431-1
In 1998, Congress enacted the Medicare Catastrophic Coverage Act (MCCA). The legislation addresses the situation when one spouse is institutionalized in long term care and the remaining spouse is at home. Allowances are provided to the non-institutionalized spouse before the joint income and resources are used to determine Medicaid eligibility for the institutionalized spouse. The provisions of this legislation are codified in 42 United States Code Section 1396r-5. There are currently no state regulations implementing the MCCA provisions. Proposed regulations were set forth in All-County Welfare Directors Letter (ACWDL) No. 90-01, January 5, 1990 and ACWDL No. 90-03, January 8, 1990 and are presently considered to reflect CDHS's implementation of the MCCA legislation.

431-2
An institutionalized spouse as an individual in a medical institution or nursing facility (and who is likely to meet this requirement for 30 consecutive days) and is married to a spouse who is not in a medical institution or nursing facility. A community spouse is the spouse of the institutionalized spouse. (42 United States Code (USC) §1396r-5(h))

For purposes of MCCA a couple is married until that marriage is dissolved or annulled. A legal separation will entitle the two spouses to the Community Spouse Resource Allowance plus the property limit for one, and for income allocation to the community spouse. (All-County Welfare Directors Letter (ACWDL) No. 91-55, June 11, 1991)

431-3 REVISED 12/09
An institutionalized spouse may transfer an amount equal to the Community Spouse Resource Allowance (CSRA), but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. Such transfer shall not be disqualifying. The CSRA, as defined in Subsection (f)(2) is the greatest of four calculations. In California, the second option, $60,000 plus an indexed figure, is used. (42 United States Code §1396r-5(f)(1))

The CSRA is $113,640 in 2012. (All-County Welfare Directors Letters (ACWDL) No. 12-05).

431-3A ADDED 9/07
The community spouse resource allowance (CSRA) shall be an amount of combined nonexempt community and separate property belonging to either or both the institutionalized and community spouses which the community spouse is allowed to retain when the institutionalized spouse applies for Medi-Cal.

(ACWDL 90-01, January 5, 1990, draft regulation §50031.7)

431-3B ADDED 9/07
The property of institutionalized spouses and community spouses shall be treated in accordance with Sections 50490.1 through 50490.7. These sections shall supersede any other section(s) of this article that are inconsistent with it.

(ACWDL 90-01, January 5, 1990, draft regulation §50490)

431-3C ADDED 9/07
In determining eligibility of an institutionalized spouse at the time of application for Medi-Cal, regardless of any State laws relating to community property or the division of marital property, the net market value of all net nonexempt property available under Section 50402 and held by either the institutionalized spouse, community spouse or both, shall be considered available to the institutionalized spouse.

(ACWDL 90-01, January 5, 1990, draft regulation §50490.3)

431-4 REVISED 12/09
The Minimum Monthly Maintenance Needs Allowance (MMMNA) as set forth in 42 USC §1396r-5(d)(3)(C) shall not exceed $1,500, subject to adjustment under Subsections (e) and (g).

Subsection (g) provides for an indexing of the $1,500. Subsection (e)(2)(B) provides that if either spouse establishes that the community spouse needs income, above the level otherwise provided by the MMMNA, due to exceptional circumstances resulting in significant financial duress, there shall be substituted an amount adequate to provide such additional income as is necessary. Such revised MMMNA is to be resolved at the state hearing provided applicants or recipients. (42 USC §1396r-5(e)(2)(B))

The basic MMMNA is $ $2841 effective January 1, 2012. (All-County Welfare Directors Letter 12-05)

431-5
Under federal law, a community spouse is entitled to retain property in the amount equal to the community spouse resource allowance and such property is not to be counted in the property reserve for purposes of determining Medicaid eligibility. Furthermore, if either spouse establishes that the CSRA, in relation to the amount of income generated by such an allowance, is inadequate to raise the community spouse's income to the Minimum Monthly Maintenance Needs Allowance (MMMNA), there shall be substituted for the CSRA under Subsection (f)(2) an amount adequate to provide such an MMMNA. This determination can only be made through a probate proceeding or through an administrative hearing decision. (42 United State Code §§1396r-5(e)(2) and (f)(2))

The Deficit Reduction Act of 2005 signed into law by President Bush on February 8, 2006 a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the MMMNA and all income available to the community spouse. These provisions are applicable to persons entering long term care March 2006 and thereafter. The amount available to the

community spouse is computed by subtracting the long term maintenance need of $35.00 from the institutionalized spouse's net income. (All County Welfare Directors Letter 06-12)

431-6
Pursuant to a policy clarification from the Health Care Finance Administration, a deposit of a Long Term Care (LTC) spouse's income into a joint account is considered a transfer of income to the spouse at home. In joint bank account situations, no further verification is necessary. However, when income is not deposited in a joint account, the beneficiary must provide documentation that the monies actually changed hands, via a canceled check, bank statement, etc. (All-County Letter Welfare Directors (ACWDL) No. 90-89, October 9, 1990)

431-7
Federal law provides for allowances to be offset from the income of an institutionalized spouse. After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to the payment for the cost of the care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance;

(B) A community spouse monthly income allowance, but only to the extent income of the institutionalize spouse is made available to or for the benefit of the community spouse;

(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member; and

(D) Amount for incurred expense for medical or remedial care for the institutionalized spouse.

This section goes on to say that the term “family member” only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(42 United States Code (USC) §1396r-5(d)(1))

431-8 REVISED 12/05
The DHCS has not issued regulations to implement the Federal Statutes governing MCCA. However, in All-County Welfare Directors Letter (ACWDL) No. 90-03, January 8, 1990, proposed regulations were set forth.

Proposed §50563.5 provides that when an aged, blind, or disabled person with LTC status has a community spouse residing in the home, the income of the person with LTC status shall be treated as follows:

(1) Determine the gross nonexempt income of the person with LTC status which is in excess of the appropriate maintenance need for that person and in accordance with the provisions of §50605;

(2) Determine the maintenance need for the community spouse in accordance with §50605(f)(1), and deduct from that maintenance need the total gross monthly income of the community spouse, with the remainder being the community spouse allowance;

(3) Determine the maximum allocation base for each family member in accordance with §50605(f)(2), and deduct from this allocation base the gross monthly income of that family member. One-third of the remainder shall be considered the family member allowance for that person. The total of all family member allowances shall be considered the total family member allowance; and

(4) Add the community spouse allowance with the total family member allowance. This is the amount which shall be allocated to the community spouse and other family members from the income amount for the person with LTC status.

