than fair market value for purposes of BEM 405.

- If the other person contributed to the principal - any payment of countable assets or countable income exceeding the other person's proportional contribution to the principal is a resource transfer for less than fair market value for purposes of BEM 405.

The look-back period for such transfers is 60 months; see BEM 405.

**MEDICAID QUALIFYING TRUST**

Use the *general definitions* in this item.

A Medicaid qualifying trust (MQT) is a trust that has all of the following characteristics:

a. It was established before August 11, 1993.

b. It is established by a person whose assets must be considered or by that person's spouse.

c. The person whose assets must be considered is the beneficiary of all or part of the payments from the trust.

d. The amount distributed from the trust is determined by one or more trustees who are permitted to exercise at least some discretion with respect to the amount to be distributed to the person in (c) above.
A trust that is established by a person's guardian or legal representative, acting on the person's behalf, using the person's assets is treated as having been established by the person.

**Exceptions:**

- A trust is not considered an MQT if the sole beneficiary is a person who has a developmental disability who resides in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID) and the trust or initial trust decree was established prior to April 7, 1986.

- A trust established by a will is not considered an MQT.

### Countable MQT Assets

The countable asset amount for each person for whom assets must be considered is:

- The maximum payment that could be made from the trust (principal or income) to that person as a beneficiary of the trust if the trustee exercised his full discretion under the terms of the trust

- Minus actual payments made by the trust to or on behalf of the person.

Clauses such as those that prohibit distributions that would affect MA eligibility are not considered limits on a trustee's discretion for purposes of this policy. To do otherwise would effectively negate the MQT policy.

### Countable MQT Income

Count payments made to a beneficiary of an MQT as that person's unearned income.

### OTHER TRUSTS

Use the *general definitions* in this item.

Use this policy for any trust that is not a Medicaid trust or an MQT.

### Countable Assets

The trust principal is considered an available asset of the person who is legally able to:
• Direct use of the trust principal for his/her needs.
• Direct that ownership of the principal revert to himself.

Count only the value of assets that are countable for the MA category being tested per BEM 400. Assume the person owns the asset in determining what is countable.

Transfers to Trust

Do a complete divestment determination when:

• A person has transferred assets to a trust,
• The principal is unavailable, and
• The person is in a penalty situation per BEM 405.

Countable Income

Count as a person's unearned income any payment received from the trust. This includes Exception A, Special Needs Trust and Exception B, Pooled Trust trusts.

VERIFICATION REQUIREMENTS

Verify income from a trust:

• Prior to authorizing benefits at application.
• At redetermination, and
• Whenever a change affecting income occurs.

Verify the value of a trust's principal if any portion is countable unless countable assets exceed the asset limit based on the client’s statement of value.

See BEM 405 regarding verifications for divestment.

Verification Sources

Sources to verify income from a trust include:

• Trust records.
• Trustee correspondence.

Sources to verify the value of a trust's principal include:

• Statements from experts for the types of assets held by the trust.
- Trust records.
- Trustee correspondence.

**LEGAL BASE**

**MA**

**Before August 11, 1993**

Social Security Act, Section 1902(a)(10) and 1902(k)
42 CFR 435.840-.845
MCL 400.106

**Starting August 11, 1993**

Social Security Act, Section 1902(a)(18) and 1917(c)-(e)
DEPARTMENT POLICY

MA Only

Unless the *special exception policy* in this item applies, an initial asset assessment is needed to determine how much of a couple’s assets are protected for the community spouse. Do an initial asset assessment when one is requested by either spouse, even when an MA application is **not** made; see *definitions* and *initial asset assessment*.

FIP-Related MA Only

There is no asset test for Group 2 Pregnant Woman and MAGI categories.

It may be necessary to do an SSI-related MA determination in the future if such FIP-related MA eligibility ends. Therefore, initiate an initial asset assessment for an L/H or waiver client with a community spouse if one has not already been done. However, do **not** deny/terminate a Group 2 Pregnant Woman or MAGI MA category if the client chooses not to cooperate with the initial asset assessment. Also, do **not** delay authorizing MA while completing an initial asset assessment; see *definitions* and *initial asset assessment*.

SSI-Related MA Only

Use this item to determine asset eligibility for the first period of continuous care (see *definitions* in this item) that began on or after 9-30-89 when an L/H, PACE, or waiver client:

- Has a community spouse (see below), **and**
- A presumed asset eligible period has **not** yet been established, **or**
- If established, the presumed asset eligible period has **not** ended; see *presumed asset eligible period* in this item.

Use BEM 400 to determine asset eligibility for clients who do **not** meet the above conditions; see EXHIBIT II.

**Example:** Mary entered LTC on 5-3-03 and applied on 5-5-03. Frank, her spouse, stated he had been in the hospital for more than 30 days back in June and July 2001, but Mary has not been in a
hospital or LTC for 30 days or more. The initial asset assessment date would be 5-3-03.

**Example:** Anthony enters LTC on 4-6-03. His wife Joann applies for him on 4-18-03 and states that he had been in the hospital for 17 days and then LTC for the next 20 days beginning 12-12-99, but she had been in LTC for more than 30 days in July in 1999. The initial asset assessment date would be 12-12-99.

The continuous period of care applies to the L/H client who is applying, not the spouse who was hospitalized or in LTC first.

### SPECIAL EXCEPTION POLICY

Do **not** do an *initial asset assessment*, even if the client or community spouse requests it, and do **not** do *initial eligibility* (in this item) when at the time a client becomes an L/H, PACE, or waiver client:

- The individual is already eligible for and receiving, SSI-related MA and one or both of the following is true:
  - The client’s asset group for SSI-related MA included the spouse who is now the community spouse.
  - The community spouse is eligible for, and receiving, SSI-related MA from Michigan, including as an SSI recipient.

The client is considered asset eligible; therefore:

- Begin the client’s *presumed asset eligible period*.
- Do **not** compute a community spouse resource allowance.
- Do **not** send a DHS-4588, Initial Asset Assessment Notice; or DHS-4585, Initial Asset Assessment and Asset Record.

### DEFINITIONS

**MA Only**

**Community spouse** - Client’s spouse when the spouse:

- Is not currently in, and is **not** expected to be, in a hospital and/or LTC facility for 30 or more consecutive days or approved for a waiver or Freedom to Work; or
- For waiver clients, the spouse is **not** also approved for the waiver or PACE.
- For PACE clients, the spouse is **not** also approved for the waiver or PACE.

**Continuous period of care** - A period of at least 30 consecutive days where the institutionalized spouse/applicant has been, or is expected to be:

- In a hospital, and/or
- In an LTC facility, and/or
- Approved for the waiver as defined in BEM 106.
- Approved for PACE as defined in BEM 167.

The period is no longer continuous when none of the above is true for 30 or more consecutive days.

**Example:** Institutionalized spouse/applicant is in the hospital for 10 days, returned home for 5 days and then entered LTC. Because the applicant was not out of the hospital for 30 days or more, the continuous period of care begins with the hospital admission date.

**Waiver** - Provides home and community-based services to persons who, if they did **not** receive such services, would require nursing home care. The waiver is administered by the Michigan Department of Health and Human Services (MDHHS) through contracts with Pre-Paid Ambulatory Health Plans; see BEM 106 for more information.

**COUNTABLE ASSETS**

**MA Only**

Use SSI-related fiscal group policy in BEM 211 to determine fiscal groups. Use SSI-related MA policy in BEM 400 to determine countable assets.

**CLIENT’S ASSET ELIGIBILITY**

**Initial Eligibility**

**SSI-Related MA Only**

Apply the following formula to:

- Each past month, including retro MA months, and the processing month for applicants, and
- The first future month for MA recipients.

**Exception:** Do not do initial eligibility when the special exception policy in this item applies.

Begin the client’s *presumed asset eligible period* in this item.

### Initial Eligibility Formula

**SSI-Related MA**

The formula for asset eligibility is:

- The value of the couple’s (applicant, spouse, joint) countable assets for the month being tested.

- **MINUS** the protected spousal amount (in this item).

- **EQUALS** the client’s countable assets. Countable assets must not exceed the limit for one person in BEM 400 for the category(ies) being tested.

**Exception:** The client is asset eligible when the countable assets exceed the asset limit, if denying MA would cause undue hardship; see *undue hardship* in this item. Assume that denying MA will not cause undue hardship unless there is evidence to the contrary.

### Presumed Asset Eligible Period

**SSI-Related MA Only**

Applicants eligible for the *processing month* and recipient’s eligible for the first future month are automatically asset eligible for up to 12 calendar months regardless of:

- Changes in the community spouse’s assets, or
- The number of MA applications or eligibility determinations that occur during the period.

The 12-month period begins with the month following the processing month and is called the presumed asset eligible period.

**Exception:** The 12-month period ends sooner if any of the following becomes true:

- The continuous period of care ends.
• The client’s spouse no longer meets the definition of a community spouse when the spouse enters L/H, a waiver, or PACE.

• The client’s spouse dies or the couple divorces.

Note: Do not extend the original 12-month period when the client becomes eligible for additional MA benefits (for example: QMB benefits were effective 8-1-91; Group 2 coverage began 10-1-91).

Presumed Asset Eligible Period Ends

SSI-Related MA Only

When the presumed asset eligible period ends, use BEM 400 to determine the client’s asset eligibility. Count only the client’s assets, not the spouse’s assets, to determine continued eligibility. Verify all assets which are still owned by the individual, by the spouse, and jointly owned. Verify the transfers of all assets which were owned at the IAA, but which are no longer owned. Review all transfers for divestment.

Note: Because only the client’s assets are counted after the presumed asset eligible period, the client may have to transfer some assets to his spouse to make sure that he owns no more than the asset limit for one person at the end of the presumed asset eligible period; see asset transfer information in this item.

ASSET TRANSFER INFORMATION

SSI-Related MA Only

The presumed asset eligible period allows time for the client to transfer assets to the community spouse. The client is not required to transfer assets to the spouse. However, if they fail to do so, the client may be ineligible for MA after the presumed asset eligible period.

When the rules in this item no longer apply, BEM 400 is used to determine continuing asset eligibility. The community spouse is not an asset group member. The protected spousal amount is not used. Therefore, the client’s own countable assets must not exceed the appropriate asset limit (currently $2,000 for AD-Care or Extended Care categories)
Community Spouse Resource Allowance

SSI-Related MA Only

Federal law requires that the client and community spouse be told how much the community spouse resource allowance is and how it was calculated. Do this only when an applicant is MA eligible for the processing month or a recipient's eligibility continues.

Exception: Do not compute the allowance, notify the client or community spouse of the allowance or send the asset transfer notice when the special exception policy in this item applies.

The allowance is:

- The protected spousal amount. (MINUS the value of the community spouse's current countable assets).

  Note: Do not count cash value assets owned jointly by the client and community spouse in this calculation.

- EQUALS the community spouse resource allowance.

However, the value of assets fluctuates constantly. Therefore, what the couple really needs to know is: when the rules in BEM 402 no longer apply, the client's countable assets must not exceed the appropriate asset limit (currently $2000 for the AD-Care and Extended Care categories). All of the above information is in the asset transfer notice.

Notification

SSI-Related MA Only

Notify both the client and community spouse in writing of the above information:

- At the time an applicant is notified that he is eligible for the processing month or a recipient continues eligible for MA, and

- When requested by the client, the community spouse or the representative of either spouse.

Send both of the following to give notice:

- DHS-4586, Asset Transfer Notice.
• DHS-4585, Initial Asset Assessment and Asset Record.

Exception: Do not send the DHS-4585 when the special exception policy in this item applies.

INITIAL ASSET ASSESSMENT

MA Only

An initial asset assessment is needed to determine how much of a couple’s assets are protected for the community spouse.

An initial asset assessment means determining the couple’s (applicant’s, spouse’s, joint) total countable assets as of the first day of the first continuous period of care that began on or after September 30, 1989.

Example: A married man entered a nursing home on 12/6/89. He was released on 6/10/90 and returned home.

On 3/16/91 he re-entered the nursing home and has been there continuously ever since.

He applied for MA on 10/2/91. To determine his asset eligibility, do an initial asset assessment for 12/6/89 - the first day of the first continuous period of care that began on or after September 30, 1989.

Example: A married woman is approved for the waiver on 6-2-93. She is hospitalized from 6-10-93 until 6-30-93 when she returns home and again receives care management and waiver services.

She applies for MA on 8-24-94. To determine her asset eligibility, do an initial asset assessment for 6-2-93, the first day of the first continuous period of care that began on or after September 30, 1989.

The federal law requires that an initial asset assessment be done when requested by either spouse even when an application for health care coverage is not made.

Exception: Do not do an initial asset assessment (even if the client or community spouse requests it) when the special exception policy in this item applies.
Form

MA Only

The DHS-4574-B, Assets Declaration, is used to request an initial asset assessment.

Notification

MA Only

Notify both spouses in writing of the results of the initial asset assessment whether it is done prior to, or at the time of, an MA application. Use the following:

- DHS-4588, Initial Asset Assessment Notice, and
- DHS-4585, Initial Asset Assessment and Asset Record.

The above notices inform the couple of the:

- Total amount of their countable assets, and
- The protected spousal amount, and
- Their hearing rights.

Send copies of all verifications or other documents used in making the initial asset assessment along with each copy of the notices.

Standard of Promptness

MA Only

Complete an initial asset assessment and mail notices within 45 days. The period begins on the date the local office receives the signed DHS-4574-B.

A person, who requests an initial asset assessment, without applying for MA, must be given the same assistance in completing the assessment and obtaining verification that would be provided to any client. See BAM 130 for types of verification, sources and timeliness standards. An initial asset assessment cannot be completed if a client or the spouse refuses to provide verification or has not made a reasonable effort to obtain it within the time standards in BAM 130.

Do not deny/terminate a Group 2 Pregnant Woman or MAGI category if the client chooses not to cooperate with the initial asset assessment.
PROTECTED SPOUSAL AMOUNT

MA Only

The protected spousal amount is the amount of the couple's assets protected for use by the community spouse. It is the greatest of the amounts in 1-3 below.

1. Minimum Resource Standard:
   - $25,284 effective January 1, 2019.
   - $23,844 effective January 1, 2016.
   - $23,844 effective January 1, 2015.
   - $23,448 effective January 1, 2014.
   - $23,184 effective January 1, 2013.
   - $22,728 effective January 1, 2012.
   - $21,912 effective January 1, 2010.
   - $21,912 effective January 1, 2009.
   - $20,880 effective January 1, 2008.
   - $20,376 effective April 1, 2007.
   - One-half the initial asset assessment amount (see initial asset assessment in this item), but not more than:
     - $126,420 effective January 1, 2019.
     - $123,600 effective January 1, 2018.
     - $119,220 effective January 1, 2016.
     - $119,220 effective January 1, 2015.
     - $115,920 effective January 1, 2013.
     - $104,400 effective January 1, 2008.

2. The amount determined in a hearing per BAM 600.

3. The amount of assets transferred to the community spouse by the client pursuant to a court order requiring the client to:
   - Pay support to the community spouse, and
Immediately Refer Court Orders

SSI-Related MA Only

If a court has ordered a transfer of asset to a spouse for the spouse’s support, use the value of the assets transferred in the order as the Protected Spousal Amount. Delay any asset denial and proceed as follows immediately upon receipt of such an order:

1. Prepare a memo with the following:
   - Subject - BEM 402.
   - Specialist name, telephone number and local office.
   - Client’s name and case number.
   - Community spouse’s name.
   - If already computed:
     - Initial asset assessment amount.
     - Protected spousal amount per policy.
     - Amount of couple’s countable assets.

   **Note:** Do not delay the memo to compute these amounts. We have only 20 days to appeal the order.

2. Attach a legible copy of the order to the memo and send them via ID mail to:

   Michigan Department of Health and Human Services
   Legal Affairs Administration
   333 South Grand Avenue, 5th Floor
   P. O. Box 30195
   Lansing, MI 48909

   Central Office will send further instructions.

UNDUE HARDSHIP

SSI-Related MA Only

A client whose countable assets exceed the asset limit is nevertheless asset eligible when an undue hardship exists. Assume that denying MA will not cause undue hardship unless there is evidence to the contrary.
An undue hardship exists when the client’s physician (M.D. or D.O.) states that:

- Necessary medical care is **not** being provided, and
- The client needs treatment for an emergency condition.

A medical emergency is any condition for which a delay in treatment may result in the person’s death or permanent impairment of the person’s health.

A psychiatric emergency is any condition that must be immediately treated to prevent serious injury to the person or others.

See BEM 100, Policy Exception Request Procedure.

**Period of Eligibility**

**SSI-Related MA Only**

The existence of a hardship **cannot** be used to establish eligibility for any month prior to the processing month because there must be a current need for medical care for a current emergency condition.

However, once eligibility is established for the processing month, the client is asset eligible for the presumed asset eligibility period.

**INFORMATION UNAVAILABLE**

**SSI-Related MA Only**

A spouse remains the applicant's spouse for Medicaid eligibility until there is a Judgement of Divorce. If the community spouse's whereabouts are unknown (a couple separated prior to the client entering an LTC/hospital setting and the client does **not** know where the spouse is living or how to contact the spouse), the client’s countable assets are compared to the appropriate asset limit in BEM 400 to determine eligibility.

**Refusal** of the community spouse to provide necessary information or verification about his assets results in ineligibility for the client.
VERIFICATION REQUIREMENTS

MA Only

The MA verification requirements in BEM 400 apply. In addition, the statement of the client’s physician (M.D. or D.O.) is necessary to establish undue hardship.

INSTRUCTIONS

MA Only

A completed, signed DHS-4574-B is used to request an initial asset assessment. All such requests, whether or not in conjunction with an MA application, must be registered and completed.

EXHIBIT I - DETERMINING SSI-RELATED MA ASSET ELIGIBILITY PER BEM 402

The determination of asset eligibility is a multi-step process.

1. Do INITIAL ASSET ASSESSMENT.
2. Determine PROTECTED SPOUSAL AMOUNT.
3. Determine applicant's (spouse, joint) countable assets for month being tested.
4. Subtract PROTECTED SPOUSAL AMOUNT from the couple's assets.
5. Compare result from step 4 to client’s asset limit to determine if asset eligibility exists for month being tested.

Repeat steps 3, 4 and 5 for each month tested. For applicants, test each past month, including retro MA months, and the processing month. For MA recipients, test only the first future month.

6. Calculate the Community Spouse Resource Allowance only when an applicant is eligible for the processing month or a recipient's eligibility continues. Then, the client’s Presumed Asset Eligible Period begins.
**Example:**

- January 4 - Mr. J admitted to hospital
- January 10 - Mr. J transferred to LTC
- January 17 - MA application made, and initial asset assessment requested
- February 27 - Case processed

**Initial asset assessment amount:** $76,200 the couple’s (his, her, their) countable assets on January 4 consist of joint checking and savings accounts).

**Protected spousal amount:** $38,100 (one-half the initial asset assessment amount).

**Asset Eligibility**

<table>
<thead>
<tr>
<th></th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple’s countable assets (lowest balance during month tested):</td>
<td>$47,600</td>
<td>$40,050</td>
</tr>
<tr>
<td><strong>MINUS</strong> the protected spousal amount (see above):</td>
<td>38,100</td>
<td>38,100</td>
</tr>
<tr>
<td><strong>EQUALS</strong> Mr. J's countable assets:</td>
<td>9,500</td>
<td>1,950</td>
</tr>
<tr>
<td>Asset limit:</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Result:</td>
<td>excess assets</td>
<td>eligible</td>
</tr>
</tbody>
</table>

**Community Spouse Resource Allowance**

- Protected spousal amount (see above): $38,100
- **MINUS** Mrs. J's countable assets for the processing month (all joint cash assets are considered the L/H spouse’s): 0
- **EQUALS** community spouse resource allowance: 38,100

**EXHIBIT II - WHEN TO USE BEM 400 TO DETERMINE SSI-RELATED ASSET ELIGIBILITY**

Policy in BEM 400 is used for married L/H, PACE, and waiver clients when policy in this item does not apply. For example:
• The month being tested is **not** an L/H, PACE or waiver month.

• The continuous period of care began before September 30, 1989.

• A continuous period of care ends because of the client’s discharge of 30 or more days to a non-LTC/hospital/waiver/PACE setting.

• The client’s spouse is in, or expected to be in, a hospital/LTC facility for at least 30 days.

• Both the client and spouse are approved for the waiver or PACE.

• The location of the client’s spouse is unknown; see INFORMATION UNAVAILABLE, in this item.

• The client’s spouse dies or the client and spouse divorce. Use BEM 400 starting with the month after divorce or the spouse’s death.

• A presumed asset eligible period ends; see Presumed Asset Eligible Period.

**LEGAL BASE**

**MA**

Social Security Act, Sections 1915(c) and 1924
DEPARTMENT POLICY

Medicaid (MA) ONLY

Divestment results in a penalty period in MA, not ineligibility. Divestment policy does not apply to Qualified Disabled Working Individuals (QDWI); see Bridges Eligibility Manual 169.

Divestment is a type of transfer of a resource and not an amount of resources transferred.

Divestment means a transfer of a resource (see resource defined in this item and in glossary) by a client or his spouse that are all of the following:

- Is within a specified time; see look back period in this item.
- Is a transfer for less than fair market value; see definition in glossary.
- Is not listed in this item under transfers that are not divestment.

Note: See annuity not actuarially sound and joint owners and transfers in this item and BEM 401 about special transactions considered transfers for less than fair market value.

During the penalty period, MA will not pay the client’s cost for:

- Long Term Care (LTC) services.
- Home and community-based services.
- Home help.
- Home health.

MA will pay for other MA-covered services.

Do not apply a divestment penalty period when it creates an undue hardship; see undue hardship in this item.

RESOURCE DEFINED

Resource means all the client’s and spouse’s assets and income. It includes all assets and all income, even countable and/or excluded assets, the individual or spouse receive. It also includes all assets and income that the individual (or spouse) were
entitled to but did not receive because of action by one of the following:

- The client or spouse.
- A person (including a court or administrative body) with legal authority to act in place of or on behalf of the client or the client’s spouse.
- Any person (including a court or administrative body) acting at the direction or upon the request of the client or his/her spouse.

TRANSFER OF A RESOURCE

Transferring a resource means giving up all or partial ownership in (or rights to) a resource. Not all transfers are divestment. Examples of transfers include:

- Selling an asset for fair market value (not divestment).
- Giving an asset away (divestment).
- Refusing an inheritance (divestment).
- Payments from a MEDICAID TRUST that are not to, or for the benefit of, the person or his spouse; see BEM 401 (divestment).
- Putting assets or income in a trust; see BEM 401.
- Giving up the right to receive income such as having pension payments made to someone else (divestment).
- Giving away a lump sum or accumulated benefit (divestment).
- Buying an annuity that is not actuarially sound (divestment).
- Giving away a vehicle (divestment).
- Putting assets or income into a Limited Liability Company (LLC)
- Purchasing an asset which decreases the group’s net worth and is not in the group's financial interest (divestment).

Also see Joint Owners and Transfers for examples.
Transfers to a
LLC

Treat transfers to an LLC as a divestment unless the client retains the rights to the asset or income invested and may withdraw the asset invested on demand.

Treat transfers to an LLC that has no discernible product (goods and or services) produced as a divestment.

Transfers by
Representatives

Treat transfers by any of the following as transfers by the client or spouse.

- Parent for minor.
- Legal guardian.
- Conservator.
- Court or administrative body.
- Anyone acting in place of, on behalf of, at the request of or at the direction of the client or the client’s spouse.

Joint Owners and
Transfers

When a client jointly owns a resource with another person(s), any action by the client or by another owner that reduces or eliminates the client’s ownership or control is considered a transfer by the client.

**Example:** Mr. Jones is applying for MA. In 2005, he added his sister’s name to his bank account. Each is free to withdraw as much money as desired so adding the sister’s name did not affect the client’s ownership or control. On September 1, 2007, the sister withdrew $10,000 and deposited the money in her own bank account. Mr. Jones is considered to have transferred $10,000 on September 1, 2007, the day he no longer had ownership and control of his money.

**Example:** Mr. Jones is applying for MA. On September 1, 2007, Mr. Jones gave his sister half interest in real estate. His equity value at the time was $100,000. The ownership arrangement prevents either sibling from selling without the other’s permission. Mr. Jones transferred a resource on September 1, 2007, the day he reduced his ownership and control by giving his sister part ownership and the power to prevent sale. The amount transferred
depends on whether his sister is refusing to sell. The transferred amount is:

**Example:**

- $100,000 if she now refuses to sell.

**Note:** The transferred amount is used to calculate the divestment penalty. It is not used towards the countable asset limit for Mr. Jones’ eligibility.

- $50,000 if she now agrees to sell.

  **Note:** Unless otherwise excluded, one-half the equity for the month being tested is a countable asset for purposes of Mr. Jones’ asset eligibility and the other half is used to calculate the divestment penalty.

The same policy applies to resources the client’s spouse owns jointly with other persons.

**Exception:** No penalty is imposed if the parties involved verify that the resource transferred actually belonged solely to the person to whom it was transferred.

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### Annuity Not Actuarially Sound

Purchase of an annuity that is not actuarially sound is a transfer for less than fair market value. The transfer was made by the annuity’s owner.

**Owner** means the person who pays the premium for the annuity.

**Annuitant** means the person to whom the annuity payments are made during the guarantee period of the annuity.

An annuity is not actuarially sound if the annuitant is not expected to live until the end of the guarantee period of the annuity. Use the Life Expectancy Tables, EXHIBIT I to make this determination.

**Note:** Guarantee period may be called annuity certain or period certain.

**Example:** John purchased an annuity at age 65 with a guarantee period of 10 years and payments starting at purchase. John’s life expectancy is 16.67 years. The annuity is actuarially sound.
Example: Sally purchased an annuity at age 70 with a guarantee period of 15 years and payments starting five years after purchase. The annuity is not actuarially sound because Sally’s life expectancy at purchase was 15.72 years while the guarantee period ends in 20 years (five-year delay plus 15 years).

Example: Diane purchased an annuity at age 65 with a guarantee period of 25 years. The annuity is not actuarially sound because Diane’s life expectancy is only 19.50 years.

The amount transferred for less than fair market value for an annuity that is not actuarially sound is the amount that would be paid after the end of the person’s life expectancy. The amount transferred for less than fair market value is the value of the payments due in the last 5.5 years of the annuity (25 minus 19.50 = 5.50).

Example: Sally purchased an annuity at age 70 with a guarantee period of 15 years and payments starting five years after purchase. The annuity is not actuarially sound because Sally’s life expectancy at purchase was 15.72 years while the guarantee period ends in 20 years. The amount transferred for less than fair market value is the value of the payments due in the last 4.28 years of the annuity (20 - 15.72 = 4.28).

LOOK-BACK PERIOD

The first step in determining the period of time that transfers can be looked at for divestment is determining the baseline date; see baseline date in this item.

Once the baseline date is established, you determine the look-back period. The look back period is 60 months prior to the baseline date for all transfers made after February 8, 2006.

Entire Period

Transfers that occur on or after a client’s baseline date must be considered for divestment. In addition, transfers that occurred within the 60-month look-back period must be considered for divestment.

Penalty Situation

A divestment determination is not required unless, sometime during the month being tested, the client was in a penalty situation. To be
in a penalty situation, the client must be eligible for MA (other than QDWI) and be one of the following:

- In an LTC facility.
- APPROVED FOR THE WAIVER; see BEM 106.
- Eligible for Home Help.
- Eligible for Home Health.

**Baseline Date**

A person’s baseline date is the first date that the client was eligible for Medicaid and one of the following:

- In LTC.
- APPROVED FOR THE WAIVER; see BEM 106.
- Eligible for Home Health services.
- Eligible for Home Help services

A client’s baseline date does not change even if one of the following happens:

- The client leaves LTC.
- The client is no longer APPROVED FOR THE WAIVER; see BEM 106.
- The client no longer needs Home Help.
- The client no longer needs Home Health.

**LESS THAN FAIR MARKET VALUE**

Less than fair market value means the compensation received in return for a resource was worth less than the fair market value of the resource. That is, the amount received for the resource was less than what would have been received if the resource was offered in the open market and in an *arm’s length transaction* (see glossary).

**Note:** Also see *annuity not actuarially sound* in this item.

Compensation must have tangible form and intrinsic value.

Relatives can be paid for providing services; however, assume services were provided for free when no payment was made at the time services were provided. A client can rebut this presumption by providing tangible evidence that a payment obligation existed at the
time the service was provided (for example a written agreement signed at the time services were first provided). The policy in Bridges Administrative Manual (BAM) 130 allowing use of best available information or best judgment as verification does not apply.

**Value of Transferring Right to Income**

When a person gives up his right to receive income, the fair market value is the total amount of income the person could have expected to receive.

Use EXHIBIT I - Life Expectancy Table, to compute the fair market value of a lifetime income source such as a pension. Base the calculation on the person’s sex and age on the date of transfer.

**Personal Care & Home Care Contracts**

**Personal Care Contract** means a contract/agreement that provides health care monitoring, medical treatment, securing hospitalization, visitation, entertainment, travel/transportation, financial management, shopping, home help or other assistance with activities of daily living.

**Home Care Contract** means a contract/agreement which pays for expenses such as home/cottage/care repairs, property maintenance, property taxes, homeowner’s insurance, heat and utilities for the homestead or other real property of the client’s.

Home Care and Personal Care contracts/agreements may be between relatives or non-relatives. A relative is anyone related to the client by blood, marriage or adoption.

**Note:** When relatives provide assistance or services they are presumed to do so for love and affection and compensation for past assistance or services shall create a rebuttable presumption of a transfer for less than fair market value. Fair market value of the services may be determined by consultation with area businesses which provide such services. Contracts/agreements that include the provision of companionship are prohibited.
All Personal Care and Home Care contracts/agreements, regardless of whether between a client and a relative or a client and a non-relative, must be considered and evaluated for divestment.

Personal Care and Home Care contracts/agreements shall be considered a transfer for less than fair market value unless the agreement meets all of the following:

- The services must be performed after a written legal contract/agreement has been executed between the client and the provider. The contract/agreement must be dated and the signatures must be notarized. The services are not paid for until the services have been provided (there can be no prospective payment for future expenses or services); and

- At the time the services are received, the client cannot be residing in a nursing facility, adult foster care home (licensed or unlicensed), institution for mental diseases, inpatient hospital, intermediate care facility for individuals with intellectual disabilities or be eligible for home and community-based waiver, home health or home help; and

- At the time services are received, the services must have been recommended in writing and signed by the client’s physician as necessary to prevent the transfer of the client to a residential care or nursing facility. Such services cannot include the provision of companionship; and

- The contract/agreement must be signed by the client or legally authorized representative, such as an agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative cannot be the provider or beneficiary of the contract/agreement.

- MDHHS will verify the contract/agreement by reviewing the written instrument between the client and the provider which must show the type, frequency and duration of such services being provided to the client and the amount of consideration (money or property) being received by the provider, or in accordance with a service plan approved by MDHHS.

Assets transferred in exchange for a contract/agreement for personal services/assistance or expenses of real property/homestead provided by another person after the date of application are considered available and countable assets.
Transferring Non-countable or Excluded Resources

Transfers of resources that are excluded or not countable assets under SSI-related MA policy may be divestment.

Transfer of the following may be divestment:

- Homestead of L/H and waiver client (see BEM 106) or the L/H and waiver client’s spouse even if the transfer occurred before the client was institutionalized or approved for the waiver.
- Assets that are not countable because they were unavailable or not salable.

TRANSFERS THAT ARE NOT DIVESTMENT

Transferring Excluded Income

Transferring income that is not countable income for SSI-related MA according to BEM 500 is not divestment.

Transfers Involving Spouse

It is not divestment to transfer resources from the client to:

- The client’s spouse.
- Another SOLELY FOR THE BENEFIT OF the client’s spouse.

Transfers from the client’s spouse to another SOLELY FOR THE BENEFIT OF the client’s spouse are not divestment.

Transfers Involving Child

A transfer to the client’s blind or disabled (see BEM 260) child, regardless of the child’s age or marital status, are not divestment. This includes transfers to a trust established SOLELY FOR THE BENEFIT OF the child.
Transfer to Funeral Plan

See Life Insurance Funded Funeral in BEM 400 when a person has irrevocably transferred ownership in life insurance or a similar device designated for funeral expenses.

Transfer to Trust

Transfers to a trust established SOLELY FOR THE BENEFIT OF a disabled (see BEM 260) person under age 65 are not divestment.

Purchase of Funeral Contract

Placing money in an irrevocable prepaid funeral contract (see BAM 805) is not divestment.

Asset Conversion

Converting an asset from one form to another of equal value is not divestment even if the new asset is exempt. Most purchases are conversions.

Example: Using $5,000 from savings to buy a used car priced at $5,000 is conversion for equal value.

Example: Trading a boat worth about $8,000 for a car worth about $8,000 is conversion for equal value.

Payment of expenses such as one’s own taxes or utility bills is also not divestment.

Transferring Homestead to Family

It is not divestment to transfer a homestead to the client's:

- Spouse; see Transfers Involving Spouse above.
- Blind or disabled child; see Transfers Involving Child above.
- Child under age 21.
- Child age 21 or over who:
  - Lived in the homestead for at least two years immediately before the client’s admission to LTC or BEM 106 waiver approval, and
Provided care that would otherwise have required LTC or BEM 106 waiver services, as documented by a physician's (M.D. or D.O.) statement.

• Brother or sister who:
  • Is part owner of the homestead, and
  • Lived in the homestead for at least one year immediately before the client’s admission to LTC or BEM 106 waiver approval.

Transfers for Another Purpose

As explained in this item, transfers exclusively for a purpose other than to qualify or remain eligible for MA are not divestment.

A transfer of resources to a religious order by a member of that order in accordance with a vow of poverty are transfers for another purpose.

Assume transfers for less than fair market value was for eligibility purposes until the client or spouse provides convincing evidence that they had no reason to believe LTC or waiver services might be needed.

Example: Mr. Smith, age 40, was in good health when he gave his vacation cottage to his nephew. The next day Mr. Smith was in an automobile accident. His injuries require long-term care. The transfer was not divestment because Mr. Smith could not anticipate his need for LTC services.

Exception:

• Preservation of an estate for heirs or to avoid probate court is not acceptable as another purpose.

• That the asset or income is not counted for Medicaid does not make its transfer for another purpose.

Trustee Fees

Trusts which designate a business as trustee (for example a bank) usually must compensate the trustee. Reasonable compensation is not divestment. Reasonable compensation means compensation within the prevailing rate for the community. For example, banks usually base their fee on a percentage of the value of the principal.
There may be a basic charge in addition to the percentage or the percentage may vary based on the value of the trust.

**SOLELY FOR THE BENEFIT OF**

All of the following conditions must be met for a transfer or for a trust to be solely for the benefit of a person.

- The arrangement must be in writing and legally binding on the parties.
- The arrangement must ensure that none of the resources can be used for someone else during the person's lifetime, except for trustee fees.
- The arrangement must require that the resources be spent for the person on an actuarially sound basis. This means that spending must be at a rate that will use up all the resources during the person's lifetime. Life expectancies are in Exhibit I.

**PENALTY PERIOD**

**No Maximum Penalty**

There is no maximum limit on the penalty period for divestment. There is no minimum amount of resource transfer before incurring a penalty, determine a penalty on any amount of resources that are transferred and meet the definition of a divestment even if the penalty is for one day. Divestment is a type of transfer not an amount of transfer.

Any penalty period established under previous policy continues until it ends.

Apply the penalty policy in place at the time of transfer for any transfers made before February 8, 2006.

**Computing Penalty Period**

Compute the penalty period on the total Uncompensated Value of all resources divested.

Determine the Uncompensated Value for each resource transferred and combine into a total Uncompensated Value.
Divide the total Uncompensated Value by the average monthly private LTC Cost in Michigan for the client’s Baseline Date. This gives the number of full months for the penalty period. Multiply the fraction remaining by 30 to determine the number of days for the penalty period in the remaining partial month.

Apply the total penalty months and days. Apply a penalty even if the total amount of the penalty is for only a partial month.

Apply the penalty to the months (or days) an individual is eligible for Medicaid and actually in LTC, Home Health, Home Help, or the MIChoice Waiver. Do not apply the divestment penalty to a period when the individual is not eligible for Medicaid for any reason (that is the case closes for any reason or is eligible for Medicaid but is not in LTC, Home Help, Home Health, or the MIChoice Waiver. Restart the penalty when the individual is again eligible for Medicaid and in LTC, Home Help, Home Health, or MIChoice Waiver. When a medical provider is paid by the individual, or by a third party on behalf of the individual, for medical services received, that month is not a penalty month. Do not count that month as part of the penalty period. This does not include payments made by commercial insurance or Medicare; see Resources Returned in this item.

**Note:** An individual is not eligible for MA in a month they have pre-paid for LTC. Because federal law directs a resident in a nursing facility must have access to all monies held by the facility for the resident, count the money held by a nursing facility as cash.

A group 2 deductible eligible individual is not eligible for Medicaid until the deductible is met. Apply the penalty only to the days of the month after the deductible is met.

The 1st day the client is eligible to receive MA coverage for LTC, MIChoice, home help, or a home health service is the 1st day after the penalty period ends.

<table>
<thead>
<tr>
<th>Baseline Date In Calendar Year</th>
<th>LTC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>$8469</td>
</tr>
<tr>
<td>2018</td>
<td>$8261</td>
</tr>
<tr>
<td>2017</td>
<td>$8018</td>
</tr>
<tr>
<td>2016</td>
<td>$8282</td>
</tr>
</tbody>
</table>
The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, or home help or home health services), and is not already part of a penalty period. When a medical provider is paid by the individual, or by a third party on behalf of the individual, for medical services received, the individual is not eligible for Medicaid in that month and the month is not a penalty month. That month cannot be counted as part of the penalty period. This does not include payments made by commercial insurance or Medicare.

<table>
<thead>
<tr>
<th>Baseline Date In Calendar Year</th>
<th>LTC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$8084</td>
</tr>
<tr>
<td>2014</td>
<td>$7867</td>
</tr>
<tr>
<td>2013</td>
<td>7631</td>
</tr>
<tr>
<td>2012</td>
<td>$7032</td>
</tr>
<tr>
<td>2011</td>
<td>$6816</td>
</tr>
<tr>
<td>2010</td>
<td>$6618</td>
</tr>
<tr>
<td>2009</td>
<td>$6362</td>
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<tr>
<td>2008</td>
<td>$6191</td>
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<td>2007</td>
<td>$5938</td>
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<td>2006</td>
<td>$5549</td>
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<td>2005</td>
<td>$5367</td>
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<td>$3981</td>
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<tr>
<td>1998</td>
<td>$3711</td>
</tr>
<tr>
<td>1997</td>
<td>$3507</td>
</tr>
<tr>
<td><strong>Before January 1997</strong></td>
<td><strong>$3441</strong></td>
</tr>
</tbody>
</table>
Note: If a past unreported divestment is discovered or an agency error is made which should result in a penalty, a penalty must be determined under the policy in place at the time of discovery. If a penalty is determined for a transfer in the past, apply the penalty from the first day after timely notice is given; see Recipient Exception in this item.

Recipient Exception

Timely notice must be given to LTC recipients and (BEM 106) waiver recipients before actually applying the penalty. Adequate notice must be given to new applicants.

Uncompensated Value

The uncompensated value of a divested resource is

- The resource’s cash or equity value.
- Minus any compensation received.
- The uncompensated value of a promissory note, loan, or mortgage is the outstanding balance due on the baseline date.

Spouses Sharing a Penalty

Penalize a client if her or his spouse divests. The penalty is imposed on whichever spouse is in a penalty situation; see BEM 211, MA Group Composition. If both spouses are in a penalty situation, the penalty period (or any remaining part) must be divided between them.

Example: Mr. and Mrs. Brown divested themselves of assets prior to Mr. Brown entering an LTC facility and applying for Medicaid. Mr. Brown is in LTC and under a divestment penalty for 24 months. When Mrs. Brown enters the facility 6 months later, the remaining 18 months of Mr. Brown’s penalty are divided between them, giving Mr. and Mrs. Brown each 9 months of the penalty still to complete. If either Mr. or Mrs. Brown dies before they complete their penalty the remainder of their penalty is transferred to their spouse.

Example: Mr. Brown enters a LTC facility and applies for Medicaid. He is found eligible for Medicaid. During the presumed asset eligibility period Mrs. Brown transfers Mr. Brown’s assets to herself and then transfers the assets to her children (the first transaction is permitted the second transaction is divestment). Mr.
Brown incurs the divestment penalty. Mrs. Brown then enters the LTC facility. Mr. and Mrs. Brown divide the remainder of the incurred divestment penalty.

**Resources Returned**

Cancel a divestment penalty if either of the following occurs before the penalty is in effect:

- All the transferred resources are returned and retained by the individual.
- Fair market value is paid for the resources.

Recalculate the penalty period if either of the following occurs while the penalty is in effect:

- All the transferred resources are returned.
- Full compensation is paid for the resources.

Use the same per diem rate originally used to calculate the penalty period.

Once a divestment penalty is in effect, return of, or payment for, resources cannot eliminate any portion of the penalty period already past. However, recalculate the penalty period. The divestment penalty ends on the later of the following:

- The end date of the new penalty period.
- The date the client notified you that the resources were returned or paid for.

**UNDUE HARDSHIP**

Waive the penalty if it creates undue hardship. Assume there is no undue hardship unless you have evidence to the contrary.

Undue hardship exists when the client's physician (M.D. or D.O.) says:

- Necessary medical care is not being provided, and
- The client needs treatment for an emergency condition.

A medical emergency exists when a delay in treatment may result in the person's death or permanent impairment of the person's health.
A psychiatric emergency exists when immediate treatment is required to prevent serious injury to the person or others.

See BEM 100, Policy Exception Request Procedure.

**VERIFICATION REQUIREMENTS**

Verification is not required when the client states he and his spouse have not transferred resources unless:

- The client’s statement is unclear, inconsistent or conflicts with known facts, or
- Existing information in the case record indicates divestment may have occurred.

Verify the following to document divestment:

- Date of transfer.
- Fair market value or cash value.
- Uncompensated value.

Obtain a statement from the LTC or waiver client’s physician (M.D. or D.O.) to verify:

- Undue hardship, or
- The client’s non-disabled child age 21 or older provided care that would otherwise have required LTC or waiver services.

Verify the child's length of residence if a homestead was transferred to a nondisabled child age 21 or older.

Verify the sibling's ownership interest and length of residence in the homestead if a homestead was transferred to a sibling.

Verify disability and blindness according to BEM 260.

**Verification Sources**

Sources to verify transfers and the reasons for them include, but are not limited to, the following:

- Legal documents.
- Payment or tax records.
- Bills of sale.
Sources to verify ownership interest in a homestead include, but are not limited to:

- Deeds.
- Mortgages.
- Purchase agreements.
- Contracts.
- Other court or county records.

Sources to verify length of residence in a homestead include, but are not limited to:

- Driver’s license or State I.D.
- Income tax returns.
- Voter registration.
- Cancelled mail.
- Other type of I.D., which has both name and address.
- Written statement from one of the following who has knowledge of length of residence in the homestead:
  - Physician.
  - Clergy.
  - Other professional.

**PET CODE**

Program enrollment type (PET) code EXM-DIVM indicates a divestment penalty.

**EXHIBIT I - LIFE EXPECTANCY TABLE**

<table>
<thead>
<tr>
<th>Exact Age</th>
<th>Male Life Expectancy</th>
<th>Female Life Expectancy</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>1</td>
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<tr>
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</tr>
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<td>Exact Age</td>
<td>Male Life Expectancy</td>
<td>Female Life Expectancy</td>
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<tr>
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<td>------------------------</td>
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Example Female: In January 2004, Mrs. Jay established a Medicaid trust and ordered her $500 per month pension paid to the trust. She was 78 years old. The trustee cannot use the pension for Mrs. Jay. Mrs. Jay transferred $63,120 ($500 X 12 months X 10.52 years).

Example Male: In January 2004, Mr. Jay established a Medicaid trust and ordered his $500 per month pension paid to the trust. He was 78 years old. The trustee cannot use the pension for Mr. Jay. Mr. Jay transferred $52,800 ($500 X 12 months X 8.80 years).

LEGAL BASE

MA

Social Security Act, Sections 1902(a)(18), 1917
All Programs

This item identifies both of the following:

- Which income types are considered earned.
- Which earned income types are excluded or counted for each type of assistance.

To create a new income record, go to the income questions screen and answer yes to the appropriate question for that income type. This will add the appropriate income-related logical unit of work (LUW) to the driver flow and cause Bridges to consider this income.

To view or change an existing income record, select the appropriate income-related LUW from the left navigation.

Logical Unit of Work (LUW)

An income-related LUW is a series of data collection screens. Completion is required to collect the information needed to determine countable income.

Data entered in an LUW is not saved until all screens in the LUW are completed and saved. Use the tabs across the top of the Bridges screens to identify which screens are contained within the LUW.

Income data is not considered in the eligibility result until eligibility determination/benefit calculation (EDBC) is run. Income data does not affect benefit issuance until eligibility results are certified for that program.

STRIKERS’ COUNTABLE EARNINGS

Food Assistance Program (FAP) Only

If an individual is on strike, pre-strike and current wages both must be entered in the Bridges Employment LUW. Bridges will count the higher of:

- The earnings of the individual prior to the strike.
• The individual’s current earnings.

**Note:** Strike benefits other than wages are unearned income; see Bridges Eligibility Manual (BEM) 503, STRIKE BENEFITS.

### STUDENT EARNINGS DISREGARD

#### All Programs

This disregard applies to all sources of **earned** income including wages and training income. It ends the month after the student stops meeting a requirement (Example: month after reaching age 18).

**Note:** There is a different disregard for Workforce Innovation and Opportunity Act (WIOA)-funded training income; see TRAINING INCOME.

Bridges continues the student earnings exclusion during school breaks and vacations as long as the student plans to return as indicated by student’s education details in Bridges.

See BEM 400, **Student's Saving Exclusion** for the asset exclusion policy.

#### Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC) and FAP Only

Bridges disregards the earnings of an individual who is **all** of the following:

- Under age 18.
- Attending elementary, middle or high school including attending classes to obtain a GED.
- Living with someone who provides care or supervision.

#### Low-Income Family Medicaid (LIF) Only

Bridges disregards the earnings of a dependent child in the LIF eligibility determination group (EDG).
Group 2 Pregnant Women (G2P), Group 2 Under 21 (G2U) and Children Under 19

Bridges disregards the earnings of an individual under age 19 who is living with someone who provides care or supervision.

EARNED INCOME TYPES

All Programs

In addition to the earned income types identified in this item, income from self-employment is considered earned; see BEM 502.

Sometimes income from rental/room and board is considered earned income; see BEM 504, Income From Rental/Room and Board.

AMERICORPS

AmeriCorps VISTA

All Programs

Volunteers in Service to America (VISTA) is now called AmeriCorps VISTA. This is a Domestic Services Volunteers Act, Title I program. Bridges excludes these payments as income and as assets.

AmeriCorps Community Service

AmeriCorps, a national community service program, encompasses AmeriCorps State, AmeriCorps*National and AmeriCorps*NCCC.

Participants in these programs may receive any or all of the following:

- Living allowance.
- Child care allowance.
- Health insurance.
- Services to individuals with disabilities.
- National service education award.

FIP, RCA, SDA, CDC and FAP

Bridges excludes all allowances and benefits as income and as assets.
Medicaid

Bridges counts the living allowance as wages, and excludes all other allowances and benefits as income and assets.