Exceptional circumstances that result in financial duress shall include, but are not limited to, costs associated with the purchase of housing modifications to the extent the community spouse maintenance need is inadequate to cover such purchases; costs associated with the ongoing purchase of prescribed medical diet foods and dietary supplements; utility costs associated with the use of prescribed medical equipment to the extent the community spouse maintenance need is inadequate to cover such costs; repairs necessary to maintain the home in a livable condition, which shall not include optional or cosmetic changes; and unusual and unforeseeable circumstances such as fire, flood, or other special circumstances which result in loss of normal housing, clothing, household goods, and other necessary possessions. (Proposed §50605.5(c))

Exceptional circumstances resulting in financial duress shall not include the usual increases for rent, food, housing, clothing, and other customary living expenses. (Proposed Subsection (d))

Once a finding of exceptional circumstances resulting in financial duress has been established, the state ALJ shall establish a new maintenance need for the community spouse (i.e. the minimum monthly maintenance need allowance) which shall include an amount sufficient to cover such expenses, and specify whether such maintenance need level will be temporary or continuing. If the order specifies that the maintenance need is temporary, the ALJ shall establish the duration of the new maintenance need and advise the claimant that he/she must request an extension through the state hearing process if the exceptional circumstance continues. The DHCS has issued tables which set forth the community spouse maintenance need, as set forth above. In 200_, that maintenance need standard is $_____. DHCS has also issued an allocation base, for attribution of income from the LTC family member to the other family members. For _____ persons, that allocation base is $_____. (Proposed Subsection (f); All-County Welfare Directors Letters (ACWDLs) No. _____)

431-8A ADDED
4/12If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance an amount adequate to provide such

additional income as is necessary. Any such modification must be based on a determination at a fair hearing or by a court. (42 United States Code (USC) §1396r-5(e)(2))

DHCS has defined "exceptional circumstances that result in financial duress" as including, but not limited to, costs associated with the purchase of housing modifications to the extent the community spouse maintenance need is inadequate to cover such purchases; costs associated with the ongoing purchase of prescribed medical diet foods and dietary supplements; utility costs associated with the use of prescribed medical equipment to the extent the community spouse maintenance need is inadequate to cover such costs; repairs necessary to maintain the home in a livable condition, which shall not include optional or cosmetic changes; and unusual and unforeseeable circumstances such as fire, flood, or other special circumstances which result in loss of normal housing, clothing, household goods, and other necessary possessions. (Proposed §50605.5(c) set forth in ACWDL 90-03)

431-8A1 REVISED 10/10
The family-member maximum base allocation amount is used to determine how much income the long-term care beneficiary may allocate to family members. The family member base allocation is $1839 effective July 1, 2011. (All County Welfare Director's Letters 11-32, August 16, 2011)

431-8B ADDED 5/05
Where there are minor children in the home but no community spouse and there is a parent in LTC; or where a person in board and care or a medically indigent adult in LTC has a spouse and/or children living in the home, the existing allocation methodology will continue to apply. The family's net nonexempt income will be deducted from the maintenance need for a family of appropriate size with the remainder allocated to the family living in the home. (ACWDL 90-03, January 8, 1990)

431-8C ADDED 3/09
A person with LTC status shall retain an amount of income to pay for the support of a disabled relative if the disabled relative is not the LTC patient's spouse or child (as defined in §50030) and the LTC patient has contributed and will continue to contribute to the support of the disabled relative on a regular basis. (ACWDL 90-03, draft regulation §50605(d))

The amount allowed for the support of the disabled relative, if the conditions of §50605(d) are met shall be the lesser of the actual amount contributed, or the maintenance need level for one person in accord with § 50603(a)(1), minus the disabled relative's net income. (ACWDL 90-03, draft regulation §50605(e))

432-1
To be eligible as a Qualified Medicare Beneficiary (QMB) individual, one must be entitled to Part A Medicare hospital insurance benefits; meet the qualifying income level, as defined in §50570; and meet the qualifying resource limit, as defined in §50421. (§50258(a))

Eligibility for the QMB Program shall begin the first of the month following the month of approval. (§50258(b))

DHCS shall pay Medicare premiums, coinsurance, and deductibles. (§50258(c))

432-2
Federal law defines a "qualified Medicare beneficiary" as an individual who is entitled to hospital insurance benefits under Part A of Subchapter XVIII; whose income does not exceed the official poverty line for a family of such size; and whose resources do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under the SSI Program. Such individuals are eligible to receive, from the state, certain premiums under Subchapter XVIII (including Parts A and B), deductibles and coinsurance fees. (42 United States Code §1396d-p)

The DHCS policy as to implementation of this program is set forth in All-County Welfare Directors Letter (ACWDL) No. 90-02, January 8, 1990; Medi-Cal Eligibility Procedures Manual (MEPM) 5F, issued as part of ACWDL No. 91-09, February 7, 1991, referencing ACWDLs 90-02, 90-29, 90-71 and 90-73.

432-3
For qualified Medicare beneficiaries (QMBs), the DHCS shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the Social Security Act, when the person's income does not exceed the federal poverty level, and resources do not exceed 200% of the SSI Program standard. (Welfare and Institutions Code (W&IC) §14005.11) DHCS shall also pay applicable additional premiums, deductibles, and coinsurance for drug coverage, as offered to categorically needy recipients, as defined in W&IC §14050.1 and Title XIX of the Social Security Act. (W&IC §14005.11(b))

432-4 REVISED 12/09
The four QMB requirements are:

1. A QMB must be eligible for Medicare Part A (Hospital Insurance)

2. A QMB must have income less than 100% of the federal poverty level.

3. A QMB must have property valued at $4000 or less if a single person, or $6000 or less if married and living with a spouse.

4. A QMB must meet certain other Medi-Cal program requirements, such as California residency.

For 2010, the property (resource) limits are $6,600 for an individual and $9,910 for a couple.

(All-County Welfare Directors Letter (ACWDL) No. 97-34, ACWDL 09-52)

432-5

A Specified Low-Income Medicare Beneficiary (SLMB) is ineligible as a Qualified Medicare Beneficiary (QMB) solely due to excess income.

A SLMB must be entitled to Part A Medicare hospital insurance benefits, meet the qualifying income level as defined in §50570(b), and meet the qualifying resource limit as defined in §50421.

The period of eligibility shall include the first month eligibility is approved, and may include three months of retroactive benefits from the month of application. If eligibility exists, the DHCS shall pay Medicare Part B premiums as defined in §50091.5. (§50258.1)

432-6
The DHCS policy on the Specified Low-Income Medicare Beneficiary (SLMB) Program, established under Public Law 101-508 (§4501 of OBRA, 1990) requires counties to phase in payments for certain Medicare beneficiaries beginning January 1, 1993. A SLMB must be entitled to Medicare Part A, have no more than twice Medi-Cal's property limit, have income below 120% of the federal poverty level (FPL) in 1996 and thereafter, and be a citizen or alien who would be eligible for full Medi-Cal benefits. (All-County Welfare Directors Letter No. 92-61, October 23, 1992; Medi-Cal Eligibility Procedures Manual §5J-1)

A SLMB is ineligible as a QMB solely due to excess income. The DHCS shall pay Medicare Part B premiums for SLMB as defined in §50091.5. (§50258.1)

432-7 REVISED 12/09
The Specified Low-Income Beneficiary (SLMB) Program is limited to the payment of the Medicare Part B premium. It does not pay the Medicare Part A premium or the Part B deductibles or coinsurance. The SLMB's Medicare Part B premium will be purchased under the State Buy-In process.

To be eligible a SLMB must:

- Be entitled to Medicare Part A and B;

- Have no more than twice the Medi-Cal property limit ($4,000 for one person, $6,000 for a couple);

- Have income below 120 percent of the Federal Poverty Level (FPL); and

- Be a citizen or alien who would be eligible for full-scope Medi-Cal benefits if he or she were eligible for a regular Medi-Cal program, except for excess income or property.

For 2010, the property (resource) limits are $6,600 for an individual and $9,910 for a couple.

A SLMB who meets the Medi-Cal eligibility requirements for a different Medi-Cal program may receive benefits under both programs (SLMB and Medi-Cal) in the same month.

Scope of Medicare Part B Benefits

Medicare Part B medical insurance includes doctor's services, outpatient hospital care, home health care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies.

(Medi-Cal Eligibility Procedures Manual §5J-1; ACWDL 09-52))

432-8 ADDED
4/12Net non-exempt income for the QMB, SLMB or QI program shall be determined in accordance with all the applicable provisions of Article 8 and Article 10, except that the health insurance premiums as specified under Section 50555.2 are not allowed (§50570)

433-1 REVISED 12/09
The Balanced Budget Act of 1997 established a new Medi-Cal program which pays some or all of the Medicare Part B premium for those eligible to the Qualifying Individuals (QI) program. The QI program is divided into the QI-1 and QI-2 programs. (The QI-2 program was sunsetted effective December 31, 2002)

If an individual has income under 100% of the Federal Poverty Level (FPL) and meets other eligibility criteria such as residency and resource limits, the individual is eligible under the QMB program.

If an otherwise eligible individual has income between 100% and 120% of the FPL, the individual is eligible for the SLMB program.

If an otherwise eligible individual has income of at least 120% but less than 135% of the FPL, the individual is eligible under the QI-1 program. The QI-1 program will pay the full Part B Medicare premium.

The resources limit for the QMB, SLMB and the QI programs is $4000 for an individual and $6000 for a couple.

For 2010, the property (resource) limits are $6,600 for an individual and $9,910 for a couple.

(All-County Welfare Directors Letter (ACWDL) No. 98-47, October 22, 1998, referencing ACWDLs 97-45 and 98-15; ACWDL No. 03-02, and 09-52)

433-2
Counties must review medically needy applications and eligibility redeterminations to determine if there is eligibility for the Qualified Medicare Beneficiary (QMB) program. If the individual is not eligible as a QMB due to income, counties must evaluate the individual for either the Specified Low Income Medicare Beneficiary (SLMB) or the Qualified Individual (QI) program, so that the DHCS can claim funding for the state payment of Medicare Part B payments. While federal law prohibits a QI from being eligible for any other Medicaid program, medically needy individuals with an SOC may be eligible for QI in those months the SOC is not met. (All-County Welfare Directors Letters No. 99-61, November 17, 1999)

433-3
The QI-1 Program is limited to the payment of the Medicare Part B premium. It does not pay the Medicare Part A premium, or the Part B deductibles or copayments.

To be eligible a QI-1 must:

- be entitled to Medicare Part B (which includes doctor's services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and other health services and supplies);

- have income at or above 120 percent of the Federal Poverty Level (FPL) and up to but not including 135 percent of the FPL;

- have no more than twice the Medi-Cal's property limit ($4,000 for one person, $6,000 for a couple); and

- be a citizen or alien who would be eligible for a regular Medi-Cal program except for excess income or property.

QI-1, Other Medi-Cal Coverage:

1. An individual may not be determined eligible for the QI-1 program if he or she is eligible for any other zero SOC Medi-Cal program, such as SSI cash-based Medi-Cal, or ABD-MN with no Share of Cost (SOC).

2. A QI-1 with an SOC is not considered eligible for the SOC program until the SOC is met. Therefore, the QI-1 may be reported to MEDS in both the QI-1 and the SOC aid code in the same month.

(Medi-Cal Eligibility Procedures Manual §5J-5(B.1))

433-4 REVISED 7/12
The QI-1 program provides the state payment of the Medicare Part B premium for individuals with income below 135 percent of the federal poverty level. The QI-1 program was scheduled to sunset on December 31, 2002. That sunset date has been extended several times.

The QI-1 program sunset date has again been extended, this time to December 31, 2012. Counties are to continue accepting applications and determining eligibility for the QI-1 program until the DHS notifies them that the QI-1 program has been discontinued.