GREEN THUMB/SENIOR COMMUNITY SERVICE EMPLOYMENT

All Programs

Bridges excludes income earned under the senior community service employment program (example: Green Thumb) established by Title V of Public Law 100-175 (Older Americans Act). Bridges excludes as income and as an asset.

HONORARIA

All Programs

An honorarium is a voluntary payment received for services rendered as distinguished from employment income (examples: guest speaker, participant in DHS advisory committee). Some or all of the payment might be reimbursement for expenses; see BEM 500, Reimbursements.

DHS Honorarium

Bridges excludes a DHS-paid honorarium as a reimbursement.

Other Honorarium

Bridges counts any amount not meeting the definition of a reimbursement as earned income; see WAGES.

S CORPORATION (S CORP)/LIMITED LIABILITY COMPANY (LLC)

All Programs

Bridges counts the income a client receives from an S-Corp or LLC as wages, even if the client is the owner; see WAGES.
Refer to BEM 503, Unearned Income, regarding dividends and interest paid to an individual from an S-Corp. or LLC.

**SENIOR COMPANION**

This is a Domestic Services Volunteers Act, Title II program. Payments are excluded earned income under Title II of Public Law 93-113. Bridges excludes as income and asset.

**TRAINING INCOME**

**All Programs**

The training program decides if payments are from the Workforce Innovation and Opportunity Act (WIOA) and if payments are for on-the-job training (OJT). If a payment includes WIOA and Non-WIOA funds, apply appropriate policy below to the separate portions.

See BEM 400, **Student Savings Exclusion** for asset policy.

**On-the-Job Training (OJT)**

Bridges counts OJT (or paid work experience) income as earnings.

**Exceptions:**

- Bridges disregards OJT income received under the Summer Youth Employment and Training Program.
- Bridges disregards OJT if received by an individual who is **any** of the following:
  - Under age 18.
  - Age 18 and living with someone providing care or supervision.
  - For LIF only, age 19 and a dependent child.

**Workforce Innovation Opportunity Act (Not OJT)**

Bridges excludes payments from WIOA training income that are **not** for OJT.
Other Training Income

Training income that is not specifically addressed in policy is countable earned income. This includes vocational training or training allowances that cannot be excluded due to being OJT, WIOA funded, MRS or reimbursements.

UNIVERSITY YEAR FOR ACTION

All Programs

This is a Domestic Services Volunteers Act, Title I program. Payments are excluded earned income under Title I of Public Law 93-113. Bridges excludes as income and asset.

WAGES

All Programs

**Wages** are the pay an employee receives from another individual organization or S-Corp/LLC. Wages include salaries, tips, commissions, bonuses, severance pay and flexible benefit funds not used to purchase insurance.

Enter an employee's regular wages paid during a vacation or illness as earned income.

Enter a wage advance as earnings when the employer actually pays it. Do not count the money withheld to offset the advance.

Enter wages held by the employer at the request of the employee. Bridges will count as earnings. However, wages held as a general practice by the employer are not income until actually paid, and should not be entered in Bridges until anticipated or received.

**Exception:** Income received in one month that is intended to cover several months (for example contractual income) is considered available in each of the months covered by the income; see BEM 505. Bridges counts gross wages except as explained in this item or BEM 503 for:

- Earned Income Tax Credit (EITC).
- Flexible Benefits.
- STRIKERS’ COUNTABLE EARNINGS.
- STUDENT EARNINGS DISREGARD.
- **Census Workers.**

**FIP, RCA, SDA, CDC, Medicaid**

Enter wages received for temporary census workers in the earned income LUI. Bridges excludes wages paid for temporary census workers.

**FAP Only**

Bridges counts wages for temporary census workers as earned income.

**Earned Income Tax Credit (EITC)**

**All Programs**

Some individuals elect to receive a portion of an anticipated EITC in regular pay checks. Do not include these amounts in the earned income pay details entered in Bridges. Advance payments of the EITC are excluded as income and as assets.

**Flexible Benefits**

Some employers give employees a flexible benefit allowance from which they may choose to purchase health insurance.

Flexible benefit amounts used to purchase insurance are excluded as income. Do not enter such amounts in Bridges.

Include any flexible benefit payments included in an individual’s paycheck and **not** used to purchase insurance, in the amounts entered in pay details. They are considered wages.

**Independent Living Services (ILS)**

Enter income as wages for an individual who provides ILS (also known as adult home help) as earned income. This income is not counted for the individual receiving the service.
Military Combat Pay

**FAP Only**

Military combat pay is paid to military personnel as a result of deployment to a combat zone. Bridges excludes military combat pay for FAP. Determine the excluded income amount by calculating the difference between the military pay received by the household before and after the military individual’s deployment to the combat zone; see Exhibit I - Designated Combat Zones.

Enter **Combat Pay Period Amount** on the pay details screen in Bridges.

TANF-Funded Subsidized Employment Income

**FIP, RCA, CDC and FAP**

All TANF-funded subsidized employment income in the form of wages, regardless of the source of TANF funding, is countable earned income.

Military Subsistence Supplemental Allowance

**All Programs**

The Subsistence Supplemental Allowance is paid to certain military personnel. Payments appear on the leave and earnings statement. Count the allowance as earned income by including them in wage amounts entered in Bridges.

Work Study

**All Programs**

Bridges excludes wages that are earned as part of a post-secondary education financial assistance package.
VERIFICATION REQUIREMENTS

All Programs

Note: The Work Number is not an automated system match which must be checked at application, redetermination, semi-annual or mid-certification contact. The client has primary responsibility for obtaining verification. However, if for example, verification of income is not available because the employer uses the Work Number and won’t provide the employment information, it is appropriate to use the Work Number.

Do not deny or terminate assistance because an employer or other source refuses to verify income; see BAM 130, VERIFICATION AND COLLATERAL CONTACTS

All Programs, except Children Under 19

Verify non-excluded earned income at all of the following:

- Application, including a program add, prior to authorizing benefits.
- At member add, only the income of the member being added.
  
  Note: See BAM 220, CDC MEMBER ADD for CDC member add requirements.

- Redetermination.
- When program policy requires a change be budgeted.

Exception: For FIP, RCA, SDA, CDC and FAP, verify income that decreases or stops. Do not verify starting and increasing income unless income change information is unclear, inconsistent or questionable. Select starting or increasing income as the verification source. Selecting client statement as the verification source results in Bridges incorrectly pending eligibility and generating a Verification Checklist.

Children Under 19

Income and expenses are not verified for Children Under 19 MAGI-related Medicaid. Client statement is an acceptable verification source for income and expenses.
COMMON VERIFICATION SOURCES

See BEM 500, COMMON VERIFICATION SOURCES.

SPECIFIC VERIFICATION SOURCES

Independent Living Services Income

- Consolidated Inquiry with a statement from the individual receiving the service (also known as adult home help) if there are any co-pays.
- Statement from individual receiving the service.

Military Combat Pay

FAP Only

- Military individual’s leave and earnings statement (LES).
- Orders issued to military individual.
- Client’s statement of the amount of combat pay received from the military.
- Any other reasonable method of verifying deployment to a combat zone; see Exhibit I in BEM 501 - Designated Combat Zones.

Tips

- Pay stub if client confirms the accuracy of the amount listed on the pay stub. (Tips shown on pay stubs are often a percentage of sales for tax purposes.)
- Client statement.
Wages, Salaries, and Commissions

All Programs

- Check stubs or earnings statement.
- DHS verification of employment forms, for example DHS-38, Verification of Employment.
- Employer signed statement providing all necessary information.
- Employer generated work schedule, when pay frequency, pay day and rate of pay are known. When this source is used, select other acceptable as the verification source.
- The Work Number.
- Employment services contractors including the one-stop service center, the work participation provider and refugee employment services contractors.
- Starting or increasing income. Select this verification source when an individual reports starting or increasing income, other than at application or redetermination. No VCL will be produced.
- Federal income tax forms and schedules are allowable for Medicaid determinations.
EXHIBIT - DESIGNATED COMBAT ZONES
### Executive Order 12744

<table>
<thead>
<tr>
<th>Country</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Arabian Sea Portion that lies North of 10 degrees North Latitude and West of 68 degrees East Longitude</td>
<td>January 17, 1991</td>
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<tr>
<td>Bahrain</td>
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<tr>
<td>Gulf of Aden</td>
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<td>Gulf of Oman</td>
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<td>Kuwait</td>
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<td>Qatar</td>
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<td>Oman</td>
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<td>Red Sea</td>
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<tr>
<td>Saudi Arabia</td>
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<td>United Arab Emirates</td>
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<tr>
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</tr>
<tr>
<td>Israel</td>
<td>January 1 - July 31, 2003</td>
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<tr>
<td>Eastern Mediterranean</td>
<td>March 19 - July 31, 2003</td>
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<td>Jordan</td>
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<tr>
<td>Egypt</td>
<td>March 19 - April 20, 2003</td>
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### Executive Order 13239

<table>
<thead>
<tr>
<th>Country</th>
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<tr>
<td>Afghanistan</td>
<td>September 19, 2001</td>
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### Direct Support of Executive Order 13239

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<tr>
<td>Tajikistan</td>
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<td>Jordan</td>
<td>September 19, 2001</td>
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<tr>
<td>Incirlik Air Force Base</td>
<td>September 21, 2001 - December 31, 2005</td>
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<td>Turkey</td>
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<td>Kyrgyzstan</td>
<td>October 1, 2001</td>
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<td>Uzbekistan</td>
<td>October 1, 2001</td>
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<tr>
<td>Philippines</td>
<td>January 9, 2002</td>
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<tr>
<td>(only troops with</td>
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<td>orders that reference</td>
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<td>OEF)</td>
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<tr>
<td>Yemen</td>
<td>April 10, 2002</td>
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<tr>
<td>Djibouti</td>
<td>July 1, 2002</td>
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<td>Somalia</td>
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Executive Order 13119 Public Law 106-21
Establishing Kosovo as Qualified Hazardous Duty Area

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<tr>
<td>The Federal Republic of Yugoslavia (Serbia/Montenegro)</td>
<td>March 24, 1999</td>
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<td>Albania</td>
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<tr>
<td>The Adriatic Sea</td>
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<tr>
<td>The Ionian Sea north of the 39th parallel</td>
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Public Law 104-117 Establishing a Qualified Hazardous Duty Area

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<td>Macedonia</td>
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</table>

LEGAL BASE

| FIP | MCL 400.1 et. seq. |
SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151–400.3180

RCA

45 CFR 400.66

CDC

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

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106

FAP

7 CFR 273.9
Child Care and Development Block Grant of 1990, P. L. 101-508, Section 5105(a)(3)
P. L. 108-447
DEPARTMENT POLICY

All Programs

This item identifies all the following:

- Unearned income types.
- Definition of each unearned income type.
- Whether an unearned income type is countable or excluded for each type of assistance.

To create a new income record, go to the income questions screen and answer yes to the unearned income question. This will add the unearned income logical unit of work (LUW) to the driver flow and cause Bridges to consider this income.

To view or change an existing income record, select the unearned income logical unit of work from the left navigation.

EXPENSES OF OBTAINING UNEARNED INCOME

Bridges excludes amounts paid or withheld from unearned income which are essential expenses of obtaining the income. Enter these amounts in the expense screen of the unearned income logical unit of work.

Examples:

- Legal and medical expenses withheld from a lawsuit settlement.
- Disability insurance premiums which must be paid to continue current disability payments.

Medicaid (MA) Only

There is a limit to the deduction of court-ordered guardianship and conservator expenses. See Bridges Eligibility Manual (BEM) 536, 540, 541 or 546 depending on the type of budget being done. Enter guardianship/conservator expenses on the support expense details screen in Bridges.
UNEARNED INCOME TYPES

All Programs

ACCELERATED LIFE INSURANCE PAYMENTS

An accelerated life insurance payment is payment of the death benefit of a life insurance policy prior to the insured individual's death. Some companies call the payment a living need payment or accelerated death payment. Details of the payment option vary from company to company. Under most plans, payment is available when the insured individual meets any of the following:

- Needs care in a long-term care (LTC) facility.
- Has a catastrophic illness.
- Is terminally ill.

The individual might have the option of receiving the payments over a period of months or all at once.

Receipt of such payments might reduce the cash surrender value of the insurance policy. In some cases, a lien might be attached to the insurance policy. Accelerated life insurance payments are not:

- Conversion of an asset from one form to another.
- A potential benefit for which an individual must apply.

Bridges counts the gross amount of an accelerated life insurance payment as unearned income.

**Exception:** It is a lump sum if payment is received all at once; see BEM 500, LUMP SUMS AND ACCUMULATED BENEFITS.

ADOPTION SUBSIDIES

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance Program (RCA), Child Development and Care (CDC)

An adoption subsidy is a payment to the adopting parent(s) of an adopted child who would remain in foster care without the subsidy incentive. There are two types of adoption subsidies:
Support Subsidy

- A support subsidy is a payment for ongoing care and support of the child. Bridges includes support subsidies as income.

Medical Subsidy

- A medical subsidy is a payment for medical expenses due to a physical, mental or emotional condition of the child. Bridges excludes medical subsidies as income. They are reimbursements.

Do not include funds from these payments in liquid asset amounts entered in Bridges. They are excluded assets.

Note: Support Subsidy is excluded as income for Medicaid programs and Food Assistance Program (FAP).

AGENT ORANGE PAYMENTS

All Programs

Agent Orange payments are received from Aetna Life and Casualty because of the Agent Orange lawsuit settlement and Public Law 101-201. Bridges excludes these payments as income. Do not include funds from these payments in liquid asset amounts entered in Bridges. They are excluded assets.

ALIEN SPONSOR INCOME

FIP, RCA, SDA, CDC, MA,

Bridges counts actual contributions an alien receives from their sponsor as unearned income.

FAP Only

See BEM 550, SPONSORS OF ALIENS about how Bridges counts both of the following:

- The sponsor’s actual contributions to the alien.
- An amount deemed to the alien from the sponsor by policy.
AMERICAN INDIAN PAYMENTS

All Programs

Gaming Revenue

Individuals may receive income from tribal gaming profits including casino profit sharing. Bridges counts as unearned income all payments made to American Indians from gaming revenues. Bridges does not exclude any part of these payments. If a payment is intended to cover multiple months, use the appropriate payment frequency in Bridges to average the income for applicable type of assistance.

Payments Excluded by Federal Laws

Many federal laws exclude all or a part of payments made to American Indians. These have been programmed into Bridges and are identified in EXHIBIT I- NATIVE AMERICAN PAYMENT EXCLUSIONS in this item.

ANNUITY INCOME

All Programs

Payments an individual receives from an annuity are unearned income. Bridges counts annuity payments as the individual’s unearned income.

Note: For MAGI Medicaid some structured annuity income that is non-taxable may not be counted toward an individual’s Medicaid income; see BEM 401 for further information.

BLACK LUNG

Black Lung benefits are administered by the federal government. The purpose of the program is to provide wage replacement and medical benefits to coal miners who are totally disabled due to black lung disease. Payments are also made to disabled coal miners’ eligible survivors. Bridges counts black lung payments as the individual’s unearned income.
**CHILD/COMMUNITY SPOUSE ALLOCATION**

**MA and FAP Only**

Sometimes policy deems someone’s income (or a portion of income) available to another person. Deeming rules are programmed into Bridges and deemed amounts are automatically calculated.

Money diverted by an L/H patient to their community spouse or dependents at home per BEM 546 is a contribution. Count the gross amount actually received as the community spouse’s or dependent's unearned income.

**CHILD FOSTER CARE PAYMENTS**

**FIP, RCA, SDA, CDC, MA**

Bridges excludes government, court or private agency payments for child foster care and independent living stipends.

**Note:** For FIP, recipients of child foster care payments have an eligibility determination group (EDG) participation status of excluded; see BEM 210, FIP Group Composition.

**FAP only**

Bridges counts these payments as the unearned income of the foster child who has a FAP program request status of yes.

**Reminder:** A foster parent may choose whether or not to request FAP on behalf of a foster child. When FAP program request status for foster child is no, Bridges does not consider the child’s needs or income in the FAP eligibility determination: see BEM 212, *Foster Children*, for details.

**Note:** Contact the children’s service worker for the amount paid.

**Independent Living Stipend**

Independent living stipends (ILS) are payments made to a former foster child who is in an independent living arrangement. Michigan Department of Health & Human Services (MDHHS) services manual defines independent living as: “The youth’s own unlicensed
residence or the unlicensed residence of an adult who has no supervisory responsibility for the youth."

**FIP, RCA, SDA, CDC**

Recipients of independent living stipends (ILS) have an eligibility determination group (EDG) participation status of excluded. Bridges does not consider the recipient’s need, income or assets: see BEM 210, **WHO IS IN THE FIP EDG?**; BEM 214 and BEM 215, **Mandatory RCA EDG Members**.

**FAP**

Bridges counts independent living stipend payments as unearned income.

**CHILD SUPPORT**

**All Programs**

Child Support is money paid by an absent parent(s) for the living expenses of a child(ren). Medical, dental, child care and educational expenses may also be included. Court-ordered child support may be either **certified** or **direct**. Certified support is retained by the state due to the child’s FIP activity. Direct support is paid to the client.

Child support is income to the child for whom the support is paid.

**FIP, RCA, SDA, CDC, FAP**

Child support payments, including arrearage payments, received by a custodial party for an adult child or a child no longer living in the home, are considered the other unearned income of the payee if the money is not forwarded to the adult child or child. If the money is forwarded to the adult child or child, it is the other unearned income of the adult child or child.

**Note:** If the child support payments are paid for a minor child who has been removed from the home of the custodial parent, the income is still the income of the child, unless documented otherwise.

**Exception: MA Only** - Arrearage payments received and retained by a parent for an adult child, or a child not living in the home, are considered unearned income for the parent. Any amount of the
payment which is passed through to the adult child it is not income
to the parent.

**MAGI Medicaid**

Child support payments are not countable in a MAGI Medicaid
determination.

**Child Support Certified**

**All Programs**

Certified support means court-ordered payments the Michigan
State Disbursement Unit (MiSDU) sends to MDHHS due to a child’s
receipt of assistance. Office of Child Support refers to these
collections as retained support. This may include court-ordered
medical support payments.

**CDC Only**

Bridges excludes as income, both of the following:

- The amount of collections retained by MDHHS (certified
  support).

- Direct Support payments the group receives (in error) after the
  child support certification effective date and returns to MDHHS.

**FAP Only**

Bridges excludes collections retained by MDHHS (certified support)
and court-ordered support payments the group receives after the
child support certification effective date.

**FIP Only**

The effective date for court-ordered child support certification at FIP
opening depends on the initial FIP eligibility date and the date initial
FIP eligibility is certified in Bridges.

When the initial eligibility date is the first of a month, certification of
child support is effective the first of the month following the day
initial FIP eligibility is certified in Bridges.

When the initial eligibility date is the 16th of a month, court-ordered
child support is certified the later of:
• The first of the month following the initial eligibility date.
• The first of the month following the day you certify initial FIP eligibility in Bridges.

**Note:** Certification effective date changes if a FIP eligibility determination group is closed and then reinstated.

Bridges counts certified child support only in the FIP child support income test; see BEM 255, Support Certification Effective Date, BEM 505, PROSPECTIVE BUDGETING/INCOME CHANGE PROCESSING and BEM 518, FIP/RCA/SDA INCOME BUDGETING.

### Child Support Non-FIP Arrears

#### FIP Only

For FIP eligibility determination groups whose initial eligibility is approved on or after October 1, 2009, collections attributed to a time when the family was not receiving FIP, are not retained by the state. Office of Child Support (OCS) refers to these payments as pre-assistance arrears.

#### FIP and RCA Only

These payments are excluded income.

#### MA Only

Arrearage payments received and retained by a parent for an adult child, or a child not living in the home, are considered unearned income for the parent. Any amount of the payment which is passed through to the adult child it is not income to the parent.

#### CDC Only

This type of child support income has no effect on CDC eligibility when received by FIP recipients because they are eligible for CDC through the CDC Protective Services category.

When received by a non-FIP recipient, this is countable unearned income.

#### FAP Only

This type of child support income is countable.
Child Support Certified Potential Family Arrears

All Programs

For FIP eligibility determination groups whose initial eligibility of ongoing benefits was approved prior to October 1, 2009, collections attributed to a time when the family was not receiving FIP, are retained by the state. Office of Child Support refers to these payments as potential family arrears.

Child Support Direct (Court-Ordered)

All Programs

Court-ordered direct support means child support payments an individual receives directly from the absent parent or the MiSDU. Bridges counts the total amount as unearned income, except any portion that is court-ordered or legally obligated directly to a creditor or service provider: see BEM 518, Voluntary/Direct Support, for direct support income disregard for FIP.

Child Support Refund

All Programs

Child support refund means a payment issued to a current or former FIP recipient when support was misdirected to MDHHS (retained in error) due to a delay in child support decertification. Office of Child Support refers to these payments as late decerts. Bridges excludes as income.

Child Support Reimbursement

All Programs

Child support reimbursement means a payment issued to a current or former FIP recipient when the state receives certified support exceeding the amount that may be retained to offset FIP paid. Office of Child Support refers to these payments as excess Unreimbursed Grant (URG) amount.
Bridges excludes as income.

**Child Support Voluntary (Not-Court Ordered)**

**All Programs**

Voluntary support means child support payments that are **not** court-ordered. The payments are received by the individual directly from the absent parent. Bridges counts the total amount as the child’s unearned income. See BEM 518, Voluntary/Direct Support, for direct support income disregard for FIP.

**DEATH BENEFIT**

**All Programs**

Death benefits are money an individual receives from Social Security or an insurance company due to the death of another individual. Enter as **death benefit** in both the unearned income logical unit of work and lump sum logical unit of work.

**FIP, RCA, SDA, CDC and FAP Only**

A **death benefit** is a lump sum; see BEM 500, **LUMP SUMS AND ACCUMULATED BENEFITS**.

**Medicaid**

A death benefit is unearned income. Bridges counts the gross benefit minus the amount used to pay the last medical expenses and burial costs of the deceased individual.

**DONATIONS/CONTRIBUTIONS**

**All Programs**

**Home Heating Fuel Supplier or Public/Government Agency**

Bridges excludes as income, a donation given to an individual by a home heating fuel supplier or a public/government agency for food, clothing, shelter or home energy.
Individual Outside the EDG

A donation to an individual by family or friends is the individual's unearned income. Bridges counts the gross amount actually received, if the individual making the donation and the recipient are not members of any common eligibility determination group.

**Exception:** See BEM 500, *Inconsequential Income*.

**Note:** A donation or gift from this source is not countable income for MAGI Medicaid.

Private, for Profit/Other Donations

Donations from a private, for profit organization are countable unearned income. Donations from sources other than those specified in policy are countable unearned income.

**Note:** A donation or gift from this source is not countable income for MAGI Medicaid.

Private, Nonprofit Organization Assistance

This means money an individual receives from a private, nonprofit organization based on need, as determined by the contributing organization. Bridges excludes the first $300 received during a calendar quarter. Amounts more than $300 per calendar quarter are counted as unearned income.

**Note:** A donation or gift from this source is not countable income for MAGI Medicaid.

EDUCATIONAL ASSISTANCE (NOT WORK STUDY)

All Programs

Grants, Loans, Scholarships etc.

Educational assistance includes grants, loans, scholarships, assistantships, stipends and fellowships for education. Bridges excludes these income types as income and as assets.
See BEM 501, Work Study income.

Operation Graduation

The Operation Graduation School Dropout Prevention Program is funded by the Michigan Department of Education and operated by local school districts. Recipients are secondary school students ages 12 through 18.

Bridges excludes as income.

FACTOR CONCENTRATE LITIGATION SETTLEMENT (WALKER VS. BAYER)

All Programs

Four manufacturers of blood plasma settled a lawsuit involving hemophilia patients who became infected with human immunodeficiency virus. The court case was referred to as Susan Walker vs. Bayer Corporation. Beneficiaries of the lawsuit may receive a settlement worth $100,000. Payment may be a one-time payment or periodic payments. Enter one-time payments as a lump sum. Enter periodic payments in the unearned income logical unit of work.

The recipient may have documents from the settlement law group regarding factor concentrate litigation settlement.

FIP, RCA, SDA, CDC, and FAP Only

Bridges will count lump sums as assets beginning the month received.

Bridges will count the amount of periodic payments as unearned income.

Medicaid

Bridges excludes all settlement payments as both income and assets.
FILIPINO VETERANS EQUITY COMPENSATION FUND

All Programs

These payments are issued to certain veterans and surviving spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during World War II.

Bridges excludes the payments as income and assets.

FLEXIBLE BENEFITS

See BEM 501, Wages.

FOSTER GRANDPARENTS

All Programs

This is a Domestic Volunteer Services Act, Title II program. Payments are excluded under Public Law 93-113 as income and as an asset.

GOVERNMENT AID

Child Care Nutrition Payments

Child care nutrition payments may be made through the National School Lunch Act or the Child Nutrition Act of 1965. This income type is excluded for all programs when payment is received only for an individual’s own child(ren). In this situation, do not enter any payments in Bridges.

This income type appears only in the self-employment logical unit of work for use when an individual receives payment on behalf of someone else’s children for whom child care is provided.

**Exception: FAP Only**

When a child care provider receives payments for someone else’s children, payments must be entered in the self-employment logical
unit of work. Bridges will determine countable income from this source, for FAP only: see BEM 502, Child Care Nutrition Payments.

**Child Development and Care Program (CDC)**

**All Programs**

When CDC is approved for a parent/substitute parent (PSP), do not enter CDC payments as income for the PSP. These payments are excluded income for the family receiving the care.

See BEM 502: **INCOME FROM SELF-EMPLOYMENT** for an individual who provides care in his/her home and not the home of the child or BEM 501, **INCOME FROM EMPLOYMENT**, for an individual who provides the care in the home where the child lives.

**Family Support Subsidy**

**All Programs**

Department of Community Health makes payments to families with impaired or autistic children under age 18. Bridges excludes Department of Community Health family support subsidy payments to families when the child is living in the home. These payments are for needs **not** covered by the state standard of assistance.

**Federal Emergency Management Assistance (FEMA)**

**All Programs**

The FEMA program makes payments to individuals for a variety of emergent needs.

Bridges excludes these payments as income and as an asset.

**Exception: FAP only**

If money received from the FEMA program is for temporary housing, and exceeds the actual cost, Bridges counts the difference as unearned income unless it is returned to the FEMA program.
FOOD
ASSISTANCE
PROGRAM

All Programs
Do not enter FAP issuances as income in Bridges. Food assistance is excluded as income and as an asset.

FIP, RCA or SDA
Cash Assistance

FIP, RCA, SDA, CDC, MA
Bridges excludes FIP, RCA and SDA as income.

FAP Only
FIP, RCA and SDA benefits are considered the unearned income of the FIP, RCA or SDA head of household (HOH, formerly grantee). Bridges counts as unearned income, the amount of cash assistance benefits minus any excludable portion.

The following portions of cash assistance benefits are excluded by Bridges:

- The amount of non-IPV administrative recoupment.
- The amount of initial cash benefits intended to cover a current or previous month, when FAP benefits have already been authorized for such months.

Some types of FIP and RCA penalties, require budgeting of cash assistance for FAP, even when not received. See:

- BEM 233A, Failure to Meet Employment and/or Self-Sufficiency Related Requirements: FIP.
- BEM 233C, Failure to Meet Employment Requirements: RCA.
- BEM 255 Budgeting Last FIP Grant on FAP When FIP Closes and BEM 550, Disqualified or Ineligible Persons.

Bridges calculates countable cash assistance benefits for FAP based on program policy rules.
FIP, RCA and SDA Supplements

**FIP, RCA, SDA, CDC, MA**

When Bridges determines a cash assistance underpayment for a benefit period for which benefits have already been issued, it displays supplement on the eligibility summary screen. When the new eligibility results are certified, the difference between the original issuance and the new benefit calculation is automatically authorized.

Bridges excludes these payments as income.

FIP, RCA and SDA Reinstatement and Delayed Benefits

**FAP Only**

When initial cash assistance authorization is delayed until after FAP is authorized, Bridges does not count the cash assistance for that benefit period in the FAP benefit calculation.

Bridges counts FIP, RCA and SDA benefits issued as a result of reinstatement only if authorized before or at the same time FAP benefits are authorized for the benefit period for the first time. Bridges allows the exclusions described in FIP, RCA or SDA Cash Assistance.

Reinstatement benefits that cover or restore retroactive FIP, RCA or SDA benefits are lump sums. Lump sums are assets.

Home Help Services Under Medicaid

**All Programs**

Individual’s needing care in their homes may qualify for MDHHS to make payment on their behalf to a service provider. Do not enter these payments for the individual receiving the care. These payments are excluded income for the individual receiving the care.

Enter home help services payments received by the individual providing the service as that individual’s employment income; see BEM 501, Wages.
**Housing Assistance**

**All Programs**

The Federal Office of Housing and Urban Development (HUD) and the Farmers Home Administration (FMHA) provide many forms of housing assistance (example: subsidized housing) under the following laws:

- Subchapter II of the Uniform Relocation and Real Property Acquisition Act of 1970.
- U.S. Housing Act of 1937.
- Experimental Housing Allowance Program made under Annual Contribution Contracts entered into prior to January 1, 1975.
- National Housing Act.
- Section 101 of the Housing and Urban Development Act (HUD) of 1965.

Exclude any housing assistance with HUD or FMHA involvement as income and as an asset.

**Nutrition Program for the Elderly, Title VII**

**All Programs**

Enter payments received from the Nutrition Program for the Elderly, Title VII of the Older Americans Act of 1965, in the unearned income logical unit of work.

Bridges will exclude as income and assets.

**Out of State Diversion**

**All Programs**

Some states offer a Temporary Assistance for Needy Families (TANF) diversion program. It is intended as a one-time payment in lieu of periodic/monthly TANF assistance (Michigan uses the term FIP). This is considered a one-time payment and is excluded income for all programs.
Refugee Matching Grant

All Programs

This is an employment program administered by refugee resettlement agencies. It provides job training and maintenance assistance (food, housing, transportation, etc.) to eligible refugees. The benefits are partly cash, but mainly in-kind goods and services. Enter any cash payments made directly to the refugee in the unearned income logical unit of work.

FIP, RCA and SDA Only

Recipients of Refugee Matching Grant have an eligibility determination group participation status of excluded. Bridges does not consider the recipient’s need, income or assets: see BEM 210, BEM 214, BEM 215, Excluded RCA Eligibility Determination Group Members, and BEM 222, Refugee Matching Grant.

CDC and FAP Only

Bridges counts as unearned income.

Medicaid

Bridges excludes as income.

Refugee Resettlement Assistance

All Programs

Refugee resettlement assistance is distributed within 90 days of a refugee’s date of entry. Payments may be made to third parties such as landlords, utility companies or other service providers: see BEM 500, Third Party Assistance.

Payments may also be made directly to refugees. The number and frequency of payments are determined by the refugee resettlement agency.

FIP, RCA, SDA, CDC, Medicaid

Exclude all payments as income.
FAP Only

If payments are made monthly, exclude the first $300 per calendar quarter as this is considered a donation. If payment meets the definition of a lump sum, see BEM 500, Lump Sums and Accumulated Benefits. Budget remainder of payments made to refugees as unearned income.

Robert T. Stafford Disaster Relief

Payments from the Robert T. Stafford Disaster Relief and Emergency Assistance Act (formerly the Disaster Relief Act of 1974), are excluded as income and as an asset.

State Emergency Relief (SER)

Do not enter SER payments in Bridges. Such payments are excluded as income and assets.

Women, Infants and Children (WIC)

This is a supplemental food program for women, infants and children. WIC is excluded as income and as an asset.

Guardianship Assistance Program

FIP, SDA, RCA, CDC, FAP

Guardianship Assistance Program is counted as unearned income.

HEALTH PROFESSIONALOPPORTUNITY GRANT

All Programs

These payments are issued to provide education and training in the health care field to Temporary Assistance to Needy Families recipients and other low-income individuals.

Bridges excludes as income and assets.
HOME EQUITY CONVERSION PLANS

FIP, SDA, RCA, CDC and FAP

Reverse Mortgage

Reverse mortgages allow a homeowner to borrow, via a mortgage contract, some percentage of the value of his home. The homeowner receives periodic payments (or a line of credit) that does not have to be repaid while the homeowner lives in the home.

Money the homeowner receives from a reverse mortgage is a loan and is not countable as an asset or income.

Some reverse mortgages involve the purchase of an annuity and are called reverse annuity mortgages.

Payments the homeowner receives from a reverse annuity mortgage are unearned income. Count the gross amount.

SSI Related MA Only

Payments that a homeowner receives from a reverse mortgage are loan proceeds and are not countable income. See BEM 400, ASSETS regarding the resource value.

Sale-Lease Back Income

All Programs

The homeowner sells a home on an installment note and receives monthly payments from the buyer. The buyer allows the former homeowner to live in the home in exchange for rent. The difference between the buyer's payment and the rent is money the former homeowner can use for current expenses. Sometimes the arrangement involves the purchase of an annuity that pays money to the former homeowner.

Payments the former homeowner receives from an annuity are unearned income. Bridges counts the gross amount.

Bridges counts payments the former homeowner receives from the buyer, minus allowable expenses, as unearned income. Allowable expenses are the former homeowner’s cost of things such as mort-
gage or land contract payments, taxes and insurance on the property sold. The former homeowner’s rent is **not** an allowable expense.

**SSI-Related MA Only**

**Note:** See BEM 400, *Sale-Lease Back Asset Value* regarding the asset value.

### Time Sale

**All Programs**

The homeowner signs a contract to sell his home at death, but maintains ownership and can continue living in the home. The buyer makes monthly payments to the homeowner now and agrees to pay certain expenses such as property taxes, insurance, and some maintenance.

The contract may call for purchase of an annuity.

Payments the homeowner receives from an annuity are unearned income. Count the gross amount.

Count payments from the buyer to the homeowner, minus allowable expenses, as the homeowner’s unearned income. Allowable expenses are the homeowner's costs of things such as mortgage or land contract payments. Expenses paid by the buyer are **not** allowable.

Payments the former homeowner receives from an annuity are unearned income. Count the gross amount.

### INDIVIDUAL DEVELOPMENT ACCOUNTS

**All Programs**

Individual Development Accounts (IDA) are established pursuant to Michigan Public Act 361 of 1998 and section 404(h) of the Social Security Act or Public Law 105-285. IDAs allow low-income families to promote their economic independence by saving for any of the following:

- Postsecondary educational expenses.
- First home purchase.
Business capitalization.

IDAs are funded by periodic contributions from the family’s earnings and matching contributions by or through a nonprofit organization. The IDA must be a trust or a joint account that requires the signatures of both the nonprofit organization and a family member to authorize withdrawals.

Bridges excludes matching contributions and interest or dividends earned by an IDA are excluded as income and assets.

INSURANCE PAYMENTS FOR MEDICAL EXPENSES

All Programs

Insurance payments that are specifically made as reimbursement for incurred medical expenses are excluded as income and as assets.

Common sources of such payments are:

- Health insurance; see Bridges Policy Glossary (BPG).
- Health Reimbursement Arrangements/accounts.
- Automobile insurance that covers medical expenses.
- Long term care facility insurance.

Note: Other insurance must pay claims for medical expenses before MA. See BEM 257, Third Party Resource Liability, for reporting insurance coverage using the DCH-0078, Request to Add, Terminate or Change Other Insurance.

INTEREST AND DIVIDENDS PAID DIRECTLY TO CLIENT

All Programs

Bridges counts interest and dividends paid directly to an individual as unearned income. Choose unearned income type of Interest Paid Directly to Client and budget over the period intended to cover. Interest and dividends that are reinvested or deposited back into the asset are excluded as income.
**Example:** Nicole receives a quarterly interest check from her certificate of deposit (CD). Choose income frequency of contractual/single payment covering more than one month, and enter the number of months intended to cover three.

**Example:** Tiffany has an IRA and chooses to let her interest automatically reinvest in the IRA rather than receiving interest checks. Do not enter these payments in Bridges.

**Note:** An S-corporation and LLC may pay shareholders or partners dividends and/or interest. This is unearned income to the individual.

**JAPANESE AND ALEUT PAYMENTS**

**All Programs**

To acknowledge the fundamental injustice of being evacuated during World War II, payments are made under Public Law 100-383 to U.S. citizens of Japanese ancestry, resident Japanese aliens and Aleuts. Bridges excludes as income and assets.

**JURY DUTY**

**All Programs**

Enter payments an individual receives for being on jury duty in the unearned income logical unit of work. Bridges excludes money an individual receives for being on a jury.

**LEASE OF NATURAL RESOURCES**

**All Programs**

Enter payments received for leasing natural resources in the unearned income logical unit of work. Bridges counts the gross amount received for leasing natural resources as unearned income. This includes storage rights. Examples of natural resources are:

- Timber.
- Gravel.
- Oil and natural gas.

**Exception:** Lease income received by an American Indian might be excluded under Public Law 93-134; see EXHIBIT I-Native American Payment Exclusions in this item.
LOAN PROCEEDS

All Programs

Enter loan proceeds in the unearned income logical unit of work. Bridges excludes funds an individual has borrowed provided it is a bona fide loan. This includes a loan by oral agreement if it is made into a bona fide loan.

Bona fide loan means all the following are present:

- A loan contract or the lender's written statement clearly indicating the borrower's indebtedness.
- An acknowledgment from the borrower of the loan obligation.
- The borrower's expressed intent to repay the loan by pledging real or individual property or anticipated income.

This exclusion does not apply to either of the following:

- Purchases made with borrowed money.
- Interest earned on borrowed money. However, the interest might be Inconsequential Income as defined in BEM 500.

MICHIGAN REHABILITATION SERVICES PAYMENTS

All Programs

Payments from Licensing and Regulatory Affairs, and Michigan Rehabilitation Services are considered reimbursements. Enter this type of income in the unearned income logical unit of work.

Bridges excludes as income and as an asset.

MEDICAL LOSS RATIO REBATES

All Programs

Medical loss ratio rebates are paid by insurance carriers when less than 80 percent of premiums are spent on medical care. Eligible households receive the payments by August 1 each year.

Bridges excludes as income.
MILITARY ALLOTMENTS

All Programs

Allotments are payments for the support of dependents of military personnel, usually initiated by the service member.

It is possible to obtain an involuntary allotment when both of the following conditions are met:

- A court or administrative order for support exists.
- Payments are past due.

Support specialists can provide information on involuntary allotments. The local chapter of the Red Cross can assist in obtaining voluntary allotments.

Intact Families

A family is intact when an individual is temporarily absent from the home due solely to being in the military. Enter military allotments or money made available to the family at home as military allotment/contribution from absent member. Absent member is in the FIP eligibility determination group and earnings are counted; absent member is not in the FAP eligibility determination group so the allotment/contribution only is counted as unearned income.

Estranged Families

A family is estranged when the individual in the military is not temporarily absent due solely to being in the military. When a military allotment is intended for a child, enter the payments as voluntary child support. When payments are intended for an adult, enter as other unearned income.

NAZI VICTIMS' COMPENSATION

All Programs

Bridges excludes payments made as compensation for Nazi persecution. Enter the gross amount and pay details in the Bridges unearned income logical unit of work. Do not include these payments in liquid assets amounts entered in Bridges.
Austrian Social Insurance Payment

Payments made as compensation for Nazi persecution from paragraphs 500 through 506 of the Austrian General Social Insurance Act.

German Restitution Act

Payments made as compensation for Nazi persecution from the Federal Republic of Germany under the German Restitution Act.

Netherlands Act Victims of Persecution

Payments made as compensation for Nazi persecution from the Dutch government under the Netherlands Act on Benefits for Victims of Persecution 1940-1945 (Dutch acronym WUV).

OLDER AMERICAN VOLUNTEER PROGRAM

All Programs

This is a Domestic Services Volunteers Act, Title II program. Payments are excluded unearned income under Title II of Public Law 93-113.

Bridges excludes as income and as an asset.

USDA PAYMENT-IN-KIND (PIK) PROGRAM - -

MA Only

This program pays farmers to divert land or reduce crop acreage. Count the payments received as unearned income.

FIP, RCA, SDA, CDC and FAP

See BEM 502, Income from Self-Employment.
RADIATION EXPOSURE COMPENSATION

All Programs

Exclude payments received from Public Law 101-426, Radiation Exposure Compensation Act.

Exclude as income and as assets.

RAILROAD RETIREMENT BOARD BENEFITS

All Programs

Current and former employees of railroads and related industries and their families can receive the following types of benefits.

- Disability.
- Retirement.
- Sickness.
- Strike.
- Survivors.
- Unemployment.

The U.S. Railroad Retirement Board makes the payments.

Count the gross benefit amount as unearned income.

Note: Allowances in Railroad Retirement Board benefits for the Medicare Part B premiums are not considered a reimbursement and should be included in the amounts entered in the Bridges unearned income logical unit of work.

RETIRER SENIOR VOLUNTEER PROGRAM (RSVP)

All Programs

This is a Domestic Services Volunteers Act, Title II program. Payments are excluded unearned income under Title II of Public Law 93-113.

Bridges excludes as income and as an asset.
All Programs

Other retirement income includes annuities, private pensions, military pensions, and state and local government pensions.

Refer to the specific sections in this item for policies regarding:

- Railroad Retirement Board benefits.
- Retirement, Survivors and Disability Insurance (RSDI).
- U.S. Civil Service and Federal Employee Retirement System.

Count the gross benefit as unearned income.

Note: Allowances in pension benefits for the Medicare Part B premiums are not considered a reimbursement and should be included in the amounts entered in the Bridges unearned income logical unit of work.

Sometimes benefits are reduced because of a previous overpayment. In such cases, the reduced amount is the gross amount; see BEM 500, Reduced Benefits Due to Overpayment.

All Programs

RSDI is a federal benefit administered by the Social Security Administration that is available to retired and disabled individuals, their dependents, and survivors of deceased workers.

Bridges counts the gross benefit amount as unearned income.

Exceptions:

- Special rules apply when determining MA eligibility for certain former SSI recipients; see BEM 155, 503 Individuals, 157, Early Widow(er)s, and 158, Disabled Adult Children. These
special rules do not apply to post-eligibility patient-pay amount calculations in BEM 546.

- Exclude Medicare premium refunds as income and as assets. Refunds are made because there is a delay of about 120 days between when Medical Services Administration initiates Medicare buy-in and an individual's benefit check changes; see Bridges Administrative Manual (BAM) 810.

- The Social Security Administration authorizes qualified organizations to deduct a fee for acting as a representative payee. Exclude the fee withheld by an authorized organization.

- See BEM 500, Returned Benefits.

- See BEM 400, Retroactive RSDI and SSI Exclusion.

**Medicaid Only**

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

Special budgeting rules apply when determining eligibility for MAGI Medicaid.

- All RSDI income is countable to tax-filers and adults not claimed as dependents.

- A child/tax-dependent’s RSDI is countable only if that child or tax-dependent is required to file taxes.

- If a child or tax-dependent meets an exception outlined in BEM 211 then all their RSDI income is countable to them even if they are not required to file taxes.

**Example:** A child is claimed by their grandparent. Because they are claimed by someone other than a parent or spouse use not tax-filer rules to determine their household. Any RSDI income they receive is countable.

- **Note:** The RSDI budgetable income worksheet is no longer valid in determining how much RSDI income may be countable to an applicant.
RICKY RAY HEMOPHILIA RELIEF ACT

All Programs

The Ricky Ray Hemophilia Relief Act (P.L. 105-369) established a temporary fund administered by the U.S. Secretary of the Treasury to pay money for certain human immunodeficiency virus infected individuals.

A payment an individual receives from that fund is excluded as income and as assets.

S-CORPORATION (S-CORP) AND LIMITED LIABILITY COMPANY (LLC)

All Programs

Dividend or interest income received from an S-Corp or LLC as a shareholder or partner, is unearned income. See interest and dividends paid directly to client in this item.

Wages paid to an individual from an S-Corp or LLC are earned income; see BEM 501, Income From Employment.

SALE OF PROPERTY IN INSTALLMENTS

All Programs

This section applies only to the sale of real property with payments in installments (example: land contract). Other sales of real property are conversion of an asset from one type to another.

Bridges counts each installment payment, minus allowable expenses, as unearned income.

The seller may remain liable for certain expenses on the property even though the property has been sold. Such expenses are allowable. Examples include:

- Taxes.
- Insurance.
- Debts secured by property lien.
SCORE OR ACE

Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) are Domestic Services Volunteers Act, Title II programs. Payments are excluded unearned income under Title II of Public Law 93-113.

Bridges excludes as income and as an asset.

SICK AND ACCIDENT INSURANCE PAYMENTS

All Programs

Sick and accident insurance pay a flat-rate benefit due to illness or injury without regard to actual charges or expenses incurred. This does not include long term care facility insurance payments. Examples include:

- $60 for each day hospitalized.
- Lost wage benefits following a car accident.
- Short or long-term disability payments.

Enter the gross amount of these payments as unearned income.

Bridges counts as unearned income. If there is an expense for obtaining these income types (for example insurance premium payment), enter the expense in Bridges.

SPOUSAL SUPPORT

All Programs

Spousal support is a payment from a spouse or former spouse because of a legally enforceable obligation for financial support. It includes maintenance and alimony payments.

See BEM 500, Third-Party Assistance, if support is paid to a creditor or service provider.

Spousal Support Certified

Certified spousal support means court-ordered payments the Michigan State Disbursement Unit (MiSDU) sends to MDHHS due to an
individual's FIP activity. This occurs occasionally, when spousal support is part of a child support order.

Certified support is counted only in the FIP support income test.

**Spousal Support Direct**

Direct spousal support is a payment received by the spouse or ex-spouse because of a legally binding obligation.

Bridges counts the total amount as unearned income, except any portion that is court-ordered or legally obligated directly to a creditor or service provider.

**Spousal Support Voluntary**

Voluntary spousal support is a payment received by the spouse or ex-spouse that is not court ordered. Bridges counts the total amount as unearned income.

**STRIKE BENEFITS**

**All Programs**

Bridges counts the gross amount received as unearned income.

**FAP Only**

See BEM 227, Strikers, for budgeting policies.

**SUPPLEMENTAL SECURITY INCOME (SSI)**

**All Programs**

SSI is a benefit administered by the Social Security Administration. SSI is a means-tested program that can be received based on age, disability or blindness.

Michigan SSI benefits include a basic federal benefit and an additional amount paid from state funds. The amount paid by the state and the payment process varies by living arrangement; see BEM 660, State SSI Payment.
For SSI recipients in independent living or household of another, refer to Current SSA-Issued SSI, Retroactive SSA-Issued SSI and State SSI Payments below. For SSI recipients in other living arrangements, refer to just Current SSA-Issued SSI and Retroactive SSA-Issued SSI.

**Current SSA-Issued SSI**

**FIP, RCA, Medicaid**

Bridges excludes the amount of current SSA-issued SSI as income.

**SDA, CDC, and FAP Only**

Bridges counts the gross amount of current SSA-issued SSI as unearned income. SSI amounts withheld to recoup overpayments due to an intentional program violation (IPV) as defined below are also included in the gross amount.

**IPV** means there was a finding of fraud or an agreement to repay in lieu of prosecution. Bridges counts recouped SSI only if IPV information is volunteered by the SSI recipient or other reliable source. Do not initiate any contacts; see BEM 500, Reduced Benefits Due to Overpayment.

**Exception:** The Social Security Administration authorizes qualified organizations to deduct a fee for acting as a representative payee. Exclude the fee withheld by an authorized organization.