(ACWDL 12-18, June 8, 2012)

433-4A REVISED 7/12
The QI-1 program provides the state payment of the Medicare Part B premium for individuals with income below 135 percent of the federal poverty level. The QI-1 program was scheduled to sunset on December 31, 2002. That sunset date has been extended several times.

The QI-1 program sunset date has again been extended, this time to March 31, 2015. Counties are to continue accepting applications and determining eligibility for the QI-1 program until the DHS notifies them that the QI-1 program has been discontinued.

(ACWDL 14-25, May 6, 2014)

434-1 REVISED 11/05
To be eligible for the TB program, a person must:

1. Be infected with TB, as certified by a Medi-Cal physician.

2. Not be a Medi-Cal beneficiary whose coverage is mandated by federal laws, such as AFDC, SSI/SSP, other Public Assistance (PA) or one of the federal poverty level programs.

3. Be a United States citizen or a person who has satisfactory immigration status (SIS).

4. Have income and resources which do not exceed the maximum amount for a disabled individual under the SSI program.

   Income cannot exceed the "TB income standard."

   Property cannot exceed $2,000 for an individual or for a couple, except when determining a child's eligibility, with two parents, in which case it is $3000.

5. Meet all other Medi-Cal requirements, such as cooperation, verification, and status reporting.

(Medi-Cal Eligibility Procedures Manual (MEPM) §5N-1 - 5N-6; All-County Welfare Directors Letters (ACWDLs) No. 95-12, February 10, 1995; 95-39, July 14, 1995, and 95-73, November 22, 1995, and 98-02 (superseding 97-52), January 5, 1998; 99-62, November 24, 1999; 01-03, January 8, 2001)

434-2 REVISED 11/05
In determining net income in the TB program, Medi-Cal regulations governing disabled persons are used to determine deductions and exemptions.

There are three exceptions to this general rule: (1) Parental allocation to ineligible children; (2) parental deduction; (3) non-deeming by certain ineligible spouses.

If the net nonexempt income exceeds the appropriate TB income standard, the individual person is ineligible for the TB program. (MEPM §5N-4, 5)

434-3

The TB resource limit is $2,000 for a single person or for a married couple. These limits increase to $3,000 if the couple's child lives in the home.

Resources are determined under Medi-Cal regulations, except if the TB applicant is a child there are special deeming rules. (MEPM §5N-5, 6; All-County Welfare Directors Letter (ACWDL) No. 95-39, July 14, 1995)

The value of resources is determined as of 12:01 a.m. on the first day of the month. (All-County Welfare Directors Letter No. 95-12, February 10, 1995, Question 20, citing 20 CFR §416.1207)

434-4
In the TB program, the scope of benefits is limited to TB-related services such as physician specified clinics, out-patient hospital services, clinic services, federally qualified health center services, case management services, and services (other than room and board) to monitor prescribed drugs. (MEPM §5N-6, 7)

If a TB infected person is eligible for full-scope Medi-Cal with an SOC, that person should be evaluated for the TB program as that person could be eligible for the TB program and not have an SOC for out-patient TB services, (All-County Welfare Directors Letter No. 95-12, February 10, 1995, Question 11)

435-1
EPSDT supplemental services means health care, diagnostic services, and other treatment that:

(1) Are identified in 42 United States Code §1396d(r)

(2) Are available only to persons under 21 years old

(3) Meet any medical necessity standard set forth in §51340(e), paragraph (1), (2) or (3)

(4) Are not EPSDT diagnosis and treatment services (as defined in §51184(b))

(§51184(c))

435-2
Requests for prior authorization for EPSDT supplemental services shall include the following information:

(1) The principal diagnosis and significant associated diagnoses.

(2) Prognosis.

(3) Date of onset of the illness or condition, and etiology, if known.

(4) Clinical significance or functional impairment caused by the illness or condition.

(5) Specific types of services to be rendered by each discipline associated with the total treatment plan.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.

(7) The extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care.

(8) Any other documentation available which may assist in making the required determinations.

(§51340(d))

435-3
Orthodontic services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries are covered only when medically necessary pursuant to the criteria set forth in the Medi-cal "Manual of Criteria for Medi-Cal Authorization", Chapter 8.1, as incorporated by reference in §51003(e), or when medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions or defects, pursuant to criteria in §51340(e)(1) or (e)(3). (§51340.1(a)(2))

435-4
The DHCS issued the following interpretation in regard to the EPSDT program:

> The EPSDT program is a federally mandated benefit for full-scope Medi-Cal eligibles under 21 years of age (per the Omnibus Budget Reconciliation Act of 1989 [OBRA '89]).

> Federal Medicaid law requires that states provide medically necessary screening, vision, hearing, and dental services to Medi-Cal beneficiaries under 21 years of age. Additionally, any service a state is permitted to cover that is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by EPSDT screening, must be provided to beneficiaries under 21 years of age whether or not the service or item is otherwise included in the State's Medicaid plan.

MEDICAL NECESSITY UNDER EPSDT:

Overall, there are three ways in which EPSDT supplemental services may be determined medically necessary:

1. The requested EPSDT supplemental service can meet the existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population.

2. The requested EPSDT supplemental service can meet distinct, EPSDT service specific requirements as set forth in §51340.1.

3. If the criteria of 1. above cannot be met, and if the criteria of number 2 above are not applicable to the service, then the requested EPSDT supplemental service must be

evaluated under the expanded medical necessity criteria established in the EPSDT regulations in §51340(e)(3), as summarized below:

A. The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

B. The supplies, items, or equipment to be provided are medical in nature.

C. The services are not requested solely for the convenience of the beneficiary, family, physician, or another provider of services.

D. The services are not unsafe for the individual EPSDT-eligible beneficiary, and are not experimental.

E. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.

F. Where alternative medically accepted modes of treatment are available, the services are most cost-effective.

G. The services to be provided:

(1) Are generally accepted by the professional medical and dental communities as effective and proven treatments for the conditions for which they are proposed to be used.

(2) Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the beneficiary.

H. Available scientific evidence, as described immediately above, demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

I. The predicted beneficial outcome of the services outweighs potential harmful effects.

(All-County Letter (ACL) No. 00-83, December 7, 2000, Attachment 3)

435-5
According to the DHCS, in order to fulfill partial requirements of the final judgment and permanent injunction in the case of *Emily Q. et al.* v. *Diana Bontá*, USDC, Central District of California, the new EPSDT Mental Health Services General Information Notice (MC 003) was distributed through a special mailing to all Medi-Cal beneficiaries. To complete the requirements, counties must begin informing new beneficiaries of the EPSDT services at the time of application, and annually thereafter.

Commencing August 8, 2001 the MC 003 notice was required to be distributed to new Medi-Cal applicants at the same time as other required informational forms and handouts. Because all Medi-Cal beneficiary households with children were informed of the EPSDT Mental Health Services via a special mailing in March 2001, counties will not be required to distribute the MC 003 notice at yearly renewal until April 1, 2002.

(All-County Welfare Directors Letter No. 01-47, August 20, 2001)

435-50 ADDED
1/13The Low Income Health Program (LIHP) is a California program based on a federal waiver which provides coverage to the following populations:

(1) The Medicaid Coverage Expansion (MCE) population, which means low-income individuals 19 to 64 years of age, inclusive, who are not pregnant, with family incomes at or below 133 percent of the federal poverty level, are not eligible for the Medi-Cal program or the Children's Health Insurance Program, are United States citizens, nationals, or have satisfactory immigration status, and meet the county of residence requirements.

(2) The Health Care Coverage Initiative (HCCI) population, which means low-income individuals 19 to 64 years of age, inclusive, who are not pregnant, with family incomes above 133 percent through 200 percent of the federal poverty level, are not eligible for the Medicare Program, the Medi-Cal program, the Children's Health Insurance Program, or other third-party coverage, are United States citizens, nationals, or have satisfactory immigration status, and meet the county of residence requirements.

(Welf. & Inst. Code § 15909.1)

435-51 ADDED
1/13Subject to federal approval of a demonstration project effective on or after November 1, 20120, the department shall, by no later than July 1, 2011, authorize local LIHPs to provide scheduled health care services, consistent with the Special Terms and Conditions of the demonstration project, to eligible low-income individuals 19 to 64 years of age, inclusive, who are not otherwise eligible for the Medi-Cal program or the Children's Health Insurance Program, with family incomes at or below 133 percent of the federal poverty level. To the extent federal financial participation is made available under the Special Terms and Conditions of the demonstration project pursuant to Section 15910.1, LIHP health care services may be made available to eligible individuals with family incomes above 133 percent through 200 percent of the federal poverty level.

(Welf. & Inst. Code § 15910(a))

436-1
Health care, under state law, shall include the following mental health services:

(a) Mental health services provided by a city or county.

(b) Mental health services provided in a Short-Doyle community mental health service or in a community mental health center organized under the Federal Community Mental Health Centers Act of 1963.

(c) Certain outpatient drug abuse services under the jurisdiction of the State Department of Alcohol and Drug Programs, provided by certified private or county providers.

(d) Inpatient hospital services in an institution for mental disease to persons of all ages, provided that such institution is certified as a psychiatric hospital under Title XVIII of the Social Security Act.

(e) Other diagnostic, screening, preventive, or remedial rehabilitative services designed to restore the individual to the best possible functional level, recommended by a physician or licensed practitioner of the healing arts, and provided in a facility, home, or other setting.

(W&IC §14021)

436-2
The DHCS shall add case management services as a benefit under the Short-Doyle Medi-Cal program for persons served by the State Department of Mental Health and Short-Doyle mental health programs. (W&IC §14021.3)

436-3
Community mental health services, as defined in §51341(b), provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program. (§51341(a))

"Community mental health services" include acute inpatient hospital services, psychiatric health facility services, mental health services, medication support, day treatment intensive service, day rehabilitation service, adult and crisis residential treatment services, crisis intervention, and crisis stabilization-emergency room or urgent care. (§51341(b))

436-4
Short-Doyle drug Medi-Cal substance abuse services, as defined in §§51341.1(b)-(d), provided to Medi-Cal beneficiaries, are covered by the Medi-Cal program when determined medically necessary under §51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in §51159. (§51341.1(a))

437-1
Working disabled persons whose family income is below 250% of the Family Poverty Level (FPL) may buy into the Medi-Cal program by paying a premium, from $20 to $250 monthly, on a sliding scale based on countable income.

The individual must continue to meet the federal Social Security definition of “disabled” (except that portion regarding substantial gainful activity); be eligible for SSI disability (except for earnings); and have net family income less than 250% of the FPL.

Under the 250% program, income is based on SSI methodology, including spousal deeming. Additionally, state, federal, and private disability income is exempt.

Property is also determined under SSI standards, but “resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code" are exempted for the disabled individual.

(All-County Welfare Directors Letter No. 99-67, December 3, 1999, based on Assembly Bill No. 155, Ch. 820, Stats. 1999)

437-2
The 250 percent Working Disabled (WD) program provides full-scope Medi-Cal coverage with the Aid Code of 6G. To be eligible for the 250 percent WD program the individual must:

> Be employed.

> Meet the federal definition of disability except the individual is allowed to perform Substantial Gainful Activity (SGA).

> Have net nonexempt income below 250 percent of the Federal Poverty Level (FPL).

> Be eligible to receive SSI/SSP benefits if earnings were disregarded.

> Pay a monthly premium based on the individual's income.

> Meet all other non-financial Medi-Cal eligibility requirements.

California has adopted the following options:

> Exempting the individual's disability income, and

> Exempting retirement arrangements authorized through the Internal Revenue Code.

(Medi-Cal Eligibility Procedures Manual §5R-1, issued January 4, 2002)

437-2A ADDED 4/10
Disability income received after the age of 65 or after an individual reaches their retirement age is no longer exempt. This income is considered retirement income and is counted when determining premium amount and maximum earnings. (ACWDL 09-33, June 25, 2009.

437-3
Beneficiaries in the 250% program for the working disabled who default on premium payments are subject to discontinuance from that program. (All-County Welfare Directors Letter No. 99-67, December 3, 1999)

437-3A
Individuals, eligible for the 250% working disabled program receive full-scope Medi-Cal for a monthly premium to be paid to the DHCS. Individuals will be issued a monthly premium statement by the Department, including an invoice and envelope with which to return their payments. Individuals shall be discontinued from the program if they do not pay premiums for two consecutive months. Eligibility for the program is retained for these two transition months.