**Retroactive SSA-Issued SSI**

**All Programs**

Retroactive SSI benefits may be paid as a one-time payment or in installments over several months. SSA determines how the retroactive benefits will be paid.

**FIP, SDA, RCA, RMA, CDC, and FAP Only**

Retroactive SSI benefits are considered assets whether paid as a one-time payment or as installment payments.

An individual may receive a payment that includes a portion intended as current benefits as well as a portion intended as retroactive benefits. The portion intended as current benefits is income.
Medicaid

Retroactive SSI benefits are income in the month received: see BEM 400, Retroactive RSDI and SSI Exclusion, about the income and asset exclusion for SSI-related MA.

SDA Only

When retroactive SSI is issued while an SDA application or hearing is pending, determine eligibility for each potential SDA month by budgeting the amount of the SSI intended to cover that month.

State SSI Payments

All Programs

State SSI Payments (SSP) are issued quarterly. Payments are issued in the final month of each quarter; see BEM 660, State SSI Payment.

FIP, RCA, RMA, Medicaid

Bridges excludes as income.

SDA, CDC, and FAP Only

Whenever an SSA-issued independent living or household of another payment is budgeted, Bridges counts the corresponding monthly SSP benefit amount as unearned income; see RFT 248.

Example: If the federal SSI amount being budgeted is for independent living, Bridges counts the monthly SSP benefit amount for independent living.

Bridges does not count as income, SSP benefits paid when the individual is no longer an SSI recipient.

TAX REFUNDS AND TAX CREDITS

All Programs

Tax refunds and credits are assets, not income; see BEM 400, Tax Refund and Tax Credit Exclusion.
Earned Income Tax Credit, EITC, Advanced

Individuals can elect to receive a portion of an anticipated Earned Income Tax credit in regular pay checks. Do not enter advance payments of the Earned Income Credit as part of wages or as unearned income. They are not countable for any type of assistance; see BEM 501, Wages.

TRUST PAYMENTS

All Programs

Count payments from a trust to a beneficiary as the beneficiary's unearned income.

FIP, SDA, CDC, and FAP Only

In addition, count any amount of trust income that the beneficiary can instruct the trust to pay him. It is the beneficiary's unearned income.

UNEMPLOYMENT BENEFITS

All Programs Except Freedom To Work (FTW)

Unemployment benefits include all the following:

- Unemployment benefits (UB) available through the Michigan Unemployment Insurance Agency (UIA) and comparable agencies in other states.
- Supplemental unemployment benefits (SUB pay) from an employer or other source.
- Trade Readjustment Act (TRA) payments.

Count the gross amount as unearned income.

Exception: Sometimes benefits are reduced because the individual has earnings. In such cases, the reduced amount is the gross amount. See BEM 500, Returned Benefits, about excluding amounts listed under recoupment on the unemployment insurance agency payment stub.
FTW Only

Bridges excludes UB as income.

URBAN CRIME PREVENTION

This is a Domestic Services Volunteers Act, Title I program. Payments are excluded unearned income under Title I of Public Law 93-113.

Bridges excludes as income and as an asset.

U. S. CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM

All Programs

The U.S. Office of Personnel Management makes payments because of the disability, retirement or death of a federal employee.

Bridges counts the gross amount as unearned income.

*Exception:* Exclude Medicare premium refunds as income and as assets. The refunds are because there is a delay of about 120 days between when Medical Services Administration initiates Medicare buy-in and an individual's benefit check actually changes; see BAM 810, Part B Buy-In Program.

VETERANS BENEFITS

All Programs

The Department of Veterans Affairs (VA) has numerous programs that make payments to veterans and their families. The most common types are discussed below.

VA PENSION AND COMPENSATION

All Programs

Pension payments are based on a combination of need, age, and/or nursing home status. Pensions are normally paid monthly.
However, the VA may make the payment quarterly, twice a year or annually if the amount is small (less than $19 per month).

Compensation payments are based on service-connected disability or death.

The pension and compensation payment can also include:

- The Aid and Attendance
- Housebound allowance
- VA Clothing Allowance
- Adjustment for Unusual Medical Expenses
- Augmented Benefits

**Note:** These allowances are **not** identifiable on a check stub or award letter. Accept the client’s statement that the payment does **not** include any of these additional allowances.

Bridges counts the gross amount of the pension or compensation as unearned income.

**Exceptions:**

- Bridges excludes any portion of a payment resulting from an Aid and Attendance or Housebound allowance; see *VA aid and attendance and housebound allowances* in this item.

- Bridges may exclude augmented benefits; see *augmented benefits* in this item.

Bridges excludes any portion of a payment resulting from unusual medical expenses; see *VA Adjustment for Unusual Medical Expenses* in this item. The VA calls a payment that is increased because of a dependent an augmented benefit. If the VA chooses to pay the dependent's portion directly to the dependent, it is called an apportionment payment; see *apportionment payment in this item*.

**VA Educational Benefits**

**All Programs**

VA provides educational benefits under several programs.

Bridges excludes as income and as an asset.
VA Aid and Attendance and Housebound Allowances

**All Programs**

Payments are made to veterans, spouses of disabled veterans, and surviving spouses who are:

- Housebound.
- In regular need of the aid and attendance of another individual.

The payment is included with the pension or compensation payment.

Bridges excludes as income and as an asset the portion of a VA pension or compensation that is the aid and attendance or housebound allowance.

**Note:** Aid and Attendance is **not** excluded from the patient pay calculation; see BEM 546.

VA Adjustment for Unusual Medical Expenses

**All Programs**

VA increases some pension and compensation payments due to unusual medical expenses.

Bridges excludes the increase due to unusual medical expenses as income and as an asset.

VA Clothing Allowance

**All Programs**

A lump-sum clothing allowance is payable in August of each year to veterans with a service-connected disability for which a prosthetic or orthopedic appliance or wheelchair is used.

Bridges excludes the clothing allowance as income and as an asset. It is a reimbursement.
VA Spina Bifida Benefits

All Programs

Benefits are available to Vietnam veterans’ natural children with spina bifida.

Bridges excludes these benefits as income and as assets.

Apportionment Payment

All Programs

Apportionment is direct payment of VA benefits to a dependent of the veteran or veteran’s surviving spouse. The VA decides whether and how much of such benefits to pay on a case-by-case basis.

These payments are the dependent’s countable unearned income.

Augmented Benefit

All Programs

An augmented benefit is a VA benefit that has been increased because of a dependent. The increase is usually included in the payment made to the veteran or the veteran’s surviving spouse.

The dependent’s portion of an augmented benefit is the dependent’s income. That portion is countable as the dependent’s unearned income when the dependent lives with the individual receiving the VA benefit.

Bridges does not count the dependent’s portion as income of either the dependent or the individual receiving the benefit if the dependent does not live with the individual receiving the VA benefit.

Note: Actual payments by the VA beneficiary to the dependent when they live apart are budgeted as unearned income to the dependent when determining the dependent’s eligibility.
WORKERS’ COMPENSATION

All Programs

Workers' compensation payments are available under various federal and state laws to individuals with a job-related illness or injury and to survivors of a deceased worker. Payments might be made by a government agency, an insurance company or an employer.

Count the gross payment as unearned income.

Exception: Exclude compensation awarded for a use which carries legal sanction if used for another purpose. Exclude as income and as an asset.

YOUTHBUILD

All Programs

On-the-job training payments are disregarded as income if received by an individual who is:

- Under age 18.
- Age 18 and living with someone providing care or supervision.
- For LIF only, age 19 and a dependent child.

Other types of payments (stipends, grants, etc.) under Youthbuild are excluded.

VERIFICATION REQUIREMENTS

All Programs except Children Under 19 (U19)

Verify non-excluded income at all the following:

- Application, including a program add, prior to authorizing benefits.
- At member add, only the income of the member being added.

Note: See BAM 220, CDC Member Add, for CDC member add requirements.
- Redetermination.
- When program policy requires a change be budgeted.
**Exception:** For FIP, RCA, SDA, CDC and FAP verify income that decreases or stops. Do not verify starting or increasing income unless income change information is unclear, inconsistent or questionable. Select *starting or increasing income* as the verification source. Selecting *client statement* as the verification source results in Bridges incorrectly pending eligibility and generating a Verification Checklist.

**Exception:** For MA, Bridges accepts client statement regarding changes in income for ongoing eligibility determination groups unless you are completing a redetermination.

Use available electronic methods (for example consolidated inquiry or SOLQ) to verify income. When electronic verification is not available or inconsistent with client statement, the client has primary responsibility for obtaining verification. Do not deny assistance based solely on an employer or other source refusing to verify income; see BAM 130, Verification and Collateral Contacts, and BEM 702, CDC Verifications.

**Children Under 19 (U19)**

Income and expenses are **not** verified for Children Under 19 (U19). Client statement is an acceptable verification source for income and expenses.

**VERIFICATION SOURCES**

**All Programs**

- Child Support Certified, Direct (court ordered), Refund and Reimbursement

  - Consolidated Inquiry.
  - Letter or document from person/agency making payment.
  - Check stub.
  - Data obtained from the Michigan child support enforcement system (MiCSES). (Select other acceptable).
• Contact with child support specialist. (Select other acceptable).

• Information from the friend of the court (DHS-243, Verification of Public Records).

**Child Support Voluntary (Not Court Ordered)**

• Letter or document from person making payment.

• Other acceptable method that provides necessary information.

**Refugee Matching Grant**

• DHS-1564, Verification of Matching Grant.

• Letter or document from refugee resettlement agency.

**Refugee Resettlement Income**

• DHS-1565, Verification of Refugee Resettlement Income.

• Letter or document from refugee resettlement agency.

**RSDI and SSI**

• Recent check stub(s).

• Consolidated Inquiry.

• SOLQ.

• BENDEX/SDX.

• Award letter.

• Statement from or contact with a reliable source. (Select other acceptable as the verification source.)

**Unemployment Benefits**

• Recent check stub.

• Consolidated Inquiry.

• Unemployment Insurance Agency

• Other acceptable method that provides necessary information.

**VA Benefits**

• DHS-75, Verification of VA Payments.

• Other acceptable method that provides necessary information.

**MA only**

• Award letter from the VA. The letter may be dated up to 18 months prior to the application or recertification.

• Contact with the VA which breaks down the amounts of the VA payments if the breakdown is not included on the letter. The breakdown amounts may be written on the award letter.
EXHIBIT- NATIVE AMERICAN PAYMENTS EXCLUSION

All Programs

Bridges excludes payments to Native Americans under the following laws as income and as assets:

- Public Law 92-203: Tax exempt portions of payments under the Alaska Native Claims Settlement Act.

- Public Law 92-254: Judgment funds to members of the Blackfeet Tribe of Blackfeet Reservation, Montana, and Gros Ventre Tribe of the Fort Belknap Reservation, Montana.

- Public Law 93-134: Funds distributed to members of the Indian tribes and the purchases made with such funds. Also, exclude up to $2,000 per year of income received by an individual Indian that is derived from leases or other uses of individually-owned trust or restricted lands.

- Public Law 93-531: Relocation assistance payments to members of the Hopi and Navajo Tribes.

- Public Law 94-114: Receipts distributed to members of certain Indian tribes.

- Public Law 94-189: Payments received under the Sac and Fox Indian agreements.

- Public Law 94-540: Judgment funds to the Grand River Band of Ottawa Indians.

- Public Law 95-433: Payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation.

- Public Law 96-420, Section 5: Payments to the Passamaquoddy Tribe and the Penobscot Nation or any of their members received pursuant to the Maine Indian Claims Settlement Act of 1980.

- Public Law 98-64: Funds distributed to members of Indian tribes and purchases made with such funds.
Exception: For FAP only, if recurring payments are made from funds held in trust by the Secretary of the Interior, count the amounts over $2,000 per person as unearned income. Amounts of onetime payments over $2,000 per person are countable assets. (Public Laws 97-458 and 98-64).

- Public Law 98-123: Funds distributed to members of the Red Lake Band of Chippewa Indians.
- Public Law 98-124: Funds distributed to the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Peck Indian Reservation.
- Public Law 99-346: Payments and distribution of judgment funds to the Saginaw Chippewa Indian Tribe of Michigan. May be called payments from the Investment Fund or Elderly Assistance Investment Fund.
- Public Law 105-143: Distributions under this law are NOT considered income or assets. This law provides funds to Ottawa and Chippewa Indians of Michigan.

LEGAL BASE

FIP

MCL 400.1 et seq.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

RCA

45 CFR 400
P.L. 106-386 of 2000, Section 107

CDC

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

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106

FAP

7 CFR 273.9, 273.12(e)(3)
Child Care and Development Block Grant of 1990, as amended
42 USC 4601 et seq., 1437 et seq., 3001, 5121 et seq., 4950,
2210, 1612 (a)(2), 9858 et seq.
300 c-22
43 USC 1601 et seq.
50 USC app 1989b-4
25 USC 1401 et seq., 459 e
12 USC 1701
P. L. 108-447, 111-5, 1002(g)(2)
American Recovery and Reinvestment Act of 2009
Filipino Veterans Equity Compensation Fund

All Programs

P. L. 111-291, Sec.101(f)(2) of the Claims Resolution Act of 2010:
Payments received from the Cobell v Salazar Settlement
Affordable Care Act, Public Law 111-148
DEPARTMENT POLICY

FIP, RCA and SDA Only

Financial eligibility is documented for each FIP/RCA/SDA group in data collection and eligibility results in Bridges.

Documentation of financial eligibility is required at application, redetermination and when program policy requires a budget; see BEM 505, 515. Documentation must reflect the group's current financial eligibility status.

The remainder of this item covers the completion of the DHS-1172 for the FIP, RCA and SDA programs. The budget calculations are automatically completed as part of the eligibility determination and benefit calculation in Bridges and an automated budget worksheet are displayed in eligibility summary. In addition, hyperlinks can be used to view individual income and asset details.

Bridges applies all of the following rules when computing a FIP/RCA/SDA budget:

- Drop cents before entering any amount used to compute the issuance amount on the worksheet.
- If an entry on the worksheet is the result of a computation using other amounts that do not appear on the worksheet, cents are included in the computation and dropped from only the final result which is entered on the form.
- When the result of a computation is a negative number, a zero is entered on the worksheet.
- Cents amounts are included when computing recouped, vended and benefit amounts.
- All amounts entered on the worksheet are monthly amounts unless otherwise specified in the instructions.
- Only countable, available income and assets, as defined in BEM 400, 500, 505 and 518, are entered on the worksheet.

The absence of an entry on any worksheet line in sections A-G is considered to represent an entry of zero. However, zero may be entered whenever appropriate.
DHS-1172
COMPLETION
INSTRUCTIONS

Use these instructions if it is necessary to complete a budget worksheet manually.

**ID Block:**

**Case Name** - Enter the name of the grantee.

**Case Number** - Enter the group's assigned number.

**Benefit Mo/Yr** - Enter the month and year of the benefit month the worksheet being completed for.

**County/Dist/Section/Unit/Specialist** - Enter the load number.

**Program** - Check off the program type.

**Process** - Check off the budgeting process type.

**Group Size** - Enter the number of persons in the FIP/SDA eligible group. Include eligible children who are **not** immunized.

---

**Section A; Cash Assets**

**Family Independence Program (FIP), Refugee Cash Assistance (RCA) and State Disability Assistance (SDA) Only - See BEM 400**

1. Enter the total countable value of all the checking accounts.
2. Enter the total countable value of all the savings accounts.
3. Enter the total countable value of all the other liquid assets.
4. Enter the sum of lines 1, 2, and 3.
5. Enter the program’s asset limit.

---

**Section B; Payment Standard**

**FIP, RCA and SDA Only - See BEM 515**

1. **SDA-SLA Only** - Enter the monthly rate for the SLA and level of care; see RFT 235.

2. **SDA-SLA Only** - Enter the SLA Incidentals allowance; see RFT 235.
3. **SDA-SLA Only** - Add the amounts on lines 1 and 2 and enter the sum.

4. **FIP/RCA/SDA-Independent only** - Enter the amount of the payment standard for this group's program, eligible group size and grantee status or living arrangement; see RFT 210 or 225.

5. **Immunization Penalty (FIP Only)** - Enter the amount on line 4 less the amount of the immunization penalty, if the group is subject to it.

6. **Payment Standard** - Subtract the amount in line 5 from the sum of line 3 plus line 4.

**Section C; Qualifying Income Test**

**FIP and RCA Only - See BEM 518.**

1. Enter the total gross earned income for the group that is from employment.

2. Enter all the self-employment income; see BEM 502.

3. Enter the sum of lines 1 and 2.

4. For each member with earnings enter the lesser of $200 or the amount on line 3.

5. Subtract line 4 from the total in line 3.

6. Enter 20 percent of the total in line 5.

7. Subtract line 6 from the remainder in line 5.

8. Enter all the countable unearned income.

9. Enter the sum of line 7 and line 8.

10. Enter the lesser of the child support income or $50.00.

11. Subtract line 10 from the remainder in line 9.

12. Enter the child support expense.

13. Subtract line 12 from the remainder in 11. If this is less than the payment standard in B6 continue onto section D.
Section D; Issuance Test

**FIP, RCA and SDA Only**

1. Enter the total gross earned income for the group.
2. Enter all of the self-employment income; see BEM 502.
3. Enter the sums of lines 1 and 2.
4. For each member with earnings enter the lesser of $200 or the amount on line 3.
5. Subtract line 4 from the total in line 3.
6. Enter 50 percent of the total in line 5.
7. Subtract line 6 from the remainder in line 5.
8. Enter all of the countable unearned income.
9. Enter the sum of line 7 and line 8.
10. Enter the lesser of the child support income or $50.00.
11. Subtract line 10 from the total in line 9.
12. Enter the child support expense.
13. Enter the Spousal Deduction.
14. Subtract lines 12 and 13 from the remainder in line 11.

Section E; Child Support Income Test

**FIP Only**

1. Enter the total monthly certified current support amount to the direct and voluntary support amount.
2. Enter the child support exclusion the group is eligible to receive. Enter the lesser of the amount on line 1 or $50.
3. Enter the total from line D7.
4. Enter the monthly unearned income that the client receives.
Note: The amount in line 4 should not include any child support payments.

5. Subtract line 2 from line 1 then add lines 3 and 4.

6. Enter the amount paid for the court ordered child support; see BEM 518.

7. Subtract line 6 from line 5.

Section F; Issuance Amount

FIP, RCA and SDA Only

1. Enter the amount from line B6.
2. Enter the amount from line D14.
3. Enter the recoupment amount.
4. Subtract line 2 and line 3 from the amount on line 1 and enter the result.

Note: Divide line 4 by 2 if the first month of issuance is only going to be the second half of the month.

Example: Client applies for FIP August 17th. The earliest the group can start to receive benefits is the second half of September.

Section G; Countable Income for Food Assistance

FIP, RCA and SDA Only - See BEM 550.

1. Enter the amount from line F4.
2. Enter an amount if recoupment is due to IPV.
3. If the group is subject to an immunization penalty enter $25, if not enter $0.
4. Enter the sum of line 1, line 2, and line 3.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended
RCA

45 CFR 400.66

SDA

MDHHS Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180
DEPARTMENT POLICY

This item applies to Group 2 Under 21 and Caretaker Relative categories only.

A fiscal group is established for each person requesting MA and budgetable income is determined for each fiscal group member.

Since how a client’s income must be considered may differ among family members, special rules are used to prorate a person’s income among the person’s dependents, and themselves.

Follow the multi-step process outlined below to determine a fiscal group member’s income, then follow FISCAL GROUP’S NET INCOME in this item.

DETERMINING BUDGETABLE INCOME

Group 2 Under 21 and Caretaker Relative Follow Step 1 through Step 16 below for each fiscal group member with income. Apply the deductions in the order the steps are listed.

Step 1 - Countable Earned Income

Use the policies in BEM 500 and 530 to determine each fiscal group member’s countable earned income.

Step 2 - Standard Work Expense

Deduct $90 from the countable earnings of each fiscal group member with earnings.

Step 3 - $30 Plus 1/3 Disregard

Deduct $30 plus 1/3 of a fiscal group member’s remaining earned income if the member received FIP or LIF in at least 1 of the four calendar months preceding the month being tested.

Note: Received, for purposes of this disregard, includes months a member has been found eligible for LIF.
Example: Harry’s countable monthly earnings are $420.98. The deductions are applied to $420. $420 - $90 = $330. $330 - $30 = $300. 1/3 of $300 is $100. $300 - $100 = $200.

Step 4 - Dependent Care Deduction

Deduct an amount for dependent care expenses arising from employment from the remaining earnings of the parent in the fiscal group who pays for the care.

Compute the dependent care deduction separately for each fiscal group member who pays for dependent care. The deduction is $200 per month for each person receiving care, unless one of the rules below prohibits a deduction.

The following rules apply:

- The person receiving dependent care must:
  - Be living with the fiscal group member paying for the care, and
  - Be that fiscal group member’s child, and
  - Be under age 13 or be under age 18 and need care due to a mental or physical limitation.

- If two parents in the fiscal group claim expenses for the same child, allow the deduction for the fiscal group member with the highest income.

- Do not allow the deduction if the employed person is paying a responsible relative of either the person paying for or the person needing care. Responsible relative means:
  - A person’s spouse.
  - The parent of an unmarried child under age 18.

- Do not allow a deduction for a person receiving care if the total cost is paid by CDC or a third party.

Performing dependent care services should not interfere with the caregiver’s schooling or employment.
Step 5 - Countable Child Support

Use policies in BEM 500 and 530 to determine countable child support income.

Step 6 - Child Support Disregard

Deduct $50 from the child support received by a fiscal group member.

Step 7 - Other Unearned Income

Use the policies in BEM 500 and 530 to determine the fiscal group member’s other countable unearned income.

Step 8 - Total Net Income

Add together the fiscal group member’s remaining:

- Earned income, and
- Child support income, and
- Other unearned income.

Step 9 - Court-Ordered Support

Deduct court-ordered support paid by a fiscal group member to a child who does not live with the fiscal group. The deduction cannot be greater than the amount ordered for the month; arrearage payments are not deducted.

Step 10 - Guardianship/Conservator Expenses

Deduct $83 per month for court-appointed guardian and/or conservator expenses if verified paid by a fiscal group member.

Guardianship/conservator expenses include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.
Fiscal Group Member's Total Net Income

The result after Step 10 is the fiscal group member’s total net income.

Step 11 - Determine Dependents

Determine the number of dependents living with the fiscal group member.

Dependent means a person’s spouse and child (ren).

Child (ren) means an unmarried person under age 18.

Note: Do not count the member being processed as a dependent. The member is included in Step 12 and Step 15.

Skip Step 12 and Step 13 if a member's number of dependents is zero.

Step 12 - Prorate Divisor

Add 2.9 to the amount determined in Step 11. (2.9 is a calculation using federal needs allowances.) The result is the prorate divisor.

Step 13 - Child's or Adult's Prorated Share

Divide the person’s total net income (the result from Step 10) by the prorate divisor (Step 12). The result is the prorated share of the fiscal group member’s income.

Step 14 - Non-Parent Caretaker Relative’s Prorate Divisor

This step applies to a fiscal group member who meets the following criteria:

- This person’s Group 2 MA eligibility is based on BEM 135, Group 2 Caretaker Relative, and
This person is a core relative who is acting as parent for one or more dependent children in the home who are not the person’s own children. Example: Person is acting as parent for a grandchild or a stepchild who is a dependent child.

**Note:** Dependent child is defined in BEM 135. Also, keep in mind the following policies from BEM 135:

- A child can have only one non-parent caretaker relative.
- A non-parent can act as parent even if the parent is in the home. If the parent and non-parent both claim to be acting as parent, assume the parent is caring for the child.

Skip **Step 14, Step 15** and **Step 16** if the person does not meet the criteria above.

If the fiscal group member being tested meets the criteria above, determine the number of dependent children who:

- Are unmarried and under age 18, and
- This member acts as a parent for but is not the parent of.

**Step 15 - Non-Parent Caretaker Relative’s Prorate Divisor**

Add the following three amounts:

- Amount from **Step 11**, and
- Amount from **Step 14**, and
- 2.9.

**Step 16 - Non-Parent Caretaker’s Prorated Share**

Divide the person’s total net income (the result from **Step 10**) by the non-parent caretaker relative’s prorate divisor (**Step 15**). The result is the prorated share of the fiscal group member’s income for purposes of determining the member’s eligibility.

Repeat **Step 1** through **Step 13** and if appropriate, **Step 14** through **Step 16** for each fiscal group member with income before proceeding to **FISCAL GROUP’S NET INCOME**.
FISCAL GROUP’S NET INCOME

Group 2 Under 21 and Caretaker Relative

Child’s Fiscal Group’s Net Income

A child’s fiscal group’s net income is the total of the following amounts:

- The child’s net income (Fiscal Group Member’s Total Net Income) if the child has no dependents or 2.9 prorated shares of the child’s own income if the child has dependents (child’s Step 13 times 2.9), plus

- For each parent in the fiscal group, 3.9 prorated shares of the parent’s own income (each parent’s Step 13 times 3.9), plus

  Note: This is the child’s and parent’s share of the parent’s income.

- One prorated share of each of the parent’s own income (each parent’s Step 13) when:
  - Both of the child’s parents are in the child’s fiscal group, and
  - The parents are married to each other.

  Note: This is the couple’s share of each other’s income.

Adult’s Fiscal Group’s Net Income

An adult’s fiscal group’s net income is the total of the following amounts:

- The adult’s net income (Fiscal Group Member’s Total Net Income) if the adult has no dependents or 2.9 prorated shares of the adult’s own income if the adult has dependents (adult’s Step 13 times 2.9), plus

- If the spouse is in the adult’s fiscal group:
  - 3.9 prorated shares of the spouse’s own income (spouse’s “Step 13” times 3.9), plus
• One prorated share of the adult’s (person requesting MA) income (adult’s amount from Step 13).

Note: This is the couple’s share of each other’s income.

INCOME ELIGIBILITY

Group 2 Under 21 and Caretaker Relative

Group 2 Determination

Use the policies in BEM 544 and 545 to complete the determination of income eligibility for each person requesting MA.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10).
42 CFR 435.831(a)(1).
MCL 400.106.
Medicaid (MA) Only

This item applies to SSI-related MA for children. A child is an unmarried person under age 18.

Exception: This item does not apply to Extended-Care (BEM 164).

An SSI-related child's income is:

- The child's own countable income from BEM 500 and BEM 530, plus
- Income deemed to him from his parent(s).

Deductions from an SSI-related child's income in this item explains what amounts must be deducted from an SSI-related child's income.

PARENTAL INCOME DEEMING

When Deeming Applies

Parents with sufficient income deem a portion to their SSI-related child. Deeming applies only when:

- Eligibility is not being determined under BEM 170, Home Care Children; BEM 171, Children’s Waiver; or BEM 172, SED Waiver; and
- The child lives with (BEM 211) only one parent and that parent is not a FIP or SSI recipient; or
- The child lives with both parents and neither parent is a FIP or SSI recipient.

Use the following procedure when deeming applies.

Parental Income

1. Determine the parent’s countable unearned income (see BEM 500 and 530). If two parents, add the amounts together. Go to 2.
2. Deduct court-ordered child support paid by a parent to a child who does not live with the group. Deduct the amount specified in the court order or the actual amount paid.

3. Determine the parent's countable earned income (see BEM 500 and 530). If two parents, add the amounts together.

End procedure if the parents have no countable income. Go to *Deductions from an SSI-related child's income* in this item.

Go to 4 if the parents have countable income.

Allocation to Non-SSI-Related Children

4. Determine if the parents have non-SSI-related child(ren) living in the home. A non-SSI-related child is a child or stepchild who:

- Is unmarried and under age 18; and
- Is not an SSI, FIP, SDA or title IV-E recipient; and
- Is not a Department ward; and
- Is not an applicant for, or recipient of, MA based on disability or blindness.

If the parents do not have a non-SSI-related child in the home, the total allocation is zero. Go to 6.

Follow steps (a) through (e) separately for each non-SSI-related child living with the parents to compute the child's allocation. Then go to 4.

a. Determine the child's countable unearned income (see BEM 500 and 530). Go to b.

b. Determine the child's countable earned income (see BEM 500 and 530). If the child is a full-time or half-time student (as determined by the institution), subtract $1700 from his countable earned income to get remaining earned income. Go to c.

c. Add the child's countable unearned income and his remaining earned income (a + b above) to get remaining income. Go to d.
d. Deduct the following from the child's remaining income (c above):

- Court-ordered support paid by the child, and
- $83 for guardianship/conservator expenses paid by the child; see Guardianship/Conservator Expenses in this item.

The income left after these deductions is called net income. Go to e.

e. Determine the allocation for the child. No income allocation is allowed to a child from his parents, if the child's net income (d above) is equal to or more than:

- $386 for months in calendar year 2019.
- $375 for months in calendar year 2018.

If the child's net income (d above) is less than $386, the difference ($386 minus d) is the allocation to this child from his parents.

Follow steps (a) through (e) for each non-SSI-related child and then go to 4.

**Total Allocation Deduction**

5. Add up all the allocations (3e above) to get the total allocation. Go to 5.

6. Subtract the total allocation (4 above) from the parents' countable unearned income (1 above) first. If countable unearned income is reduced to zero, subtract the remainder of the total allocation from the parents' countable earned income (2 above).

If the parents have no countable unearned income, subtract the total allocation (4 above) from their countable earned income (2 above).

Any countable unearned income left after the total allocation is subtracted is called remaining countable unearned income. Any countable earned income left is called remaining countable earned income. Go to 6.
Deductions for Parental Needs

7. Subtract the appropriate amount based on parents' remaining income after step 5.
   - Subtract $20 from the parents' remaining unearned income. Subtract $20 from the parents' remaining earnings if there is no remaining unearned income.
   - Disregard $65 plus 1/2 of the parents' earned income. Use RFT 295 to determine this amount.
   - Add the remaining unearned and earned incomes together. Subtract:

<table>
<thead>
<tr>
<th>One Parent</th>
<th>Two Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td>Amount Subtracted</td>
</tr>
<tr>
<td>2019</td>
<td>$771</td>
</tr>
<tr>
<td>2018</td>
<td>$750</td>
</tr>
<tr>
<td>2017</td>
<td>$735</td>
</tr>
<tr>
<td>2016</td>
<td>$733</td>
</tr>
</tbody>
</table>

Go to 7.

Deemed Income

8. The income after the deductions in step 6 above is the amount of deemable income. The amount of deemable income is divided by the number of the parents' children who:
   - Live with the parents (BEM 211), and
   - Are unmarried and under age 18, and
   - Are SSI recipients, or
   - Are:
     - Applicants for, or recipients of, MA based on blindness or disability; and
     - Meet the nonfinancial eligibility factors for MA in BEM 155 or 166; and
Are not having MA eligibility determined, or are not receiving MA, under BEM 170, 171, 172, Home Care Children, Children’s Waiver or SED Waiver.

**Note:** There is always at least one such child; that is, the child whose eligibility is being determined.

The result of the division calculation in this step is the amount of income deemed to the child whose eligibility is being determined.

Go to Deductions from an SSI-related child's income in this item.

**DEDUCTIONS FROM AN SSI-RELATED CHILD’S INCOME**

The following are subtracted from an SSI-related child's income in the order listed.

**Blind and Impairment-Related Work Expenses**

Blind work expenses are costs which are reasonably attributable to a blind child earning income.

Impairment-related work expenses are the cost of certain impairment-related services and items that a disabled child needs in order to work.

Subtract allowable work expenses paid by a blind or disabled child from his own countable earned income.

See BEM 260 for definitions of blindness and disability.

See EXHIBIT in BEM 541 for a list of allowable blind work expenses (BWE) and impairment-related work expenses (IRWE).

Do not deduct:

- Normal living expenses such as meals outside work hours and cosmetics.
- Costs paid (or reimbursed) by an employer, other person or other source (such as insurance or Medicaid).
Student Child Disregard

Subtract $1700 from the child's remaining earned income when the child:

- Is a full-time or half-time student (as determined by the institution), and
- Lives with a person who provides for the child's physical care or supervision.

1/3 Child Support Disregard

Subtract one-third of the child support received by a child from his continuously absent parent from the child's countable unearned income when the child lives with a person who provides for the child's physical care or supervision.

$20 Disregard

Subtract $20 from the child's remaining unearned income (including parental deemed income). Subtract $20 from the child's remaining earned income if there is no remaining unearned income or parental deemed income.

$65 + 1/2 Disregard

Disregard $65 plus 1/2 of the child's remaining earned income.

Guardianship/Conservator Expenses

Deduct $83 for court-appointed guardianship/conservator expenses if verified paid by the child from the child's remaining income (such as remaining unearned plus remaining earned income).

Guardianship/conservator expenses include:

- Basic guardianship fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.
LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)
42 CFR 435.831(a)(2)
**DEPARTMENT POLICY**

**Medicaid (MA) Only**

This item applies to SSI-related MA for adults. Adult means a person who is married or age 18 or over. Apply the deductions in the order listed to countable income as determined by using BEM 500 and 530.

*Exception:* This item does not apply to Extended-Care; see BEM 164.

**COURT ORDERED CHILD SUPPORT**

Deduct court-ordered child support paid by an initial person’s spouse to a child who does not live with the fiscal group. The amount deducted is: the amount specified in the court order or the actual amount if less than the court order or the actual amount if more than the court order and the amount includes arrearages. Arrears must be paid on behalf of a dependent child to allow the deduction.

**BLIND AND IMPAIRMENT-RELATED WORK EXPENSES**

Blind work expenses are costs which are reasonably attributable to a blind person earning income.

Impairment-related work expenses are the cost of certain impairment-related services and items that a disabled person needs in order to work.

Subtract allowable work expenses paid by a blind or disabled person from his own countable earned income.

See BEM 260 for definitions of blindness and disability.

See *allowable work expenses* in this item for a list of allowable blind work expenses (BWE) and impairment-related work expenses (IRWE). Do not deduct:

- Normal living expenses such as meals outside work hours and cosmetics.
- Costs paid (or reimbursed) by an employer, other person or other source (such as insurance and Medicaid).

**ALLOCATION TO NON-SSI-RELATED CHILDREN**

Allocate parents’ and stepparents’ income to meet the needs of their non-SSI-related child(ren) living with them; see BEM 211. A non-SSI-related child is a child who:

- Is unmarried and under age 18; and
- Is **not** an SSI, FIP, SDA or title IV-E recipient; and
- Is **not** a department ward; and
- Is **not** an applicant for, or recipient of, MA based on disability or blindness.

**Allocation Calculation**

Calculate the allocation for each non-SSI-related child (defined above) separately as follows:

1. Determine the non-SSI-related child's countable unearned income; see BEM 500 and 530. Go to 2.
2. Determine the non-SSI-related child's countable earned income; see BEM 500 and 530. If the child is a full-time or half-time student (as determined by the institution), subtract $135 from his countable earned income. Go to 3.
3. Add the non-SSI-related child's countable unearned income and his remaining earned income (1 + 2 above). Go to 4.
4. Deduct the following from the non-SSI-related child's remaining income (3 above):
   - Court-ordered support paid by the child, and
   - $83 for guardianship/conservator expenses if verified paid by the child; see *guardianship/conservator expenses* in this item.

   The income left after these deductions is called net income. Go to 5.
5. If the non-SSI-related child’s net income (4 above) is less than $386, the difference ($386 minus net income) is the allocation
to this non-SSI-related child. Otherwise, the allocation to this child is zero.

**Note:** Use $386 for months in calendar year 2019.

Repeat steps 1-5 separately for each non-SSI-related child before proceeding to step 6.

6. Add up the individual allocations to get the total allocation. Go to 7.

7. Deduct the total allocation from the parents'/stepparents’ countable unearned income first. If unearned income is reduced to zero, deduct the remainder of the total allocation from the parents'/stepparents’ remaining earnings.

If the parent/stepparent has no countable unearned income, deduct the total allocation from the parents'/stepparents' remaining earnings.

**$20 DISREGARD**

Subtract $20 from the fiscal group's remaining unearned income. Subtract $20 from the fiscal group's remaining earnings if there is no remaining unearned income.

**$65 + 1/2 DISREGARD**

Disregard $65 plus 1/2 of the fiscal group's remaining earnings.

**GUARDIANSHIP/CONSERVATOR EXPENSES**

Deduct $83 for court-appointed guardian and/or conservator expenses paid by a fiscal group member from the remaining combined income of the fiscal group. Verification of the expense is required.

Guardianship/conservator expenses include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

**ALLOWABLE WORK EXPENSES**
<table>
<thead>
<tr>
<th>TYPE OF EXPENSE</th>
<th>DEDUCTIBLE AS BWE</th>
<th>IRWE</th>
<th>AMOUNT DEDUCTIBLE</th>
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<tbody>
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<td>A guide dog</td>
<td>x</td>
<td>x</td>
<td>The cost of purchasing the dog and all associated expenses (such as its food, breast straps, licenses, veterinary services, etc.)</td>
</tr>
<tr>
<td>Fees</td>
<td>x</td>
<td>x</td>
<td>The amount paid.</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Licenses</td>
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<td>• Professional association dues</td>
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<td>• Union dues</td>
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<tr>
<td>Transportation to and from work</td>
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<td>x</td>
<td>Actual cost of bus, carpool or cab fare. Private automobile; see BAM 825 for rate.</td>
</tr>
<tr>
<td>Vehicle modifications</td>
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<td>x</td>
<td></td>
</tr>
<tr>
<td>Training to use an impairment-related item or an item which is reasonably attributable to work</td>
<td>x</td>
<td>x</td>
<td>The cost of the training plus travel expense to and from the training facility. Compute travel expenses to and from the training facility in the same manner as transportation to and from work (shown previously in this chart). + To be deductible as an IRWE, the training must be for an impairment-related item or service (such as a one-handed typewriter, telecommunication device for a deaf person, etc.).</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cane travel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Braille</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of special equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Grammar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of vision and sensory aids for the blind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of one-handed typewriter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Computer program course for a computer operator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stenotype instruction for a typist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Training does not include general education courses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal, State and local income taxes</td>
<td>x</td>
<td></td>
<td>The amount withheld. Assume the amount withheld reflects the individual’s tax liability.</td>
</tr>
<tr>
<td>Social Security taxes</td>
<td>x</td>
<td></td>
<td>The actual amount paid on wages and self-employment income.</td>
</tr>
<tr>
<td>TYPE OF EXPENSE</td>
<td>DEDUCTIBLE AS</td>
<td>AMOUNT DEDUCTIBLE</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BWE</td>
<td>IRWE</td>
<td></td>
</tr>
<tr>
<td>Mandatory pension contributions</td>
<td>X</td>
<td></td>
<td>The actual amount of the contribution. <strong>Note:</strong> Mandatory pension contributions are considered reasonably attributable to earning income and, therefore, deductible. Voluntary pension contributions are considered savings plans and, as such, are life maintenance expenses and not deductible.</td>
</tr>
<tr>
<td>Meals consumed during work hours</td>
<td>X</td>
<td></td>
<td>The actual value of the meals.</td>
</tr>
<tr>
<td>Attendant care services which are rendered in the:</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Work setting, or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Process of assisting an individual in making the trip to and from work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structural modifications to the individual's home to create a work space or to allow the individual to get to and from work.</td>
<td>X</td>
<td>X</td>
<td>The cost of the modification.</td>
</tr>
</tbody>
</table>
| Medical devices                                          | X   | X    | The cost of the items plus maintenance and repair of such items whether the individual works at home or at the employer’s place of business. **Examples:**
| • Wheelchair                                            |     |      |                              |
| • Respirator                                             |     |      |                              |
| • Pacemaker                                              |     |      |                              |
| • Inhalers                                               |     |      |                              |
| • Braces                                                 |     |      |                              |
| Prostheses                                               | X   | X    | The cost of the item plus maintenance and repair of such item. |
| Other work-related equipment/services                    | X   | X    | The cost of the item plus maintenance and repair of such item whether the individual works at home or at the employer’s place of business. **Examples:**
<p>| • One-handed typewriters                                |     |      |                              |
| • Typing aids (e.g. page turning devices)                |     |      |                              |</p>
<table>
<thead>
<tr>
<th>TYPE OF EXPENSE</th>
<th>DEDUCTIBLE AS BWE</th>
<th>IRWE</th>
<th>AMOUNT DEDUCTIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Vision and sensory aids for the blind&lt;br&gt;• Telecommunications devices for the deaf&lt;br&gt;• Special tools designed to accommodate an individual’s impairment&lt;br&gt;• Translation of materials into braille</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonmedical equipment/services&lt;br&gt;<strong>Examples:</strong>&lt;br&gt;• Safety shoes&lt;br&gt;• Tools used on the job&lt;br&gt;• Uniforms&lt;br&gt;• Child care costs&lt;br&gt;• Air conditioners&lt;br&gt;• Air cleaners&lt;br&gt;• Humidifiers&lt;br&gt;• Posture chairs&lt;br&gt;• Portable room heaters</td>
<td>X</td>
<td>+</td>
<td>The cost of the item plus maintenance and repair of such item whether the individual works at home or at the employer’s place of business.&lt;br&gt;+ To be deductible as an IRWE, the item or service must be impairment-related.</td>
</tr>
<tr>
<td>Drugs and medical services which are essential to enable the individual to work (e.g., medication to control epileptic seizures)</td>
<td>X</td>
<td>X</td>
<td>The amount paid.</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>X</td>
<td>X</td>
<td>The amount paid.</td>
</tr>
<tr>
<td>Expendable medical supplies&lt;br&gt;• Bandages&lt;br&gt;• Face masks&lt;br&gt;• Catheters&lt;br&gt;• Incontinence pads</td>
<td>X</td>
<td>X</td>
<td>The amount paid.</td>
</tr>
</tbody>
</table>
LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)
42 CFR 435.831(a)(2)
MCL 400.106
Medical (MA) Only

This item completes the Group 2 MA income eligibility process.

Income eligibility exists for the calendar month tested when:

- There is no excess income.
- Allowable medical expenses (defined in EXHIBIT I) equal or exceed the excess income.

When one of the following equals or exceeds the group’s excess income for the month tested, income eligibility exists for the entire month:

- Old bills (defined in EXHIBIT IB).
- Personal care services in client's home, (defined in Exhibit ID), Adult Foster Care (AFC), or Home for the Aged (HA) (defined in EXHIBIT ID).
- Hospitalization (defined in EXHIBIT IC).
- Long-term care (defined in EXHIBIT IC).

When one of the above does not equal or exceed the group’s excess income for the month tested, income eligibility begins either:

- The exact day of the month the allowable expenses exceed the excess income.
- The day after the day of the month the allowable expenses equal the excess income.

In addition to income eligibility, the fiscal group must meet all other financial eligibility factors for the category processed. However, eligibility for MA coverage exists only for qualified fiscal group members. A qualified fiscal group member is an individual who meets all the nonfinancial eligibility factors for the category processed.

Group 2 for Pregnant Women

The deductible for a pregnant woman is usually met at the first office visit because the woman incurs the full cost of obstetric (OB) services (including labor and delivery) at their first OB visit.
total cost of the OB services must be equal to or greater than the amount of the deductible in order to open. She is Medicaid eligible for the remainder of the pregnancy and two months post-partum.

RULES FOR MA GROUP 2 INCOME ELIGIBILITY

Use the following rules to determine MA Group 2 income eligibility.

The individual must be given the most advantageous use of their old bills (also known as incurred expenses). The individual may request coverage for the current month, up to six future months (see eligibility based on old bills in this item), and for any prior months.

1. Use the budgeting rules in BEM 530. Determine income eligibility in calendar month order, starting with the oldest calendar month.

2. Use BEM 546 to determine the post-eligibility patient-pay amount (PPA) for each L/H month that a beneficiary is Group 2 eligible.

3. Determine Medicare Savings Program eligibility separately for Group 2 beneficiaries entitled to Medicare Part A (see BEM 165).

4. Request information about all medical expenses incurred during and prior to each month with excess income.

5. Notify the group of the outcome of each determination. NOTIFICATION explains which forms to use and when.

MONTHS WITHOUT EXCESS INCOME

Income eligibility exists for the entire month tested when the group does not have excess income.

For L/H months, also go to BEM 546 to determine the post-eligibility PPA.
MONTHS WITH EXCESS INCOME

Income eligibility exists for all or part of the month tested when the medical group’s (defined in BEM 544, EXHIBIT I) allowable medical expenses (BEM 545, EXHIBIT I) equal or exceed the fiscal group’s excess income. The NON-L/H and L/H sections that follow list the exact order in which to subtract specific types of these allowable expenses.

NON-L/H PAST AND PROCESSING MONTHS

Use these instructions to determine Group 2 income eligibility for each non-L/H past and processing month with excess income.

Old Bills

1. Compare the medical group's allowable old bills (defined in EXHIBIT IB) to the excess income.
   - If there are no old bills, go to 2.
   - If there are old bills and they total less than the excess income, subtract the old bills to get the remaining excess income. Go to 3.
   - If the old bills equal or exceed the excess income, subtract the excess income from the allowable old bills to get the unused old bills.

   Income eligibility exists for the entire month tested, and:
   • If this is a past month, stop.
   • If this is the processing month, go to NON-L/H FUTURE MONTH.

Personal Care Services

2. If a group member is/was receiving personal care services in his/her home, AFC, or HA does income eligibility exist based on “EXHIBIT ID”?
   - If no, go to 3.
   - If yes, income eligibility exists for the entire month.
• If this is a past month, stop.

• If this is the processing month, income eligibility may be ongoing unless you project a change(s); see Exhibit II.

• If you project a change, go to NON-L/H FUTURE MONTH.

LTC Expenses

3. Determine each qualified fiscal group member’s LTC (or hospice care in LTC) expenses for the month.

• If expenses incurred by one qualified fiscal group member equal or exceed the excess income, income eligibility exists for the entire month. If expenses incurred by one qualified fiscal group member are less than the excess income, go to 4.

Inpatient Hospital

4. Determine each qualified fiscal group member’s allowable hospital expenses for the month.

• If expenses incurred by one qualified fiscal group member for one admission equal or exceed the excess income, income eligibility exists for the entire month.

• If expenses incurred by one qualified fiscal group member for one admission are less than the excess income, go to 5.

All Medical Expenses

5. Determine the medical group’s allowable medical expenses for the month.

• If less than the remaining excess income, income eligibility does not exist for this month.

• If this is a past month, stop.

• If this is the processing month, the group has or continues to have a deductible. Go to “deductible.”

• If equal to or more than the remaining excess income, income eligibility exists starting on:
- The **day after the day the expenses equaled** the excess income.
- The **exact day the expenses exceeded** the excess income. However, MA may only be billed for the amount that exceeds the group’s liability; go to **identifying a group’s liability** in this item.

## Identifying a Group’s Liability

Use these instructions to determine a fiscal group’s liability for all or part of a medical expense incurred on the first day of MA coverage. A fiscal group is not responsible for liabilities of less than $1.00.

1. Identify a group’s liability on the date allowable medical expenses exceeded its excess income as follows:
   - The group’s excess income for the month tested.
   - MINUS allowable medical expenses for the month tested through the day before the date MA coverage begins.
   - EQUALS the group’s liability.

   If the group’s liability is less than $1.00, stop. If it is $1.00 or more, go to 2.

2. Total the group’s non-qualified expenses (defined below) incurred on the date expenses exceeded the excess income.

   A non-qualified expense is an allowable expense used to meet a deductible but not billable to MA. Such expenses include those incurred:
   - For services not covered by MA.
   - By fiscal or medical group members who are not eligible for MA coverage for this date.