There is a six-month penalty period following the month of discontinuance based on nonpayment of premiums. Individuals wishing to reenroll in the program during the 6 month penalty period must either:

> Pay the premiums for the current month and the premiums owed for the two transition months in which premiums were not paid; or

> Reapply after the six-month penalty has passed. No premiums will be owed for past months; the individual is treated as a new applicant.

(Medi-Cal Eligibility Procedures Manual §5R-1, issued January 4, 2002)

437-4
According to the DHCS, for purposes of the 250% of the Federal Poverty Level Working Disabled program, "work" is undefined. The DHCS indicates that an eligible only needs to provide proof of employment. Examples of a person who is working for another include pay stubs or written verification from the employer; for the self-employed or independent contractor they include contracts, W-2 forms or a 1099 form. Beneficiaries are also considered to be working if they are receiving vacation or sick leave pay from their employer. (All-County Welfare Directors Letter No. 00-51, September 27, 2000, Question 12; Medi-Cal Eligibility Procedures Manual §5R-2)

437-5
The 250 percent Working Disabled (WD) beneficiary is to be treated as "Other Public Assistance (PA)." He or she is in his or her own MFBU. Couples are in the MFBU together only if both parties of a couple meet the eligibility criteria for the 250 percent WD program.

To determine the MFBU:

> First evaluate the whole family, including the working disabled individual for §1931(b) eligibility.

> If the entire family is ineligible for §1931(b) with the working disabled person, evaluate the working disabled person for the 250 percent WD program.

> If he or she is eligible, he or she is considered "other PA" and is in his or her own MFBU.

> Evaluate the rest of the family for the §1931(b) program without the 250 percent WD individual in that MFBU.

> If the family is ineligible for §1931(b), usual Medi-Cal procedures are followed to determine that family's eligibility for other Medi-Cal programs.

(Medi-Cal Eligibility Procedures Manual §5R-2, issued January 4, 2002)

437-6
Determine net nonexempt income for the 250% WD program in accord with the provisions outlined in 22 California Code of Regulations (CCR) Article 5, except as follows:

1. Determine in-kind income using Supplemental Security Income's (SSI's) requirements for treating in-kind support and maintenance (ISM). See Section VII, and the attached Section 14 of the Pickle Handbook which provides detailed instructions about ISM.

2. Disregard all disability income, including worker's compensation, of the working disabled individual.

3. Deduct all impairment related work expenses (IRWEs) from income as based on SSI methodology. IRWEs are the expenses of a working applicant/beneficiary that are necessary for the individual to become or remain employed (e.g., attendant care services, transportation costs, and medical devices.

4. Base spousal/parental deeming on SSI methodology.

5. Disregard one-third of child support received by a child applicant.

   (Note: The methodology for determining income, including the above exceptions, is contained in the new income test worksheet forms.)

(Medi-Cal Eligibility Procedures Manual (MEPM) §5R-2, 3, issued January 4, 2002)

437-6A
In the 250% WD program, the following are the net income limits:

2. For a child, or individual without a spouse, net nonexempt income must be less than 250 percent of the FPL for one person.

3. For an applicant with an ineligible spouse, whose income is not to be counted using SSI spousal deeming rules, net nonexempt income must be less than 250 percent of the FPL for one person.

4. For an applicant with an ineligible spouse, whose income is to be counted using SSI spousal deeming rules, the net nonexempt income must be less than 250 percent of the FPL for two persons.

(MEPM §5R-3, issued January 4, 2002)

437-7
Determine net nonexempt property for the 250% WD program in accord with the provisions outlined in 22 California Code of Regulations (CCR) Article 9. Exempt the resources of the working individual in the form of retirement arrangements authorized under the Internal Revenue Code. This includes:

> Individual Retirement Accounts (IRAs).

> Plans for self-employed individuals, such as KEOGH Plans.

> Work related pension funds administered by an employer or union, for income when employment ends, such as Deferred Compensation and Thrift Plans.

(MEPM §5R-2, issued January 4, 2002)

437-8
Determine whether the working disabled individual would be eligible for SSI/SSP in the absence of his or her earnings:

1. Review alien status:

    a. Aliens who are or would be limited to restricted services under a regular Medi-Cal program are ineligible under federal requirements for SSI/SSP, so these aliens are also ineligible for the 250 percent WD program.

(Medi-Cal Eligibility Procedures Manual (§5R-3, 4, issued January 4, 2002)

437-9
The premium amounts for the 250% WD program are set forth: Based on the nonexempt net countable income as determined by completin

g the MC 338, "250 Percent Income Test Work Sheet for the 250 Percent Working Disabled Program Adults" for either an individual or a couple; or the MC 338B, "250 Percent and SSI/SSP Income Test Work Sheet for the 250 Percent Working Disabled Program-Child Applying With or Without Ineligible Parent(s)" for a child, the county will determine the monthly premium

amount according to the following chart.

Net C
From
$1
$601
$701
$901
$1,101
$1,301
$1,501
$1,701
$1,901
$2,101

*One eligible individual is defined: as an eligible child; an eligible unmarried adult; or a married individual with an ineligible spouse when no spousal deeming applies.

**Eligible couple is defined: as having their eligibility based on the countable income of both individuals and tested against the FPL for two. This includes an individual with an ineligible spouse when spousal deeming applies. (MEPM §5R-2, issued January 4, 2002)

437-10

Counties are reminded that there is now a program, the 250% Working Disabled Program that allows individuals to earn above the Substantial Gainful Activity (SGA) limit and still qualify for linkage through disability. Because of this, counties must not base a decision to process a

disability determination for working persons on SGA. The county must refer the case to the Disability and Adult Programs Division (DAPD) and alert the DAPD analyst to evaluate the individual's disability based on criteria for the 250% Working Disabled program. (All County Welfare Director's Letter (ACWDL) 02-40, July 3, 2002)

437-11 ADDED
4/12A 250% Work Disabled Recipient remains eligible during temporary periods of unemployment up to 26 weeks if premiums continue to be paid. (Welfare and Institutions Code (W&IC) 14007.9, ACDWL 11-38)