   Go to 3.

3. Subtract the group's total non-qualified expenses from the group's liability. Is the remainder less than $1.00?

   If **yes**, stop.
   If **no**, the remainder is the group's liability balance. Go to 4.
4. Arrange the rest of the expenses incurred on the date expenses exceeded excess income as follows:
   a. Largest to smallest paid expenses.
   b. Largest to smallest unpaid expenses.

   Go to 5.

5. Subtract the first (next) expense in the order arranged in step 4 above from the group’s liability balance. Is there a remainder?
   - If no, enter the group's liability balance on the DHS-114 as the client payment for this expense. Stop.
   - If yes, enter the entire amount of this expense on the DHS-114 as the client payment. The remainder becomes the group's liability balance. Go to 6.

6. Is the group's liability balance less than $1.00?
   - If yes, stop.
   - If no, repeat step 5.

**NON-L/H FUTURE MONTH**

Use these instructions to determine ongoing income eligibility for non-L/H months with excess income.

**Old Bills**

1. Compare the medical group's allowable old bills (EXHIBIT IB) to the excess income.
   - If there are no old bills, go to 2.
   - If there are old bills and they total less than the excess income, the group has or continues to have a deductible. Go to deductible. If the old bills equal or exceed the excess income, go to eligibility based on old bills in this item to determine whether one or more future month(s) of income eligibility exists.

**Personal Care Services**

2. If a group member is receiving personal care services (Exhibit ID) in their home, AFC, or HA, does income eligibility exist based on “EXHIBIT II”?
• If no, the group has or continues to have a deductible. Go to deductible.

• If yes, income eligibility exists for the entire month and continues.

L/H PAST AND PROCESSING MONTHS

See BRG for the definitions of L/H patient and L/H month.

For L/H months, the L/H patient is the only medical group member. Use only his medical expenses to establish income eligibility. Do not recalculate a PPA for the month of death.

Use these instructions to determine Group 2 income eligibility for each L/H past and processing month with excess income.

LTC and Hospital Expenses

1. Determine the beneficiary's allowable LTC and hospital expenses for the month.

   • If less than his excess income, go to 2.
   • If equal to or more than his excess income, income eligibility exists for the entire month; go to post eligibility in this item.

Old Bills

2. Compare the beneficiary's allowable old bills (see EXHIBIT IB) to the excess income.

   • If they are less than his excess income, subtract the old bills to get the remaining excess income. Go to 3.
   • If the beneficiary's allowable old bills equal or exceed the excess income, income eligibility exists for the entire month; go to post eligibility in this item.

All Medical Expenses

3. Determine the beneficiary's allowable medical expenses for the month.
• If **less** than the remaining excess income, income eligibility does not exist for the month.

  • If this is a **past** month, stop.
  • If this is the **processing** month, this client has or continues to have a deductible; go to Deductible in this item. If **equal to or more** than the remaining excess income, income eligibility exists for the entire month. Go to **post eligibility** in this item.

**L/H FUTURE MONTH**

Use these instructions to determine ongoing income eligibility for L/H patients with excess income.

**LTC Expenses**

1. Determine the L/H patient's allowable LTC expenses for the month.

• If **less** than his excess income, go to 2.
• If **equal to or more** than his excess income, income eligibility exists for the entire month; go to **post eligibility** in this item.

**Old Bills**

2. Compare the L/H patient's allowable old bills to his excess income.

• If the old bills are **less** than his excess income, he has or continues to have a deductible; go to **Deductible in this item.** If the beneficiary's old bills **equal** his excess income, income eligibility exists for the entire month.

  If his old bills **exceed** his excess income, income eligibility may exist for more than one month; go to **eligibility based on old bills** in this item.

  Also, go to **post eligibility** in this item to determine the post-eligibility PPA.

**POST-ELIGIBILITY**

You determined the L/H patient is income eligible for the entire month.

You now must calculate the amount of the beneficiary's liability to the hospital or LTC provider by completing a separate
determination. The result of this second determination is called the **post-eligibility patient-pay amount (PPA)**.

Go to BEM 546 to determine the post-eligibility PPA, then:

1. Authorize MA coverage:
   - for the month tested if this is a past month or the processing month, **or**
   - on an ongoing basis if this is a future month.

2. If this is a **past month**, stop.

   If this is the **processing month**, determine continued income eligibility as follows:
   - If the client is still in a hospital or LTC facility on the processing date, go to *L/H future month*.
   - If not, go to *non-L/H future month*.

If this is a **future month**, and the client was income eligible based on old bills, go to *eligibility based on old bills*.

**ELIGIBILITY BASED ON OLD BILLS**

A group with excess income can delay deductible for one or more future months based on allowable old bills; see EXHIBIT IB in this item.

**Determining the Number of Months to Delay Deductible**

1. Do the total old bills equal or exceed the group’s excess income?
   - If **yes**, go to 2.
   - If **no**, go to 5.

2. Divide the total old bills by the group’s excess income. Drop any fractions. The result equals the number of months the group may delay deductible.
   - If the result is more than one month, go to 3.
• If not, authorize MA for the future month. Go to 5.

3. Authorize MA for the additional months, but not more than a total of six future months. Go to 4.

4. Set a follow-up for whichever is earliest:
   • The fifth future month, or
   • The month before the last month of MA coverage. Go to 5.

5. Transfer the case to active deductible effective the month following the last month the group’s old bills exceeded its excess income.
   
   Go to Deductible in this item.

Old Bills Follow-up

At follow-up:
   • Re-verify the group’s liability for old bills, if any.
   • Authorize up to six additional months of MA if the group is eligible.
   • Notify the group of:
     • Additional MA coverage, or
     • Transfer to active deductible (see step 5 above).

DEDUCTIBLE

Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred.

Active Deductible

Open an MA case without ongoing Group 2 MA coverage on Bridges as long as:
   • The fiscal group has excess income, and
   • At least one fiscal group member meets all other Group 2 MA eligibility factors.

Such cases are called active deductible cases. Periods of MA coverage are added each time the group meets its deductible.
Deductible Period

Each calendar month is a separate deductible period.

Starting the First Deductible Period

The first deductible period:

- Cannot be earlier than the processing month for applicants.
- Is the month following the month for which MA coverage is authorized for recipients.

Deductible Amount

The fiscal group’s monthly excess income is called a deductible amount.

Meeting a Deductible

Meeting a deductible means reporting and verifying allowable medical expenses (defined in “EXHIBIT I) that equal or exceed the deductible amount for the calendar month tested.

Use the NON-L/H PAST AND PROCESSING MONTHS section for non-L/H months and the L/H PAST AND PROCESSING MONTHS section for L/H months to determine both:

- The order in which to deduct expenses.
- When to identify a group’s liability.

IDENTIFYING A GROUP’S LIABILITY explains how to determine the group’s share of its expense(s) on the first day of MA coverage.

Example: The client incurs a medical expense in January 2016. The expense was reported and verification turned in to DHHS in August 2016.

- As the expense was reported later than the last day of the third month (April 30, 2016) after the expense, it cannot be used for January 2016.
- The expense can be used as an old bill.
- When eligibility determination is done in August 2016 the old bill (Jan 2016 expense) can be used for May 2016, June 2016, July 2016, August 2016 or future months. To
allow the client to choose the most advantageous month(s) in which they want to use the old bill, enter the "Apply to Deductible Determination From/To Dates" Most Advantageous does not mean they can turn in an expense at any time and eligibility can be determined for the month the expense was incurred. If the client had reported the January 2016 expense between January 1 and April 30th 2016 but had not verified, then the expense can be used for the January 2016 expense when the verifications are received. It is important for the specialist to document when the client reports an expense even if the client does not yet have the bill to verify the expense. The expense does not need to be verified before using as an expense.

Example: The client applies for Health Care Coverage in January 2016. Determination of eligibility is not completed until August 2016 and results in the determination of a deductible case for January 2016 ongoing. The client has until the last day of the third month (that is November 2016) following the notification that they client has a deductible case (notice sent August 2016) to report the expense.

Remember: to use an old bill the group/individual's current liability for the expense must be verified by the specialist.

Adding MA Coverage

Add periods of MA coverage each time the group meets its deductible; see INSTRUCTIONS for details.

Renewal

Renew eligibility for active deductible cases at least every 12 months unless the group has not met its deductible within the past three months.

If a group has not met its deductible in at least one of the three calendar months before that month and none of the members are QMB, SLMB or ALMB eligible, Bridges will automatically notify the group of closure.
Processing Changes

The group must report changes in circumstances within 10 days. Redetermine the group's eligibility when a change that may affect eligibility is reported.

Apply changes for the corresponding period as follows if MA coverage has been authorized:

Reductions in MA Coverage

A reduction in MA coverage means:

- Higher hospital or LTC patient-pay amount.
- Transfer from MA coverage to active deductible.
- Later MA eligibility begin date.

Do not reduce MA coverage already authorized on Bridges for the processing month or any past month.

Increases in MA Coverage

An increase in MA coverage means:

- Lower hospital or LTC patient-pay amount.
- Transfer to ongoing MA coverage from active deductible.

Increase MA coverage for any month(s) with coverage already authorized on Bridges.

- Start increased coverage the calendar month the change occurred, if reported within 10 days.
- Start increased coverage the calendar month the change was reported, if not reported within 10 days.

Expenses Reported After Coverage Authorized

A group may report additional expenses that were incurred prior to the MA eligibility begin date you calculated for that month.
Do not alter the MA eligibility begin date if you have already authorized coverage on Bridges. However, any expenses the group reports that were incurred from the first of such a month through the day before the MA eligibility begin date might be countable as old bills.

See EXHIBIT IB and EXAMPLE 7 in EXHIBIT IV.

Closures

Close an active deductible case when any of the following occur:

- No one in the group meets all nonfinancial eligibility factors.
- Countable assets exceed the asset limit.
- The group fails to provide needed information or verification.

**Exception:** Do not close the case just because the group fails to verify sufficient allowable medical expenses to meet its deductible.

- The group does not return the redetermination form.
- You cannot locate any of the group members.

Use adequate notice to close the case.

NOTIFICATION

This section contains a list of the form(s) you need to notify groups about MA Group 2 eligibility determinations and tells you when to send them.

Send the group a DHS-1606, Health Care Coverage Notice when you:

- Approve or deny MA.
- Add periods of MA coverage to an active deductible case.
- Transfer an active deductible case to ongoing MA coverage.

Use a DHS-114 or its Bridges equivalent to notify the group of:

- The start of or transfer to active deductible.
- A change in its deductible amount.
- The begin and end date(s) of MA coverage, when added.
• Its share of the expenses incurred on the date it meets its deductible.

• The names of all providers notified to collect payment from the group for all or part of an expense used to meet deductible.

When a group is liable for all or part of any expense(s) incurred on the first day of MA coverage, send a copy of the DHS-114 (or Bridges equivalent) to each provider(s) who must collect all or part of an expense from the group.

**DHS-114A, Deductible Report**

Send a DHS-114A to the group with every Deductible Notice. At their option, groups may use the DHS-114A to report:

• Incurred medical expenses.

• Changes in circumstances.

**MSA-Pub. 617, Medicaid Deductible Information**

Give the group a MSA-Pub. 617 or send one with the deductible notice when an active deductible starts and at each redetermination.

**VERIFICATION REQUIREMENTS**

Verify the following before using an allowable medical expense to determine eligibility:

• Date expense incurred.

• Amount of expense.

• Current liability for an old bill.

• Receipt of personal care services provided in a home, an adult foster care home, or home for the aged; see EXHIBIT ID or Exhibit II if verifying ongoing eligibility.

Verify both of the following when you authorize MA based on a personal care co-payment:

• Amount DHHS has authorized for personal care services.

• Amount required but not covered by DHHS payment.
See EXHIBIT II in this item.

**Note:** Verify continuing residence in a long-term care facility / AFC home at application and redetermination as verification of allowable medical expenses when determining on-going eligibility.

### Verification Sources

Sources to verify an incurred expense include:

- Bill from medical provider.
- Receipt from medical provider.
- Contact with medical provider or the provider's billing service.

Sources to verify current liability for an old bill include:

- Current billing or statement from provider.
- Contact with medical provider or provider’s billing service.

### EXHIBIT I - MEDICAL EXPENSES

A **medical expense** must be incurred for a medical service listed below. Except for some transportation, the actual charge(s) minus liable third-party resource payments counts as an allowable expense. However, not all sources of payment are considered liable third-party resources; see THIRD PARTY RESOURCES, EXHIBIT IA.

**Note:** A charge cannot be incurred until the service is provided.

You will need additional information to calculate the costs of some medical services. Such information is detailed in separate exhibits. You will be referred to the necessary exhibit where these services are listed.

Count allowable expenses incurred during the month you are determining eligibility for, whether paid or unpaid. You may also count certain **unpaid** expenses from prior months that have not been used to establish MA eligibility; see OLD BILLS, EXHIBIT IB.

### Medical Services

Medical services include the following:

- Cost of a diabetes patient education program.
• Service animal (such as a guide dog) or service animal maintenance. In Michigan the animal must be fully trained and cannot be for emotional support, companionship, therapy for others, or crime deterrence.

• Personal cares services in home, AFC, or HA; see EXHIBIT ID.

• Transportation* for any medical reason.

• Medical service(s) provided by any of the following:
  • Anesthetist.
  • Certified nurse-midwife.
  • Chiropractor.
  • Christian Science practitioner, nurse or sanatorium.
  • Clubhouse psychosocial rehabilitation programs.
  • Dentist.
  • Family planning clinic.
  • Hearing aid dealer.
  • Hearing and speech center.
  • Home health agency.
  • Hospice; see EXHIBIT III.
  • Hospital; see EXHIBIT IC.
  • Laboratory.
  • Long-term care facility; see EXHIBIT IC.
  • Maternal support services provider.
  • Medical clinic.
  • Medical supplier. ***
  • Mental health clinic.
  • Nurse.
  • Occupational therapist.
  • Ophthalmologist.
  • Optometrist.
  • Oral surgeon. Orthodontist.
  • Pharmacist. ***
  • Physical therapist.
  • Physician (MD or DO).
  • Podiatrist.
  • Psychiatric hospital; see EXHIBIT IC.
  • Psychiatrist.
  • Psychologist.
  • Radiologist.
  • Speech therapist.
  • Substance abuse treatment services provider.
  • Visiting nurse.
* Includes ambulance at actual cost and other transportation for medical services at the rates in BAM 825. Includes clients driving themselves for episodic and pharmacy trips at the rate they are paid in BAM 825 for chronic ongoing trips.

** Includes purchase, repair and rental of supplies, such as:

- Prosthetic devices.
- Orthopedic shoes.
- Wheelchairs.
- Walkers.
- Crutches.
- Equipment to administer oxygen.
- Personal response system (for example Lifeline Emergency Services).

*** Includes:

- Legend drugs (that is, can only obtained by prescription).
- Aspirin, ibuprofen and acetaminophen drug products which are prescribed by a doctor and dispensed by a pharmacy.
- Non-legend drugs and supplies, such as:
  - Insulin.
  - Needles.
  - Syringes.
  - Drugs for the treatment of renal (kidney) diseases.
  - Family planning drugs and supplies.
  - Ostomy supplies.
  - Oxygen.
  - Surgical supplies.
  - Nicotine patches and gum.
  - Incontinence supplies.

It does not include medicine chest and first aid supplies, such as:

- Band-Aids.
- Alcohol.
- Cotton swabs.
- Nonprescription cold remedies.
- Ointments.
- Thermometers.
EXHIBIT IA - THIRD PARTY RESOURCES

Third party resource payments are payments from any liable third party for medical care. They include payments Medicare, other health insurers or any liable third party made or will make.

Payments made by any third party cannot be included as part of the beneficiary's medical expense for any of the medical service(s) listed in EXHIBIT I. Therefore, you must try to find out if any liable third-party resource payment has been, or will be made to determine a beneficiary's costs. Count only the beneficiary's cost as a medical expense. However, do not delay the eligibility determination just because third party payment information is not readily available.

Exceptions: Payments made by the following are not third-party resource payments:

- Indian health service.
- Payments made by a state- or locally-funded government program are not third-party resource payments. State- and locally-funded government programs include those administered by:
  - County health departments.
  - Community Mental Health.
  - State and county DHHS.

Any program that receives federal funds is not a state- or locally-funded program.

Such payments can be used to meet the beneficiary's deductible as follows:

- Count the entire expense for the month during which the service was provided.
- Count only the portion of the expense the client must actually pay when using an expense as an old bill; see EXHIBIT IB.

Example: Community Mental Health (CMH) provides $300 in services to a client in February 2016. CMH determines the beneficiary's ability to pay is $30. Therefore, CMH will not attempt to collect more than $30 from the client for February's services.

The client applies for MA on May 31, 2016, and requests MA for February, March and April.
This medical expense could be counted in one of two ways:

A. **The month being tested is February.**
   
   Count the entire expense ($300) for February.

B. **The month being tested is March or April or May.**
   
   The client was not eligible for February and verifies:
   - His February CMH bill is unpaid, and
   - He is still liable for the $30 for February.

   Count the $30 the client is still liable for as an old bill; see **EXHIBIT IB** in this item.

**Note:** All services and supports provided by a CMH program, including case management services, are considered medically necessary and all charges for these services should be applied fully to the beneficiary's monthly deductible obligation.

**EXHIBIT IB - OLD BILLS**

Medical expenses listed under **Medical Services** in **EXHIBIT I** can be used as **old bills** if they meet **all** of the following criteria:

- The expense was incurred in a month prior to the month being tested.

- During the month being tested:
  - The expense is/was still unpaid, and
  - Liability for the expense still exists (existed).

- A third-party resource is **not** expected to pay the expense.

- The expense was **not** previously used to establish MA income eligibility.

- The expense was one of the following:
  - Incurred on a date the person had no MA coverage.
  - **Not** an MA covered service.
  - Provided by a non-MA enrolled provider.

- A member of the medical group incurred the expense. This includes expenses incurred by a deceased person if both:
The person was a medical group member's spouse or unmarried child under 18.

The medical group member is liable for the expense.

**Note:** An expense which has been turned over for collection is still a medical expense until the provider has written off the expense.

You must give groups that have excess income the opportunity to verify old bills before you start an active deductible case.

Use old bills in chronological order by date of service.

**EXHIBIT IC - HOSPITAL AND LONG-TERM CARE EXPENSES**

A person cannot incur hospital care or long-term care expenses until he is actually admitted to the facility.

A person may receive hospice care in a hospital or long-term care facility. Do not consider the expense of such care a hospital or long-term care expense; see EXHIBIT III, HOSPICE CARE, in this item.

**Hospital Care**

Calculate the expense of inpatient hospital care or inpatient care in a private psychiatric facility as follows:

\[
\text{Actual charge for inpatient care} - \text{Liable third-party resource payments}^* = \text{Countable expense of hospital care}
\]

**Long-term Care**

Calculate the expense of long-term care as follows:

\[
\text{LTC facility's charge at the private rate} - \text{Liable third-party resource payments}^* = \text{Countable expense of long-term care}
\]

Medicare Part A may cover up to 100 days of care per episode of illness. If so, the first 20 days the Medicare beneficiary's LTC
expenses are zero, because there is no coinsurance. Beneficiaries must pay coinsurance for days 21 through 100.

*Liable third-party resource payments are explained in EXHIBIT 1A.

EXHIBIT ID - PERSONAL CARE SERVICES

Allowable medical expenses (EXHIBIT I) include amounts the medical group incurs for personal care services in their home or AFC, or Home for the Aged. Clients may receive personal care services while living in their own home, an adult foster care (AFC) home or a home for the aged (HA).

Personal care expenses in their home, AFC or HA are incurred monthly regardless of when services are paid for.

In addition, the client may be liable for the employer's portion of FICA taxes. This FICA liability is an allowable medical expense. If the client claims this expense, use the current percentage for the employer's portion of the FICA tax on the incurred cost rather than the actual FICA payment. The services specialist has information about the current percentage for the employer's portion of the FICA tax.

Allowable Services

Personal care services in their home, AFC or HA must be services related to activities of daily living. Activities of daily living include:

- Eating/Feeding.
- Toileting.
- Bathing.
- Dressing.
- Transferring.
- Grooming.
- Ambulation.
- Taking medication.

Household services provided in the beneficiary's home must be services essential to the ill person's health and comfort. Such services include:

- Personal laundry.
- Meal preparation/planning.
• Shopping/errands.
• Light housecleaning.

Excluded Services

The following services are not allowable as personal care:

• Heavy housecleaning.
• Household repairs.
• Yard work.

The following services are not allowable as personal care for clients residing in an AFC or HA:

• Room.
• Board.
• Supervision.
• Household services.
• Remedial services; see BEM 544.

Personal Care Services in Beneficiary’s Home, AFC, or HA

The personal care services provider cannot be a responsible relative of the person requiring care if the client lives in his own home. Responsible relative means:

• A person’s spouse.
• The parent of an unmarried child under age 18.

A physician (MD or DO) must verify the need for personal care services in their home, AFC, or HA and the estimated duration of need. At the end of the estimated duration of need, a physician must verify continued need.

If available, use the verifications obtained by Adult Services for the Home Help eligibility determination or the Adult Community Placement (ACP).

Verifications

The personal care services provider must verify all of the following:

• Date the service was provided.
• The charge for that day for the services provided.
- That the services rendered are services related to activities of daily living.

- That household services rendered in the beneficiary's home are services essential to the ill person's health and comfort. See Exhibit ID.

EXHIBIT II - MA ELIGIBILITY AND PERSONAL CARE

Beneficiary's with excess income who are receiving personal care Home Help Services in their home, AFC, or HA may be eligible for ongoing MA coverage. MA coverage can be authorized or continued at the beneficiary's option provided all conditions in this Exhibit are met.

The beneficiary's option to pay a portion of his personal care cost works much the same as paying a patient-pay amount to a hospital or long-term care facility. When a client chooses this option, his services specialist subtracts his excess income from the MDHHS payment for personal care services. The client is then responsible for paying his excess income amount directly to his personal care provider. This ensures MA does not pay the beneficiary's liability.

Discuss this policy option with the client. Advise the client that he will be responsible for paying his excess income to his Home Help Services personal care provider, AFC provider, or HA provider. This cost may include the employer's portion of FICA taxes. The services specialist has information about what portion of the beneficiary's excess income is for the provider and what portion, if any, is for FICA taxes.

Sometimes personal care costs exceed the maximum amount services will pay. In such cases the client is responsible for the amount services will not pay. If the client chooses the policy option described in this Exhibit, he will be responsible for the amount services will not pay in addition to his excess income. Under these circumstances, this option may not be advantageous to the client.

Conditions of Eligibility

1. The client must meet all nonfinancial eligibility factors and all financial eligibility factors except income.
2. The client must have an active Adult Services case with Home Help or ACP services and be receiving personal care services in his home, AFC, or HA. Consider the services case active as soon as the services specialist begins to work with the client. The services specialist is responsible for obtaining verification of the need for personal care services and making the ACP or Home Help eligibility determination.

3. The amount DHHS has or will approve for personal care services must exceed the beneficiary’s excess income. Contact the services specialist for the following information:

   • The amount DHHS has or will approve for personal care services.

   • The amount of personal care services required but not approved by MDHHS (ACP determines the need for personal care, AFC determines the cost for the personal care).

4. The beneficiary must agree to pay his excess income to his provider.

If all of the above conditions exist, income eligibility begins the month DHHS reduces or will reduce its payment for personal care services by the amount of the beneficiary’s excess income. The beneficiary’s excess income becomes his personal care co-payment.

Within two working days of determining the client is eligible under this option, notify the services specialist in writing of the MA effective date and the amount of the beneficiary’s personal care co-payment.

Income eligibility does not exist if any of the above conditions are not met. Return to the procedure that sent you to this Exhibit.

Changes in Circumstances

MA eligibility cannot continue based on this policy option if the beneficiary’s circumstances change for reasons including, but not limited to, the following:

• The beneficiary no longer needs personal care services in their home, AFC, or HA.
• The cost of personal care no longer exceeds his excess income.

• The beneficiary enters LTC.

Notify the services specialist in writing within two working days when a change(s) in the beneficiary's circumstances changes the amount of his personal care co-payment. Send a memo to the services specialist for SSI-related cases.

If the personal care co-payment decreases, use adequate notice. The begin date for the lower personal care co-payment is the first day of the month in which you make the determination.

If the personal care co-payment increases, use timely notice (see BAM 220). The begin date for the higher personal care co-payment is the first day of the month following the month in which the negative action period ends.

Do not close a case eligible under this option because the beneficiary does not pay the provider. MA funds will not be used to pay the beneficiary's liability because the beneficiary retains responsibility for that portion of his incurred expenses. The issue of payment of these expenses remains between the individual, services and the personal care services provider.

EXHIBIT III - HOSPICE CARE

A terminally ill person may receive hospice care. Hospice organizations provide or arrange for all care related to the person's terminal illness. Hospice organizations do not provide or arrange other medical services (such as dental care).

A person is eligible for hospice care under MA when all of the following are true: He knows of the illness and his life expectancy. He chooses to receive hospice services. A doctor (MD or DO) certifies he has six months or less to live.

The hospice notifies the Michigan Department of Health and Human Services (MDHHS) when an MA beneficiary enrolls. MDHHS authorizes the appropriate PET code on Bridges.

Hospice Services

Hospice services fall under five categories:
1. **Routine home care** - Non-continuous at-home care.

2. **Continuous home care** - Predominantly nursing care provided at home as short-term crisis care. May also include home health aide or homemaker services.

3. **Inpatient respite care** - Short-term inpatient care for the terminally ill individual to give the at-home caregiver relief. Inpatient respite care is usually five continuous days or less in a hospital, nursing facility, intermediate care facility or freestanding hospice facility.

4. **General inpatient care** - Usually for pain control or acute or chronic symptom management. May be provided in a hospital, nursing facility or freestanding hospice facility.

5. **Routine at-home care in a nursing facility** - Individuals who do not have a home or family member or friend who can care for them may stay in a nursing facility and receive routine home care from the hospice.

**EXHIBIT IV - MA GROUP 2 CASE EXAMPLES**

**EXAMPLE 1**

**Deductible Delayed with Old Bills**

10/15/16 - Mr. B. applies for MA. He also requests MA coverage for July, August and September 2016.

Mr. B. verifies an old bill for $315.00.

11/22/16 - Process Mr. B’s application and determine the excess income is $30.00.

Mr. B. is eligible for MA coverage for 10 months based on old bills. You set a follow-up for 3/17.

After the DHS-176 Deadline Date you send Mr. B. a DHS-176, DHS-114, DHS-114A and MSA-Pub. 617 to notify him his case will have a $30.00 monthly deductible effective 5/1/17.
4/1/17 - Any day on or before the DHS-176 Deadline Date, transfer Mr. B's case to active deductible:

EXAMPLE 2

Deductible Met with Old Bill Balance and Current Bills

5/3/16 - Mr. B. contacts you, indicating he has met his $30.00 deductible for May 2016. He drops off copies of a prescription charge for $14.71 for 5/2/16 and a doctor's office visit on 5/3/16 for $25.00. You also verify he still owes the $315.00 old bill he reported at application. $300.00 of the old bill was used to establish 10 months of initial income eligibility, leaving a $15.00 balance.

5/10/16:
- Allow the $15.00 unused old bill, $14.71 prescription and $25.00 office call.
- Calculate a new budget.
- Determine Mr. B. met his deductible on 5/3/16.

Authorize MA coverage:

Send Mr. B. a DHS-1606, DHS114 and DHS-114A. The DHS-114 notifies Mr. B. that:
- He has MA coverage for 5/3/16 - 5/31/16, and
- His monthly deductible is $30.00.

Mr. B.’s liability for 5/3/16 is less than $1.00. Therefore, Mr. B. doesn't have to pay it.

EXAMPLE 3

Deductible Met With Incurred Expenses

7/8/16 - Ms. J. submits a DHS-114A and attaches the following verification:
- Office call 7/2/16 - $35.00.
• X-rays 7/316 - $60.00.
• Prescriptions 7/5/16 - $34.93.

Ms. J.'s monthly deductible amount is $115.00.

7/12/16 - Calculate a budget on Bridges. The beneficiary is liable for $20.00 for 7/5/16.

Send the beneficiary a DHS-114 and a DHS-114A. The DHS-114 indicates Ms. J. is eligible for MA coverage for 7/5/16 through 7/31/16 but is responsible for $20.00 to the pharmacist for services rendered 7/5/16.

Send the pharmacist a copy of the notice to verify the beneficiary's $20.00 liability for services rendered 7/5/16.

Authorize MA:

EXAMPLE 4

Ongoing MA to Active Deductible

Mrs. N. has received MA coverage for five years.

10/8/16 - Mrs. N. reports additional continuing income that results in excess income of $43.00 per month.

10/11/16 - Request incurred medical expense information. Mrs. N. states that she has no old bills.

10/12/16 - Start timely negative action procedures to transfer the case from ongoing Group 2 MA to active deductible, effective 11/1/16.

Send the beneficiary a DHS-114, DHS-114A and MSA-Pub. 617. The DHS-114 informs Mrs. N. that her case is being transferred to active deductible effective 11/1/16, with a deductible amount of $43.00 per month.

EXAMPLE 5

Excess Assets

2/4/16 - Mr. M. has an active deductible case. His monthly deductible amount is $456.00. He reports $95,000 from the sale of his apartment building (previously excluded as income-producing property).
2/7/16 - Send Mr. M. adequate notice (DHS-417, Excess Assets Notice) and close the case based on excess assets.

EXAMPLE 6

Deductible Not Met in Three Months

Jodi H. has an active deductible case. Her annual renewal is due 1/17.

12/6/16 - Jodi's case appears on the 12/16 RD-093. You review the case and determine that Jodi has not met her deductible in 9/16, 10/16 and 11/16.

Bridges automatically generates a negative action notice.

EXAMPLE 7

Expenses Reported After MA Coverage Added

Mr. C. has a $55.00 deductible amount.

10/7/16 - Mr. C. reports the following allowable medical expenses:

- 10/1/16 Dentist for filling - $37.50.
- 10/6/16 Outpatient blood test - $52.00.

10/14/16 - Authorize full MA coverage effective 10/6/16 with Mr. C's liability = $17.50.

10/28/16 - Mr. C. verifies the following additional allowable medical expenses:

- 10/2/16 Specialist exam - $75.00
- 10/2/16 Prescription - $18.75

Determine that the specialist exam is unpaid. However, Mr. C. paid for the prescription.

Coverage cannot be backdated to an earlier date in 10/16. Therefore, you complete a budget on Bridges for 11/16, counting the $75.00 expense as an old bill. The paid prescription cost cannot be counted.
Mr. C. meets his deductible for 11/16, based on the $75.00 old bill. $20.00 remains as an unused old bill.

Authorize MA coverage for 11/1/16 through 11/30/16 and send Mr. C. a DHS-1606, DHS-114 and DHS-114A.

EXAMPLE 8

Changes in the Deductible Amount

Tina has a $45.00 deductible.

On 9/3/16, Tina submits the following:

- A DHS-114A, indicating a change in income for 7/16 and 8/16 due to overtime.
- Check stubs for 7/16 and 8/16. A statement of expected hours for 9/16.

On 9/6/16, calculate budgets for 7/16, 8/16 and 9/16. You determine Tina’s deductible amounts are:

- $61.00 for 7/16.
- $57.00 for 8/16.
- $42.00 for 9/16.

Send Tina a DHS-114 to notify her of her new deductible amounts for 7/16, 8/16 and 9/16.

Deductible and SLMB

Mr. A. applies for MA on 3/12/16. You process the application on 3/26/16 and determine Mr. A.:

- Is eligible for limited-coverage QMB (SLM), but
- Has $342.00 excess income for Group 2 MA.

Mr. A. submits proof of the following medical expenses:

- Doctor’s Office 3/2/16 - $200.00.
- Prescription 3/2/16 - $142.00.

Mr. A.’s expenses on 3/2/16 equal his excess income, so Group 2 MA eligibility exists starting 3/3/16.
Send Mr. A. a DHS-1606, DHS-114, DHS-114A, DHS-4660 and MSA-Pub. 617 to notify him of all of the following. He:

- Is eligible for SLMB starting 3/1/16.
- Has an active deductible case with a deductible amount of $342.00, starting 4/1/16.

Send a copy of the QMB memo to DHHS-MSA.

3/26/16, authorize MA coverage:

EXAMPLE 11

Deductible and ALMB

Mr. C. applies for MA on 3/4/16. Process the application on 3/25/16 and determine that Mr. C.:

- Has $572.00 excess income for Group 2 MA, and
- Has incurred expenses equaling his deductible on 3/3/16, and
- Would have qualified for ALMB except for his March MA eligibility.

On 3/25/16, authorize MA coverage:

Send Mr. C. a DHS-1606, DHS-114, DHS-4660, DHS-114A and MSA Pub. 617 to notify him that he:

- Is eligible for MA 3/4/16 - 3/31/16, and
- Has an active deductible case with a $572.00 deductible amount starting 4/1/16, and
- Is qualified for ALMB starting 4/1/16.

Note: You did a future month (April 2016) budget on Bridges to show Mr. C. ALMB-qualified and to get the ALMB notice.

Bridges updates the scope coverage.

LEGAL BASE

MA

42 CFR 435.831(b)-(d)
MCL 400.106, .107
DEPARTMENT POLICY

Medicaid (MA) Only

Use this item to determine post-eligibility patient-pay amounts. A post-eligibility patient-pay amount is the L/H patient’s share of the cost of LTC or hospital services.

First determine MA eligibility. Then determine the post-eligibility patient-pay amount when MA eligibility exists for L/H patients eligible under:

- A U19 Healthy Kids category.
- A Group 2 (G2U, G2C) category.
- An SSI-related Group 1 or 2 category except:
  - QDWI.
  - Only Medicare Savings Program (with no other MA coverage).

MA income eligibility and post-eligibility patient-pay amount determinations are not the same. Countable income and deductions from income often differ. Medical expenses, such as the cost of LTC, are never used to determine a post-eligibility patient-pay amount. Do not recalculate a patient-pay amount for the month of death.

PATIENT-PAY AMOUNT

The post-eligibility patient-pay amount is total income minus total need.

Total income is the client’s countable unearned income plus his remaining earned income; see Countable Income in this item.

Total need is the sum of the following when allowed by later sections of this item:

- Patient allowance.
- Home maintenance disregard.
- Community spouse income allowance.
- Family allowance.
- Children’s allowance.
- Health insurance premiums.
- Guardianship/conservator expenses.
COUNTABLE INCOME

For all persons in this item, determine countable income as follows:

- RSDI, Railroad Retirement and U.S. Civil Service and Federal Employee Retirement System.
- Non-SSI income for SSI recipients.

Use countable income per BEM 500, 501, 502, 503, 504 and 530. Deduct Medicare premiums actually withheld by:

- Including the L/H patient’s premium along with other health insurance premiums, and
- Subtracting the premium for others (example, the community spouse) from the unearned income.

**Exception:** Do **not** use the following special exclusion policies regarding RSDI. These policies only apply to eligibility, **not** post-eligibility patient-pay amounts. VA Aid and Attendance income is not excluded from the Patient Pay Calculation.

- BEM 155, 503 COUNTABLE RSDI.
- BEM 157, COUNTABLE RSDI.
- BEM 158, COUNTABLE RSDI.
- BEM 503, Countable VA PENSION.

**Note:** The benefits of clients on buy-in increase about three months after buy-in is initiated. Recompute the patient-pay amount when the client’s benefits actually change. BAM 810 has information about buy-in.

- **Earned and Other Unearned Income.**

Use BEM 500, 501, 502, 503, 504 and 530. For clients, use MAGI- or SSI-related policy as appropriate. Use SSI-related policies for all other persons.

For the **client only**, disregard $65 + 1/2 of his or her countable earned income. Earned income minus the disregard is **remaining earned income.**
PATIENT ALLOWANCE

The patient allowance for clients who are in, or are expected to be in, LTC and/or a hospital the entire L/H month is $60.

**Exception:** The patient allowance for a veteran is $90 per month.

**Note:** The VA determines who receives the Improved Pension and therefore the $90 allowance. The VA may give the Improved Pension to a widow or other member of the veteran's family, see exhibit in this item.

Use the appropriate protected income level for one from RFT 240 for clients who enter LTC and/or a hospital but are not expected to remain the entire L/H month.

**Reminder:** The patient-pay amount is not reduced or eliminated in the month the person leaves the facility.

HOME MAINTENANCE DISREGARD

Medicaid beneficiaries who will be residents of a long term care facility for less than six L/H months may request a disregard to divert income for maintenance of their home for a maximum of six months.

Beneficiaries who have been or are expected to remain in long term care for longer than six months do not meet the criteria for this disregard.

The PPA will be reduced when all of the following are true:

- A physician has certified the beneficiary is medically likely to return home in less than six months from the date of admission.
- The request is being made for an individual who is a current Medicaid beneficiary and responsible for a patient pay amount.
- The beneficiary is a current resident of a long term care facility.
- The beneficiary has a legal obligation to pay housing expenses and has provided verification of the expenses. The housing
expenses must be in the beneficiary's name. A foreclosure, eviction or bankruptcy proceedings must not have begun.

- The home is not occupied by a community spouse or children eligible for a family allowance income deduction.

- The written or verbal request is being made by the beneficiary or an individual authorized to act on behalf of the Medicaid beneficiary.

The effective date of the disregard is the first day of Medicaid eligibility as a nursing facility resident. The disregard is for a maximum of six months but may be granted multiple times if the total months do not exceed six months.

COMMUNITY SPOUSE INCOME ALLOWANCE

L/H patients can divert income to meet the needs of the community spouse. The community spouse income allowance is the maximum amount they can divert. However, L/H patients can choose to contribute less. Divert the lower of:

- The community spouse income allowance.
- The L/H patient's intended contribution; see Intent to Contribute in this item.

Compute the community spouse income allowance using steps one through five below. An L/H client can transfer income to the spouse remaining in the home even if that spouse no longer meets the definition of a community spouse because they are in a MA waiver program such as PACE, MIChoice, or others listed in the BEM manual.

That is because without the transfer of income the spouse would not be able to remain in the home and avoid also becoming an L/H client.

1. **Shelter Expenses**

   Allow shelter expenses for the couple's principal residence as long as the obligation to pay them exists in either the L/H patient's or community spouse's name.

   Include expenses for that residence even when the community spouse is away (for example, in an adult foster care home). An
adult foster care home or home for the aged is not considered a principal residence.

**Shelter expenses** are the total of the following monthly costs:

- Land contract or mortgage payment, including principal and interest.
- Home equity line of credit or second mortgage.
- Rent.
- Property taxes.
- Assessments.
- Homeowner's insurance.
- Renter's insurance.
- Maintenance charge for condominium or cooperative.

Also add the appropriate heat and utility allowance if there is an obligation to pay for heat and/or utilities. The heat and utility allowance for a month is $617.25.

Convert all expenses to a monthly amount for budgeting purposes.

2. **Excess shelter allowance.**

Subtract the appropriate shelter standard from the shelter expenses determined in step one. The shelter standard for a month is $634.25.

The result is the **excess shelter allowance**.

3. **Total allowance.**

Add the excess shelter allowance to the appropriate basic allowance. The basic allowance for a month is $2113.75. The result, up to the appropriate maximum, is the **total allowance**. The maximum allowance for a month is $3160.50.

**Exception:** In hearings, administrative law judges can **increase** the total allowance to divert more income to an L/H patient's community spouse; see BAM 600.
4. **Countable income.**

Determine the community spouse’s countable income; see **COUNTABLE INCOME** in this policy.

5. **Community spouse income allowance.**

Subtract the community spouse’s countable income from the total allowance. The result is the **community spouse income allowance**.

**Exception:** Use court-ordered support as the community spouse income allowance if:

- The L/H patient was ordered by the court to pay support to the community spouse, **and**
- The court-ordered amount is **greater** than the result of step five.

### Intent to Contribute

**DHS-4592, Intent to Contribute Income:**

- Determines the amount of income an L/H patient intends to contribute to his community spouse.
- Instructs the L/H patient to report how much income he intends to make available.
- Should be returned within 10 days.

If the DHS-4592 is **not** returned within 10 days:

- Do **not** delay case actions, and
- Budget the entire community spouse income allowance.

The entire allowance will be budgeted **until** the DHS-4592 is returned indicating the L/H patient intends to contribute **less**.

When the DHS-4592 indicating an intent to contribute **less** income is received:

- **Decrease** the income diverted to the community spouse to the indicated amount.
- Do **not increase** the income diverted to the community spouse without a new DHS-4592.

- **Decrease** the income diverted if:
  - The community spouse's circumstances change, **and**
  - The change reduces the community spouse income allowance **below** the amount indicated on the DHS-4592.

- Use timely negative action procedures to increase the patient-pay amount.

Do **not** use amounts from previous DHS-4592s when diverting income again after stopping a diversion for one of these reasons:

- An L/H patient is discharged to a non-L/H setting for 30 or more days.

- An L/H patient's ongoing Medicaid case (including active deductible) terminates.

- An L/H patient's spouse is hospitalized or in LTC for 30 or more consecutive days.

Start the diversion process from the beginning.

**FAMILY ALLOWANCE**

An L/H patient's income is diverted to meet the needs of certain family members. The amount diverted is called the **family allowance**.

**Family members** must:

- Live with the community spouse, **and**

- Be **either** spouse's:
  - Married and unmarried children under age 21.
  - Married and unmarried children age 21 and over if they are claimed as dependents on either spouse's federal tax return.
  - Siblings and parents if they are claimed as dependents on either spouse's federal tax return.
The **basic allowance** for each dependent is the monthly amount minus the dependent's countable income, divided by 3. The monthly amount is $2030.

The **family allowance** is the sum of the dependents' basic allowances.

**CHILDREN’S ALLOWANCE**

L/H patients without a community spouse can divert income to their unmarried children at home who:

- Are under age 18, and
- Do not receive FIP or SSI.

The amount diverted is called the **children’s allowance**. It is the children’s protected income level from RFT 240 minus their net income. **Net income** is:

- 80 percent of countable earned income, plus
- Countable unearned income.

Do not divert income if information concerning the children’s income is not provided.

**HEALTH INSURANCE PREMIUMS**

Include as a need item the cost of any health insurance premiums (including vision and dental insurance) the L/H patient pays for another member of their fiscal group, regardless of who the coverage is for. This includes Medicare premiums that a client pays. See Bridges Glossary for the definition of health insurance.

**Example:** L/H patient pays health insurance premiums for two (self and spouse). Allow health insurance premiums for two.

Do not include premiums paid by someone other than the L/H patient as a need item. If the community spouse pays their own premium it is included in the CSIA budget. Verify who pays the premium if questionable.

Convert the cost of all premiums to a monthly amount for budgeting purposes.
Note: Allow the $5 deduction paid by GM retirees which includes LTC insurance coverage as an insurance expense deduction.

GUARDIANSHIP/CONSERVATOR EXPENSES

Allow $83 per month when an L/H patient pays for his court-appointed guardian and/or conservator.

Guardianship/conservator expenses must be verified and include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

DHS-3227, TENTATIVE PATIENT-PAY AMOUNT NOTICE

Send a DHS-3227, Tentative Patient-Pay Amount Notice, within five working days of application when:

- The applicant is in LTC, and
- A final determination will not be made within five working days from date of application.

Send the DHS-3227 to the client and the LTC facility.

NOTIFICATION

Notify both L/H patients and their community spouses in writing of:

- Their hearing rights, and
- The amount of and method for computing the:
  - Community spouse income allowance, and
  - Family allowance.

Provide notice when:

- First calculating community spouse income or family allowance.
- The amount of either allowance changes.
- L/H patients, their community spouses, or representatives of either spouse request it.
Use the following forms to provide notice:

- DHS-4587, Community Spouse and Family Income Allowance Notice.
- DHS-4584, Community Spouse and Family Income Allowance Record.

Send a DHS-4592, Intent to Contribute Income, when the community spouse income allowance is greater than zero.

PATIENT PAY OFFSETS

Long-term care (LTC) facilities may deduct the following from a person's patient-pay amount:

- The cost of certain medically necessary services not covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers, and
- The MA co-payments for covered services.

The remainder of the patient-pay amount is then applied to the cost of care provided by the LTC facility. The Department of Health and Human Services determines whether an offset is allowable.

Patient-pay amounts are not offset by local office staff.

**Note:** If an LTC applicant requests an offset of the patient pay to cover old medical bills see PEME in glossary and in this policy. Assist the applicant by forwarding the unpaid bills to:

Medical Services Administration  
Michigan Department of Health and Human Services  
P.O. Box 30479  
Lansing, MI 48909-9634  
Attn: PEME

**MSA will determine whether an offset is allowable.**

PEME

Pre-Eligibility Medical Expenses (PEMEs) are unpaid medical expenses incurred in the three months prior to the application for Medicaid.
The offset of the PPA is only allowed if the money is used to pay the provider(s) for the incurred medical expense and will be terminated if the recipient fails to pay the provider.

Offsets will be applied to the months following an approval. In general the allowable expenses are the same as allowed for a group 2 deductible case.

In addition the medical expense(s): Must be unpaid, and an obligation still exists to pay.

- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third-party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient-pay amount.
- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Must be reported prior to the first Long Term Care Medicaid redetermination following the initial Long Term Care eligibility.

**Note:** MSA will terminate offsets if there is a failure to pay the medical provider with the funds.

**VERIFICATION REQUIREMENTS**

Verify income per BEM 500, 501, 502, 503, 504.

Clients must verify the following before the cost can be used to determine excess shelter:

- Shelter obligation and amount.
- Heat and utility obligation but **not** amount.

These must be verified at application, redetermination or change.

Verify the cost of health insurance premiums before allowing the expense at application, redetermination or change.
Verification Sources

Shelter Obligation and Amount:

- Mortgage or rental contracts.
- Statement from mortgage company, bank or landlord.
- Tax or assessment bill or a collateral contact with the appropriate government department.
- Insurance policy, receipt or bill for premium or collateral contact with the insurance company.

Heat and Utility Obligation:

- Current bill or receipt or a written statement from the heat/utility provider.
- Collateral contact with the heat/utility provider.

Home Maintenance Disregard:

- Physician statement signed by a M.D. or D.O.

Health Insurance Premiums:

- Insurance policy (not an application for insurance).
- Receipt or bill for premium.
- Contact with insurer.

Guardian/Conservator Expenses:

- Court Documents.

EXHIBIT - VA NOTICE

This is a portion of an April 1991 letter announcing reduced VA benefits. Key wording is highlighted.

You have been a patient in a Medicaid-approved nursing home and covered by a Medicaid plan for services since (Date). Because you have no dependents and are receiving Improved Pension, the law requires that we limit your pension to $90.00 monthly while you are receiving this type of care.

For that reason, we propose to reduce your benefits from (Date). No overpayment will be created.
This $90.00 monthly payment is for your incidental needs, such as toilet articles, snacks, etc. and no part of this payment should be used by Medicaid to cover your medical expenses. You should notify your state Medicaid office that your Improved Pension is being reduced.

LEGAL BASE

MA

Social Security Act, Section 1924
42 CFR 435.725,.726 and.832
DEPARTMENT POLICY

This item applies **only** to Food Assistance Program (FAP).

Bridges uses certain expenses to determine net income for FAP eligibility and benefit levels.

- For groups with **no** senior/disabled/disabled veteran (SDV) member, Bridges uses the following:
  - Dependent care expense.
  - Excess shelter up to the maximum in Reference Tables Manual (RFT) 255.
  - Court ordered child support and arrearages paid to non-household members.