437-12 ADDED
4/12Earned income received by a 250% Work Disabled Recipient remains exempt when held in a separately identifiable account as long as it is not commingled with other resources.. (Welfare and Institutions Code (W&IC) 14007.9, ACDWL 11-38)

437-13 ADDED
4/12A 250% Working Disabled participant's Social Security disability income remains exempt if it has been converted to Social Security retirement income when the individual retires, including any increase (cost-of-living increases) in that income. (Welfare and Institutions Code (W&IC) 14007.9, ACDWL 11-38)

437-14 ADDED
4/12A 250% recipient's retirement arrangements remain exempt for those who leave the 250% program for other Medi-Cal programs that serve aged, blind and disabled individuals. (Welfare and Institutions Code (W&IC) 14007.9, ACDWL 11-38)

438-1 `
Effective January 1, 2001, the State has established an Aged and Disabled Federal Poverty Level (A&D FPL) Program which will provide zero Share of Cost Medi-Cal benefits to those person who qualify. The basics of the program, are as follows:

- Qualified individuals/couples need to be aged or disabled and not in Long-Term Care.

- Eligibility of qualified individuals will be determined using the income and property medically needy rules.

-- If qualified individuals have other family members applying for Medi-Cal benefits, qualified members will be ineligible member(s) of the other family member's Medi-Cal Family Budget Unit (MFBU). All ineligible family member's income will be used and be considered a part of the MFBU for purposes of determining the maintenance need size.

- Blind applicants or beneficiaries (under Title XVI or XIX) will be referred to the State Programs--Disability in order to determine if they meet disability criteria.

- January Social Security Cost -of-Living Allowance increases should be temporarily disregarded until the effective FPL increases are issued (generally in April).

- Disabled individuals in the A&D FPL program are not subject to an age limitation and as such children who are disabled need to be evaluated for this program.

(All-County Welfare Directors Letters (ACWDLs) No. 00-57, November 14, 2000; 00-68, December 29, 2000; and 02-38, June 28, 2002)

438-2
In determining eligibility for the A&D FPL Program, count the income of the applicant and the applicant's spouse. When the applicant is a "child", count the child's income and the income of the parent. If there is one parent and a child eligible for the program, treat each person as an individual, and not as a single unit. (All-County Welfare Directors Letter No. 01-18, March 16, 2001)

438-3
The law which authorized the aged and disabled federal poverty level (FPL) program provides, in pertinent part, the following:

(c) An aged or disabled individual shall satisfy the financial eligibility requirement of this program if both the following conditions are met:

(1) Countable income, as determined in accord with (42 United States Code (USC) §1396a(m)) does not exceed an income standard equal to 100 percent of the applicable federal poverty level, plus $230 for an individual or, in the case of a couple, $310, provided that the income standard so determined shall not be less than the SSI/SSP payment level for a disabled individual or, in the case of a couple, the SSI/SSP payment level for a disabled couple.

(2) Countable resources, as determined in accord with 42 USC §1396a(m) do not exceed the maximum levels established in that section.

(d) The financial eligibility requirements provided in subdivisions (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the Social Security Act (42 USC §401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income standard described in subdivision (c).

(g) Notwithstanding any other provision of law, the program provided for pursuant to this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available.

(h) Subject to subdivision (g), this section shall be implemented commencing January 1, 2001.

(W&IC §14005.40)

438-3A Added
1/13State law requires that the A&D FPL program income limits be the greater of: 1) the SSI/SSP payment standard; or 2) 100 percent of the FPL plus $230 for individuals or $310 for couples. As of April 1, 2010, the higher of the two limits for both individuals and couples was 100 percent of the FPL plus the $230 or $310 or $1138 for individuals, and $1536 for couples. Effective April 1, 2012 the effective limit is $1161 for individuals and $1571 for couples.

(ACWDL 11-16, April 11, 2011 and ACWDL 12-08, March 1, 2012)

438-4
It is the position of the DHCS that IHSS deductions (per §50245) are not allowable in the A&D FPL program. (All-County Welfare Directors Letters No. 02-22, April 12, 2002, and 02-22E, May 7, 2002 referencing §50551.6)

438-4A
Health care premiums and all other medically needy deductions are allowable deductions in the A&D FPL program, except for the IHSS deduction. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-5 REVISED 11/05
State law (W&IC §14005.40(c)(1)) requires that the A&D FPL couple's income standard be no less than the Supplemental Security Income/State Supplemental Program (SSI/SSP) couple payment standard. The amount of the A&D disregard can be adjusted to make the A&D FPL couple's income standard equal to the SSI/SSP couple payment standard.

(All-County Welfare Directors Letter No. 02-24, April 30, 2002 and 02-24E, June 10, 2002)

438-6
The A&D FPL program is not a Public Assistance (PA) program. Individuals participating in the program are neither PA nor other PA. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-7
It is the position of the DHCS that once the State has begun its "buy-in", a Medi-Cal beneficiary cannot pay his/her own Medicare Part B premium in order to qualify for the A&D FPL program. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-8
If both spouses are eligible for the A&D FPL program, they both will receive benefits under that program. If both spouses cannot qualify as a couple, the couple may apply for one or the other if one can qualify this way. The other spouse may be eligible for Medically Needy benefits, or decline to apply for Medi-Cal benefits. (All-County Welfare Directors Letter No. 02-38, June 28, 2002)

438-8A ADDED 12/08
In determining eligibility for zero share of cost under the Aged and Disabled Federal Poverty Level Program (A&D FPL), there is a deduction from the income of an aged or disabled person as an allocation to members of the family who are not eligible for zero share of cost under the A&D FPL program. The allocation equals the maintenance need level for the ineligible family members.