- For groups **with** one or more SDV member, Bridges uses the following; see Bridges Eligibility Manual (BEM) 550:
  - Dependent care expense.
  - Excess shelter.
  - Court ordered child support and arrearages paid to non-household members.
  - Medical expenses for the SDV member(s) that exceed $35.

Complete either a manually-calculated or Bridges budget to document expenses every time an expense change is reported.

ALLOWABLE EXPENSES

An expense is allowed if all of the following:

- The service is provided by someone outside of the FAP group.
- Someone in the FAP group has the responsibility to pay for the service in money.
- Verification is provided, if required.
Responsibility to Pay

Responsibility to pay means that the expense is in the name of a person in the FAP group.

**Exception:** If the expense is in someone else’s name, allow the expense if the FAP group claims the expense and the service address on the bill is where they live.

Do not allow any expense if the entire expense is directly paid by an agency or someone outside of the group.

An expense that is fully reimbursed is not allowed; see BEM 500, Reimbursements.

If an expense is partially reimbursed or paid by an agency or someone outside of the FAP group, allow only the amount that the group is responsible to pay, unless specific policy directs otherwise.

**Example:** HUD pays $150 toward a FAP group’s $325 rental expense. Allow only the $175 ($325 rent - $150 HUD pays = $175) that the group is expected to pay.

**Shared Expenses**

Allow only the FAP group’s portion of child support, medical or dependent care expenses if another person outside of the FAP group is jointly responsible. If the FAP group’s share can be identified, allow that portion. Otherwise, the expense is evenly prorated among the groups responsible for it and the FAP group’s prorated share is allowed.

**Note:** Shelter, the heat and utility standard and the individual utility standards are never prorated, even if the expense is shared. Refer to the following sections found in this item:

- Shelter expenses.
- Mandatory heat and utility standard.
- Mandatory individual standards.

**Member Removal**

The expenses of a FAP member who is no longer living with the group are removed when the member removal is processed.
Verification

The Michigan Department of Health and Human Services (MDHHS) must verify the responsibility to pay and the amount of certain expenses; see the individual expense policy for verification requirements. Document verification used in the case record.

Do not budget expenses that require verification until the verification is provided. Determine eligibility and the benefit level without an expense requiring verification if it cannot be verified.

Note: Do not include a medical expense that might be covered by a reimbursement if the amount of the reimbursement cannot be verified.

Treat subsequently provided verification from an eligible FAP group as a change. A supplement for lost benefits is issued only if the expense could not be verified within 30 days of the application and the local office was at fault.

BUDGETING EXPENSES

Budget Month

Expenses are used from the same calendar month as the month for which benefits are being determined.

Example: June expenses are used to determine June’s benefits.

Expenses remain unchanged until the FAP group reports a change; see Bridges Administrative Manual (BAM) 220, Change Processing.

Determining the Monthly Amount

Bridges converts all expenses (except one-time-only expenses the group does not wish to average) to a nonfluctuating monthly amount.

The same conversion method is used to determine countable available income in BEM 505. Bridges will convert a(n):

- Weekly expense, multiply the average weekly expense by 4.3.
- Twice a month expense, multiply the average weekly expense by 2.
• Every other week expense, multiply the average expense by 2.15.

• Yearly expense, average the bill over 12 months beginning with the first billing of the year.

• Quarterly expense, average the bill over three months.

• Expense billed less often than monthly. Bridges will average the one-time-only expense over the balance of the benefit period or over the period of time the client has the responsibility to pay. The expense is allowed beginning with the first benefit month the change can affect.

Example: Groups that have 24-month benefit periods must be given options for one-time-only medical expenses; see Medical Expenses in this item.

Home Equity Loan Expense

To determine the countable monthly expenses for a home equity loan, use either:

• The entire amount (principal and interest) for a fixed, non-fluctuating home equity loan.

• The average of two or more recent month’s payments (principal and interest) for a variable home equity loan payment, unless the FAP group states the payment amount is different for the benefit month being determined.

Document in the case record or in Bridges what months were used and why they were representative.

Non-Converted Expenses

Expenses that will not continue beyond the month following the benefit month being processed are not converted.

Budget non-converted expenses for the month they are billed or otherwise become due, regardless of when the FAP group intends to pay the expense.

Non-converted expenses are budgeted for one benefit month only.
Expenses for Disqualified or Ineligible Persons

The treatment of expenses paid by or billed to ineligible or disqualified persons differs depending on the reason the person is not in the group.

Determine the appropriate month’s expenses for a disqualified or ineligible person as if he were a member of the FAP group.

*Student Status*

Expenses for which the ineligible student is responsible are not budgeted.

*Employment Related Activities, IPV, Trafficking, Parole or Probation Violation or Divestment*

Budget total expenses, including medical expenses of a senior, disabled, disabled veteran (SDV) disqualified person. Allow unlimited excess shelter even if the only SDV member is the disqualified person.

*Social Security Enumeration, Citizenship/Alien Status, Child Support Non-Cooperation or Time Limited*

Shelter expenses, the mandatory heat and utility standard, mandatory individual standards and actual utility expenses are never prorated. However, only a prorated portion for dependent care expenses and child support expenses is allowed.

To determine the prorated amount to allow:

1. Divide the expense evenly by the number of group members, including the disqualified person(s) living with the FAP group.

2. Multiply the result by the number of eligible group members.

**Example:** One person in the group is disqualified with a child support expense of $200.00 per month. The total group size is 4. Bridges divides $200.00 by 4 which equals $50.00. It then multiplies $50.00 by 3 eligible group members which equals $150.00 and allows a child support expense of $150.00.

Bridges does **not** allow:

- Medical expenses for SDV disqualified persons.
CHILD SUPPORT EXPENSES

The following child support expenses are allowed:

- Unlimited excess shelter if the only SDV member is disqualified.
- The amount of court-ordered child support and arrearages paid by the household members to non-household members in the benefit month.
- Court-ordered third party payments (landlord or utility company) on behalf of a non-household member.
- Legally obligated child support paid to an individual or agency outside the household, for a child who is now a household member, provided the payments are not returned to the household.

Do not allow more than the legal obligation if the client is up-to-date on their child support payments. However, if they are behind and making arrearage payments, allow the total amount paid even if it exceeds the court-ordered amount. Current and arrearage child support expenses must be paid to be allowed.

Verification

Verify child support expenses and arrearages paid to non-household members at application, redetermination and when a change is reported. All of the following must be verified:

1. The household’s legal obligation to pay.
2. The monthly amount of the obligation for current child support.
3. The amount of child support the household actually pays.

Current payments must be entered separately from arrearage payments on Bridges. A separate arrearage order is not needed to allow arrearage payments. If MDHHS verifies child support payments are court ordered, the original court order also serves as verification of the arrearage.

Verification Sources

Acceptable verification sources include, but are not limited to:
- For the household’s legal obligation to pay and current obligation amount:
  - Court or administrative order.
  - Legally enforceable separation agreement.

- For the household’s actual child support and arrearages paid:
  - Wage withholding statements.
  - Verification of withholding from unemployment compensation or other unearned income.
  - Statements from the custodial parent regarding direct payments.
  - Statements from the custodial parent regarding third party payments the noncustodial parent pays or expects to pay on behalf of the custodial parent.
  - Data obtained from the state’s Child Support Enforcement System (MICSES).

**Note:** Documents that are accepted as verification of the household’s legal obligation to pay child support and arrearages are **not** acceptable as verification of the household’s actual monthly payment.

### DEPENDENT CARE EXPENSES

Allow an **unreimbursed** dependent care expense for a child under the age of 18 or an adult of any age who is incapacitated and a member of the FAP group, when such care is necessary to enable a member of the FAP group to work. This is the amount the FAP group actually pays out-of-pocket. The expense does **not** have to be paid to be allowed. Allow only the amount the provider expects the client to pay out-of-pocket. Work includes seeking, accepting or continuing employment; or training or education preparatory to employment.

**Note:** Unreimbursed dependent care expenses may also include:

- Activity fees associated with the care provided to the dependent such as taking an art class for an after-school program, an adult day care program, or additional equipment fees charged for attending a sports camp.
• Cost of transportation to and from dependent care facilities incurred by the household.
  • Use cents-per-mile to determine the transportation expense.
  • Go to the Michigan Department of Management and Budget at www.michigan.gov/dtmb, select Services & Facilities from the left navigation menu, then select Travel. On the travel page, choose the Premium Mileage Rate for the current year.

**Case Management Tip:** Be especially careful in following the above dependent care expense budgeting policy if the client’s dependent care is reimbursed by the Child Development and Care program (CDC) or another agency or person.

**Verification**

Verify dependent care expenses at application, reported change and redetermination.

**Verification Sources**

Acceptable verification sources include, but are not limited to:

• Bills or written statement or collateral contact with the provider for the dependent care expenses including activity fees.

• Written statement from the client on the number of miles from home to the facility and use the same miles from the facility to home.

**MEDICAL EXPENSES**

**Application and Redetermination**

Consider **only** the medical expenses of SDV persons in the eligible group or SDV persons disqualified for certain reasons; see Expenses for Disqualified or Ineligible Persons in this item. Estimate an SDV person’s medical expenses for the benefit period. Base the estimate on all of the following:

• Verified allowable medical expenses.
• Available information about the SDV member’s medical condition and health insurance.

• Changes that can reasonably be anticipated to occur during the benefit period.

During the Benefit Period

A FAP group is not required to, but may voluntarily report changes during the benefit period. Process changes during the benefit period only if they are one of the following:

• Voluntarily reported and verified during the benefit period such as expenses reported and verified for MA deductible.

• Reported by another source and there is sufficient information and verification to determine the allowable amount without contacting the FAP group.

One-Time-Only Expenses

Groups that do not have a 24-month benefit period may choose to budget a one-time-only medical expense for one month or average it over the balance of the benefit period. Bridges will allow the expense in the first benefit month the change can affect.

Exception: Groups that have 24-month benefit periods must be given the following options for one-time-only medical expenses billed or due within the first 12 months of the benefit period:

1. Budget it for one month.

2. Average it over the remainder of the first 12 months of the benefit period.

3. Average it over the remainder of the 24-month benefit period.

Example: Sally has a $1,200 emergency room bill in 11/08. It is not covered by Medicaid or any medical insurance and she received the first bill for this service in 1/09. Her FAP benefit period is 10/1/08 through 9/30/10. She can elect to use:

• The entire $1,200 deduction to affect 2/09 benefits. This would probably increase her FAP to the maximum amount for that one month.

• $150 per month ($1,200 bill divided by 8 months remaining in the first 12 months of her benefit period) to affect 2/09 through
9/09. This would probably increase her FAP benefits by $50 per month for eight months.

- $60 per month ($1,200 bill divided by 20 months remaining in the benefit period) to affect 2/09 through 9/10. This would probably increase her FAP benefits by $20 for 20 months. (If she were within $20 of the maximum, this option would benefit her the most.)

Allowable Medical Expenses

Allowable medical expenses are limited to the following:

- Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional.

- Hospitalization or nursing care. Include these expenses for a person who was a group member immediately prior to entering a hospital or nursing home.

- Prescription drugs and the postage for mail-ordered prescriptions.

- Costs of medical supplies, sickroom equipment (including rental) or other prescribed medical equipment (excluding the cost for special diets).

- Over-the-counter medication (including insulin) and other health-related supplies (bandages, sterile gauze, incontinence pads, etc.) when recommended by a licensed health professional.

- Premiums for health and hospitalization policies (excluding the cost of income maintenance type health policies and accident policies, also known as assurances). If the policy covers more than one person, allow a prorated amount for the SDV person(s).

- Medicare premiums.

- Dentures, hearing aids and prosthetics including the cost of securing and maintaining a seeing eye or hearing dog or other assistance animal. (Animal food and veterinary expenses are included.)
- Eyeglasses when prescribed by an ophthalmologist (physician-eye specialist) or optometrist.

- Actual costs of transportation and lodging necessary to secure medical treatment or services. If actual costs cannot be determined for transportation, allow the cents-per-mile amount at the standard mileage rate for a privately owned vehicle in lieu of an available state vehicle. To find the cents-per-mile amount go to the Michigan Department of Management and Budget at www.michigan.gov/dtmb, select Services & Facilities from the left navigation menu, then select Travel. On the travel page, choose Travel Rates and High Cost Cities using the rate for the current year.

- The cost of employing an attendant, homemaker, home health aide, housekeeper, home help provider, or child care provider due to age, infirmity or illness. This cost must include an amount equal to the maximum FAP benefits for one person if the FAP group provides the majority of the attendant’s meals. If this attendant care cost could qualify as both a medical expense and a dependent care expense, it must be treated as a medical expense.

- A Medicaid deductible is allowed if the following are true.

  • The medical expenses used to meet the Medicaid deductible are allowable FAP expenses.

  • The medical expenses are not overdue. See below.

**Note:** Medical marijuana is not an allowable medical expense.

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**Estimating and Determining an Allowable Medical Expense**

Estimate an SDV person’s medical expenses for the benefit period. The expense does not have to be paid to be allowed. Allow medical expenses when verification of the portion paid, or to be paid by insurance, Medicare, Medicaid, etc. is provided. Allow only the non-reimbursable portion of a medical expense. The medical bill cannot be overdue.

The medical bill is not overdue if one of the following conditions exists:
- Currently incurred (for example, in the same month, ongoing, etc.).

- Currently billed (client is receiving the bill for the first time for a medical expense provided earlier and the bill is not overdue).

- Client made a payment arrangement before the medical bill became overdue.

**VERIFICATION**

Verify allowable medical expenses including the amount of reimbursement, at initial application and redetermination. Verify reported changes in the source or amount of medical expenses if the change would result in an increase in benefits.

Do not verify other factors, unless questionable. Other factors include things like the allowability of the service or the eligibility of the person incurring the cost.

**VERIFICATION SOURCES**

Acceptable verification sources include, but are not limited to:

- Current bills or written statement from the provider, which show all amounts paid by, or to be paid by, insurance, Medicare or Medicaid.

- Insurance, Medicare or Medicaid statements which show charges incurred and the amount paid, or to be paid, by the insurer.

- DHS-54A, Medical Needs, completed by a licensed health care professional.

- SOLQ for Medicare premiums.

- Written statements from licensed health care professionals.

- Collateral contact with the provider. (Most commonly used to determine cost of dog food, over-the-counter medication and health-related supplies, and ongoing medical transportation).
SHELTER EXPENSES

Allow a shelter expense when the FAP group has a shelter expense or contributes to the shelter expense. Do not prorate the shelter expense even if the expense is shared. Shelter expenses are allowed when billed. The expenses do not have to be paid to be allowed.

Late fees and/or penalties incurred for shelter expenses are not an allowable expense.

Note: When a shelter expense is paid in advance, continue to allow the ongoing monthly shelter expense. Example: A client’s monthly shelter expense is $300. They pay $900 to the landlord to cover the months of April-June. Continue to allow the monthly shelter obligation of $300 in the FAP budgets for April-June.

Housing Expenses

Housing expenses include rent, mortgage, a second mortgage, home equity loan, required condo or maintenance fees, lot rental or other payments including interest leading to ownership of the shelter occupied by the FAP group.

The expense must be a continuing one. Payments that exceed the normal monthly obligation are not deductible as a shelter expense unless the payment is necessary to prevent eviction or foreclosure, and it has not been allowed in a previous FAP budget. Additional expenses for optional charges, such as carports, pets, etc. are not allowed.

Note: Some finance companies or banks may combine billings for allowable shelter expenses with other loans. Be careful to only allow the portion that is an allowable shelter expense. Home equity loans are allowable, see Determining the Monthly Amount, Home Equity Loan Expense in this item.

Temporary Housing

If FIP or SDA shelter vendor payments are made on behalf of a FAP group residing in temporary housing per BEM 500, Government Aid section, subtract the vendor payment from the total shelter amount to determine the allowable shelter expense.
**Rental Income Situations**

Do not deduct the cost of doing business from the shelter expense of a FAP group with rental income.

**Property Taxes, Assessments and Insurance**

Property taxes, state and local assessments and insurance on the structure are allowable expenses. Do not allow insurance costs for the contents of the structure, for example, furniture, clothing and personal belongings.

Deduct the entire insurance charge for structure and contents when the amount for the structure cannot be determined separately.

Renter's insurance is not allowed.

**Home Repair Expenses**

Allow charges for repair of a home which was substantially damaged or destroyed due to a natural disaster such as fire or flood.

**Note:** Do not allow any portion of an expense that has been or will be reimbursed by any source.

**Verification**

Verify shelter expenses at application and when a change is reported. If the client fails to verify a reported change in shelter, remove the old expense until the new expense is verified.

Verify the expense and the amount for housing expenses, property taxes, assessments, insurance and home repairs.

**Verification Sources**

Acceptable verification sources include, but are not limited to:

- Mortgage, rental or condo maintenance fees contracts or a statement from the landlord, bank or mortgage company.
- Copy of tax, insurance, assessment bills or a collateral contact with the appropriate government or insurance office.
• Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address if verifying shelter, the provider of the service and the name of the person paying the expense.

• DHS-3688, Shelter Verification form. A copy of this form will be sent to the FAP group and a task and reminder sent to the specialist when a change of address is done in Bridges. The due date will be on the form. The specialist must monitor for return of the form and take appropriate action if it is or is not returned.

• Current lease.

MANDATORY HEAT AND UTILITY STANDARD

The heat/utility (h/u) standard covers all heat and utility costs including cooling, except actual utility expenses, for example, installation fees etc.; see Actual Utilities in this item. Do not prorate the h/u standard even if the heating/cooling expense is shared.

FAP groups that qualify for the h/u standard do not receive any other individual utility standards. Do not require verification of the other utility standards if the household is already eligible for the h/u standard.

Note: FAP groups whose heat is included in their rent may still qualify for the h/u standard. Some additional ways include but are not limited to, receipt of the Home Heating Credit (HHC) or a Low Income Home Energy Assistance Payment (LIHEAP). The amount of either payment must be greater than $20 in the month of application or in the immediately preceding 12 months prior to the application month.

Heating Separate from Housing Costs

A FAP group which has a heating expense or contributes to the heating expense separate from rent, mortgage or condominium/maintenance payments must use the h/u standard.

Note: Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero,
are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

**Heat Verification**

Verify heating separate from housing costs at application or when a change is reported.

**Exception:** For groups that have verified that they own or are purchasing the home that they occupy, verify the heat obligation only if questionable.

**Heat Verification Sources**

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for heating/cooling expenses.
- Collateral contact with the landlord or the heating/cooling provider.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
- DHS-3688, Shelter Verification.
- Current lease.

**Cooling Separate from Housing Costs**

FAP groups who pay for cooling (including room air conditioners) are eligible for the h/u standard if they verify they have the responsibility to pay for non-heat electric.

**Note:** Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to
receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Verification

Verify non-heat electric at application or when a change is reported.

**Verification Sources**

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for electric expenses.

- Collateral contact with the electric provider.

- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

- DHS-3688, Shelter Verification.

- Current lease.

**Heat Included in Rent or Fees**

FAP groups whose heat is *included* in their rent or fees are not eligible for the h/u standard, *unless* they are billed for excess heat payments from their landlord.

**Note:** Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

**Verification**

Verify the excess heat expense at application or when a change is reported. Client statement is no longer acceptable; verification is required.
**Verification Sources**

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the landlord for excess heat expenses.
- Collateral contact with the landlord.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

**Home Heating Credit (HHC)**

**New Applications**

FAP groups who have received a HHC in an amount greater than $20 in the application month or in the immediately preceding 12 months prior to the application month are eligible for the h/u standard.

**Existing FAP Groups**

FAP groups who are at redetermination and have received a HHC in an amount greater than $20 in the certification month or in the immediately preceding 12 months prior to the certification month are eligible for the h/u standard.

**Note:** Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

**Verification**

Verify receipt of HHC at application, redetermination or when a change is reported.

**Verification Sources**

Acceptable verification sources include, but are not limited to:
Low Income Home Energy Assistance Payment (LIHEAP)

**New Applications**

FAP groups who have received a LIHEAP payment or a LIHEAP payment was made on their behalf in an amount greater than $20 in the application month or in the immediately preceding 12 months prior to the application month are eligible for the h/u standard.

**Existing FAP Groups**

FAP groups who are at redetermination and have received a LIHEAP payment or a LIHEAP payment was made on their behalf in an amount greater than $20 in the certification month or in the immediately preceding 12 months prior to the certification month are eligible for the h/u standard.

**Note:** LIHEAP payments may include State Emergency Relief (SER) energy related payments or Michigan Energy Assistance Program (MEAP) payments. Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

**Verification**

Verify receipt of a LIHEAP payment at application, redetermination or when a change is reported.

**Verification Sources**

Acceptable verification sources include, but are not limited to:

- Bridges inquiry. (HHC Approved Client Inquiry).
- Letter from provider.
- Collateral contact with provider.
- Copy of HHC warrant.
Electricity Included in Rent or Fees

FAP groups whose electricity is included in their rent or fees are not eligible for the h/u standard unless their landlord bills them separately for excess cooling.

Verification

Verify separate excess cooling expense at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- A written statement from the landlord for separate cooling expense.
- Collateral contact with the landlord.

Shared Meters or Expenses

If the FAP group has any responsibility for the heating/cooling expense, use the h/u standard.

Verification

Verify the heating/cooling expense at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the landlord.
- Collateral contact with the landlord.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
MANDATORY
INDIVIDUAL
STANDARDS

FAP groups not eligible for the h/u standard who have other utility expenses or contribute to the cost of other utility expenses are eligible for the individual utility standards. Use the individual standard for each utility the FAP group has responsibility to pay. Do **not** prorate the utility standard even if the expense is shared.

**Non-Heat Electric Standard**

A FAP group which has no heating/cooling expense but has a responsibility to pay for non-heat electricity separate from rent/mortgage or condo/maintenance fees must use the non-heat electric standard. The standard covers **only** non-heat electric.

**Verification**

Verify non-heat electric expense at application or when a change is reported.

**Verification Sources**

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for electric expenses.
- Collateral contact with the electric provider.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
- DHS-3688, Shelter Verification.
- Current lease.

**Water and/or Sewer Standard**

A FAP group which has no heating/cooling expense but has a responsibility to pay for water and/or sewer separate from
rent/mortgage or condo fees, must use the water and/or sewer standard. The standard covers only water and/or sewer expenses.

Verification

Do not verify the water or sewer expense, unless questionable; see BAM 130 regarding verification of questionable data.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for water or sewer expenses.
- Collateral contact with the water or sewer provider.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Telephone Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for a traditional land-line service, cellular phone service including per-minute or per-call service and voice over Internet protocol (VoIP) must use the telephone standard. The standard covers only the telephone expense.

Verification

Do not verify the telephone expense, unless questionable; see BAM 130 regarding verification of questionable data.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the telephone provider.
- Collateral contact with the telephone provider.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
Cooking Fuel Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for cooking fuel separate from rent/mortgage or condo fees must use the cooking fuel standard. The standard covers **only** cooking fuel expenses.

** Verification **

Do not verify the cooking fuel expense, unless questionable; see BAM 130 regarding verification of questionable data.

** Verification Sources **

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for cooking fuel expenses.
- Collateral contact with the cooking fuel provider.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Trash Removal Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for trash or garbage removal separate from rent/mortgage or condo fees must use the trash removal standard. The standard covers **only** trash removal.

** Verification **

Do not verify the trash or garbage removal expense, unless questionable; see BAM 130 regarding verification of questionable data.

** Verification Sources **

If the trash or garbage removal expense is questionable, acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for trash removal.
Collateral contact with the trash removal provider.

Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

**ACTUAL UTILITIES**

Actual utility expenses will be used for the following expenses only:

- Utility installation charges (not deposits).
- Water well installation and maintenance.
- Septic installation and maintenance.

**Note:** Do not allow an actual utility expense for reconnection fees after service has been turned off for the same people at the same address.

**Verification**

Verify the actual expense.

**Verification Sources**

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider.
- Collateral contact with the provider.
- Cancelled checks, receipts or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

**SHELTER COSTS FOR UNOCCUPIED HOME**

Allow shelter costs for a home temporarily unoccupied by the FAP group due to:

- Employment or training away from home.
- Illness.
- Abandonment caused by a natural disaster or casualty loss.
Include shelter costs for a temporarily unoccupied home, provided all of the following are true:

- The FAP group intends to return to the home.
- The current occupants of the home, if any, are **not** claiming shelter costs on that home for FAP purposes.
- The home is **not** being leased or rented to others during the FAP group’s absence.

**Allowable Expenses**

Allow the following expenses:

- Basic shelter expenses as described above.
- Heat and Utility Standard, or individual utility standards.
- Utility installation fees charged by the utility provider, excluding deposits.
- Well/septic installation and maintenance.

*Exception:* Heat and utility expenses may only be claimed for one home.

**Verification**

The FAP group **must** verify these expenses for a deduction to be allowed. MDHHS is not required to assist FAP groups in obtaining verification of shelter costs for an unoccupied home in another county or state.
### FAP ALLOWABLE EXPENSES - DESK AID

| Ineligible student has expense? | If no, go to the next section.  
|                               | If yes, do not allow the expense. |
| Disqualified due to:           | If no, go to the next section.  
| • Lack of SSN, alien status.   | If yes, allow full shelter, heat and utility expenses.  
| • Time limited, child support. | **Note:** Prorate other expenses, such as child support and dependent care expenses, between the household members. Allow the prorated portion designated for the eligible group members.
| Has expense?                  | If no, go to the next section.  
|                               | If yes, allow full expense. |
| Disqualified due to:           | If no, go to the next section.  
| • IPV.                        | If yes, allow full expense. |
| • Employment related.         |                                |
| • Divestment.                 |                                |
| Has expense?                  | If no, go to the next section.  
|                               | If yes, allow only the portion of the rent for which the client is responsible. |
| Receives subsidized housing?  | If no, go to the next section.  
|                               | If yes, allow only the portion of the rent for which the client is responsible. |
| Verifications.                | **Required** at application and reported change.  
|                               | **Acceptable verifications:**  
|                               | • DHS-3688.  
|                               | • Current lease.  
|                               | • Rent receipt.  
|                               | • Collateral contact with the landlord.  
|                               | • Statement from HUD.  
|                               | **Note:** These types of verifications must identify the client and the client’s address and obligations. |
| Housing/rent responsibility?  | If no, do not allow an expense. Go to the next section.  
|                               | If yes, allow the full expense.  
|                               | Do not allow late fees, penalties or one-time deposits. |
| Verifications. | **Required** at application and reported change. **Acceptable verifications:**  
- DHS-3688.  
- Current lease.  
- Rent receipt  
- Collateral contact with landlord.  
**Note:** These types of verifications must identify the client’s address and obligations. |
|---|---|
| Purchasing home or ownership responsibility? | If no, do not allow an expense. Go to the next section. If yes, allow the full expense.  
**Note:**  
1. Allow taxes, insurance, required maintenance and condo fees the client is responsible for that are not included in the mortgage payment.  
2. Do not allow late fees or penalties. |
| Verifications. | **Required** at application and reported change. **Acceptable verifications:**  
- DHS-3688.  
- Land contract.  
- Tax bills.  
- Insurance bills.  
- Mortgage papers.  
- Assessment bills.  
- Collateral contact.  
**Note:** These types of verifications must identify the client’s address and obligations. |
| Responsible for heating expenses separate from mortgage/rent/fees? | If no, do not allow the heat and utility (h/u) standard. Go to the next section. If yes, allow the h/u standard, which includes all the individual utility standards. |

Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.
Heat Verifications.

At application and reported change, enter the appropriate verification source, if available.

**Acceptable verifications:**
- DHS-3688.
- Current lease.
- Current bill that identifies the expense.
- Collateral contact with the landlord or provider.

**Note:**
1. Verify the heat obligation only if questionable for groups that have verified that they own or are purchasing the home they occupy.
2. If the heating bill is in someone else’s name, allow the expense if the client claims the expense and the service address on the bill is where the FAP group lives.

Responsible for cooling expenses separate from rent/fees?

If no, do not allow the h/u standard. Go to the next section.
If yes, allow the h/u standard, which includes all the individual utility standards if the client verifies they have a non-heat electric expense.

Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Cooling Verifications

Enter the appropriate verification source, if available.

**Acceptable verifications:**
- DHS-3688.
- Current lease.
- Current bill that identifies the expense for the FAP group.
- Collateral contact with the landlord or provider.

**Note:** If the non-heat electric bill is in someone else’s name, allow the expense if the client claims the expense and the service address on the bill is where the FAP group lives.

Heat included in rent/fees, but responsible for:

- Excess heat costs.

If no, do not allow the heat and utility standard. Go to the next section.
If yes, allow the h/u standard.

Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living
Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Excess heat verifications. Enter the appropriate verification source, if available.

Acceptable verifications:
- Current bills or written statement from the landlord.
- Collateral contact with the landlord.
- Cancelled checks, receipts or money order copies, if current.

Receipt of HHC in an amount greater than $20 in the current month or preceding 12 months. If no, do not allow h/u standard. Go to next section.
If yes, allow the h/u standard.

Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

HHC verifications Enter the appropriate verification source, if available.

Acceptable verifications:
- Bridges inquiry. (HHC Approved Client Inquiry).
- Letter from provider.
- Collateral contact with provider.
- Copy of HHC warrant.

Receipt of LIHEAP payment or a LIHEAP payment was made on the group's behalf in an amount greater than $20 in the current month or immediately preceding 12 months. (SER or MEAP) If no, do not allow h/u standard. Go to next section.
If yes, allow the h/u standard.

Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

LIHEAP payment verification. Enter the appropriate verification source, if available.

Acceptable verifications:
- Bridges inquiry. (Benefit issuance for energy related SER.)
- Letter from provider.
<table>
<thead>
<tr>
<th><strong>Collateral contact with provider.</strong></th>
<th><strong>Proof of MEAP payment.</strong></th>
</tr>
</thead>
</table>
| **Electricity included in rent/fees, but responsible for:** | If no, do not allow the heat and utility standard. Go to the next section.  
If yes, allow the h/u standard. |
| Excess cooling costs. | |
| **Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.** | |
| **Excess cooling verifications.** | Enter the appropriate verification source, if available.  
**Acceptable verifications:**  
- Written statement from the landlord.  
- Collateral contact with the landlord. |
| **Responsible for non-heat electric expenses and not eligible for the h/u standard?** | If no, do not allow the heat and utility standard. Go to the next section.  
If yes, allow the non-heat electric standard. |
| **Non-heat electric verifications.** | Enter the appropriate verification source, if available.  
**Acceptable verifications:**  
- DHS-3688.  
- Current lease.  
- Current bill that identifies the expense for the FAP group.  
- Collateral contact with the landlord or provider.  
| **Note:** If the non-heat electric bill is in someone else’s name, allow the expense if the client claims the expense, and the services address on the bill is where the FAP group lives. |
| **Responsible for water and/or sewer expenses and not eligible for the h/u standard?** | If no, do not allow the heat and utility standard. Go to the next section.  
If yes, allow the water and/or sewer standard. |
<table>
<thead>
<tr>
<th>Expense Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water and or sewer verifications</td>
<td>Not required, unless questionable. Acceptable verifications:</td>
</tr>
<tr>
<td></td>
<td>• Current bill that identifies the expense for the FAP group.</td>
</tr>
<tr>
<td></td>
<td>• Collateral contact with the landlord or provider.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> If the water and/or sewer bill is in someone else’s name, allow the expense if the client claims the expense and the service address on the bill is where the FAP group lives.</td>
</tr>
<tr>
<td>Responsible for telephone, monthly cellular phone</td>
<td>If no, do not allow the heat and utility standard. Go to the next section.</td>
</tr>
<tr>
<td>plans and not eligible for the h/u standard (Y/N)?</td>
<td>If yes, allow the telephone standard.</td>
</tr>
<tr>
<td>Telephone verifications</td>
<td><strong>Not</strong> required, unless questionable. Acceptable verifications:</td>
</tr>
<tr>
<td></td>
<td>• Current bill that identifies the expense for the FAP group <strong>and</strong> must include at least the monthly basic fee.</td>
</tr>
<tr>
<td></td>
<td>• Collateral contact with the provider.</td>
</tr>
<tr>
<td>Responsible for cooking fuel expenses and not</td>
<td>If no, do not allow the heat and utility standard. Go to the next section.</td>
</tr>
<tr>
<td>eligible for the h/u standard?</td>
<td>If yes, allow the cooking fuel standard.</td>
</tr>
<tr>
<td>Cooking fuel verifications</td>
<td><strong>Not</strong> required, unless questionable. Acceptable verifications:</td>
</tr>
<tr>
<td></td>
<td>• Current bill that identifies the expense for the FAP group.</td>
</tr>
<tr>
<td></td>
<td>• Collateral contact with the provider.</td>
</tr>
<tr>
<td>Responsible for trash removal expenses and not</td>
<td>If no, do not allow the heat and utility standard. Go to the next section.</td>
</tr>
<tr>
<td>eligible for the h/u standard (Y/N)?</td>
<td>If yes, allow the trash removal standard.</td>
</tr>
<tr>
<td>Trash removal verifications</td>
<td><strong>Not</strong> required, unless questionable. Acceptable verifications:</td>
</tr>
<tr>
<td></td>
<td>• Current bill that identifies the expense for the FAP group.</td>
</tr>
<tr>
<td></td>
<td>• Collateral contact with the provider.</td>
</tr>
</tbody>
</table>
### Actual utility expenses?

<table>
<thead>
<tr>
<th>If no, go to the next section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, allow only the following expenses:</td>
</tr>
<tr>
<td>Utility installation charges (<strong>not deposits</strong>).</td>
</tr>
<tr>
<td>Water well installation and maintenance.</td>
</tr>
<tr>
<td>Septic installation and maintenance.</td>
</tr>
</tbody>
</table>

### Actual utility verifications.

**Verify** the actual expense.

**Acceptable verifications include, but are not limited to:**
- Current bills or a written statement from the provider.
- Collateral contact with the provider.
- Cancelled checks, receipts or money order copies, if current.

The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

**Note:** Do not allow an actual utility expense for reconnection fees after the service has been turned off for the same people at the same address.

### LEGAL BASE

7 CFR 273.8(h)
7 CFR 273.9(d),.10(d)(6),.11(c),.21
7 CFR 273.9 (c)(10)(11)
42 USC 8621 - 8630

Michigan Low Income Heating Assistance and Shut Off Protection Act, MCL 400.1201 et. seq.

Agricultural Act of 2014, Section 4006
DEPARTMENT POLICY

FAP Only

A food assistance worksheet must be completed at initial application, semi-annual, mid-certifications and at each redetermination for all approvals, denials and closures made on the basis of income. In addition, the worksheet is used to document changes in assets, income and expenses, and to document supplemental benefits. The worksheet is not needed to document withdrawn requests or applications but this must be documented somewhere within the case.

Specialists must use the automated food assistance budget in Bridges to complete the required worksheet whenever possible.

Note: Traditional Categorical eligible groups automatically meet the asset test for food assistance; see BEM 213, FAP Categorical Eligibility.

COMPLETING THE DHS-2242, FOOD ASSISTANCE WORKSHEET

Complete the DHS-2242, Food Assistance Worksheet, in the following manner:

1. Complete the Case Name and Case Number/EDG and specialist name and date when completing the form.

2. Complete the first line of the Action box.
   - Check New, if the worksheet is being prepared for an initial application and application date.
   - Check Redetermination, if the worksheet is being prepared for a redetermination.
   - Check Change, if the worksheet is being prepared as the result of a change.
• Check Semi-Annual, if the worksheet is being prepared as a result of processing the DHS-1046, Semi-Annual Contact Report.

• Check Mid-Cert, if the worksheet is being prepared as a result of processing the DHS-2240-A, Mid-Certification Contact Notice.

3. Enter the number of members in the Food Assistance Group.

4. Complete the Categorical Food Assistance section.
   • Check Traditional (no asset test).
   • Check DVPS Categorical Eligible.
   • Not Categorical Eligible.

5. Complete the SDV section.
   • Senior/Disabled/Veteran or
   • Non-Senior/Disabled/Disabled Veteran.

**Countable Assets**

Complete the Countable Assets section of the worksheet. If the FAP group exceeds the asset limit, (BEM 400) deny FAP benefits.

6. Complete the INCOME CALCULATION section.

**Note:** Individual calculations used to arrive at each income and expense figure for lines 1 through 41 must be clearly documented. Cents are included in the computation for each person’s earned income then dropped before totaling the group's gross earned income. The same computation is completed for each person’s unearned income. No cents are involved when totaling the final group amounts to enter on lines 3 and 6. Complete the income calculation to determine the benefit amount.

Line 1- Enter Monthly Self-Employment Income minus allowable farm income loss. Use the Self-Employment Income Workspace (on page 2). Round the monthly amount down by dropping all cents from the final figure. If farm income loss exceeds self-employment income, enter zero and record any remaining farm loss income in the Remarks section for use in line 1.
Line 2- Calculate the countable total of all other monthly earned income by using the Other Countable Earned Income Workspace (on page 2). List each countable source of earned income and the verified gross income used as the basis of the calculation. Then, determine the countable monthly amount for each source. Round the monthly amount down by dropping all cents from the final figure, and enter it in the Monthly Amount column.

Line 3- Self-explanatory.

Line 4- Enter the amount of FIP/RCA/SDA income.

Line 5- Calculate the countable total of all other unearned income (RSDI, SSI, UCB, retirement benefits, etc..) by using the Other Countable Unearned Income Workspace (on page 3). List each countable source of unearned income and the verified gross income used as the basis of the calculation. Then, determine the countable monthly amount for each source. Round the monthly amount down by dropping all cents from the final figure, and enter it in the Monthly Amount column.

Line 6- Self-explanatory.

Line 7- Determine the amount of Total Countable Income by adding the amount from line 3 to the amount from line 6 and deducting any remaining allowable farm income loss; see line 1.

**Note:** For non-Senior/Disabled/Disabled Veteran groups who are not categorically eligible **only** if the amount on line 10 exceeds the gross income maximum in RFT 250, Column A, FAP Income Limits, deny benefits.

Line 8- Enter 80 percent of the amount on line 3. Drop cents.

**Exception:** Not allowing 20 percent earned income deduction is used by recoupment specialists only when determining the overissuance amounts for failure to report earned income timely; see BAM 720, Intentional Program Violation:

- For IPV overissuances issued in or after October 1987.
• For client error overissuances issued in or after September 1996.
  Line 9- Enter the amount from line 6.
  Line 10- Determine the amount of gross income by adding
           the amount from line 8 to the amount from line 9
           and deducting any remaining allowable farm
           income loss; see line 1.
  Line 11- Enter standard deduction; see RFT 255.
  Line 12- Self-explanatory.

7. Complete Medical Expenses Calculation.

   Note: For non-Senior/Disabled/Disabled Veteran groups,
   enter 0 on line 13. Go to line 17. For Senior/Disabled/Disabled
   Veteran groups, complete lines 13-16, if applicable.

  Line 13- Total allowable monthly medical expenses. Round
           down if cents are 01-49, round up if cents are 50-
           99. Enter total.
  Line 14- $35 medical deduction.
  Line 15- Self-explanatory.
  Line 16- Self-explanatory.

8. Complete Dependent Care Calculation.

  Line 17- Enter Actual Monthly Out-of-Pocket Dependent
           Care Costs. Round down by dropping cents.


  Line 18- Enter monthly child support expenses. Drop cents
           after totaling.
  Line 19- Self-explanatory.
  Line 20- Self-explanatory.

10. Complete Shelter Expense Calculation section.

    In lines 22-31 enter only the heat and utility expenses the
        group is responsible to pay or contributes to; which are
        separate from rent. Unless otherwise noted.
Line 21- Enter allowable monthly shelter costs (rent, mortgage, taxes, insurance, etc.). Use exact amount including cents.

Line 22- If the group has a heat expense separate from shelter, enter the h/u standard; see RFT 255. Go to line 31.

Line 23- Enter non-heat electric standard if applicable; see RFT 255.

Line 24- Greater than $20 of LIHEAP, SER energy-related or MEAP, enter the h/u standard; see RFT 255.

Line 25- Home Heating Credit greater than $20, enter the h/u standard; see RFT 255.

Line 26- Excess Cooling - is the household responsible for excess cooling billed by their landlord and their non-heat electric is included in their rent, enter the h/u standard; see RFT 255.

Note: If the client is eligible for the h/u standard, then go to line 31.

Line 27- Enter water/sewer standard if applicable; see RFT 255.

Line 28- Enter telephone standard if applicable; see RFT 255.

Line 29- Enter cooking fuel standard if applicable; see RFT 255.

Line 30- Enter trash/garbage removal standard if applicable; see RFT 255.

Line 31- Enter actual utilities expense. Enter monthly amount for initial heat or utility installation, or well/septic installation and/or maintenance if applicable.

Line 32- Add lines 21 - 31. Round down if cents are 01 - 49, round up if cents are 50 - 99.

Line 33- Divide the amount on line 20 by 2 and enter the result. Drop cents.

Line 34- Subtract line 33 from line 32 Excess Shelter.

Line 35- For Non-SDV groups enter the shelter maximum; see RFT 255.
Line 36- Enter the lesser of line 34 or line 35 for non-SDV.
Enter line 34 for SDV.

Line 37- Self-explanatory.

**Note:** If Line 36 Exceeds Maximum Net Income in
RFT 250 Column B and Categorical FAP Criteria is
not Met - Deny Benefits.

11. Complete Benefit Calculation; see RFT 260, Food Assistance
Issuance Tables. For FAP group size 8 or less, go directly to
line 41.

Line 38- Enter the amount of benefits the FAP group would
receive if it had 0 income; see RFT 260.

Line 39- Multiply line 37 by 3 (30%) and enter the result.
Round up.

Line 40- Self-explanatory. If amount is zero, deny benefits or
close the program except for recoupment situations
or in the case of temporary ineligibility.

**Note:** If the benefit is reduced to zero due to
recoupment, the Food Assistance case must
remain active with zero benefits as long as all other
eligibility criteria are met.

Line 41- If benefits require proration and Bridges is **not**
accessible, use the following formula: Multiply the
monthly benefits by the number of days remaining
in the month including the application date. Divide
this amount by the total number of days in the
month. Drop cents. If the benefit amount is less
than $10.00, the FAP group will **not** receive an
initial benefit. (This applies to initial benefits only.)

Line 42- If the case has an administrative recoupment, enter
amount. Drop cents when calculating AR benefit
reduction amount.

Line 43- Subtract line 42 from 40.

12. Complete the Approved/Denied section.
• Decision - check whether Food Assistance benefits were approved or denied. (Denied is checked if a change results in closure.)


• Benefit Period - Indicate the month(s)/year(s) of the benefit period.

• Effective Date - For approval of an application filed during any period a FAP group was not certified for benefits, the effective date is one of the following:

  • The date of application if the group is eligible for the application month (even if the benefit amount prorates to zero).

  • The first day of the application month for a migrant/seasonal farmworker group that received FAP benefits in the month before the application month (this will prevent proration of benefits on Bridges).

  • The first day of the month following the application month if the group is not eligible for the month of application but is eligible in the next month.

  • The actual date the group complies with all application eligibility requirements if the application was delayed beyond the 30-day standard of promptness and the group was at fault for the delay.

This effective date indicates whether the FAP group should be authorized full or prorated benefits for the first month of eligibility.

For approval of an application filed during a current benefit period, the effective date is the first day of the month of the new benefit period.

For a change - The effective date is the first day of the month that a change is reflected in the FAP group’s issuance.

LEGAL BASE

7 CFR 273.10
DEPARTMENT POLICY

FAP

The Michigan Combined Application Project (MiCAP) is a Food Assistance demonstration project approved by the Food and Nutrition Service (FNS). MiCAP is a series of waivers that allows Michigan Department of Health and Human Services (MDHHS) to issue Food Assistance Program (FAP) benefits to Supplemental Security Income (SSI) individuals who qualify for this program.

The program is administered by the centrally located MiCAP unit. Final eligibility determination and redeterminations are the responsibility of the MiCAP unit.

All eligibility factors in this item must be met.

MiCAP Targeted Population

The targeted MiCAP population is SSI individuals with the following characteristics:

- Age 18 or older.
- Receives SSI income and no other type of income.
- Meets the Social Security Administrations (SSA) definition of independent living (Living arrangement code A).
- Resides in Michigan.
- Purchases and prepares food separately.

Application of MiCAP

A simplified application form, DHS-513, Michigan Combined Application Project (MiCAP), is used when determining eligibility for MiCAP. The MiCAP unit automatically sends a DHS-513 to all SSI individuals who may qualify when their SSI case is opened in Bridges informing them of the program and giving them the opportunity to apply for MiCAP.
ELIGIBILITY DETERMINATION

The MiCAP unit determines eligibility for MiCAP whenever it receives a DHS-513.

The MiCAP unit registers the application and determines FAP eligibility at application and redetermination. Once an individual has been determined eligible, a Bridge card will be issued if an individual has never received one.

Clients may receive only one free replacement Bridge card during their lifetime. Clients’ available benefits will be reduced to cover the cost of all subsequent replacement cards, with no exceptions granted.

The MiCAP unit is responsible for:

- Running the MiCAP Application Report (Social Security Administration interface) daily and mailing the DHS-513 to individuals on the report.
- Completing a file clearance to determine if an individual has an active FAP case.
- Registering the application on Bridges.
- Completing the case actions and certifying eligibility in Bridges.
- Referring individuals to customer service at 888-678-8914 to assign a Bridge card personal identification number and for Bridge card replacements.
- Maintaining the MiCAP case record.
- Completing redeterminations.

BENEFITS

Benefit Period

Once an individual is determined eligible for MiCAP, eligibility will be for a 36-month benefit period. A redetermination of eligibility will be completed every 36 months. Food Assistance benefits continue for the duration of the benefit period unless an individual is no longer eligible for MiCAP or fails to return the DHS-542, MiCAP Redetermination Form.
Note: Eligibility factors are the same at application and redetermination.

Eligibility for MiCAP begins the first day of the month the application is received in the MiCAP unit via U.S. mail, fax or local office referral. The begin date of the benefit period for MiCAP is always the first day of the application month. There is no proration of benefits.

Benefit Amount

The amount of Food Assistance Program (FAP) benefits MiCAP individuals receive is determined by their total shelter expenses, (shelter plus heat and utility expenses). If an individual’s total shelter expenses are below $1,000, the FAP benefit is $100 per month. If the total shelter expenses are equal to or exceed $1,000, the benefit amount is $190 per month.

NONFINANCIAL ELIGIBILITY FACTORS

Residence

An individual must be a resident of the State of Michigan. Individuals are considered residents if they live in Michigan and intend to remain in Michigan.

Age

An individual must be age 18 or older.

Concurrent Receipt of Benefits

An individual cannot receive both MiCAP and FAP in the same month.

FINANCIAL ELIGIBILITY FACTORS

Group Composition

The MiCAP group is always a group of one.
Assets

There is no asset test.

Income

There is no income test.

ONGOING ELIGIBILITY

Once eligible, eligibility continues unless an individual:

- Loses SSI eligibility.
- Moves out of state.
- Is ineligible due to a change in the SSA living arrangement code.
- Dies.
- Becomes a mandatory member of another active FAP case.

**Exception:** An adult child, age 18-22, who meets the criteria under MiCAP Targeted Population, may receive MiCAP benefits even if living with parents.

**Example:** SSI individual has a baby and applies for food assistance benefits at a MDHHS local office. The SSI individual is a mandatory member of the baby’s active FAP case so the MiCAP case must be closed.

ELIGIBILITY FOR OTHER PROGRAMS

When a MiCAP individual applies for FAP at a MDHHS local office, contact the MiCAP specialist to request case closure. The MiCAP phone number is 877-522-8050.

REFERRALS TO MiCAP

The MDHHS local offices may refer an individual to MiCAP. The DHS-513 must be completed and signed by an individual, then sent to the MiCAP unit as follows:

- Send or give the client a MiCAP application.
Provide the client with the fax number 517-324-9919 and the mailing address.

MiCAP
PO Box 8123
Royal Oak, MI 48068-9985
Phone number: 877-522-8050
Fax number: 517-324-9919

If the DHS-513 is returned to the local office, it should be faxed to the MiCAP unit.

Or give the client the MiCAP unit’s phone number 877-522-8050 so an application may be mailed to them.

CASE TRANSFERS

Do not transfer any case records to the MiCAP unit. Retain them at the local office.

MiCAP cases are not transferred to local offices; they remain at the MiCAP office.

LEGAL BASE

Food and Nutrition Act of 2008, as amended
7 USC 2026
AGENCY POLICY

FAP Only

A Time-Limited Food Assistance (TLFA) individual must meet specific work requirements to receive benefits. Failure to do so limits the individual's Food Assistance Program (FAP) eligibility to three months within a 36-month period. TLFA individuals who meet all other FAP eligibility criteria are eligible for three countable months of FAP benefits during a 36-month period.

The 36-month period is a standardized period. Eligible individuals can receive three countable months of benefits within each of the following periods:

First Period: January 1, 2017, through December 31, 2019

Second Period: January 1, 2020, through December 31, 2022

TLFA Counties

Effective October 1, 2018, all counties will be subject to TLFA policy, for both applicants and active cases.

TLFA Implementation

TLFA policy will be implemented based on an individual's FAP redetermination for all new counties. This does not apply to Kent, Ottawa, Oakland, Washtenaw, Allegan, Barry, Ionia, Grand Traverse, Clinton, Eaton, Ingham, Kalamazoo and Livingston Counties.

Example: Bill lives in Alcona and has a redetermination date of November 2018. Effective October 1, 2018, Bill will receive FAP benefits without TLFA work requirements. Upon completing his redetermination, Bill does not meet any deferral criteria and he is not working 20 hours per week/80 hours a month. Effective December 1st, 2018 Bill must meet TLFA work requirements or he will receive his first countable month.

Example: Judy lives in Alcona and has a redetermination on January 5, 2019. Judy provided verification that she is caring for a disabled person. Judy will remain eligible for FAP and will not be subject to TLFA requirements. Her deferral will be reviewed at her next redetermination unless she reports a change in her circumstance.
Prior to redetermination, individuals that are potentially subject to TLFA policy will receive a DHS-142R, Time Limited Food Assistance Redetermination Notice, notifying them of their TLFA requirements.

New individuals applying for FAP after October 1st, 2018 will be subject TLFA policy at application.

Example: Dale applied for Food Assistance October 8, 2018. During the interview it was determined Dale did not meet any deferral criteria and was not working 20 hours per week/80 hours per month. Effective November 1, 2018 Dale will be subject to TLFA policy and will need to meet TLFA work requirements or she will receive a countable month. Dale will not have a work requirement for October since it is a prorated month.

ELIGIBILITY FACTORS

TLFA individuals

All FAP individuals age 18 through 49 are TLFA unless deferred; see below.

Note: The policy applies to the first calendar month after the 18th birthday through the calendar month prior to the 50th birthday.

TLFA Deferrals

To be deferred from TLFA policy an individual must be one of the following:

- A member of a FAP group that includes a FAP group member under age 18, even if the individual under age 18 is disqualified or otherwise not eligible; see BEM 212.

- In any stage of pregnancy.

- Determined to be medically certified as physically or mentally unfit for employment:
  - Participating in a Michigan Rehabilitation Services program.
  - Obviously mentally or physically unfit for employment, as determined by the worker.

- Deferred from employment related activities per BEM 230B.
- A victim of domestic violence.
- Chronically homeless.

Chronic homelessness is defined as homeless with a disabling condition and residing in a place not meant for human habitation, a safe-haven, or in an emergency shelter and has been homeless and residing in such a place for at least 12 months or on at least four separate occasions in the last three years where the combined occasions must total at least 12 months.

Example: John applies for FAP benefits in April and states that he has recently moved to Michigan and is currently homeless. John states that he is currently staying with friends, sleeping at a different place each night until he can secure housing. John is not subject to TLFA policy in April since it is a prorated month. The MDHHS specialist gives John good cause for May in order for John to secure housing. John will be subject to TLFA policy beginning in June.

Example: Stan applies for FAP benefits and is potentially subject to TLFA policy. Stan states at the interview that he has been homeless for the last three years. The MDHHS specialist requests and receives verification from HARA verifying that Stan has been homeless for the past 3 years. The MDHHS specialist observes during the interview that Stan has poor hygiene and struggles with social skills. Based on the MDHHS specialist's observations of poor hygiene and that Stan struggles with social skills, the verification received from HARA and information provided by Stan, the MDHHS specialist defers Stan from TLFA policy due to being chronically homeless and having a disabling condition due to poor hygiene and his struggle with social skills. The MDHHS specialist enters the deferral in Bridges and documents the deferral information in case comments.

Example: Terry submits documentation on May 2nd that he has applied for UC. The MDHHS specialist enters the deferral and Terry will be deferred from TLFA work requirements until a decision has been made on his UC application.

Note: TLFA policy does not apply when an individual is deferred per BEM 230B.

Noncompliance and refusing employment penalties in BEM-233B may apply to TLFA applicants or recipients; see BEM 233B.
**TLFA Work Requirement**

For a FAP benefit month not to be countable, a TLFA individual must perform one of the following:

- Work at least 80 hours monthly (20 hours/week on average).

  Work includes:

  - Work in exchange for money, including self-employment.
  - Work in exchange for goods or services (in-kind).

- Participate 80 hours monthly (20 hours/week on average) in an employment and training program administered by the local Michigan Works! Agency (MWA) if available in the county.

Individuals in an MWA employment and training component cannot be required to participate more than 30 hours per week. The MWA may permit a participant to substitute hours of education to meet the 80-hour requirement.

**Note:** Local variations, restrictions and/or policies may apply. Check with the local MI Works! Agency to determine what employment and education/training services are available in the area.

- Combine work hours and MWA work hours, except workfare or self-initiated community service, that total an average of 80 hours per month.

- Participate in MWA-assigned workfare. The number of hours worked must at least equal the FAP benefit divided by minimum wage ($9.25/hr.), as determined by Bridges.

- Engage in self-initiated community service activities for a non-profit organization. The number of hours worked must equal the FAP benefit amount divided by minimum wage ($9.25/hr.), as determined by Bridges.

**Note:** Do not include TLFA recipients in simplified reporting as outlined in BAM 200. See *change reporting* in this item for a complete explanation.
FAP Groups with Multiple TLFA Members

The TLFA requirement of 80 hours a month, averaged 20 hours weekly is an individual requirement not a group requirement. If one TLFA member in the FAP group does not meet their individual hour requirement, they may receive a countable month, but the other member(s) will not if they have met their own hour requirement.

Exception: If any TLFA group member opts to complete self-initiated community service or workfare to meet their required hours, the entire group must participate in this activity; see self-initiated community service in this item.

MET REQUIREMENTS

In some instances, individuals may have met TLFA Requirements but still received a countable month. Reasons for met requirements:

- Late hour entry.
- Hearing decision.
- Work requirement was met – other.

If the individual or MWA verifies that the individual met requirements, indicate in the TLFA summary under the good cause tab, the met the requirement reason and document in the comments box how the individual met requirements.

Example: John completed SICS with a local non-profit agency in the month of October. John returned his DHS 1997; to verify his SICS on November 3rd. John received a countable month for October due to not verifying his SICS hours until November. The MDHHS specialist indicated in the TLFA summary that John met requirements due to late hours entry. Bridges removed the countable month and sent John a MDHHS-5538, Countable Month Correction Notice.

Good Cause for Work Absence

Good cause is having a valid reason for failing to work at least 80 hours monthly (20 hours/week on average), failure to participate in an employment and training program at the MWA or failure to participate in workfare or self-initiated community service.
An individual who worked or participated less than the required hours is considered to have met the work requirement if all the following conditions are met:

- The absence was due to circumstances beyond the individual’s control.
- It was temporary.
- The individual has retained the job, MWA employment and training slot, workfare slot or community service position.

Document the good cause determination on the *FAP Time-Limited Good Cause* screen. Case comments detailing the reason for good cause are mandatory. The following are examples of good cause reasons:

- Personal illness.
- Death or illness of a household member requiring the presence of the TLFA recipient in the home.
- The unavailability of transportation.
- Lack of work (employer must verify).
- Household emergency.
- Temporarily unfit for work.

**Verification of Good Cause**

Verification of good cause is only required if the specialist considers the claim questionable. If questioning the good cause, the specialist will need to answer yes to the question *Is the good cause claim questionable* on the *FAP Time-Limited Good Cause* screen. A MDHHS -3503 will be triggered when EDBC is run, to request the verification. Once received, the specialist will need to return to this screen and select the appropriate verification source from the drop-down menu to approve the good cause reason. If the verification is not returned, the month will remain countable.

**Note:** If the month that the good cause was not verified is the third countable month, Bridges will take the appropriate action to close the FAP case (if a single person case) or disqualify the TLFA individual.
PENALTIES

Noncompliance or refusing employment penalties in BEM 233B do not apply to TLFA countable months. Use *countable month* and *36-month time-period policies* in this item instead.

**Countable Month**

A countable month is a calendar month in which a full FAP benefit is posted to an EBT account and the recipient does not meet a TLFA deferral or work requirement, without good cause.

The specialist must explain to each TLFA individual that the work requirement is in effect for the first full month of benefits and the individual is responsible for meeting the work requirement in that first month.

Example: A TLFA individual applies for FAP on February 6th and is approved, with March being the first full month of benefits. The individual is referred to the MWA in March but does not attend until later in the month and does not complete 80 hours of MWA participation or meet the work requirement in another way. March is a countable month. As February is a prorated month, the individual is not subject to the TLFA requirements.

Example: The MWA documents that the individual was assigned to a work activity on August 1st but did not meet the participation requirement for the month. If the individual did not have good cause, August is countable.

A month is also countable if the individual begins meeting the work requirement but does not continue through the end of the month, without good cause, and the individual does not become deferred.

Example: A nonprofit agency documents that an individual offered janitorial help, which is self-initiated community service. On August 25-26 the individual completed 10 hours (out of 14 hours needed to work-off the $130 FAP benefit). The individual did not return to complete the hours and did not have good cause. August is countable.

A month in which an individual received FAP benefits in another state as a TLFA individual, beginning January 1, 2017, without meeting the work requirement or deferral criteria, is countable. Accept the other state’s word and document in Bridges on the *FAP Time-Limited Details Screen*. 
Example: Maude moved from Colorado in June and reported she had been receiving FAP benefits ongoing. The MDHHS specialist confirmed that two of the months received were countable time limited months. The MDHHS specialist added the months to the FAP Time-Limited Details Screen. Maude has one countable month remaining.

Bridges tracks each TLFA individual’s countable months, on the FAP Time-Limited Details Screen, as well as displaying the countable months on the FAP EDG screen. Other FAP group members may remain eligible even if one TLFA group member uses three countable months and is no longer eligible. See disqualified or ineligible persons in BEM 550 and closure and member disqualification, in this item.

When a Month is Not Countable

A month is not countable toward the three-countable-month limit for receiving FAP benefits if the individual:

- Receives prorated FAP benefits.
- Meets the TLFA work requirement.
- Receives FAP benefits erroneously and then pays them back in full.
- Is deferred from the work requirement on any day of the month.

Example: An employed individual provided verification of an injury for one week in July and cannot complete 80 hours for the month. This individual has good cause for not meeting the work requirement and this must be documented in the case file. July is not a countable month.

Example: An individual residing in Kent County moves to Wayne County on July 10. The individual applies for FAP benefits on July 10 and receives a pro-rated month of benefits for July. The individual is not subject to TLFA policy for July and July is not a countable month since the individual received a pro-rated amount of benefits for the month.
Deleting a Countable Month

Delete a month recorded as countable if later information verifies the month should not have been countable by updating the information on the FAP Time-Limited Good Cause Screen.

The individual failed to work, cooperate with the MWA or perform community service in July and August. Medical documentation received in September verifies she has been pregnant since July.

Update the Time-Limited Good Cause to give good cause to July and August. Document the good cause reason in Bridges.

The individual completed only part of the required community service hours for July and August. In September verification is provided documenting illness and inability to work during the last two weeks of July. Update the Time-Limited Good Cause Screen to give good cause to July. August remains a countable month.

36-Month Time Period

Individuals who are neither deferred nor meeting the TLFA work requirement may receive FAP benefits for only three countable months in a 36-month period from January 2017 through December 2019.

If an applicant has used some countable months, but has initial countable months remaining, Bridges will approve the application for the number of months remaining.

Follow Redetermination procedures before the end of the current benefit period; see BAM 210. Unless the individual is deferred or meets the TLFA work requirement, deny further eligibility until the 36-month period expires or the individual meets regained eligibility criteria in this item, whichever is earlier. Do not continue eligibility based on individual assurance that requirements will be met.

Regained Eligibility

An individual who has received three countable months of FAP benefits can regain FAP eligibility (within the 36-month period) by meeting one of the following within any 30-day period after the last benefit month but prior to application:
• 80 hours of employment.

• Self-initiated community service for the number of hours determined by Bridges (the number of hours must equal the FAP benefit amount divided by minimum wage) that would have equaled the individual’s FAP benefit for that period.

• TLFA deferred; see Time-Limited Deferrals in this item.

Note: Individuals who regain eligibility via deferral, then lose the deferral, must meet one of the other criteria above before benefits can be authorized, including the three-month extension.

Do not prospect regained eligibility; unless deferred, the applicant must have met the 30-day work requirement prior to application. If the individual wants to perform self-initiated community service determine the monthly benefit and required hours. The individual must complete the community service hours prior to authorization of any benefits. If the individual plans to work or participate in an employment and training component, 80 hours must be completed prior to authorization of any benefits.

At application, treat the work requirement like a verification requirement. If the individual meets the work requirement within any 30-day period prior to the application date, the begin date is the date of application. If the individual fails to meet regain criteria within any 30 day period prior to the application date, the application will be denied.

Individuals who regain eligibility remain eligible each month that they continue to meet one of the above work requirements or are deferred.

Regained Eligibility - Expedited FAP

TLFA individuals who indicate on the application or during the FAP interview that they have regained eligibility but have not provided proof of their regained eligibility activity, can be eligible for expedited food benefits if all other eligibility factors are met.

The MDHHS specialist will request the regained eligibility verification and approve expedited FAP. Once the verification is returned the MDHHS specialist can proceed with normal case
processing. If the verification is not returned, the MDHHS specialist will close the FAP for failure to return verifications.

TLFA individuals who have not indicated they have regained eligibility on the application or during the FAP interview are not eligible for expedited food benefits.

Regaining at Redetermination

An individual who has used their 3 countable months may regain eligibility at redetermination by completing TLFA work requirements, by the end of their redetermination month.

Upon regaining eligibility at redetermination, the individual must continue to meet the TLFA work requirements each month to remain eligible for FAP benefits.

The individual will be sent a MDHHS-142R, Time Limited Food Assistance Redetermination Notice, notifying them of TLFA work requirements prior to the redetermination month.

If the individual does not meet the regain TLFA work requirements prior to the end of the redetermination month, FAP benefits will close at the end of the month, for having used their 3 countable months.

Example: Tina previously used her 3 countable months in Ottawa County. Tina applied for FAP benefits in Newaygo County in February 2018. Tina was approved for FAP benefits and will potentially be subject to TLFA policy at her next redetermination in January 2019. Tina began working at Home Depot 25 hours a week in November 2018. In December 2018 Tina is sent the MDHHS 142R notifying her that she may be subject to TLFA policy at her next redetermination. Tina returns her redetermination packet and her MDHHS specialist completes the redetermination. Since Tina is meeting the TLFA work requirements she will continue to receive FAP benefits.

Example: Helen previously used her 3 countable months in Oakland County. Helen applied for FAP benefits in Wayne county in February 2018. Helen was approved for FAP benefits and will be subject to TLFA policy at her next redetermination in January 2019. In December 2018, Helen is sent the DHS 142R notifying her that she may be subject to TLFA policy at her next redetermination. Helen returns her redetermination packet and her MDHHS specialist completes her redetermination. Helen is not working 20
Three-Month Extension

Individuals who have regained eligibility by meeting the TLFA work requirement, then fail to maintain the work requirement, receive three additional months of benefits if otherwise eligible. The first month of these extended months, is the first month the work requirement is not met.

The extended months of benefits cannot be interrupted, regardless of whether the individual participates in a work activity or becomes deferred. Bridges will end the benefits during the extension months only if the individual fails to meet other FAP eligibility criteria. The extension is available only once in a 36-month period.

Example: The individual regained TLFA eligibility for the first time by meeting the work requirement in July, then failed to meet it in August and is not deferred. They are eligible for extension benefits for August, September and October. To receive November benefits, they must first meet the work requirement or be deferred.

Example: The individual regains eligibility for July due to a medical condition that does not extend beyond July. They are not eligible for extension benefits in August, September or October because they did not regain eligibility through the work requirement. To receive further benefits during the 36-month period, they must meet one of the criteria in regained eligibility in this item.

Note: A policy exception is required for any adjustment to extension months.

After the Three-Month Extension

There is no limit to the number of times an individual can regain eligibility. Following the extension, for the remainder of the 36 months, Bridges will determine the individual’s eligibility on a month-to-month basis. Each month, the individual must meet the TLFA work requirement or be deferred to receive benefits. If the individual fails to meet the work requirement after the three-month extension, FAP benefits must be recouped for any benefits received for any months the work requirements were not met or the individual was not deferred.
BENEFIT PERIODS

Bridges will determine a benefit period based on the individual's situation at application and redetermination and will assign the benefit period end date to avoid ineligible issuances.

Example: The individual has already used one countable month. Bridges will assign only a one-month benefit period for each month, to ensure benefits are not issued incorrectly. Bridges will review data entered Bridges for employment, MWA participation or community services when determining eligibility for the next benefit period.

After regaining eligibility, the individual has again failed to meet the work requirement; see regained eligibility and three-month extension in this item. Bridges will assign a benefit period to end three months after the individual last met the work requirement.

Note: Bridges will issue the DHS 142R, Time Limited Food Assistance Redetermination Notice, to individuals who are subject to TLFA policy at redetermination.

For individuals deferred due to an incapacity expected to last longer than three months, Bridges will set the benefit period to end the month the incapacity will end; see deferral for disability in BEM 230B and TLFA deferrals in this item.

It is the individual's responsibility to report changes if it results in under 20 hours of any activity. If a change is not reported timely, establish an over-issuance for any ineligible months. See BEM 700 Benefit Overissuance.

Change Reporting

TLFA applicants and recipients are required to report as specified in BAM 105. Do not include TLFA applicants or recipients who are not working 20 hours or more per week in simplified reporting; see BAM 200. If a FAP recipient who is following simplified reporting requirements becomes subject to TLFA requirements during the 6-month benefit period, do the following:

If a change is reported during the benefit period:

- Process the change according to policy outlined in BAM 220, Case Actions.
• End the simplified reporting requirement. Do not change the benefit period.

**Note:** TLFA individuals working over 20 hours a week can remain a simplified reporter until their hours drop below 20 hours a week.

• Bridges will issue the individual MDHHS-2240, Change Report.

• Inform the individual of the eligibility requirements for TLFA as outlined in policy; see **informing individuals** in this item.

• Bridges will assign the appropriate benefit period based on client participation documented in the system.

If a change is discovered at redetermination:

• Inform the individual of the eligibility requirements for TLFA; see **informing individuals** in this item.

• Process the redetermination as a new TLFA application.

• Do not process any over-issuances or penalize the individual.

**INFORMING INDIVIDUALS**

Bridges will issue the MDHHS-142, Time Limited Food Assistance Notice, to everyone who becomes subject to the TLFA requirements. Use the MDDHS-142 to explain Time-Limited FAP policy to every TLFA individual at application, redetermination, and when a change results in TLFA status (for example, individual reports employment ended).

**Note:** Bridges will generate the MDHHS-142-B, Time Limited Food Assistance Requirements Ending, to inform individuals when they are no longer subject to TLFA requirements. This notice will be issued in the following instances:

• The individual has moved out of a county implementing TLFA.
• The individual becomes deferred.
• The individual is no longer subject to TLFA requirements.

**Example:** Aretha lives in Kent County. On July 28, the MDHHS specialist updates Bridges indicating she moved to Wayne County. Bridges will issue the MDDHS-142-B the night of July 28.
SELF-INITIATED COMMUNITY SERVICE

Self-initiated community service (SICS) is unpaid work for a nonprofit organization in exchange for FAP benefits. Local MDHHS offices may maintain and make available a list of nonprofit organizations willing to accept volunteers. The MDHHS-1997, Community Services Activity Report, will be sent monthly when it is indicated in Bridges that the individual intends to use this activity to meet their TLFA requirement.

If an applicant has used countable months but has initial countable months remaining, Bridges will approve the application for that number but will require verification of the self-initiated community service monthly, via the MDHHS-1997, to avoid a countable month.

The number of hours worked must equal the monthly FAP benefit divided by minimum wage ($9.25), as determined by Bridges.

**Note:** Bridges will display the allowed SIC hours on the FAP EDG, as well as populating them on the MDHHS-1997, FAP Community Service Activity Report.

Instruct the individual on community service policy and potential sites. It is the individual’s responsibility to approach the organization and to obtain the signed MDHHS-1997, Community Service Activity Report, from an agency representative certifying the number of hours to be worked each month.

FAP Groups with Multiple TLFA Members

If a FAP group has more than one TLFA member and one member selects SICS or workfare (in counties where available) to meet their required hours, all TLFA members must participate in this activity. As the hours of participation for SICS and workfare are based on the FAP benefit divided by the state minimum wage, the entire group is subject to these hours, and they must be completed in this activity.

One group member can meet the SICS or workfare hour requirement for the whole group. The other member will be determined to have met their work requirement in these instances. However, if one individual fails to meet the SICS or workfare hours
without good case, all TLFA members will receive a countable month.

Example: In a single-member case with $192 in monthly FAP benefits, the individual must perform 20 hours per month of community service ($192 / $9.25 = 20.75 hours), round down.

Example: In a two-member case with $268 in monthly FAP benefits, a total of 28 hours, or 14 hours per month of community service per individual ($268 / 2 people / $9.25 = 28.97 hours, or 14 hours each), must be performed.

Example: Harold and Maude are a married couple who are both subject to TLFA work requirements. They opt to complete SICS as their activity. Their combined hourly requirement for SICS is 43 hours a month. Harold volunteers at the local food bank for 43 hours each month and both TLFA members meet the requirement and do not receive any countable months.

Example: In the month of October, Harold only completes 38 hours of SICS of the 43 hours required. Maude does not complete any hours of SICS. It is determined that he does not have good cause, and both TLFA members receive a countable month.

REFERRAL TO MWA (IN COUNTIES WHERE AVAILABLE)

Bridges will generate an automated FAP TLFA referral to the one-stop service centers’ One Stop Management Information System (OSMIS), as well as generating a DHS-4785-F, FAP Employment and Training Appointment Notice, which is sent to the participant, at the following times:

- Application.
- Redetermination.
- Case change or end of a deferral.
- Member add.

Bridges will automatically refer each mandatory TLFA individual to the local MWA when the MDHHS specialist runs eligibility. If the TLFA individual does not attend the MWA, OSMIS will interface this information to Bridges, but there will be no negative action to the benefits.
Note: Individuals working 20-29 hours or those who are participating in SICS will not receive the automated MDHHS-4785-F.

The MDHHS-4785-F will be generated overnight and can be viewed the next day in Bridges correspondence history. When generating the TLFA referral and the MDHHS-4785-F, Bridges will allow 6 days for the referral to be processed through central print before requiring the client to attend the MWA. Bridges will include the date, time and location to appear for their FAP employment and training assignment on the automated DHS-4785-F.

If the TLFA individual indicates to the MDHHS specialist that they intend to complete self-initiated community service instead of participating at the MWA, the MDHHS specialist will indicate this by answering yes to the question Has the individual indicated an interest in completing self-initiated community service to meet the TLFA participation on the FAP Time Limited Community Service Activity Screen. This will end the referral to the MWA and Bridges will generate the MDHHS-1997, Community Service Activity Report.

Bridges will notify OSMIS when a referred applicant is denied FAP benefits, a member is removed, or the case is closed.

MWA Assessment

MWA assesses employability and need for employment support services. TLFA recipients are then assigned to an appropriate employment-related activity.

MWA Participation

OSMIS will interface participation compliance daily which will be populated into the FAP Time-Limited MWA Activity screen. Participation hours will be summarized per activity and month. Bridges will determine if the TLFA individual has met their required hours or will be assigned a countable month. The specialist will need to go into OSMIS to view other information relevant to the MWA participation.

The MWA may continue to monitor individuals for 90 days after employment begins, even if the FAP case closes, for retention services. OSMIS will interface all terminations to Bridges through the overnight file.
**REFERRAL TO THE REFUGEE CONTRACTOR**

Refer mandatory refugee TLFA individuals who have arrived in the U.S. within the last 5 years to the refugee contractor upon application when a recipient’s reason for deferral ends or a member add is requested. When a referral to the refugee contractor is required, the MDHHS specialist must manually generate the DHHS 4785-RF, FAP Refugee Employment and Training Notice, and the DHS 142, Time Limited Food Assistance Notice.

The MDHHS specialist will generate the MDHHS 4785-RF and MDHHS 142 for each mandatory TLFA individual who has arrived in the U.S. within the last 5 years. If the individual has been in the country for 5 years or more, the MDHHS specialist will run eligibility to automatically generate a MDHHS 4785-F, Employment and Training Referral Notice, and the individual will be referred to the local MWA.

**Note:** If the local MDHHS does not have a refugee contractor, the MDHHS specialist will use the automated process to refer the mandatory TLFA individual to the local MWA.

The last date for a participant to contact the refugee contractor is 30 days from the date the MDHHS 4785-RF is sent. If a mandatory TLFA individual calls to indicate the he or she needs more time to attend orientation at the refugee contractor, the MDHHS specialist will contact the refugee contractor to extend the deadline.

The MDHHS 4785-RF must be returned to the local office with a date stamp from the refugee contractor to verify completion of the orientation.

See **BEM 230C, Exhibit - Refugee Contract Providers**, for a list of the counties and providers.

**CASE DOCUMENTATION**

Bridges will track each countable month on the *Time-Limited Food Assistance Activities* screen which displays a month-by-month account of work, work-related activities, self-initiated community service, deferrals, countable months, case number changes and closures. Update the documentation at every redetermination, when notified by the MWA, and when a TLFA individual’s status changes.
REPORTS

TL-200 TLFA Report

The TL-200, TLFA Report, will allow users to view important details on TLFA participants and their current participation status. This daily report can be broken out by county and district. It identifies individuals age 18 through 49 who are subject to TLFA policy. They are identified by participation status, as well as the deferral/participation reason and deferral end dates, and the number of countable months that have been used.

Local offices may use this report in any manner considered beneficial.

CLOSURE OR MEMBER DISQUALIFICATION

Bridges will determine when the countable months (either the initial three or from an extension) have been exhausted for each individual; see countable months in this item.

- On the 17th of the third countable month Bridges will generate the DHS-142A, TLFA Third Countable Month/Out of State Countable Month, notice to inform the individual that unless they meet the work requirement for the third countable month the case will close, or the individual will be disqualified from the group

- If the countable months are exhausted, Bridges will generate the MDHHS-1605, client notification, with timely notice to close the case or remove the TLFA member

- If a TLFA member in a TLFA group becomes ineligible, a pro-rata share of their income counts toward the remaining eligible group members. If the benefit period will expire at or before the third countable month, just complete the redetermination

VERIFICATION REQUIREMENTS

Verify eligibility factors, work requirement criteria and educational participation.

Verify a reason for deferral from the TLFA work requirement only if it is not obvious and the information provided is questionable (for
example, information is unclear, inconsistent or incomplete); see deferrals in BEM 230B. Document in the case record the reason for granting the deferral and the length of time before the continuing need for the deferral will be reviewed.

Do not deny an application solely because an employer has not verified the income and hours. After taking reasonable measures to obtain actual income and hours, consult the individual and use the best available information. Document in Bridges the attempts to verify and why they were unsuccessful.

**Work Requirement Deferrals and Work-Related Activities**

For work requirement deferrals and work-related activities verify the following:

- Age, hours of employment and/or hours and type of employment and training component, school attendance, in-kind income, and self-initiated community service.

- Pregnancy, if not obvious.

- Good cause claims, if questionable.

- Other deferrals only if not obvious and the information is unclear, inconsistent or incomplete; see deferrals in BEM 230B.

**VERIFICATION SOURCES**

Acceptable verification sources include, but are not limited to, the following; see BEM 230B:

**Age**

- Birth Certificate.

- Hospital certificate of birth.

- Other official records that contain birth information, such as school records, medical records, baptismal records, marriage certificate, insurance policy, etc.

- Forms of identification which contain age or date of birth, such as driver’s license, state-issued I.D. card, etc.
• Written statements from two or more individuals who know the individual’s age.

**Earned Income**

See *BEM 500, Employment Income*, for a complete list of acceptable verifications.

**In-Kind Income**

Verify any gain or benefit in a form other than money using the MDHHS-1997-I, In-Kind Income Activity Report, certified by the employer.

**Physical or Mental Impairment**

Verify a medical deferral only in cases where the unfitness is not obvious to the specialist. Document in Bridges and set the review date accordingly. In addition, a statement from a nurse, nurse practitioner, designated representative at a doctor’s office, social worker, or other medical personnel may be accepted verification. If the impairment is not obvious, a MDHHS-54A, Medical Needs, or an MD/DO statement may be used. Verify receipt of RSDI based on disability or blindness and SSI.

If an individual cannot obtain verification free of charge, use a MDHHS-93A, Medical Services Authorization/Invoice, to authorize payment for medical evidence.

**CARETAKER TO A DISABLED INDIVIDUAL OR CHILD UNDER 6**

Acceptable verification of a caretaker to a child under 6 or caretaker of a disabled individual includes, but is not limited to:

• Medical records about disability.
• DHS 54A.
• Verification from MSW.
• Physician statement.
• Court order.
Domestic Violence

Use the individual’s statement as documentation of the domestic violence circumstance unless a sufficient reason exists to question it. If further documentation is necessary, use any of the following:

- Documentation of service from a domestic violence shelter.
- Medical records.
- Court records (for example, personal protection order or petition).
- Police records (for example, domestic disturbance response).
- School records (for example, statement by a school counselor).
- Statement by a licensed therapist or counselor.
- Other case record information (including children’s services).

Chronic Homelessness

Accept signed documentation from a homeless shelter, local housing assessment and resource agency (HARA), or other homeless service provider.

Self-Initiated Community Service

Case copy of a MDHHS-1997, Community Service Activity Report, certified by the nonprofit or government organization.

Eligibility Regained

Verification that the work requirement was met prior to application is required. The begin date is the application date. If verification of meeting the work requirement is not returned the application may be denied after the verification due date; see BAM 115.
Case Closure or Member Disqualification

If sending a MDHHS-1605, Client Notice, the effective date is the last workday of the third countable month unless timely notice is too late to affect that month. (Do not recoup any additional issuance provided the change was reported timely and the timeliness standard was met for processing the change.).

LEGAL BASE

FAP

DEPARTMENT PHILOSOPHY

The refugee assistance programs are federal programs which help refugees to become self-sufficient after their arrival in the U.S. Refugee Assistance Program (RAP) has two components; Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA).

DEPARTMENT POLICY

RCA is a cash program for refugees who are not eligible for the Family Independence Program (FIP). RMA is a medical program for refugees who are not eligible for other Medicaid (MA) programs.

In addition to refugees, eligibility for RCA and RMA is available to certain other non U.S. citizens with specified immigration statuses, identified in the section REFUGEES in this item. Treat these individuals as refugees, for purposes of this item.

RCA/RMA ELIGIBILITY PERIOD

RCA and/or RMA is available only during the eight months immediately following the refugee’s date of entry into the U.S. or date asylum is granted. Month one is the month containing date of entry or date of adjustment to refugee status.

PROGRAM ADMINISTRATION

Michigan Department of Health and Human Services (MDHHS) local office specialists determine eligibility for all programs. For participants in RCA, the specialist must complete the manual referral to the refugee contractor.

The Refugee Services Program under the Michigan Office for New Americans (MONA) in the Department of Licensing and Regulatory Affairs (LARA) administers the refugee assistance programs and Refugee Unaccompanied Minor Program. The Cash Policy unit under the Division of Field Operations Administration (FOA) in MDHHS is responsible for RCA and RMA policy. Additionally, MDHHS is responsible for Refugee Health Screenings.
Refugee Resettlement Agencies

Refugee Resettlement Agencies also known as Voluntary Agencies (VOLAGs) may provide the following services:

- Reception and placement services to newly arrived refugees including orientation, counseling, resettlement grants, translation/interpretation, and related services.

- Employability services such as English language instruction, transportation, child care, citizenship and employment authorization document assistance, translation/interpretation, and related services.

- Matching Grants (MG) to help refugees attain economic self-sufficiency without accessing public cash assistance.

**CONCURRENT RECEIPT OF BENEFITS**

At application, all refugees must provide the name of the resettlement or other agencies that assisted them.

**RCA**

Individuals **may** voluntarily leave the MG program by applying for cash assistance. An individual **may not** receive MG and FIP/SDA/RCA concurrently.

Notify the resettlement agency when a refugee applies for cash assistance. If a MG case is active, the resettlement agency must close the MG prior to cash approval.

**RMA**

An individual **may** receive MG and MA/RMA concurrently.

**REFUGEES**

Only a person who is a refugee (or is treated as a refugee) and who is **not** a U.S. citizen can be eligible for RCA/RMA.
United States Citizenship and Immigration Services (USCIS) determines immigration status. If the status of a refugee cannot be verified through immigration documents, contact the local resettlement agency that provided for the refugee’s initial resettlement.

Individuals with the following statuses may be eligible for RCA/MA:

- **Refugee or Asylee.** An individual from any country admitted into the U.S. with the status of refugee or asylee.

  Documentation is an I-94, Arrival/Departure Record, indicating the Individual is one of the following:

  - Admitted as a refugee under section 207 of the Immigration and Nationality Act (INA).
  - Granted asylum under section 208 of the INA.

- **Afghan and Iraqi.** Individuals granted a special immigrant visa (SIV).

- **Derivative Asylee.** A spouse and/or child of a principal asylee entering the U.S. at a later date through an Asylee Relative Petition (I-730).

- **Cuban/Haitian Entrant.** An individual admitted into the U.S. from Cuba or Haiti who meets entrant criteria.

  Documentation is an I-94, Arrival/Departure Record, indicating the Individual was admitted into the U.S. from Cuba or Haiti and one of the following:

  - Document is annotated as a Cuban/Haitian Entrant (Status Pending), parole, 212(d)(5) or Form I-589 Filed.
  - Individual has letter or notice from USCIS indicating ongoing (not final) deportation, exclusion or removal proceedings.

- **Amerasian.** An individual admitted into the U.S. under P.L. 100-202.

  Documentation is one of the following documents annotated with class code AM.

  - I-94.
  - I-551.
  - U.S. or Vietnamese Passport.
• Vietnamese Exit Visa (Laissez Passer).

• **Parolee.** An individual from Cuba or Haiti paroled into the U.S. under INA section 212(d)(5) for at least one year.

  Documentation is an I-94 annotated with INA section 212(d)(5) which has a parole end date (duration) at least one year later than the date of entry.

• **Permanent Resident.** An individual admitted for permanent residence, provided the individual previously held one of the refugee or asylee statuses identified above.

  Documentation is an I-551 annotated with class code RE, AS, SI, SQ, CH, or CU.

• **Victim of Trafficking.** An individual determined by the federal Office of Refugee Resettlement (ORR) to be a victim of trafficking.

  Documentation is **both** of the following:

  • The *original* certification letter from ORR, or for victims under age 18, an *original* eligibility letter from ORR (see Exhibits I and II).

  • Telephone contact with the ORR trafficking verification line at 1-866-401-5510 verifying the validity of the letter(s).

  **Note:** No other immigration documents are necessary for victims of trafficking.

### DATE OF ENTRY

**RCA**

USCIS determines an individual's date of entry into the U.S. and enters it on the I-94 or other immigration document. This USCIS determination is **not** subject to the MDHHS fair hearing process.

For **asylees**, acceptable alien status begins on the date asylum is granted on the I-94, or on the Asylum Approval letter, regardless of arrival date. If the date of arrival and the date asylum is granted are different, notify central office via the policy email box: Policy-FIP-SDA-RAP@michigan.gov.

For **victims of trafficking**, the date of entry is the date on the ORR certification/eligibility letter.
For **derivative asylees**, acceptable alien status does not begin on the date that asylum is granted. The acceptable alien status date begins on the I-94 entry date or the date the I-730 is approved.

For **Afghan and Iraqi special immigrants**, acceptable alien status begins with the month containing the date of entry in the U.S.

**ELIGIBILITY**

Bridges uses the following guideline when determining eligibility for refugees:

- Bridges determines eligibility for FIP and MA before determining eligibility for RCA and/or RMA.
- Bridges determines FIP and MA eligibility when an RCA/RMA recipient reports a change that indicates potential for FIP or MA eligibility for (example when an RCA recipient becomes pregnant).

**RCA**

RCA eligibility factors are listed in BEM 209, Cash Assistance General Requirements and in BEM 245, School Attendance and Student Status.

**RMA**

RCA recipients who are **not** eligible for MA are **automatically** eligible for RMA.

**Note:** Excess income for MA resulting in a deductible is not considered MA eligible.

See **EXTENDED MEDICAL COVERAGE** in this item about when RMA may be extended.

**Note:** An ex parte review (see Glossary) is required before a Medicaid closure when there is an actual or anticipated change; unless the change would result in closure due to ineligibility for all Medicaid categories. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes all consideration of all MA categories; see BAM 115, Application Processing and BAM 220, Case Actions.
Note: A full-time student in post-secondary education is not eligible for RCA or RMA. The school determines full-time enrollment and attendance; see BEM 245, School Attendance and Student Status.

Group Composition

RCA

See BEM 215 for RCA group composition policy.

RMA

See BEM 216, RMA Group Composition, for refugees who are not eligible for MA.

FINANCIAL ELIGIBILITY FACTORS

Assets

RCA

Use FIP policy in BEM 400 to evaluate assets.

Note: The following are special RCA asset rules:

- Do not consider the assets of a refugee’s sponsor in determining the refugee’s eligibility.
- Cash assistance given to a refugee from a resettlement agency is not an asset.

RMA

Use RMA policy in BEM 400 to evaluate assets.

See EXTENDED MEDICAL COVERAGE in this item

Income

RCA

Follow income policy in BEM 500.

Income eligibility exists when net income of individuals with an RCA EDG status of eligible or disqualified is less than the needs of the
certified group (CG). RCA uses the same payment standard as FIP; see RFT 210.

**RMA Only**

Income eligibility exists when net income does not exceed the income limit of Group 2 Medicaid categories.

- **Do not** count any income received by the refugee from a refugee resettlement agency or the refugee’s sponsor.
- Apply policy in BEM 546 if an eligible person is an L/H individual.
- If net income exceeds the income limit, RMA eligibility is still possible using policy in BEM 545.
- See EXTENDED MEDICAL COVERAGE in this item for recipients who lose eligibility due to excess income.

### Income and Assets at Application

**RMA**

At application, determine eligibility based on the group’s income and assets on the date of application. Bridges uses policy in BEM 536 to determine the group’s net income. **Do not** prospect income from a source if no income has been received by the date of application.

**Example:** The Smith family applies on November 6, 2009. Mr. Smith has started a job but has not received his first paycheck. **Do not** prospect any earned income for Mr. Smith in determining initial eligibility.

### Income and Assets After Application

**RMA**

After initial eligibility has been established for RMA or MA, exclude recipient’s earned income and assets for RMA determination.

**Example:** Mr. Smith (example above) reports receiving his first paycheck on November 7, 2009. These earnings are **not** counted to determine initial or ongoing eligibility.
EXTENDED MEDICAL COVERAGE

Bridges will continue or initiate RMA coverage for refugees when all of the following are true:

- RCA eligibility is lost due to excess earned income or assets.
- Members are within eight months of their date of entry into the U.S. or date asylum was granted.
- Members are not eligible for MA or MI Child.

Do not require a new application; see Benefit Periods in this item.

RMA Termination

Bridges will only terminate RMA for a group member who is either of the following:

- No longer meets the MA eligibility factors found in BEM 220, Residence.
- Becomes eligible for MA.

STANDARD OF PROMPTNESS

RCA

Approve or deny an application for RCA and mail the individual a notice within 30 days from the date of application; see BAM 115 for all other application processing policies.

BENEFIT PERIODS

RCA

Bridges sets the benefit period based on date(s) of entry.

Specialists must follow-up to remove each group member whose eligibility ends before the benefit period end date. Bridges automatically stops RCA benefits effective the month when the last group member has been in the U.S. for eight months.
RMA

Bridges sets the redetermination date based on date(s) of entry.

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

RMA

RMA recipients receive a MiHealth card. Covered services for RMA are the same as in Medicaid. Medicaid reimbursement procedures, such as billing instructions and prior authorization procedures, are used for RMA.

TRANSLATION AND INTERPRETATION SERVICES

RCA and RMA

Use the DHS-848, Certification of Translation/Interpretation for Non-English Speaking Applicants or Recipients, whenever an individual who is non-English speaking or has limited English proficiency (LEP) is provided translation/interpretation services. The 848 is documentation an individual has been provided written or verbal notice in a language they can understand.

See BAM 105, RIGHTS AND RESPONSIBILITIES, for additional information regarding translation and interpretation.

VERIFICATION REQUIREMENTS

RCA and RMA

Verify the refugee statuses of each individual at application or member add. See the REFUGEES section in this item for documents that verify refugee status. If the applicant provides verification of alien status other than what is listed in this item or in BEM 225, Citizenship/Alien Status, contact central office for approval of the verification documents via the policy mailbox: Policy-FIP-SDA-RAP@michigan.gov.
Verify each refugee's date of entry into the U.S. Use the I-94, other pertinent USCIS document, or contact with USCIS to verify date of entry.

**RMA**

Use Group 2 MA verification requirements for all other eligibility factors.
EXHIBIT I - SAMPLE ADULT VICTIM OF TRAFFICKING ORR CERTIFICATION LETTER

HHS Tracking Number
5555555555

Ms. Susie Doe
c/o Smith County Community Service Office
Department of Social Services
123 Main St.
Everytown, CA 33333-3333

CERTIFICATION LETTER

Dear Ms. Doe:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) under section 107(b) of the Trafficking Victims Protection Act of 2000. With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria. Certification does not confer immigration status.

Your certification date is JANUARY 1, 1999. The benefits outlined in the previous paragraph may offer assistance for only limited time periods that start from the date of this certification. Therefore, if you wish to seek assistance, it is important that you do so as soon as possible after receipt of this letter.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies must call the trafficking verification line at (202) 401-5510 in the Office of Refugee Resettlement to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

Nguyen Van Hanh, PhD
Director
Office of Refugee Resettlement
EXHIBIT II - SAMPLE CHILD VICTIM OF TRAFFICKING ORR ELIGIBILITY LETTER

HHS Tracking Number
5555555555

Ms. Susie Doe
c/o Community Service Office
Department of Social Services
555 Main St.
Everytown, WA 55555-5555

Dear Ms. Doe:

This letter confirms that under section 107(b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria. This letter does not confer immigration status.

Your eligibility date is JANUARY 1, 1999. The benefits outlined in the previous paragraph may offer assistance for only limited time periods that start from the date of this eligibility letter. Therefore, if you wish to seek assistance, it is important that you do so as soon as possible after receipt of this letter.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies must call the trafficking verification line at (202) 401-5510 in the Office of Refugee Resettlement to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

Nguyen Van Hanh, PhD
Director
Office of Refugee Resettlement

LEGAL BASE

45 CFR 400
P.L. 106-386 of 2000, Section 107
PROGRAM OVERVIEW

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

The Child Development and Care program is intended to promote continuity of care and to extend the time an eligible child has access to child care assistance by providing a subsidy for child care services for qualifying families.

INTRODUCTION

Once eligibility has been determined, the child(ren) will remain eligible for the entire 12-month certification period unless the CDC EDG closes for one of the reasons listed in BAM 220. A change or termination in the parent/substitute parent’s (P/SP) valid need reason will not affect the child's eligibility.

At application or redetermination, eligibility for CDC services exists when the department has established all of the following:

- There is a signed application and a request for CDC services.
- Each child for whom CDC is requested is a member of a valid eligibility group.
- Each P/SP meets the need criteria as outlined in this item.
- All eligibility requirements are met.

ELIGIBLE CHILDREN

The child(ren) needing child care services must be one of the following:

- Under age 13 at application or redetermination.
- Age 13, but under age 18 when one of the following apply:
  - Requires constant care due to a physical/mental/psychological condition.
  - Supervision has been ordered by the court.
• Age 18 and requires constant care due to a physical/mental/psychological condition or a court order, and is all of the following:
  • A full-time high school student.
  • Reasonably expected to complete high school before reaching age 19.

Verify need for CDC services for children over age 12 with a copy of the court order or a statement by a D.O. or M.D.

**Note:** Eligible children who turn age 13 during a CDC pay period are eligible through the end of the 12-month continuous eligibility period.
ELIGIBILITY CHART

The following chart provides the valid CDC services by eligibility group and need reason.

<table>
<thead>
<tr>
<th>Eligibility Groups</th>
<th>Valid Need Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Development and Care Eligibility</td>
<td>Each CDC parent/substitute parent must be unavailable due to a valid need reason.</td>
</tr>
<tr>
<td>Groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Valid Need Reasons</td>
</tr>
<tr>
<td></td>
<td>Family Preservation</td>
</tr>
<tr>
<td>Children's Protective Services</td>
<td>Yes if required by an active Protective Services Case plan</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Yes if required by an active Foster Care Case plan</td>
</tr>
<tr>
<td>FIP Related</td>
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</tr>
<tr>
<td>Migrant</td>
<td>Yes</td>
</tr>
<tr>
<td>Homeless</td>
<td>Yes</td>
</tr>
<tr>
<td>Income Eligible*</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Income Determination and Child Support Cooperation Required; see BEM 255.
PARENT/ SUBSTITUTE PARENT

At application or redetermination, each P/SP must demonstrate a valid need reason. This section specifies who must demonstrate those valid need reasons.

Parent/substitute parents are often the same for all the children in the family. However, there are some homes where the children may not all share the same P/SP. Therefore, P/SPs must be identified separately for each child for whom CDC is requested. P/SP means the following person(s) who live in the home and are unavailable to care for the child due to a valid need reason:

- The child’s legal or biological parent(s).
- The child’s stepparent.
- The child’s foster parent(s).
- The child’s legal guardian(s).
- The applicant/client, if:
  - The child has no parent, stepparent or legal guardian who lives in the home.
  - The child’s only P/SP that lives in the home is excluded from providing the care; see Need in this item.

Note: See BAM 220, CDC MEMBER ADD for CDC member add requirements.