(ACWDL 00-57, attachment worksheet (line 19))

438-9 ADDED 12/08
Rules governing the Medically Needy program are also used in the Aged and Disabled Federal Poverty Level (A&D FPL) program pursuant to All County Welfare Directors Letter 00-57. This includes rules for property determinations, income deductions and, allocations (including those to Public Assistance [PA] and other PA spouses), and exemptions.(ACWDL 08-42, September 23, 2008)

439-1 REVISED 4/12
The CSRA is $113,640 in 2012. (All-County Welfare Directors Letter No. 12-05)

439-1A REVISED 4/12
In California, the basic MMMNA is $2841effective January 1, 2012. (All-County Welfare Directors Letters No. 12-05)

439-1B ADDED 12/05
Effective _____, the CSRA was _____. Effective _____, the MMMNA was _____. (ACWDL _____)

439-1D ADDED 12/05
Effective July 1, ____ through June 30, ____, the family member maximum base allocation amount for a family member living with the community spouse of a beneficiary with LTC status is $____. (All County Welfare Director's Letter _____)

439-3 REVISED 3/09
In the TB program, the income standard for an individual effective January 2008 is $1359 and effective January 2009 is $1433. The standard allocation effective 2008 is $319 and effective 2009 is $337. The federal benefit rate (FBR) for an individual used to determine the parental

deduction is $637 in 2008 and $674 in 2009. The FBR for a couple in 2008 is $956 and in 2009 is $1011.

The resource limit is $2000. If the applicant is married when determining eligibility, use only the applicant's separate property and one-half of the community property.

When determining a child's eligibility and there is one parent present, allow the parent a $2000 property limit; if both parents are present allow $3000 for the parents

(ACWDL 07-31 December 3, 2007, 08-60, December 23, 2008)

439-3A
In the TB program, the income standard for an individual effective _____ is $____. The standard allocation is $___. The federal benefit rate used to determine the parental deduction is $____ for an individual and $___ for a couple. (ACWDL _____)

439-4 REVISED 3/09
The Medicare Part B premium was $93.50 in 2007 and $96.40 in 2008 and 2009. For individuals with income above $85,000 and couples with income above $170,000, the Part B premium may exceed $96.40 in 2009 (All-County Welfare Directors Letters 06-35, November 16, 2006, 07-26 November 14, 2007 and 08-57, December 18, 2008)

439-4A ADDED 12/05
The Medicare Part B Premium is _____ effective _____. (ACWDL _____)

439-5 REVISED 7/09
The effective income limit for an A&D FPL individual is $1133 as of April 1, 2009. This income limit is equal to $903 (100 percent of the FPL for one, effective April 1, 2008) and the $230 standard disregard for an individual

The effective income limit for an A&D FPL individual is $1097 as of April 1, 2008. This income limit is equal to $867 (100 percent of the FPL for one, effective April 1, 2008) and the $230 standard disregard for an individual.

The effective income limit for an A&D FPL couple is $1579 effective January 1, 2009.

For determinations made in 2008 the federal poverty level for two is $1141 and the income disregard is $383 which equals the SSI/SSP couple standard of $1524.

Note that per Assembly Bill X 3 6 there was a delay in the implementation of the SSP cost of living adjustment from June 2008 until October 2008.

Assembly Bill (AB) X 3 6 (Chapter 4, Statutes of 2008) resulted in delays for the implementation of the SSP Cost of Living Adjustment (COLA) increases originally scheduled for June 1, 2008 to October 1, 2008. A COLA will not be implemented on October 1, 2008. Counties are to continue using the Payment Standards for the combined federal/State payment levels effective January

1, 2008. The A&D FPL couples limit of $1,524 increased on January 1, 2009, to the 2009 SSI/SSP couple payment standard of $1,579.

Effective May 1, 2009, effective income limits for the Aged and Disabled Federal Poverty Level program will stay the same for individuals at $1133 and will be reduced to $1525 ($1215 federal poverty level plus $310 disregard) for a couple.

(All County Welfare Director's Letters 08-06, February 25, 2008, 08-13, April 3, 2008, 08-24, June 10, 2008 08-40, September 12, 2008, 09-08, February 24, 2009, and 09-20, April 23, 2009)

439-5A
The effective income limit for an A&D FPL individual is $_____ effective April 1, 20__ ($___ FPL + $230 income disregard).

The effective income limit for an A&D FPL couple is $____ effective _____ 20__ through _____ 20__ ($____ FPL effective April 1, ____ + $___ income disregard).

(ACWDL ____)

439-6 REVISED 12/05
The Specified Low-Income Medicare Beneficiary (SLMB) income limit has been 120% of the FPL since 1996. The ____ SLMB income level is

Persons	Income Level
1	$____
2	$____

The SLMB resource level is $4,000 for a single individual and $6,000 for a couple.

(All-County Welfare Directors Letter (ACWDL) No. 97-34, August 5, 1997; ACWDL No. _____)

439-6A ADDED 12/05
The Qualified Medicare Beneficiary (QMB) income limit has been 100% of the FPL since 1996. (All-County Welfare Directors Letter (ACWDL) No. 97-34, August 5, 1997)

439-7 REVISED 3/09
The Federal Poverty Level (FPL) effective April 1, 2008 for one person is $867. Effective April 1, 2009, the FPL for one person is $903. The FPL for two persons is $1167 effective April 1, 2008 and is $1215 effective April 1, 2009.

The SLMB income level (120% of the FPL) for one person is $1040 effective April 1, 2008. The SLMB level for one person is $1083 effective April 1, 2009. The SLMB level for two persons is $1400 effective April 1, 2008. The SLMB level for two persons is $1457 effective April 1, 2009.

(ACWDL 08-05, February 14, 2008; 09-06, February 18, 2009)

439-7A ADDED 12/05
The FPL effective _____ is _____ (ACWDL _____)

439-7B ADDED 3/07
For most individuals whose eligibility is based on a percentage of the FPL (including 1931 (b) applicants and recipients that receive Retirement, Survivor's, and Disability Insurance RSDI Title II income), the effective date of the revised FPL figures is April 1, 2007. However, counties must review all denials and discontinuances for the following groups back to the date specified for each group and re-evaluate eligibility based on the revised FPL figures:

- For applicants and recipients of the Medicare Savings Programs (MSP) includes Qualified Medicare Beneficiary (QMB), Specified Low income Beneficiary, and Qualified Individual 1 programs) **not** receiving RSDI Title II income, counties must apply the new FPL figures retroactively to the date of publication, which is January 24, 2007. Because California has whole month eligibility, individuals whose applications are approved based on the January 24, 2007, date receive QMB coverage for the entire month of January.

- For MSP applicants or recipients that **are** receiving RSDI Title II income, counties must review all denials and discontinuances beginning March 1, 2007, and apply the revised FPL.

(ACWDL 07-04, February 6, 2007)