NEED

There are four valid CDC need reasons listed below. Each P/SP of the child needing care must have a valid need reason when child care is requested. Each need reason must be verified.

1. Family preservation.
2. High school completion.
3. An approved activity.
4. Employment.

Note: A P/SP may be considered as unavailable and excluded from providing the care if a court order mandates that he/she not be alone with the child or if he/she is the person being investigated for the neglect or abuse of any child in a confirmed open children’s protective services case.
However, in no instance is information to be shared with the client regarding the family member's status on the central registry. If the only P/SP in the home is considered unavailable due to this reason, the availability of the applicant/client must be considered in determining need.

**Note:** In two-parent households, both parents' need reasons must be verified at application and redetermination with the appropriate verification.

**Multiple Need Reasons May Exist**

More than one need reason may exist in some cases. Consider each need reason (family preservation, high school completion, approved activity, employment) separately to determine need hours.

**Example:** A P/SP may need child care while at work and also when attending school.

In a two-parent household, there may be instances when both are unavailable at the same time, due to different need reasons. When there is more than one need reason, enter all applicable need reasons. Bridges will select the appropriate hierarchy when the case is certified.

**REQUEST FOR ADDITIONAL NEEDS**

When a client requests additional assistance during the 12-month continuous eligibility period, and verifications are needed, generate the MDHHS-5419, Child Development and Care (CDC) Request For Additional Assistance, from Bridges left navigation. The MDHHS-5419 allows the client to request additional CDC assistance (need reason, hours and/or provider).

If the MDHHS-5419 and required verifications are returned by the due date:

- Log the MDHHS-5419 into Bridges as being received.
- Process the change according to BAM 220.

**Note:** If only the verifications are returned, the MDHHS-5419 should be logged as being received, to prevent the MDHHS-5420, Child Development and Care (CDC) Continued Benefits Notice, from being automatically generated. The MDHHS-5420 is mailed to
inform the client the additional need request will not be processed due to missing or incomplete verifications.

If the MDHHS-5419 and or verifications are not received by the due date:

- The MDHHS-5420 will be generated and sent 10 calendar days after the due date on the MDHHS-5419.
- There will be no change to the client’s benefits.

**Note:** If the verifications are received after the due date, but before the MDHHS-5420 is generated, process the change according to BAM 220.

### NEED REASONS

#### 1. Family Preservation

Child care may be approved for a child whose P/SP is:

- Unavailable to provide care because they are participating in a court-ordered activity.

- Unavailable to provide care because they are required to participate in the treatment activity of another member of the CDC program group, the CDC applicant or the CDC applicant’s spouse who lives in the home.

- Unable to provide care due to a condition for which they are being treated by a physician.

- Unavailable to provide care due to an employment or educational need that is part of the child protective services/foster care services case plan.

Child care for this need reason cannot be authorized for ongoing 24-hour care.

**Note:** The family preservation need is based on the P/SP’s need, not the child’s need.

Allowable conditions may include, but are not limited to the following:

- Disability or mental disturbance.
• Chronic health conditions.
• Drug/alcohol abuse.
• Social isolation.
• Domestic violence.
• History of child abuse/neglect in family or poor, inadequate parenting.

Allowable treatment activities may include, but are not limited to the following:

• Hospitalization.
• Physical therapy.
• Occupational therapy.
• Speech therapy.
• Counseling sessions.
• Alcoholics Anonymous (AA) meetings.
• Narcotics Anonymous (NA) meetings.
• Parenting classes.
• Support classes.
• Food and nutrition classes.
• Court-ordered community service.
• Money management classes.

Unless part of the foster care services plan, allowable treatment activities do not include elementary, secondary, post-secondary or vocational education classes under this need reason. Specialists who receive notice that an educational activity is necessary as part of the foster care services plan should use family preservation as the need reason and refer the client to the one-stop service center for approval. If the one-stop service center approves the educational activity, the specialist should change the need reason to approved activity. If the one-stop service center does not approve the activity, continue to use family preservation as the need reason for as long as indicated by the foster care worker.

Note: Child care payments may not be approved for respite care, as defined in BPG Glossary.

The DHS-4575, Child Development and Care (CDC) Proof of Family Preservation Need, must be used to document the family preservation child care need. The form must be signed by one of the following:

• A physician (M.D. or D.O.).
• The MDHHS children’s protective services, foster care services, or preventive services worker if child care is needed to allow a parent/substitute parent to participate in a treatment activity as a component of an active children’s protective services, foster care services or preventive services case plan.

• A clinical psychologist.

• A clinical social worker.

• The clinical supervisor or director of a substance abuse treatment program.

• A substance abuse counselor.

• The specialist, if it is a MDHHS-assigned family support services (FSS) activity.

**Note:** Child care needed for MDHHS-assigned FSS activities may be paid using Direct Support Services (DSS) funds or the CDC program if eligibility exists. Take care to avoid duplicate payments.

The DHS-4575 must be completed at application and redetermination.

The DHS-4575 verifies:

• The reason CDC services are needed (diagnosis of condition or explanation of activity which prevents the P/SP from providing the care).

• The activities in which the P/SP is expected to participate while the child is receiving CDC services.

• How often the P/SP is being treated/seen.

• The length of time CDC services will likely be required.

• The days per week and number of hours per day that child care will be needed.

• The child(ren) needing child care.
2. High School Completion

Child care may be approved for a child whose P/SP is enrolled full or part-time, as defined by the educational institution, in order to participate in classes leading to a high school diploma or its equivalent.

Examples of this need reason would be high school completion, general educational development (GED), adult basic education (ABE) or English as a second language (ESL) classes.

Verify the educational activity and number of hours of the activity with one of the following:

- A completed copy of the DHS-4578, Child Development and Care (CDC) Proof of Education.
- Documentation from the institution that includes all of the following (contact the institution if information is questionable or not clear):
  - Student's name.
  - Name of the institution.
  - Class schedule.
  - Program begin and end dates.

If any portion of the education program is online, and time, location, and pace of instruction is the student’s choice, clarify with the institution the estimated online class time per week. Use this information to authorize hours, and document it in the case record.

If requested, authorize study time up to one hour for each hour of class time. Tutoring is considered study time.

Obtain this verification and file it in the case record at application, redetermination, or when additional assistance is requested for this need reason.

3. Approved Activity

Child care may be approved under this need reason when a P/SP needs child care to participate in one of the following:

- Employment preparation and/or training activity.
• Employment preparation and training programs are presumed to be occupationally relevant. If questionable, email the CDC office at Policy-CDC@Michigan.gov.

• Post-secondary education.
  • Online educational programs can be approved.
  • Child care benefits for this need reason cannot be approved for graduate, medical, or law school.
  • Educational programs are presumed to be occupationally relevant. If questionable, email the CDC office at Policy-CDC@Michigan.gov.

Child care needed to enable a P/SP to attend compliance test activities may also be approved under this need reason if eligibility requirements are met. Direct support services (DSS) may be used for these activities; see BEM 232. Whatever option is used, care must be taken to avoid duplicate payments.

The activity or education program must be approved by one of the following:

• Michigan Department of Health and Human Services (MDHHS).

• One-stop service center (for example Michigan Works Association).

• Refugee services contractor.

• Tribal employment preparation program.

• Michigan Rehabilitation Services (MRS).

• Michigan Department of Education (MDE), CDC program office.

Verify the activity or educational program and number of hours with one of the following:

• A completed copy of the DHS-4578, Child Development and Care (CDC) Proof of Education.

• Documentation from the institution or program that includes all of the following (contact the institution or program if information is questionable or not clear):
• Student’s name.
• Name of the institution or program.
• Class schedule.
• Program begin and end dates.

Note: If any portion of the education program is online, and time, location, and pace of instruction is the student’s choice, allow one hour per credit hour per week. If more hours are requested than supported by documentation, clarify with the institution or program the estimated online class time per week. Use this information to authorize hours, and document it in the case record.

If requested, authorize study time up to one hour for each hour of class time and required lab time. Tutoring is considered study time.

Obtain this verification and file it in the case record at application, redetermination, or when additional assistance is requested for this need reason.

4. Employment

Child care may be approved for P/SPs who are employed or self-employed and receive money, wages, self-employment profits or sales commissions.

Note: A P/SP is not eligible for CDC if his/her only need reason is employment as a license exempt-related or license exempt-unrelated child care provider, regardless of enrollment in the CDC program.

P/SPs participating in the following activities are considered to meet the need criteria based on employment including:

• Jury duty.

• Residency/internship for which wages are received.

Note: If wages are not received, the need should be categorized as approved activity.

• Required to be on call.

• Required strike duty.

• Sleep periods (up to eight hours) for the employed P/SP when:

  • This person is the only P/SP available to provide care during the time period for which CDC is being requested.
This person works during the child's normal sleep time.

This person must sleep when the child is awake.

The paid employment portion of a co-op or work study program.

**Tools to Verify Need Based on Employment/Self-Employment**

**Self-employment:** Use the following tool to verify the need for CDC based on self-employment:


**Employment:** Use one of the following as tools to verify the need for CDC based on employment:

- A copy of a work schedule indicating the number of hours worked.
- Pay stubs indicating number of work hours.
- DHS-38, Verification of Employment, completed by the employer.
- TALX/Work Number and MIS (Management Information System).
- DHS-3569, Agricultural Worker Income Verification, completed by the employer.
- **Signed statement** by the employer that contains:
  - Employment begin date.
  - Number of hours the client works.
  - For income eligible clients, dates and amounts of client’s paychecks for the requested period.
- **Collateral contact** with the employer if the employer refuses or is unable to complete the DHS-38, DHS-3569, or a signed statement, or if the client is unable to obtain his/her work schedule from the employer or the pay stubs do not indicate number of work hours. Complete the DHS-38 or DHS-3569 based on the information obtained from this contact.
**When to Verify Need**

Verification of need must be obtained at application and redetermination, or when there is a request for an increase in need hours during 12-month continuous eligibility.

**ELIGIBILITY GROUPS**

There are six eligibility groups. Five are income waived and one is income eligible. All eligibility groups must not have assets that exceed $1 million.

To be eligible for CDC payments, the P/SP must:

- Apply for CDC.
- Meet the requirements of an eligibility group.
- Have a valid need reason (at application and redetermination).
- Use an eligible provider.

Each P/SP of the child needing care must have a valid need reason when child care is requested.

All children needing care must be U.S. citizens or have an acceptable alien status; see BEM 225.

For income eligible groups; see BEM 255 for child support requirements.

Determine eligibility by assessing CDC Protective Services eligibility first, then income eligibility. More than one eligibility group may exist in some cases.

**Note:** The eligibility category is based upon the child's circumstances. Cases with more than one child may have more than one eligibility category.

**CDC PROTECTIVE SERVICES**

The following five eligibility groups are income waived and do not require an income determination:

- Children’s protective services.
- Foster care.
- FIP-related.
- Migrant farmworkers.
Children's Protective Services

- Homeless.

CDC eligibility for the child whose family has an open children’s protective services case may be based solely on the need (family preservation) verified in the case record with the DHS-4575, Child Development and Care Proof of Family Preservation Need.

Foster Care

CDC may be approved for all need reasons when the child needing care has an active MDHHS foster care case and the foster care payments are permitted to be paid to a:

- Licensed foster parent.
- Relative placement when:
  - There is a court order committing the child to MDHHS.
  - MDHHS placed the child with a non-parent relative.
  - The relative receives MDHHS state ward board and care funding for the child’s placement.

Verify the need for both foster parents in a two-parent household at application and redetermination.

Note: The case is opened in the foster parent's/non-parent relative’s name. Eligibility for CDC for the foster parent's/non-parent relative’s own child(ren) is determined via another eligibility group.

Eligibility for CDC for active MDHHS foster care cases ends on the date the child(ren) is removed from the paid licensed foster parent’s home or non-parent relative’s home.

Note: When a foster child is adopted by the child's current foster parents during the 12-month continuous eligibility period, CDC should remain open until redetermination with no negative action taken on the case. Assistance from the Bridges Resource Center (BRC) is required.

FIP Related

A child who needs care may qualify under this eligibility group if:

- The child needing care receives FIP or SSI.
- The P/SP of the child needing care receives FIP or SSI.
• The family has a pending application for FIP and CDC is needed to participate in a required one-stop service center/MDHHS activity.

Migrant Farmworkers

CDC may be approved for all need reasons when the P/SP states he/she is a migrant farmworker on the MDE-4583, Child Development and Care (CDC) Program Application, the MDHHS-1171, Assistance Application or the MI Bridges application. Eligibility based on migrant status does not need to be verified. Verification of need is required.

Homeless

CDC may be approved for all need reasons when a child is considered to be homeless based on the McKinney-Vento Homeless Assistance Act of 1987, as amended 2015. Examples of a child being homeless are:

• Sharing housing due to economic hardship or loss of housing.
• Living in motels, hotels, trailer parks, or camp grounds due to lack of alternative accommodations.
• Living in emergency or transitional shelters.
• Children whose primary nighttime residence is not ordinarily used as a regular sleeping accommodation (for example park benches, etc.)
• Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations.

Below are some questions that may be used to determine if a child is homeless:

• How long have you been living with others? Is this a temporary situation?
• Are you sharing housing due to loss of housing? Economic hardship? Other?
• Is your name on the lease? Could you be asked to leave at any time?
• Where would you live if you were not sharing housing?
Eligibility based on the homeless category does not need to be verified. Verification of need is required.

**INCOME ELIGIBLE**

If the child does not qualify for one of the CDC Protective Service groups, determine eligibility for the income eligible group.

To be eligible for the CDC program at application, a program group’s countable gross monthly income must not exceed the maximum monthly gross income limit by family size associated with the program entry limit (15 Family Contribution category). Income eligible families may have a co-payment amount called a family contribution. For program group definition; see BEM 205.

After initial eligibility has been determined, a family’s income must not exceed the maximum monthly gross income eligibility limit by family size associated with the program exit limit (90 Family Contribution category). For income limit and family contribution amounts; see RFT 270.

**Note:** During 12-month continuous eligibility, CDC income eligibility ends if the family’s gross income exceeds the program exit limit, unless the increase is determined to be temporary excess income. For temporary excess income details; see BEM 505.

**CDC for Income Eligible Clients**

CDC may be provided for income eligible clients who:

- Do not qualify as a member of a CDC Protective Services group.

- Have a valid need reason.

- Pass the income eligibility test.

- Cooperate with child support requirements; see BEM 255.

- Have child(ren) needing care who meet the U.S. citizenship/alien status requirements as described in BEM 225.

**Income Eligibility Ends**

CDC eligibility ends for this category when the program group’s income exceeds the income eligibility scale; see RFT 270.
**Exception:** CDC income eligibility will continue if the increase is determined to be temporary excess income; see BEM 505.

**LEGAL BASE**

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.
McKinney-Vento Homeless Assistance Act of 1987, amended 2015, 42 USC 11431 *et seq.*
OVERVIEW

Parent/substitute parents (P/SP) have the right to choose the type of child care provider they wish to use. Also, P/SPs have the right to full access to their children at any time while they are in care.

ELIGIBLE PROVIDERS

Care must be provided in Michigan by an eligible provider. Eligible providers are:

- Licensed Providers:
  - Child care centers.
  - Group homes.
  - Family homes.

- License Exempt Providers:
  - License exempt-tribal.
  - License exempt-military.
  - License exempt-parent on site.
  - License exempt-related.
  - License exempt-unrelated.

Note: If the client identifies an individual who is not currently enrolled as a license exempt provider, instruct the client that provider applications can be found at www.michigan.gov/childcare in the Providers section. The application should be completed by the provider applicant and submitted to the Michigan Department of Education (MDE).

PROVIDER DEFINITIONS

Licensed

Child care centers, group homes and family homes must be licensed by the Michigan Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) in order to bill and receive payment for Child Development and Care (CDC) subsidy eligible children. BCHS ensures that all required background checks are completed pursuant to Act No. 116
of the Public Acts of 1973, as amended and the rules promulgated under this act.

Clients who request assistance with finding a licensed provider should be referred to Great Start to Quality, the online early learning resource site, at www.greatstarttoquality.org. All active licensed providers are searchable. If additional assistance is needed, clients can be referred to 877-614-7328 to reach the Great Start to Quality Resource Center serving their county. Resource centers can provide personal consultation to families in need of child care.

In instances where the local office identifies a licensed child care center or a group or family home that does not have a provider ID number, and one is needed in order to authorize payments to that provider, the local office must send a request to MDHHS-Provider-Management@michigan.gov. The request must include the provider's name, license number and a contact name and phone number.

License Exempt

Certain child care centers, homes and individuals that provide child care do not require licensure under The Childcare Organizations Act (1973 PA 116). These include the following provider types:

License Exempt-Tribal

Facilities located on tribal land.

License Exempt-Military

Facilities located on federal land, including military installations.

License Exempt-Parent on Site

Child care centers where all parents are on site and readily available for the entire time the children are in care.

License Exempt-Related

A license exempt-related provider must be all of the following:

- An adult who is 18 years or older.
- Provides care for no more than six children at one time.
- Related to the child(ren) by blood, marriage or adoption as one of the following:
• (Great) Grandparent.
• (Great) Aunt or Uncle.
• Sibling (allowable only if the provider lives at a different residence).

Note: A divorce ends a relationship gained through marriage.

License Exempt-Unrelated

A license exempt-unrelated provider must be all of the following:

• An adult who is 18 years or older.
• Provides care for no more than six children at one time.
• Provides care where the child(ren) lives.

Note: An entire Agricultural Labor Camp (migrant camp), licensed by the Michigan Department of Agriculture and Rural Development, pursuant to P.A. 368 of 1978 part 124, shall be considered as the child's own home.

PROVIDER ENROLLMENT

Licensed

Licensed child care centers, group homes, and family homes can bill and receive payment for CDC subsidy eligible children, as long as the provider is not under disciplinary action, as defined in this policy item. No further enrollment activity is necessary for the CDC program.

License Exempt Enrollment Process

All License Exempt

To receive CDC subsidy payment for care of eligible children, a provider must complete and submit the appropriate application to be enrolled by MDE. Additional requirements may apply.

Each required application can be found at [www.michigan.gov/childcare](http://www.michigan.gov/childcare) in the Providers section, and each includes a list of verification requirements.

Applications and required verifications must be faxed to 517-284-7529 or mailed to:
A provider applicant who does not submit all required verifications will be notified and given an additional five business days to provide the missing verifications. Failure to provide all required verifications within this time frame will result in denial of the application. A provider applicant who is unable to meet the verification deadline, despite a reasonable effort, may request an extension by calling MDE at 866-990-3227.

If the Michigan Department of Health and Human Services (MDHHS) receives an application or a request for a facility or individual to be enrolled as a license exempt child care provider, date stamp any documents and forward the provider’s non-personally identifiable information (PII) to CDCProviderEnrollment@michigan.gov. Fax information or applications that contain PII. All documents must be date stamped and forwarded within 48 hours of the receipt. MDE will check the applications and verifications for completeness and follow-up with the provider if additional information is required.

License Exempt-Tribal

Complete the Child Development and Care (CDC) License Exempt Tribal Provider Application. To request an application, call MDE at 866-990-3227.

Each license exempt-tribal provider is monitored by a tribal oversight agency, which ensures that all required background checks are completed.

License Exempt-Military

Complete the Child Development and Care (CDC) License Exempt Military Provider Application. To request an application, call MDE at 866-990-3227.

Each license exempt-military provider is monitored by a military oversight agency, which ensures that all required background checks are completed.
License Exempt-Parent on Site

Complete the Child Development and Care (CDC) License Exempt Parent on Site Provider Application. To request an application, call MDE at 866-990-3227.

Prior to enrollment, provider applicants must complete a telephone interview with MDE staff.

License Exempt-Parent on Site child care providers, and all prospective staff members, are subject to the following background check clearances prior to enrollment/employment:

- Child Abuse and Neglect Central Registry.
- ICHAT (Internet Criminal History Access Tool).
- OTIS (Offender Tracking Information Service).
- PSOR (Public Sex Offender Registry).

Note: The following clearances require fingerprint submission.

- FBI Identity History Summary.
- NCIC (National Crime Information Center) NSOR (National Sex Offender Registry).
- Inter-state clearances for criminal history, sex offender, and child abuse and neglect.

Enrollment is complete when the completed application and all verifications have been received, the telephone interview has been conducted, all background check clearances have been returned, and the provider applicant meets all criteria to be a license exempt-parent on site provider.

Note: If a staff member separates and returns to employment, a new fingerprint submission may be required. Background check clearances based on fingerprints remain valid 180 days from the date employment ended, unless there was an out of state move.

License Exempt-Related

Complete the Child Development and Care (CDC) License Exempt Provider Application, available at www.michigan.gov/childcare.
In addition to the application, the following verifications must be provided:

- Proof of age, identity and residence.
- A copy of a valid Social Security card.

**Exception:** If a Social Security card cannot be provided, a copy of a valid birth certificate and a printout of the provider’s information, including Social Security number, from the Social Security Administration may be used.

Prior to enrollment, provider applicants may be subject to an address inquiry and must complete a telephone interview with MDE staff. An address inquiry is not required for a provider who is living in a shelter or a migrant camp.

License exempt-related providers and their household members are subject to the following background check clearances prior to enrollment:

- Central Registry.
- ICHAT.
- OTIS.
- PSOR.

Clearances are completed on the provider/applicant. If no match is found clearances are completed on any adult household members entered in Bridges on the Provider Associated Household People screen.

**Note:** This includes parents requesting child care and living in the same household as the provider. Providers denied from a background clearance result on a parent will be required to provide a written statement that the provider will only provide care for the children of the parent who does not meet program requirements and that the provider will not be eligible to receive CDC payment for any other children, regardless of where care is provided. This statement must be provided to MDE with all other verifications.

Enrollment is complete when the completed application and all verifications have been received, the telephone interview has been conducted, all background check clearances have been returned, and the provider applicant meets all criteria to be a license exempt-related provider.
License Exempt-Unrelated

Complete the Child Development and Care (CDC) License Exempt Provider Application, available at [www.michigan.gov/childcare](http://www.michigan.gov/childcare).

In addition to the application, the following verifications must be provided:

- Proof of age, identity and residence.
- A copy of a valid Social Security card.

**Exception:** If a Social Security card cannot be provided, a copy of a valid birth certificate and a printout of the provider’s information, including Social Security number, from the Social Security Administration may be used.

Prior to enrollment, provider applicants must complete a telephone interview with MDE staff.

License exempt-unrelated providers are subject to the following background check clearances prior to enrollment:

- Central Registry.
- ICHAT.
- OTIS.
- PSOR.

**Note:** The following clearances require fingerprint submission.

- MSP Criminal History Records.
- FBI Identity History Summary.
- NCIC NSOR.
- Inter-state clearances.

Enrollment is complete when the completed application and all verifications have been received, the telephone interview has been conducted, all background check clearances have been returned, and the provider applicant meets all criteria to be a license exempt-unrelated provider.

The provider applicant may be denied if the fingerprint submission is not completed within 30 days of the Fingerprint Request Form mailing date.

**Note:** Re-enrollment after provider closure may require a new fingerprint submission. Background check clearances based on
fingerprints remain valid 180 days from the date provider enrollment is closed. An out of state move voids previous clearances.

Service Begin Date

**All License Exempt**

The service begin date for an eligible license exempt provider is the receipt date of the application.

*Exception:* The service begin date is the day after the closure if the provider:

- **Was closed in error.**
- **The provider appeals a denial/closure within 30 days, and the denial/closure is overturned.**
- **The provider requests a reconsideration of his/her disqualification, and the disqualification is reversed.**

*Exception:* The service begin date will be the first day of the pay period after a provider and/or household member’s expungement, whichever is later, if the provider is approved after a Central Registry related denial/closure.

**Provider Notices**

**License Exempt-Related and License Exempt-Unrelated**

When an eligible provider is enrolled, Bridges will send a DHS-4481-D, CDC License Exempt Provider Confirmation, to the provider.

**All Child Care Providers**

When a provider is authorized to provide care for a CDC eligible child, Bridges will send a DHS-198, Child Development and Care (CDC) Provider Notice, to the provider. The client will receive a DHS-198-C, Child Development and Care (CDC) Client Notice.

Bridges will send a DHS-4807, Notice of Child Development and Care Provider Ineligibility, to a provider if he/she is denied or closed. Bridges will send the DHS-4807-C to the client and end the authorizations if the provider is associated with a CDC case.
**Closure for Training**

**License Exempt-Related and License Exempt-Unrelated**

A provider who has not completed Great Start to Quality Orientation (GSQO) within four months after enrollment may be closed due to failure to complete the required training.

**All License Exempt**

For details of required training by provider type, see BEM 706.

**Closure for Inactivity**

**License Exempt-Related and License Exempt-Unrelated**

A provider who has not submitted billing in the past 12-months may be closed due to inactivity.

**Re-enrollment After Closure**

**License Exempt-Related and License Exempt-Unrelated**

Providers who want to re-enroll after closure must submit a new Child Development and Care (CDC) License Exempt Provider Application to the CDC office.

**Health and Safety Coaching Visits**

**License Exempt-Unrelated**

A license exempt-unrelated provider must provide care where the child(ren) lives. An annual health and safety coaching visit at this location is required. This visit may be announced or unannounced. License exempt-unrelated providers must respond to the health and safety coach when they are contacted to set up this visit or when the coach arrives for an unannounced visit.

Failure to respond to repeated, documented, contact attempts shall be considered refusal to complete the health and safety visit.

An additional unannounced visit(s) may be required for corrective action plans or other concerns arising out of an annual visit, when health and safety compliance is not demonstrated.
The provider assignment to the child(ren) will end if the coaching visit is not completed, or when health and safety compliance cannot be demonstrated after a corrective action plan. A provider will not be re-assigned to care for the child(ren) until the visit has been completed.

**License Exempt-Parent on Site**

An annual health and safety visit is required for a license exempt-parent on site provider. This visit may be announced or unannounced.

An additional unannounced visit(s) may be required for corrective action plans or other concerns arising out of an annual visit, when health and safety compliance is not demonstrated.

The provider will become ineligible to receive CDC payment if the coaching visit is not completed, or when health and safety compliance cannot be demonstrated after a corrective action plan. A provider will not be re-enrolled to receive CDC payment for child care until the visit has been completed.

**Provider Changes**

**All Child Care Providers**

The following changes shall be reported within 10 calendar days to avoid unnecessary closures and disruptions to child care enrollment and services.

- Name.
- Address.
- Staff (when applicable).
- Adult household members (when applicable).
- Social Security Number or Tax ID.

When a provider reports a change to his/her information, supporting verifications may be required prior to the change being completed.

**Note:** When the local office receives a request for an address change from a license exempt provider, send an email with all pertinent information, excluding any PII, to CDCProviderEnrollment@michigan.gov.
Information Shared with Providers

Bridges sends a DHS-198 to the provider when CDC services are authorized, or when the authorization changes or ends.

Information may also be shared with the provider when an application is filed, withdrawn denied, or when the CDC case is closed.

The MiBridges online application, the MDHHS-1171, Assistance Application, and the MDE-4583, Child Development and Care (CDC) Program Application, include a release of information allowing the department to provide this information. All other provider concerns should be directed to the client.

If the client has questions about the denial of the provider enrollment, the client should be told to discuss the issue with the provider applicant.

BACKGROUND CLEARANCES

A child care provider must undergo specific background clearances based on provider type. When an individual applies to be enrolled, and exclusionary background information or disciplinary action is discovered, this information will be utilized for all future enrollment attempts for the individual, including when subsequent enrollment attempts would not otherwise require such background information.

The following are definitions of previously identified required background checks, applicable by provider type.

Disciplinary Action

An individual may not be eligible to receive CDC subsidy payment as a child care provider if one of the following actions has been taken against a license or registration, and the license or registration has not been restored.

LARA BCHS or MDHHS:

- Revoked.
- Suspended.
- Refusal to renew.
- Denial of issuance.
- Other closure under disciplinary action.
Note: A provisional license does not constitute disciplinary action for these purposes.

Child Abuse and Neglect Central Registry

The MDHHS Child Abuse and Neglect Central Registry is reviewed daily for all providers and applicable household members over the age of 18 who are identified as perpetrators of child abuse or neglect, as confirmed by Children's Protective Services (CPS).

Note: Central Registry information is confidential and cannot be released. No other clearances will be completed if there is a Central Registry match.

ICHAT

ICHAT is a public resource maintained by MSP for name-based Michigan criminal history background checks.

OTIS

OTIS provides information about criminal offenders previously or currently under the jurisdiction or supervision of the Michigan Department of Corrections (MDOC). Information is provided on any offender who is, or was, in a Michigan prison, on parole or probation under the supervision of the MDOC, has transferred in or out of Michigan under the Michigan Interstate Compact, or who has escaped or absconded from their sentence.

PSOR

PSOR is developed and maintained by MSP to better assist the public in preventing and protecting against the commission of future criminal sexual acts by convicted sex offenders.

MSP Criminal History Records

Criminal history background checks are performed through a search using fingerprints. A criminal history record includes information on misdemeanor convictions and felony arrests and convictions.

For providers, this background check is administered by LARA through the Child Care Background Check (CCBC) system. Results
are provided by the Michigan State Police, and decisions may only be appealed to LARA.

**FBI Identity History Summary**

The FBI provides an Identity History Summary, often referred to as a criminal history record or a rap sheet, listing certain information taken from fingerprint submissions kept by the FBI and related to arrests.

All arrest information included in an Identity History Summary is obtained from fingerprint submissions, disposition reports, and other information submitted by authorized criminal justice agencies.

For providers, this background check is administered by LARA through the CCBC system. Results are provided through the Michigan State Police, and decisions may only be appealed to LARA.

**NCIC NSOR**

The NCIC database includes a NSOR file of nationwide records on individuals who are required to register in a jurisdiction’s sex offender registry.

For providers, this background check is administered by LARA through the CCBC system. Results are provided through the Michigan State Police, and decisions may only be appealed to LARA.

**Inter-State Clearances**

For any individual required to submit to Michigan and national background clearances, who has resided in any other state in the past five years, the criminal background clearance shall include a check of all the following systems in each state of residence:

- The criminal registry or repository.
- The sex offender registry or repository.
- The child abuse and neglect registry and database.

For providers, this background check is administered by LARA through the CCBC system. Decisions may only be appealed to LARA.
Automated Background Clearances

For determining continued eligibility, automated clearances are completed for providers and adult household members. These monthly automated processes match providers and applicable household members.

For confirmed Michigan system matches, MDE will verify the information is correct and close the provider with the appropriate closure reason. Bridges will send the DHS-4807 and the DHS-759, Request for Administrative Review of the Denial or Termination of Provider Enrollment, to the provider, if the provider is active. A DHS-994, Michigan State Police Criminal Notice, will also be sent if the match is on ICHAT. Bridges will send the DHS-4807-C to the client and end the authorizations if the provider is associated with a CDC case.

ADMINISTRATIVE REVIEW PROCESS

License Exempt-Related, License Exempt-Unrelated and License Exempt-Parent on Site

Child care providers or applicants who have been denied or closed as a result of a criminal conviction, arrest or pending charge record based on results not housed in the CCBC system (MDE findings from Disciplinary Actions, Central Registry, ICHAT, OTIS, and/or PSOR) may request an administrative review by following the instructions on the DHS-759 when applicable. This form instructs providers to send all documentation to MDE.

If the local office receives a request for an administrative review the information should be faxed to 517-284-7529. MDE will:

- Make a determination to approve or deny the provider/applicant.
- Notify the provider/applicant of the approval or denial.
- Remove the closure reason and re-enroll the provider, if applicable.

Note: For findings housed in the CCBC system, appeal to LARA only.
Administrative Hearings

Neither child care providers nor CDC recipients are entitled to administrative hearings based on a provider’s denial or closure.

Suspected Child Abuse or Neglect

When there is reasonable cause to suspect child abuse or neglect in a child care setting, make a referral to CPS through the MDHHS Centralized Intake Unit 855-444-3911. CPS will make a determination of whether a child(ren) is at risk. If substantiated abuse results in closure of a child care setting, Bridges will send the DHS-4807 and DHS-4807-C to notify the provider and the client of the closure.

Provider Questions

If a child care provider contacts the local office regarding questions about enrollment or billing, refer him/her to 866-990-3227.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.
P.A. 368 of 1978 part 124.
OVERVIEW

A child care provider’s enrollment must be denied or closed if the Department is made aware that the provider has certain pending criminal charges or has been convicted of any of the crimes listed in the crime codes exhibit, or crimes of a similar statute, unless an administrative review of the crime(s) determines he/she is eligible; see BEM 704, Administrative Review Process.

When applicable, these requirements also apply to adult household members, age 18 and over, who live with the provider or license exempt facility staff members.

The Department shall review the arrest records and pending charges and may require additional follow-up or review. The Department reserves the right to deny an enrollment based on the provider or child care setting not being conducive to the welfare of the children.

CRIME CODES

Acess crime codes from the Michigan Department of Health and Human Services (MDHHS) website under policy manuals at:

Work/External Website Resources/Criminal Information and Tracking/Crime Codes Exhibit.

MANDATORY DENIAL

There are crimes in the following categories for which arrests and convictions may result in the mandatory denial or closure of a provider’s enrollment:

- Arson.
- Assault or battery.
- Child and vulnerable adult abuse/neglect.
- Crime against a child, including child pornography.
- Criminal sexual conduct.
- Homicide.
- Kidnapping.
- Spousal abuse.

For the complete list, see the crime codes list linked above.
LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.
Sex Offenders Registration Act, 1994 PA 295 as amended.
INTRODUCTION

Child Development and Care (CDC) payments are made when all of the following are true:

- All eligibility requirements are met.
- A CDC case is open in Bridges.
- An eligible provider is assigned to the child and provides care.
- The provider successfully bills for child care.
- Payment limits have not been reached.

FACTORS THAT IMPACT PROVIDER PAYMENT

Child care providers are paid for costs associated with child care by submitting billing through the internet billing (I-Billing) system. Providers must bill the department every two weeks for allowable child care reimbursement. Each bill covers a two-week pay period.

The amount of payment generated is based on the child, the provider and the provider’s billing.

Child factors that impact payment:

- Child’s age.
- Child’s authorization:
  - Number of approved hours.
  - Family Contribution amount and Family Contribution Limit.

Provider and billing factors that impact payment:

- Child care provider type.
- The provider’s Star Rating or Training Level.
- Number of hours billed.
  - Child Care.
  - Allowable Absences.
- Child Care Fees billed.
- Payment Limits/Caps
- Multiple billing submissions.
- Multiple providers billing.
- Previous billing for the same pay period.
CHILD FACTORS

Child’s Age

Most provider service types receive a department hourly payment rate that is higher for infants and toddlers (age birth to 2 ½ years) compared to preschool and school age children (over age 2 ½ years). For details of how a child’s age effects department hourly payment rates by provider type and star rating or training level; see RFT 270.

Approved Hours

Approved hours (sometimes referred to as authorized hours) are established in the child’s eligibility determination, based on the Parent/Substitute Parent’s (P/SP) valid need reason. A child may be authorized for any of the following increments:

- 20 hours.
- 40 hours.
- 60 hours.
- 80 hours.
- 90 hours.

Approved hours constitute the hours available for payment that all assigned providers share for the child in a two week pay period.

For more information about how approved hours are determined; see BEM 710.

Family Contribution

The Family Contribution (FC) is based on family income when the child is determined income eligible. A family may have one or more children that are income eligible and one or more children that are income waived on the same case.

Each family is responsible to pay the child care provider out of pocket for the FC amount associated with the child's most recent income eligibility determination. This FC amount is subtracted from the provider payment issued by the Department.

FC amounts are per child, per every two-week pay period, not to exceed the Family Contribution Limit per family, per every two-
week pay period. For FC amounts and limits based on income eligibility, review the Family Contribution Based on Income Eligibility chart in RFT 270.

The FC amount is waived for a child in the CDC Protective Services (income waived) eligibility category and for income eligible children assigned to a 3, 4 or 5 Star rated Child Care Center or a Family Child Care (FCC) provider, including Group Homes and Family Homes. The FC is not waived for children assigned to a 2 Star or lower rated child care program.

**Note:** A child who is reassigned from a 3 Star or higher rated child care program to a 2 Star or lower rated child care program shall not be considered to have incurred a negative action during 12-month continuous eligibility when the FC is no longer waived.

**CHILD CARE PROVIDER FACTORS**

**Provider Type**

Child care provider service types are a determining factor in the department hourly payment rate. Child care provider service types include the following:

- **Child Care Center.**
  - Licensed.
  - License Exempt-Tribal.
  - License Exempt-Military.
  - License Exempt-Parent on Site.
- **Family Child Care (FCC).**
  - **Group Home.**
    - Licensed.
    - License Exempt-Tribal.
    - License Exempt-Military.
  - **Family Home.**
    - Licensed.
    - License Exempt-Tribal.
    - License Exempt-Military.
- **License Exempt-Related.**
- **License Exempt-Unrelated.**

For detailed information about the different child care provider service types; see BEM 704.
For department hourly payment rates by provider type; see RFT 270.

Provider Star Rating

A C/FCC provider with a 2-Star Rating or higher in Great Start to Quality shall receive a department hourly payment rate higher than that of the base rate (Blank/1-Star).

For department hourly payment rates by provider star rating; see RFT 270.

Note: License Exempt-Parent on Site providers are not eligible to participate in the Great Start to Quality rating system.

Provider Training Level

The department shall issue a higher hourly payment rate for a license exempt-related or license exempt-unrelated provider who completes 10 hours of approved training per year beyond the required Great Start to Quality Orientation training, achieving a training Level 2. Failure to complete 10 hours each year shall result in a return to Level 1 status and the corresponding department hourly payment rate.

For department hourly payment rates by provider training level; see RFT 270.

BILLING AND PAYMENT

A provider must bill the department every two weeks for allowable child care reimbursement. Each bill covers a two-week pay period.

A provider must bill the department within 90 days after the end of the pay period being billed or 90 days after the authorization was entered by the local office in order to receive payment. If the provider bills and the payment is rejected as a result of late billing, the provider must contact the Child Development and Care (CDC) office at 866-990-3227 to request that the payment be released. For late billing to be approved, providers shall be required to demonstrate good cause for not billing within the 90-day period. The CDC office shall determine if good cause has been demonstrated and if the payment is to be released.
Providers cannot charge the department for care when they have already received or expect to receive reimbursement from another funding source, a non-custodial parent, employer, etc. Examples of other funding sources include, but are not limited to:

- Head Start (HS).
- Early Head Start (EHS).
- Migrant HS/EHS.
- Great Start Readiness Program (GSRP).
- AmeriCorps.
- Department of Education.

**Exception:** When there is an agreement between the CDC program office and a partner organization that allows for layered funding, or another special funding agreement, multiple funding sources may be utilized.

Child care payments are issued weekly. This accommodates those billings or authorizations that miss the first billing deadline for the pay period but meet the second deadline for the pay period.

Payments may be delayed for many reasons such as:

- Holidays.
- Postal service delays.
- Problems with billing/payment systems.
- The CDC office deems it necessary to delay issuance of a payment.

Payments are issued in the name of the provider and mailed or electronic fund transferred (EFT) to the provider, except payments for license exempt-related and license exempt-unrelated providers, which are issued to the client.

**Record-Keeping**

Providers must maintain time and attendance records for all care provided. Attendance records must be retained by the provider for four years. License exempt-related and license exempt-unrelated providers are required to use the CDC Daily Time and Attendance Record for their record-keeping. For information about provider record reviews; see BEM 707.
Child Care Hours

Child care hours may be billed for time that a child is actually in the care of the provider, as recorded on the time and attendance records and certified daily by the P/SP or their representative.

**Note:** Regardless of the method of payment issuance, all child care providers must bill CDC for the appropriate times based on actual care, allowable absences or allowable fees.

Child Absences

Child absence hours may be billed for any periods in which the child is not in care when he/she would have normally been in attendance. Normally in care means based on a historical trend or routine of when the child has been in care. This includes periods when the child care provider is open for business, as well as when the facility is closed.

Child absence hours may not be billed after the child’s last day in the provider’s care.

CDC subsidy payment for child absence hours is limited to 360 hours annually per child. Additionally, payment for absences is limited to 10 days when no care hours have been billed. The annual limit is based on a fiscal year (10/1-9/30).

Licensed providers must have a written policy to charge all families for child absences, in order to bill the CDC program for such absences.

CDC payment cannot be made for any hours that exceed any of the aforementioned limits.

**Note:** In the event that these limits cause unusual hardship; see BEM 100, Exception Requests, steps to request a policy exception.

Hourly Payment

Hourly payment is the reimbursement amount for time billed (rounded to the nearest hour) that has been multiplied by the applicable hourly rate, limited to no more than the child’s authorized hours. See RFT 270 for hourly rates.

**Note:** All payments are potentially limited by the child and provider factors listed in this policy item.
Bi-Weekly Block Reimbursement Payment

Block reimbursement rate is the reimbursement amount for child care hours billed that has been rounded up and multiplied by the applicable hourly rate. See RFT 270 for hourly rates.

Note: All payments are potentially limited by the child and provider factors listed in this policy item.

Child Care Centers, Group and Family Homes (C/FCC)

Billing 1 to 30 hours, payment is the hourly rate multiplied by the hours billed.

Billing 31 to 60 hours, payment is the hourly rate multiplied by 60 hours.

Billing 61 to 80 hours, payment is the hourly rate multiplied by 80 hours.

Billing 81 or more hours, payment is the hourly rate multiplied by 90 hours.
Example: When a child is authorized for 60 hours per pay period and a C/FCC provider bills 61 hours, payment is limited to 60 hours based on the child’s authorization limit, rather than 80 hours.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Hours Billed</th>
<th>Hours Paid</th>
<th>Reason for Payment Amount</th>
<th>Hours Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Home A</td>
<td>61</td>
<td>60</td>
<td>Hours billed (61) are between 61 and 80. Payment is limited by the child’s authorization and results in a 60-hour block payment.</td>
<td>60 – 61 = 0 hours.</td>
</tr>
</tbody>
</table>

Example: When a child is authorized for 40 hours per pay period and a C/FCC provider bills 31 hours, payment shall round to 60 hours based on the block payment limit. Nine hours remain available for billing by another provider. If the same C/FCC provider submits billing for any additional hours, no payment shall be issued, but the increased hours billed shall reduce the remaining available hours by the additional billing amount.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Hours Billed</th>
<th>Hours Paid</th>
<th>Reason for Payment Amount</th>
<th>Hours Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Home B</td>
<td>31</td>
<td>60</td>
<td>Hours billed (31) are between 31 and 60, and result in a 60-hour block payment. Note: A 40-hour authorization will allow a C/FCC provider to be paid up to the 60-hour block payment amount.</td>
<td>40 – 31 = 9 hours.</td>
</tr>
</tbody>
</table>
License Exempt-Related and License Exempt-Unrelated

A license exempt-related or unrelated provider is not eligible to receive block payment rates. See *hourly payment* in this policy item.

Billing Submission by Multiple Providers

When two providers submit billing for care of the same child, the first provider’s billing will deduct from the total authorized hours for which the child is approved. The second provider’s billing shall be limited to the remaining available hours. This allows for block payment under the guidelines described in this policy item.

**Example:** When a child is authorized for 90 hours per two-week pay period and a C/FCC provider bills 33 hours, payment will round to 60 hours based on the block payment limit. The remaining hours available for billing are 57.

If a second C/FCC provider bills 62 hours, based on the 57 remaining available hours a 60-hour block payment shall be issued.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Hours Billed</th>
<th>Hours Paid</th>
<th>Reason for Payment Amount</th>
<th>Hours Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center A</td>
<td>33</td>
<td>60</td>
<td>Hours billed (33) are between 31 and 60, resulting in a 60-hour block payment.</td>
<td>90 – 33 = 57 hours.</td>
</tr>
<tr>
<td>Center B</td>
<td>62</td>
<td>60</td>
<td>Hours billed (62) limited by remaining hours, resulting in a 60-hour block payment.</td>
<td>57 – 62 = 0 hours.</td>
</tr>
</tbody>
</table>

Multiple Submissions by One Provider

When a child care provider submits billing for a child and later amends the billing to increase the reported amount of child care that was provided, payment shall not issue when the total number of hours billed were previously paid under the block payment guidelines described in this policy item.

**Example:** When a child is authorized for 80 hours per two-week pay period, and a C/FCC provider bills 33 hours, payment shall
round to 60 hours based on the block payment limit. The remaining available hours for billing are 47.

If the C/FCC provider corrects the billing by adding 12 hours, for a billed total of 45, no payment shall be issued, because 60 hours were previously paid. The increased hours billed shall reduce the remaining available hours to 35.

If the C/FCC provider corrected the billing again by adding 18 more hours, for a billed total of 63, an additional payment would be issued for 20 hours multiplied by the provider’s payment rate. This is because the provider’s total billing has now exceeded the block amount previously paid and the provider is eligible for 80 hours, minus the 60 hours previously paid. The remaining available hours are 17.

<table>
<thead>
<tr>
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<th>Hours Billed</th>
<th>Hours Paid</th>
<th>Reason for Payment Amount</th>
<th>Hours Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center C</td>
<td>33</td>
<td>60</td>
<td>Hours billed (33) are between 31 and 60 resulting in a 60-hour block payment.</td>
<td>80 – 33 = 47 hours.</td>
</tr>
<tr>
<td>Center C</td>
<td>12</td>
<td>0</td>
<td>Total hours billed (45) by same provider are less than 60 hours, and the 60-hour block payment has already issued to this provider, so no payment is issued.</td>
<td>47 – 12 = 35 hours.</td>
</tr>
<tr>
<td>Center C</td>
<td>18</td>
<td>20</td>
<td>Total hours billed (63) by same provider are between 61 and 80 hours, so payment issues to elevate total payment to the 80-hour block payment.</td>
<td>35 – 18 = 17 hours.</td>
</tr>
</tbody>
</table>
Payment Limits/Caps

The maximum number of hours that can be authorized per child is 90 hours in a two-week pay period.

The total number of hours a provider shall be paid in a two-week pay period is limited to:

- License exempt-related or license exempt-unrelated – 2,016 hours.
- Family homes – 2,016 hours.
- Group homes – 4,032 hours.
- Child care centers – No limit.

Child Care Fee Payments

The payment of child care fees (such as registration fees, annual fees or field trip fees) supports parents by paying reasonable and mandatory fees that align with Michigan’s market rate.

A payment is issued when all of the following are true:

- The CDC Eligibility Determination Benefit Calculation (EDBC) is approved and certified.
- The child care provider has been assigned to the child in Bridges.
- The child care provider has submitted billing for a child care fee after EDBC approval/certification and provider assignment.
- The annual child care fee limit has not been reached.

The per child, per fiscal year payment issuance limit is based on provider type and can be found in RFT 270.

The fees charged to CDC clients and/or the CDC program must not exceed what is charged to the general public (including a provider’s own employees).

Child care fees may **not** be billed to cover late payment fees, bounced check fees, late pick-up fees, or other fees levied due to a family’s action.
Note: License exempt-related and license exempt-unrelated providers are not eligible for payment of child care fees.

Internet Billing

Providers must use the internet (I-Billing) to bill for hours of child care, allowable absences or child care fees. I-Billing can be accessed at www.michigan.gov/childcare.

PIN Resets

PINs are mailed to the provider when authorizations are initially certified in Bridges. Providers who have misplaced or forgotten their PIN have three options to request a PIN reset:

- Select the Forgot PIN link on the I-Billing system to reset a PIN, if security questions have previously been completed.
- Call the CDC office at 866-990-3227.
- Fax a request to 517-284-7529. Faxed requests must include the provider’s name, address, telephone number, provider ID number, and signature.

Note: The provider’s mailing address must be correct prior to requesting a PIN reset.

Correspondence

The DHS-4481, Provider Confirmation, shall be mailed to each provider upon initial approval, which shall include the provider’s Bridges ID number.

The DHS-1381, Child Development and Care (CDC) Statement of Payments, shall be mailed to all providers who have billed. This statement shows the amount paid in the previous payroll.

The DHS-198, Child Development and Care (CDC) Provider Notice, shall be mailed upon assignment in Bridges of a child care provider to a child, indicating the ability of the provider to bill for the child. A DHS-198-C, Child Development and Care (CDC) Client Notice, provides this same information to the client.

Every January providers are mailed income information for tax reporting purposes. License exempt-related and license exempt-unrelated providers are mailed an annual statement of payments, and licensed providers are mailed Form 1099-MISC.
PAYMENT ISSUANCE REQUIREMENTS

Licensed C/FCC

Providers must be registered in the State of Michigan’s Vendor Self Service (VSS) system in order to receive CDC payments.

License Exempt-Tribal and Military

Providers must be registered in the VSS system in order to receive CDC payments. Providers must be enrolled by the Michigan Department of Education (MDE) CDC office.

License Exempt-Parent on Site

Providers must be registered in the Vendor Self Service (VSS) system in order to receive CDC payments. Providers must be enrolled by the MDE CDC office prior to being able to bill for care provided.

Staff who provide unsupervised care for children must complete the Great Start to Quality Orientation (GSQO) training within 45 days of hire. Staff must register for this training in the Michigan Registry system, at www.miregistry.org.

License Exempt-Related and License Exempt-Unrelated

Providers must be enrolled by the MDE CDC office and complete the Great Start to Quality Orientation training (Level 1) prior to being able to bill for care provided. There is a $10 fee for this one-time GSQO training.

Providers are eligible to receive department payment when all of the following are true:

- The enrollment and training process is complete.
- The provider has billed for care that was provided both:
  - After enrollment.
  - Up to 30 calendar days prior to training completion.

Providers may still be assigned to a CDC case without the GSQO training being completed. Once the training is completed, if appropriate, the provider shall receive a DHS-198, Child Development and Care (CDC) Provider Notice, indicating his/her ability to bill.
Closure For Inactivity

License Exempt-Related and License Exempt-Unrelated

A provider who has not submitted billing in the past 12-months may be closed for inactivity. To begin caring for children after this closure, the provider must submit a new Child Development and Care (CDC) License Exempt Provider Application to the CDC office.

Health and Safety Coaching Visits

License Exempt-Unrelated

A license exempt-unrelated provider must provide care where the child(ren) lives. An annual health and safety coaching visit at this location is required. Additional visits may be required for corrective actions plans or other concerns arising out of an annual visit. The provider assignment to the child(ren) shall end if the annual visit is not completed. See BEM 704 for details.

License Exempt-Parent on Site

An annual health and safety visit is required for a license exempt-parent on site provider. Additional visits may be required for corrective actions plans or other concerns arising out of an annual visit. Failure to comply with this requirement shall result in the child care provider being ineligible to receive CDC payment. See BEM 704 for details.

INDIVIDUALS NOT PERMITTED TO RECEIVE PAYMENT

The following persons are not permitted to be assigned to or paid for the care of a CDC eligible child:

- A member of the CDC program group.
- The applicant/client.
- The applicant/client’s spouse who lives in the home.
- The parent of the children in care or a legal guardian who is not a member of the CDC program group.
• A sibling of the child(ren) in care who lives at the same residence as the child(ren).

• A home help provider who is also providing adult home help at the same time as child care is being provided.

• A CDC program group member, applicant or applicant’s spouse who owns in whole or part the child care center, group or family home where the child care is provided.

**Note:** If a parent/substitute parent (P/SP) is employed at the child care facility that the child attends there must be documentation that the child is not in care of the P/SP while the P/SP is working.

Additionally, an individual may not be eligible to receive CDC subsidy payment as a child care provider if one of the following actions has been taken against a license or registration by LARA BCHS or MDHHS, and the license or registration has not been restored.

• Revoked.
• Suspended.
• Renewal refused.
• Denied issuance.
• Closed under disciplinary action.

**Note:** A provisional license does not constitute disciplinary action for these purposes.

**Provider Resources**

Various resources for providers are available in the Providers section at [www.michigan.gov/childcare](http://www.michigan.gov/childcare), including:

• Child Development and Care Handbook.
• I-Billing tutorial.
• CDC Daily Time and Attendance Record.
• CDC Payment Schedule.

**Provider/Parent Questions**

Providers or parents with questions regarding CDC billing or payments should be directed to call the CDC office at 866-990-3227.
LEGAL BASE

CDC

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

Beginning Nov. 11, 2016, a special population in Genesee County may be eligible for Flint Emergency Declaration Child Development and Care (CDC) assistance for 40 hours every two weeks. Income eligibility and need requirements are waived for this group.

Follow standard policy from all applicable Bridges Policy Manuals for CDC, including Bridges Administrative Manuals (BAM) and Bridges Eligibility Manuals (BEM), with the following exceptions related to Flint Emergency Declaration CDC.

Special Population

This special population includes each child who satisfies all of the following criteria:

- The child is under age four at the time of application or redetermination.
- The child (or the child’s mother while pregnant) consumed water from the Flint water system while living, working or attending child care or other regular activity at an address that was serviced by the Flint water system at any time during the crisis [April 25, 2014 through August 14, 2016]
- The child currently resides in the Flint water system Affected Area (defined in this item).

Exception: See the Alternative Criteria in this item for clients who reside outside of the Affected Area.

Flint Emergency Declaration CDC Policy Exceptions

Request Flint Emergency Declaration CDC policy exceptions in case specific situations not covered by published policy. In addition to CDC policy exceptions defined in BEM 100, Flint Emergency Declaration CDC policy exception decisions shall be granted when the parent/substitute parent (P/SP) valid CDC need exceeds 40 hours every two weeks and/or meets the Alternative Criteria defined in this item.

The Department of Education, Office of Great Start, Child Development and Care, issues Flint Emergency Declaration CDC policy exception decisions on form DHS-1785, Policy Decision.
Policy decisions issued on the DHS-1785, is official policy, but only for the case specified on the form.

**Need Exceeds 40 Hours**

If the P/SP indicates a need for more than 40 hours of care every two weeks, inform the P/SP that upon receipt of supporting documentation a policy exception will be requested. If the P/SP can immediately produce supporting documentation (for example, check stub(s), work or school schedule, etc.), request the policy exception before certifying the eligibility results. If the P/SP is unable to provide supporting documentation immediately, certify the 40 hours of eligibility, and request a Flint Emergency Declaration CDC policy exception upon receipt of supporting documentation.

**Alternative Criteria**

Alternative Criteria for the special population exists for a child who does not currently reside in the Affected Area, but will experience hardship if the child does not have access to the Flint Emergency Declaration CDC benefit.

Request a policy exception to review potential approval for Flint Emergency Declaration CDC benefits when all of the following are true:

- The child is under age four at the time of application or redetermination.
- The child (or the child’s mother while pregnant) consumed water from the Flint water system while living, working or attending child care or other regular activity at an address that was serviced by the Flint water system at any time during the crisis [April 25, 2014 through August 14, 2016].
- The child is still attending a regular activity (school, child care, etc.) in the Affected Area identified in this item.

A policy exception is required for all children satisfying the Alternative Criteria, regardless of the number of hours requested.

**Note:** When an approved policy decision is received, assistance from the BRC is required to authorized Flint Emergency Declaration CDC hours for a child currently residing outside the Affected Area.
Exception Requests

Any staff member may initiate a request for a Flint Emergency Declaration CDC policy exception, but it must be in writing and go through regular administrative channels. Send requests to Policy-CDC@michigan.gov. Upload confidential information to the electronic case file (ECF) and include remarks in the exception request identifying which documents support the greater need hours. Do not send confidential information by email.

Flint Emergency Declaration CDC policy exception requests must include:

- Case name (group member needing exception).
- Case number.
- Name and phone number of local office contact person.
- A detailed reason for the exception request.
- Copies of all supporting documentation (if the information is confidential or is already in the ECF, note in the email).

If further information is necessary, a response will be sent by email with the specific request. If complete information is received, the decision will be sent by email. Document the decision in Bridges case comments and upload the DHS-1785 to the ECF.

If more than 40 hours of need every two weeks is approved through a policy exception, enter all need hours in a single time block under the Flint Emergency Declaration CDC need reason, regardless of the need(s) for which the exception was approved.

**Example:** The P/SP requests Flint Emergency Declaration CDC, indicates a total need greater than 40 hours for a valid BEM 703 CDC need reason, and provides supporting documentation of an activity lasting 35 hours every two weeks. Upon receiving a completed policy exception approval, enter 45 hours under the Flint Emergency Declaration need reason, which would result in 60 authorized hours.

**Note:** If a client only requests Flint Emergency Declaration CDC and has no other need, authorize 40 hours. The 40 hours of Flint Emergency Declaration CDC includes all needs considered for a parent (for example, travel time) and no calculation is done.
RIGHTS AND RESPONSIBILITIES

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

APPLICATION FILING, REGISTRATION AND PROCESSING

A client must submit the MDE-4583-Simplified Application, or the MI Bridges application, in order to request Flint Emergency Declaration CDC assistance for a child under four years of age in the Flint Emergency Declaration Affected Area.

Exception: A P/SP with an open CDC case may submit the Child Development and Care (CDC) Flint Emergency Declaration Certification form, rather than submitting a new application. This form is an official request to have currently authorized children, who are potentially eligible for Flint Emergency Declaration CDC, changed to this category. If currently authorized hours are more than 40 hours every two weeks, follow the Policy Exceptions instruction in this policy item.

If the P/SP submits information about children who are not under four years old and indicates a desire for CDC for those children on the MDE-4583-Simplified application, utilize the application as a filing form and provide or send a MDHHS-1171, Application for Assistance or MDE-4583, Child Development and Care (CDC) Application. Follow normal application filing and registration procedures.

If the P/SP has an open CDC EDG, that P/SP may submit one of the acceptable applications for the applicable child(ren). In these instances, the child(ren)'s only need reason should be listed as Flint Emergency Declaration. If this action causes the authorized hours to be reduced, review Hours Reduced in 12-month Continuous Eligibility in this item.

Interview

An interview is required for all new CDC requests. Make an initial attempt to interview the applicant. If contact fails, schedule an interview and send the applicant notification by mail. If the interview is missed, notify the applicant by mail of the need to respond and
complete an interview by the 30th calendar day of the standard of promptness.

**Note:** Clients who have ongoing CDC cases are not required to participate in an interview when they apply for Flint Declaration CDC.

### Application Location

An application must be received and processed in Genesee County only.

### Standard of Promptness

For Flint Emergency Declaration CDC, it is recommended that the Eligibility Specialist (ES) certify program approval of the application within 10 days. Allow the client every opportunity to return verifications and meet the interview requirement. Do not deny eligibility until the 30th day of the standard of promptness.

### CASE ACTIONS

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

When adding a member to the group, the waiver of income and need still applies to those children under four years old who are receiving Flint Emergency Declaration CDC.

Valid CDC EDG Closure Reasons for Flint Emergency Declaration CDC include:

- Client requests closure.
- Incarceration.
- Loss of Michigan residency.
- Only child leaves the home.
- Assets exceed one million dollars.

When a child who is eligible for Flint Emergency Declaration CDC turns four years old during the 12-month continuous eligibility period or the family changes the current address to one outside the Affected Area, Flint Emergency Declaration CDC will end at redetermination, unless all eligibility criteria are met under the Alternative Criteria. Send all necessary required information to the P/SP to request CDC eligibility under BEM 703 criteria.
CDC GROUP COMPOSITION

Because the income and need of the group are waived for Flint Emergency Declaration CDC, the only required group member(s) include the child(ren) receiving Flint Emergency Declaration CDC. When additional child(ren) are applied for outside of the Flint Emergency Declaration CDC the CDC Group Composition includes all members listed in BEM 205 and does not exclude those children receiving the Flint Emergency Declaration CDC.

Accept all provided information from any acceptable application for Flint Emergency Declaration CDC. If historical information is available from previous applications or in Bridges, confirm the historical information if possible. Do not request more than the required information.

AGE

The Flint Emergency Declaration CDC need reason is available for children from birth to under age four.

CHILD SUPPORT

Do not deny Flint Emergency Declaration CDC eligibility for a child solely because the P/SP is in non-cooperation with the Office of Child Support.

INCOME

Income is not a reporting requirement for Flint Emergency Declaration CDC need reasons. If income is or has been reported for any reason, waive the income eligibility. Do not deny Flint Emergency Declaration CDC eligibility for a child solely because the group’s income exceeds the CDC Income Eligibility Scale in RFT 270.

CDC VERIFICATIONS

Do not request verifications of need.

Do not request verification of income.
Eligibility for 40 hours of Flint Emergency Declaration CDC is not dependent on any P/SP being unavailable due to a valid need reason.

When a P/SP applies for the Flint Emergency Declaration CDC and certifies that a child under four years old has been affected by the Flint water system, meets the definition referenced in Special Population and is determined eligible, authorize 40 hours with a need reason of Flint Emergency Declaration.

Once eligibility has been determined, the child(ren) will remain eligible for the entire 12-month certification period with few exceptions; see Closure Reasons in this item.

Affected Area

The following zip codes comprise the Flint Emergency Declaration Affected Area:

- 48502.
- 48503.
- 48504.
- 48505.
- 48506.
- 48507.
- 48509.
- 48519.
- 48529.
- 48532.

Multiple Eligibility/Need Reasons

The need reason for all children in which the P/SP has made a request for Flint Emergency Declaration CDC, has certified that the child was affected according to the requirements listed above, and the family currently resides in the Affected Area should be marked as Flint Emergency Declaration. For those individuals who provide supporting documentation for more hours of need, do not enter additional need reasons. Instead, submit a Flint Emergency Declaration CDC Policy Request to Policy-CDC@michigan.gov with the appropriate information pertaining to additional need hours.
Family Contribution

Because there is no income determination for this eligibility group, waive the Family Contribution (FC) listed in RFT 270 (listed as $0). This waiver is due to high lead levels, confirmed by each applicant's self-attestation.

CDC NEED CALCULATION

Hours Reduced in 12-month Continuous Eligibility

When a child has active CDC, authorized hours cannot be lowered during 12-month continuous eligibility. Request a Flint Emergency Declaration CDC Policy Exception for any child whose hours would be reduced by changing to the Flint Emergency Declaration CDC need reason during 12-month continuous eligibility. Do not request new supporting documentation.

Need in Two-Parent Household

When requesting a policy exception for additional need hours, consider need calculation for a two-parent household according to BEM 710. If the parents indicate there is an overlap in need hours and the parent with the fewest hours has a need greater than 40 hours, submit a Flint Emergency Declaration CDC policy exception as instructed in this policy item.

Documenting the Need Determination

When a Flint Emergency Declaration CDC policy exception is approved, upload the DHS-1785, Policy Decision, and document the approval in Bridges including the following information:

- Calculations used to arrive at the need determination.
- The source of the information used in the need determination.
- The date of the policy exception approval.
Flint Emergency Declaration Policy Questions Clarification

Direct questions or clarification requests to the policy mailbox at Policy-CDC@michigan.gov.

REDETERMINATION

At redetermination follow standard policy found in BAM 210, (unless otherwise stated in this policy item), including the requirement that a client submit a DHS-1010, Redetermination, or other review document.

At redetermination if the Flint Emergency Declaration CDC eligible child fulfills the following two conditions, the child will remain eligible for 40 hours of Flint Emergency Declaration CDC until next redetermination date:

1. The child is under age four.
2. The child resides in the Affected Area during redetermination.

Policy Exception Requests at Redetermination

At redetermination, if more than 40 hours of CDC are requested:

- A new policy decision is not required if the current P/SP(s) have an approved policy decision for the same or a greater number of hours. Document the hour calculation.

- A new policy decision is required if the current P/SP(s) do not have an approved policy decision, or if the hours requested are greater than previously approved.

A new policy decision is required for a child who qualifies under the Alternative Criteria, regardless of the number of hours requested or previously approved.

Follow the policy exception guidance in this policy item to request a new policy decision.

LEGAL BASE

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

A special population may be eligible for Child Development and Care (CDC) Disaster Assistance for 40 hours every two weeks. Income eligibility and need requirements are waived for this group.

The CDC Disaster Assistance eligibility category should only be selected after a county has received official notification from the Michigan Department of Education (MDE) that this eligibility category is approved to be used.

Follow standard policy from all applicable Bridges Policy Manuals for CDC, including Bridges Administrative Manuals (BAM) and Bridges Eligibility Manuals (BEM), with the following exceptions related to CDC Disaster Assistance.

Special Population

This special population includes each child who satisfies all of the following criteria:

- The child is age eligible at the time of application or redetermination.
- The child lived in the Affected Area and was impacted by the disaster for which a State or Federal Emergency was declared, during the time-period of the emergency declaration.
- The child currently resides in the Affected Area.

CDC Disaster Assistance Policy Exceptions

Request CDC Disaster Assistance policy exceptions in case specific situations not covered by published policy. In addition to CDC policy exceptions defined in BEM 100, CDC Disaster Assistance policy exception decisions shall be granted when the parent/substitute parent (P/SP) valid CDC need exceeds 40 hours every two weeks.

The Department of Education, Office of Great Start, Child Development and Care, issues CDC Disaster Assistance policy exception decisions on form DHS-1785, Policy Decision. A policy decision issued on the DHS-1785 is official policy, but only for the case specified on the form.
Need Exceeds 40 Hours

If the P/SP indicates a need for more than 40 hours of care every two weeks, inform the P/SP that upon receipt of supporting documentation a policy exception will be requested. If the P/SP can immediately produce supporting documentation (for example, check stub(s), work or school schedule, etc.), request the policy exception before certifying the eligibility results. If the P/SP is unable to provide supporting documentation immediately, certify the 40 hours of eligibility, and request a CDC Disaster Assistance policy exception upon receipt of supporting documentation.

Exception Requests

Any staff member may initiate a request for a CDC Disaster Assistance policy exception, but it must be in writing and go through regular administrative channels. Send requests to Policy-CDC@michigan.gov. Upload confidential information to the electronic case file (ECF) and include remarks in the exception request identifying which documents support the greater need hours. Do not send confidential information or Personally Identifiable Information (PII) by email.

CDC Disaster Assistance policy exception requests must include:

- Case name (group member needing exception).
- Case number.
- Name and phone number of local office contact person.
- A detailed reason for the exception request.
- Copies of all supporting documentation (if the information is confidential or is already in the ECF, note in the email).

If further information is necessary, a response will be sent by email with the specific request. If complete information is received, the decision will be sent by email. Document the decision in Bridges Case Comments and upload the DHS-1785 to the ECF.

If more than 40 hours of need every two weeks is approved through a policy decision, enter all need hours in a single time block under the CDC Disaster Assistance need reason, regardless of the need(s) for which the exception was approved.

Example: The P/SP requests CDC Disaster Assistance, indicates a total need greater than 40 hours for a valid BEM 703 CDC need
reason, and provides supporting documentation of an activity lasting 35 hours every two weeks. Upon receiving a completed policy exception approval, enter 45 hours under the CDC Disaster Assistance need reason, which would result in 60 authorized hours.

**Note:** If a client only requests CDC Disaster Assistance and has no other need, authorize 40 hours. The 40 hours of CDC Disaster Assistance includes all needs considered for a parent (for example, travel time) and no calculation is done.

**RIGHTS AND RESPONSIBILITIES**

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

**Application Filing, Registration and Processing**

In order to request CDC Disaster Assistance a client must submit a valid application and a Child Development and Care (CDC) Disaster Assistance Certification form.

A P/SP with an open CDC case may submit the CDC Disaster Assistance Certification form, rather than submitting a new application. This form is an official request to have currently authorized children, who are potentially eligible for CDC Disaster Assistance, changed to this category. If currently authorized hours are more than 40 hours every two weeks, follow the Policy Exceptions instruction in this policy item.

If the P/SP submits information about children who are not eligible for CDC Disaster Assistance, and indicates a desire for CDC for those children, utilize the application as a filing form and provide or send a MDHHS-1171, Assistance Application, and the MDHHS 1171-CDC program specific supplement form, or a MDE-4583, Child Development and Care (CDC) Application. Follow normal application filing and registration procedures.

If the P/SP has an open CDC EDG, that P/SP may submit one of the acceptable applications for the applicable child(ren). In these instances, the child(ren)’s only need reason should be listed as CDC Disaster Assistance. If this action causes the authorized hours to be reduced, review Hours Reduced in 12-month Continuous Eligibility in this item.
Interview

An interview is required for all new CDC requests. Make an initial attempt to interview the applicant. If contact fails, schedule an interview and send the applicant notification by mail. If the interview is missed, notify the applicant by mail of the need to respond and complete an interview by the 30th calendar day of the standard of promptness.

Note: Clients who have ongoing CDC cases are not required to participate in an interview when they apply for CDC Disaster Assistance.

Application Location

An application must be received and processed in a county that is included in the State or Federally Declared Emergency.

Standard of Promptness

For CDC Disaster Assistance, it is recommended that the Eligibility Specialist (ES) certify program approval of the application within 10 days. Allow the client every opportunity to return verifications and meet the interview requirement. Do not deny eligibility until the 30th day of the standard of promptness.

CASE ACTIONS

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

When adding a member to the group, the waiver of income and need still applies to those children who are receiving CDC Disaster Assistance.

Valid CDC EDG Closure Reasons for CDC Disaster Assistance include:

- Client requests closure.
- Incarceration.
- Loss of Michigan residency.
- Only child leaves the home.
- Assets exceed one million dollars.
When a family changes the current address to one outside the Affected Area, CDC Disaster Assistance will end at redetermination.

**CDC GROUP COMPOSITION**

Because the income and need of the group are waived for CDC Disaster Assistance, the only required group member(s) include the child(ren) receiving CDC Disaster Assistance. When additional child(ren) are applied for outside of CDC Disaster Assistance, the CDC Group Composition includes all members listed in BEM 205 and does not exclude those children receiving the CDC Disaster Assistance.

Accept all provided information from any acceptable application for CDC Disaster Assistance. If historical information is available from previous applications or in Bridges, confirm the historical information if possible. Do not request more than the required information.

**AGE**

Follow standard policy for age limits for the CDC Disaster Assistance need reason.

**CHILD SUPPORT**

Do not deny CDC Disaster Assistance eligibility for a child solely because the P/SP is in non-cooperation with the Office of Child Support.

**INCOME**

Income is not a reporting requirement for the CDC Disaster Assistance need reason. If income is or has been reported for any reason, waive the income eligibility. Do not deny CDC Disaster Assistance eligibility for a child solely because the group’s income exceeds the *CDC Income Eligibility Scale* in RFT 270.

**CDC VERIFICATION**

- Do not request verification of a valid need reason.
- Do not request verification of income.
CDC PROGRAM REQUIREMENTS

Eligibility for 40 hours of CDC Disaster Assistance is not dependent on any P/SP being unavailable due to a valid need reason.

When a P/SP applies for CDC Disaster Assistance and certifies that a child was impacted by the approved State or Federal disaster, meets the definition referenced in Special Population, and is determined eligible, authorize 40 hours with a need reason of CDC Disaster Assistance.

Once eligibility has been determined, the child(ren) will remain eligible for the entire 12-month certification period with few exceptions; see Closure Reasons in this item.

Affected Area

The CDC Disaster Assistance Affected Area will be defined and communicated if this eligibility category is activated.

Multiple Eligibility/Need Reasons

The need reason for all children in which the P/SP has made a request for CDC Disaster Assistance, has certified that the child was affected according to the requirements listed above, and the child currently resides in the Affected Area, should be marked as CDC Disaster Assistance. For those individuals who provide supporting documentation for more hours of need, do not enter additional need reasons. Instead, submit a CDC Disaster Assistance Policy Exception Request to Policy-CDC@michigan.gov with the appropriate information pertaining to additional need hours.

Family Contribution

Because there is no income determination for this eligibility group, waive the Family Contribution (FC) listed in RFT 270 (listed as $0). This waiver is due to impact by a State or Federal disaster, confirmed by each applicant's self-attestation.

CDC NEED CALCULATION
Hours Reduced in 12-month Continuous Eligibility

When a child has active CDC, authorized hours cannot be lowered during 12-month Continuous Eligibility. Request a CDC Disaster Assistance Policy Exception for any child whose hours would be reduced by changing to the CDC Disaster Assistance need reason during 12-month Continuous Eligibility. Do not request new supporting documentation.

Need in Two-Parent Household

When requesting a policy exception for additional need hours, consider need calculation for a two-parent household according to BEM 710. If the parents indicate there is an overlap in need hours and the parent with the fewest hours has a need greater than 40 hours, submit a CDC Disaster Assistance Policy Exception as instructed in this policy item.

Documenting the Need Determination

When a CDC Disaster Assistance policy exception is approved, upload the DHS-1785, Policy Decision, and document the approval in Bridges including the following information:

- Calculations used to arrive at the need determination.
- The source of the information used in the need determination.
- Schedule overlap in a two-parent household.
- The date of the policy exception approval.

CDC Disaster Assistance Policy Questions Clarification

Direct questions or clarification requests to the policy mailbox at Policy-CDC@michigan.gov.

REDETERMINATION

At redetermination follow standard policy found in BAM 210, (unless otherwise stated in this policy item), including the
requirement that a client submit a DHS-1010, Redetermination, or other review document.

At redetermination if the CDC Disaster Assistance eligible child fulfills the following two conditions, the child will remain eligible for 40 hours of CDC Disaster Assistance until next redetermination date:

1. The child is age eligible.
2. The child resides in the Affected Area.

Policy Exception Requests at Redetermination

At redetermination, if more than 40 hours of CDC are requested:

- A new policy decision is **not** required if the current P/SP(s) have an approved policy decision for the same or a greater number of hours. Document the hour calculation and proof provided.

- A new policy decision is **required** if the current P/SP(s) does not have an approved policy decision, or if the hours requested are greater than previously approved.

Follow the policy exception guidance in this policy item to request a new policy decision.

**LEGAL BASE**

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

When clients request replacement of their food assistance benefits, follow policy in BAM 502, Food Benefit Replacement.

INTRODUCTION

Disaster assistance benefits are designed to provide disaster cash and disaster food assistance to households affected by federally declared disasters/mandatory evacuations including but not limited to tornadoes, floods, storms, chemical spills etc. Eligibility for cash, the Disaster Relief Program (DRP), and Disaster Food Assistance Program (DFAP) is not limited to households that are typically eligible for Financial Independence Program (FIP) and Food Assistance Program (FAP).

DFAP has also been developed for other households requesting food assistance who sustain less apparent disaster damage and provided verification of the damage. This may include water damage to furniture or essential personal items, water in the basement due to flooded sewers, and other damage.

For individual assistance, follow Disaster Assistance policy once a disaster is federally declared. Clients who come to Michigan as a result of a federally declared disaster in another state may apply for DRP. DFAP applies to Michigan residents who are victims of a federally declared disaster.

The Food and Nutrition Service (FNS) will approve the operation of a DFAP in Michigan once a federally declared disaster/mandatory evacuation occurs. The DFAP application period will occur within 48 hours of approval of the DFAP.

Federally declared disasters are listed at www.fema.gov/news/disasters.fema.

See Concurrent Receipt of Benefits and Semi-Annual Contacts/Mid-Certifications/Redeterminations in this item for treatment of ongoing cases.

DRP

DRP is a lump sum, non-recurring benefit paid to families who have been evacuated from their homes due to a natural or technological disaster. The federal government must issue a major disaster declaration for the area that includes their normal residence.
Program Benefits

The intent of issuing DRP is to do the following:

- Provide short term, non-recurring payments to families recovering from a disaster to prevent the need to apply for ongoing FIP.

- Provide financial support to families affected by a disaster that will not count toward their federal 60-month time limit or Michigan’s 48-month time limit to receive cash assistance.

- Provide financial support to families affected by a disaster in a way that will not impact Michigan’s work participation rate.

- Involve less work than processing ongoing FIP.

- Focus the work participation program employment resources on long-term FIP recipients.

- Issue disaster relief payments in lieu of State Emergency Relief (SER), saving state funds.

Disaster Food Assistance Program

This one-time food assistance payment is for households that lived or had been employed in the disaster area at the time of the disaster. These households must plan on purchasing food during the disaster period.

Note: Active FAP recipients residing in the declared disaster area may receive an automatic replacement of their FAP benefits through a Bridges mass update upon FNS waiver approval.

Eligibility Criteria

Households must have experienced at least one of the following to qualify for benefits:

- Food lost due to disaster.

- Damage to or destruction of their home or place of employment.
- Lost or inaccessible income including reduction or termination of income, or a delay in receipt of income for a substantial part of the benefit period.

- Inaccessible liquid assets for a substantial portion of the benefit period.

- Unreimbursed, out-of-pocket disaster-related expenses not expected to be reimbursed during the benefit period.

APPLICATION

DRP, DFAP

A DHS-3220, Application for Disaster Cash and Food Assistance, must be completed to request disaster benefits for Michigan residents. A request for disaster benefits may be in person or by an authorized representative applying in person for the client.

The date of application is the date the local office receives the completed application.

DRP

Clients from another state, who are applying for an out-of-state disaster, must complete the MDHHS-1171, Assistance Application, the MDHHS-1171-CASH, and the DRP addendum, Out-of-State Disaster Cash Assistance Application, to be considered for disaster assistance.

Application Period

DRP, DFAP

After the Food and Nutrition Service (FNS) approves the state's request to operate DFAP, clients may apply for disaster assistance. The application period is generally seven calendar days. However, the state has the option of decreasing the application period based on the circumstances. The disaster will be defined in Bridges to complete the registration process. If simultaneous disasters occur, Bridges will identify each disaster separately. Choose the correct disaster for which the client is applying. If a DHS-3220 is received after the seventh day, treat it as a request for assistance and provide the client a MDHHS-1171 and program specific supplement form(s), and/or DHS-1514, State Emergency Relief Application.
Note: In rare instances, the federal government may extend or shorten the application period. If Michigan determines a longer application period is needed due to high demand for disaster assistance, an extension period will be requested from the federal government.

DRP

Clients from another state may apply for disaster assistance in Michigan up to 30 calendar days after the federal government declares an out-of-state disaster.

Where to Apply

DRP, DFAP

Clients may apply for disaster assistance at a designated local office or predetermined temporary location.

Authorized Representatives

The client may choose to designate an authorized representative (AR) for disaster assistance that may file the application for the head of household. This authorized representative, or a different authorized representative chosen by the client, may receive the Bridge card and/or utilize the benefits on behalf of the client. All authorized representatives must be designated in writing. The head of household will need to call the toll-free number on the back of the new Bridge card for a personal identification number (PIN).

STANDARD OF PROMPTNESS (SOP)

DRP

The standard of promptness (SOP) is seven calendar days starting with the application date.

DFAP

The standard of promptness is three calendar days starting with the application date. Questionable applications may be given an SOP of seven calendar days and a front end eligibility (FEE) referral must be made.
INTERVIEW REQUIREMENTS

DRP, DFAP

Conduct an in-person interview at application before determining eligibility. If clients choose to have an authorized representative file an application on their behalf, the authorized representative must participate in an in-person interview.

DFAP

Active FAP clients do not need to participate in an interview or complete an application. However, they must complete the DHS-601, Food Replacement Affidavit, unless benefits are automatically replaced through a mass update upon FNS waiver approval.

DRP

An interview is not required before denying the program if it is clear from the application or other sources that the group is ineligible.

Deny DRP on the 30th day if the client has not participated in an interview.

DFAP

For DFAP only, conduct an interview before denying the application for assistance even if it is clear from the application or other sources that the group is ineligible.

Deny DFAP on the 7th day if the client has not participated in an interview.

DRP, DFAP

If the group is ineligible or refuses to cooperate in the application process, certify the denial of the appropriate program and Bridges will generate a DHS-82, Disaster Benefits Eligibility Notice.

BENEFIT PERIOD

The benefit period for disaster benefits is 30 days from the date of the federally declared disaster or the date of any mandatory evacuation preceding the declared disaster. During this 30-day period, the following are used to determine eligibility:

- The household’s income received or expected to be received.
• The household’s accessible liquid assets.
• The household’s unreimbursed disaster expenses.

Multiple Disasters

A client can receive only one disaster payment per declared disaster. If there are multiple disasters in a 30-day period, each disaster must be federally declared and identified on Bridges separately.

DFAP

Households cannot receive more than one DFAP allotment in any benefit period. If there are multiple federally declared disasters in the same disaster area in the same 30-day period, the household may participate only in one automatic replacement in the benefit period. If the second disaster destroys the original replacement, the client can request a second replacement by completing a DHS-601, Food Replacement Affidavit.

APPLICATION PROCESSING

DRP, DFAP

A new case number is given to each disaster application in Bridges, even if the head of household already has an existing case. The disaster application takes priority over any pending applications that the client may already have.

Example: Client has a pending FIP/FAP application in May. A disaster is federally declared in June and the client is eligible for DRP/DFAP. DRP/DFAP benefits are issued for June. FIP/FAP eligibility is determined for May, July and forward.

Send the DHS-3503, Verification Checklist, (VCL) out of MS Word to the client. Encourage clients to bring all verifications with them, however; do not delay processing the disaster application for the return of verifications that are not mandatory.

Note: For DFAP only, identity is the only required verification.
NON-FINANCIAL ELIGIBILITY FACTORS

Identity

The identity of the head of household must be verified. If an authorized representative is applying on behalf of the head of household, the identity of the authorized representative must also be verified.

Verification Sources

Verification of identity includes but is not limited to:

DRP and DFAP

- Driver’s license.
- State-issued ID.
- Military ID.
- School-issued identity card.
- Social Security Administration cross match in Bridges.

DFAP Only

The affidavit language in the certification section of the DHS-3220 may serve as verification of identity for the client and authorized representative, if applicable.

Residence

DRP, DFAP

For disasters that occur in Michigan, the client’s geographical location must be in a federally declared disaster area. The client must have lived or been employed in the disaster area at the time of the disaster.

Clients that are indicated as homeless in Bridges at the time the disaster occurred and state they resided in the geographical disaster location are potentially eligible for disaster assistance. Applicants who are staying in a shelter, regardless of their length of stay, are potentially eligible.

Note: The temporary address of a homeless client does not have to be in the declared geographical disaster location.
Overrides

If the client does not have a ZIP code or the ZIP code from Postal Soft is incorrect, a manager/supervisor must approve the override by initialing the DHS-3220. A daily report will indicate the cases that required a manual override.

DRP

Applicants must have been evacuated from their home or forced to relocate in order to receive a payment. The family cannot be residing in the home where the disaster occurred at the time of application.

For clients coming to Michigan from out-of-state federally declared disasters, the out-of-state address must be in the declared area (usually by county or parish). The client must have moved to Michigan due to the disaster and apply for disaster assistance within 30 days of the disaster being declared.

Note: Federally declared disasters are listed at www.fema.gov/news/disasters.fema.

A client does not have to intend to remain in Michigan to receive DRP.

Verification

DRP, DFAP

Verify residence if possible.

Verification Sources

Verification of residence includes but is not limited to:

- Driver’s License.
- Other ID with address.
- Utility bills.
- Tax bills.

Accept client statement if verification is unavailable.

Food Loss

DFAP

Food loss due to a disaster.
Verification

Verify only if questionable.

Verification Sources

- Check if residence is within the disaster area.
- Check with power company.

Group Composition

DRP

The group must contain at least one dependent child and a caretaker and/or a pregnant woman.

A dependent child is an unemancipated child, including a child who receives SSI, who lives with a caretaker and is one of the following:

- Under age 16.
- Age 16 to 18, attending high school/equivalent at the time of the disaster.

A caretaker is a legal parent, stepparent or specified relative who acts as a parent to a dependent child.

A specified relative must be at least age 18 and legally related to the child by blood, marriage or adoption. Specified relative includes:

- Grandparent (including great or great-great).
- Aunt or uncle (including great or great-great).
- Sibling (including half-sibling).
- Niece or nephew.
- First cousin or first cousin once removed.
- Spouse of any of the above, even if the marriage ended due to death or divorce.
- The parent of a child’s putative father.
- A child’s legal guardian.
- An adult at least age 21 whose petition for legal guardianship of the child is pending.
All other aspects of group composition (mandatory/optional members) are the same as FIP; see BEM 210.

**Note:** Do not include members of the household with whom applicants are temporarily staying during the disaster.

**DFAP**

All members of the household that are living and eating together at the time of the disaster are mandatory group members.

**Note:** Do not include members of the household with whom applicants are temporarily staying during the disaster.

**Group Composition Corrections**

**DRP, DFAP**

After program certification, any corrections needed for group composition, including member adds, must be done by central office.

**Verification**

Verify members of the household if questionable.

**Verification Sources**

Ask the applicant to orally list the names, ages and birthdates of all household members.

**DRP**

**Pregnancy Verification**

Verify pregnancy only if questionable and when DRP eligibility is based solely on the pregnancy.

**Pregnancy Verification Sources**

Use a statement, including expected date of delivery, from one of the following:

- Doctor of medicine (MD).
- Doctor of osteopathy (DO).
- Physician’s assistant (PA).
- Ob-gyn nurse practitioner (NP).
- Ob-gyn clinical nurse specialist (NS).
- Certified nurse-midwife.
Disqualified Group Members

- Form DHS-49, Medical Examination Report, DHS-54A, Medical Needs or other written statement may be used.

**DRP, DFAP**

Disqualified clients are potentially eligible for disaster benefits unless they are disqualified in an active EDG.

Pete is currently disqualified on an active FIP and FAP EDG for failing to provide his Social Security number. He is not eligible for disaster benefits. However, if the EDG is closed, Pete would be potentially eligible for disaster benefits.

An applicant’s status as any of the following is not relevant to his or her eligibility for DFAP:

- Student.
- Striker.
- Citizen or alien.
- Work program participant.
- Someone disqualified under the regular FAP program.

**Social Security Number**

**DRP**

A Social Security number (SSN) must be provided or the client must cooperate in obtaining an SSN for each group member.

**Verification**

Client statement is acceptable.

**DFAP**

An SSN is not a requirement. Do not deny/disqualify a client if they refuse or are unable to provide an SSN.

**Citizenship/Alien Status**

**DRP**

Individuals must meet citizenship/alien status requirements; see BEM 225.
Verification

Client statement is acceptable.

DFAP

Citizenship and alien status is not a requirement.

School Attendance and Student Status

DRP

Clients who are 16 to 18 years old and not the head of household must be attending high school/equivalent full-time at the time of the disaster to be eligible for a DRP benefit. If the disaster is during a vacation, the 16 to 18-year old must be returning to school after break.

Verification

Client statement is acceptable.

DFAP

School attendance and student status determination is not a requirement.

Intentional Program Violation (IPV)

DRP

A client who is disqualified for an IPV is not eligible to receive DRP.

DFAP

A client who is disqualified for an IPV may still receive benefits under DFAP.

Concurrent Receipt of Benefits

DRP, DFAP

The eligibility determination month (EDM) for disaster benefits will be the month in which the disaster occurred or the month of the mandatory evacuation date, whichever is earlier.
**Example:** Mandatory evacuation date is 6/29. Disaster occurred 7/1. Benefits issued 7/3. EDM is June. Benefit period will be 6/29 to 7/29. Client is potentially eligible for regular FIP/FAP benefits in July.

**DRP**

A client is not eligible for FIP benefits the same month as a DRP benefit.

Send a DHS-3782, Out-of-State Inquiry, for clients who come to Michigan from out-of-state. Do **not** delay processing while waiting for a response. Advise clients if they receive duplicate benefits that they must return any assistance they receive from another state for the same period. Failure to return benefits from another state for the same period could result in a 10-year federal disqualification for cash, food, SSI and MA.

**DFAP**

A client is not eligible for FAP benefits the same month as a disaster benefit.

**Ongoing FAP Recipients**

Active FAP recipients residing in the declared disaster area may receive an automatic replacement of their FAP benefits through a Bridges mass update upon FNS waiver approval.

**Assets**

**DRP, DFAP**

There is no asset limit for disaster benefits. However, accessible liquid assets are used to determine eligibility; see Budgeting Income, Assets and Expenses in this item.

**Pursuit of Benefits**

The client is not required to pursue any potential benefit; see BEM 270.

**Child Support**

Child support is not a condition of eligibility; see BEM 255.
Employment Related Activities

Disaster assistance does not have any employment and training requirements as in the BEM 230 series.

BUDGETING INCOME, ASSETS AND EXPENSES

DRP, DFAP

Budget income, accessible liquid assets and disaster-related expenses the household expects to receive/have during the 30-day disaster benefit period. Only budget unreimbursed, out-of-pocket, disaster related expenses, not expected to be reimbursed during the 30-day disaster benefit period.

Income

Prospect the net earnings the household received or expects to receive in the 30-day benefit period. All income of all household members regardless of age and type of income is countable. Net pay is defined as:

- Wages a household receives after taxes and all other payroll withholding such as child support payments, 401K deductions, garnishments, etc. are deducted.

- Self-employment income minus the expenses.

- Unearned income such as RSDI/SSI, unemployment compensation, FIP, worker's compensation, etc. (after all deductions).

**Exception**: DRP income is not budgeted as unearned income in the DFAP budget.

**Note**: The DRP payment is excluded as income for FAP, CDC and MA. For SER, it is excluded income but any amount of the DRP in the client’s possession at the time of SER is a cash asset.

**Verification**

Verify if possible. Accept client's statement if verification is unavailable.
Assets

Budget all accessible liquid assets. Liquid assets include only:

- Cash on hand.
- Accessible checking/draft and savings/share account balances.

**Note:** Remember, with ATM cards and electronic transmission, few liquid assets are truly inaccessible.

**Verification**

Verify if possible. Accept client’s statement if verification is unavailable.

**Disaster-Related Expenses**

Allow the deduction of disaster-related expenses paid or anticipated to be paid **out-of-pocket** by the household during the disaster benefit period. If the household receives or anticipates receiving a reimbursement for these expenses during the disaster period, only the net expense is deductible (do not allow the reimbursable expense).

**Note:** If the household pays disaster-related expenses using a credit card and will pay their credit card bill after the disaster benefit period, that expense is not considered out-of-pocket and is not deductible.

No other expenses are considered in determining eligibility for disaster benefits.

**Example:** If a client pays voluntary child support, it is not considered a disaster expense and is not allowable.

Examples of deductible disaster-related expenses:

- Home repairs.
- Temporary shelter expenses.
- Evacuation expenses.
- Disaster-related personal injury expenses.
- Disaster-related funeral expenses.
• Disaster-related pet boarding fees.

• Expenses related to replacing necessary personal and household items such as clothing, appliances, tools, and educational materials.

• Clean-up items.

• Disaster-damaged vehicle expenses.

• Disaster-related moving and storage expenses.

**Note:** Do not mistakenly equate a household’s total disaster losses with disaster expenses. For example, a family might report the destruction of their $80,000 home. However, only that household’s out-of-pocket expenses that were not reimbursed or are **not** expected to be reimbursed during that benefit period would be considered for determination of eligibility, not the entire value of their destroyed home.

**Verification**

Verify disaster-related expenses only if questionable.

**Benefit Calculation**

**DRP, DFAP**

The household’s net (take-home) income received or expected to be received during the benefit period **plus** its accessible liquid assets **minus** unreimbursed disaster-related expenses equals the countable disaster income. Bridges compares this amount to the disaster income limits based on group size. If the household’s disaster income is less than or equal to the disaster income limit, the household is eligible for DRP and /or DFAP; see Income Eligibility and Allotment Tables in this item.

**Note:** The DHS-3221, Disaster Food Assistance Application Worksheet, may be completed if Bridges is unavailable.

**BENEFIT ISSUANCE**

Disaster assistance is issued through the normal electronic benefit transfer (EBT) process; see BAM 401E, Electronic Benefit Transfer Issuance System.
FIP, FAP, CDC

EDG’s that are active and due for review in the month the disaster occurred will have their review date extended by two months in Bridges. The FAP certification period end date will also be extended in Bridges. This allows workload relief so redeterminations, semi-annual contacts and mid-certifications are not handled during the disaster.

HEARINGS

DRP, DFAP

Who May Request

Any household that applied for disaster assistance benefits and was denied benefits may request a fair hearing.

Who May Not Request

Households that never applied for disaster assistance for any reason do not have a right to a fair hearing. This includes households that were unaware of the DRP/DFAP programs or were not able to apply during the application period.

Denials

Clients do not have the right to reopen their denied case in order to have their eligibility recalculated because their personal circumstances have changed during or after the application period.

Supervisory Review

A household which has requested a fair hearing is entitled to an immediate, on-site expedited supervisory review which in no way shall interfere with the applicant’s right to a fair hearing.
Withdrawal of Request

If a head of household wants to withdraw its request for a fair hearing, the request may be done verbally or in writing. Send a written confirmation of the withdrawal when the client verbally withdraws their fair hearing request.

Hearing Decisions

If an administrative law judge finds in favor of the client, and the client is due a benefit issuance, central office will issue the benefit through a manual process.

RECOUPEMENT

Recoupment for DRP and DFAP will be a manual process. The DRP and DFAP agency error, client error and suspected intentional program violation (IPV) must be a priority for recoupment specialists. Recoupment must be started within six months after the disaster. The recoupment procedures will follow current processes in place for each type of error excluding the exceptions listed below.

An IPV committed in DRP/DFAP will increase the number of IPV's a client has. The IPV will be served on regular cash and/or FAP.

Exceptions

Overissuance Processing

When the specialist discovers a potential overpayment (OP) regarding the disaster, make a referral to the recoupment specialist (RS) within 30 days of suspecting an OP has occurred using the DHS-4701, Overissuance Referral.

The RS must make disaster OPs their first priority. Within 30 days of receiving the referral, the RS must establish the claim or refer the suspected intentional program violation (IPV) to Office of Inspector General (OIG).

Suspected IPvVs must be a priority with OIG and within 30 days an agent must have determined if the overissuance is an agency or client error or OIG continues on with the investigation for IPV. Within 120 days of receiving the referral, OIG must determine if the case is an IPV and return to the RS for entering the claim on Bridges.
**Overissuance Period**

The benefit period for DFAP will be one month. DRP will be three months of benefits for each disaster.

**Benefit Collections**

Overissued disaster benefits will automatically be recouped from all respective ongoing benefits. Automated recoupment will never be deducted from disaster benefits.

Collections of disaster benefits will follow the current processes.

**LEGAL BASE**

**DRP**

42 USC 602(a)

**DFAP**

7 CFR 280.1
INCOME ELIGIBILITY AND ALLOTMENT TABLES

DRP Payment Standard

<table>
<thead>
<tr>
<th>Group Size</th>
<th>DRP Payment</th>
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<tr>
<td>1</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
<td>$1,476</td>
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<tr>
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<tr>
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<td>$2,715</td>
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<tr>
<td>8 or more</td>
<td>Add $240 for each additional person</td>
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DRP Monthly Income Limit

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<th>Group Size</th>
<th>Monthly Income Limit</th>
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<td>Add $623 for each additional person</td>
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DFAP Maximum Allotment Effective 10-1-18
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<td>8</td>
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<tr>
<td>Each Additional Member</td>
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</table>

**DFAP Monthly Income Limit Effective 10-1-18**

<table>
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<th>Group Size</th>
<th>Income Limit</th>
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