ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Medical Assistance Eligibility Policy Manual

Need help? Call 855-HEA-PLUS (855-432-7587).

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Last Updated: 04/25/2025

Medical Assistance Policy Manual (Archive) Part 1 of 2

Chapters 100 to 1900

Effective until 2025-04-25

Introduction

Getting Started

Welcome to Arizona's Medical Assistance Eligibility Policy Manual.

View the **Quick Start** page for basic instructions.

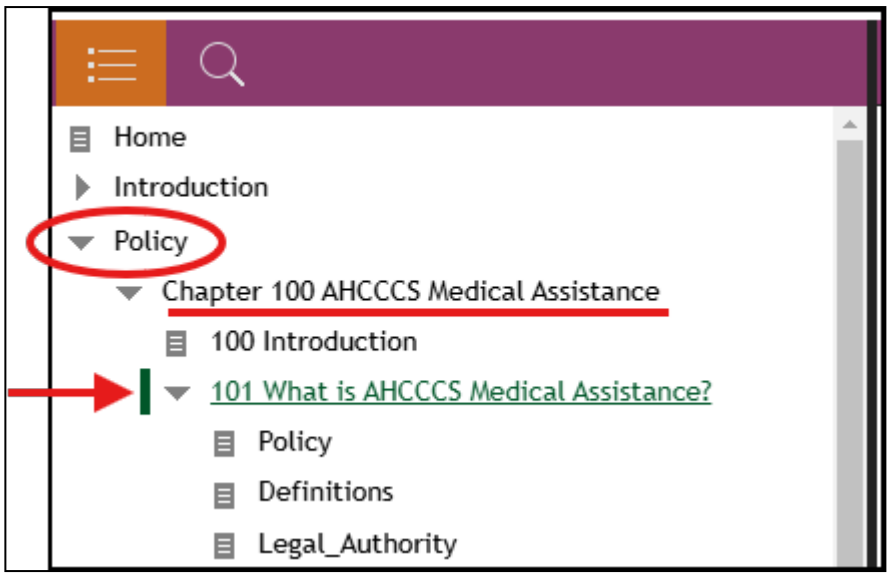
View the **Navigating This Manual** page for additional instructions and tips.

Quick Start

To get to a specific policy manual section use the Table of Contents to the left and open the policy section followed by the appropriate chapter.

Example: To get to “Chapter 101 - What is AHCCCS Medical Assistance?” you would need to:

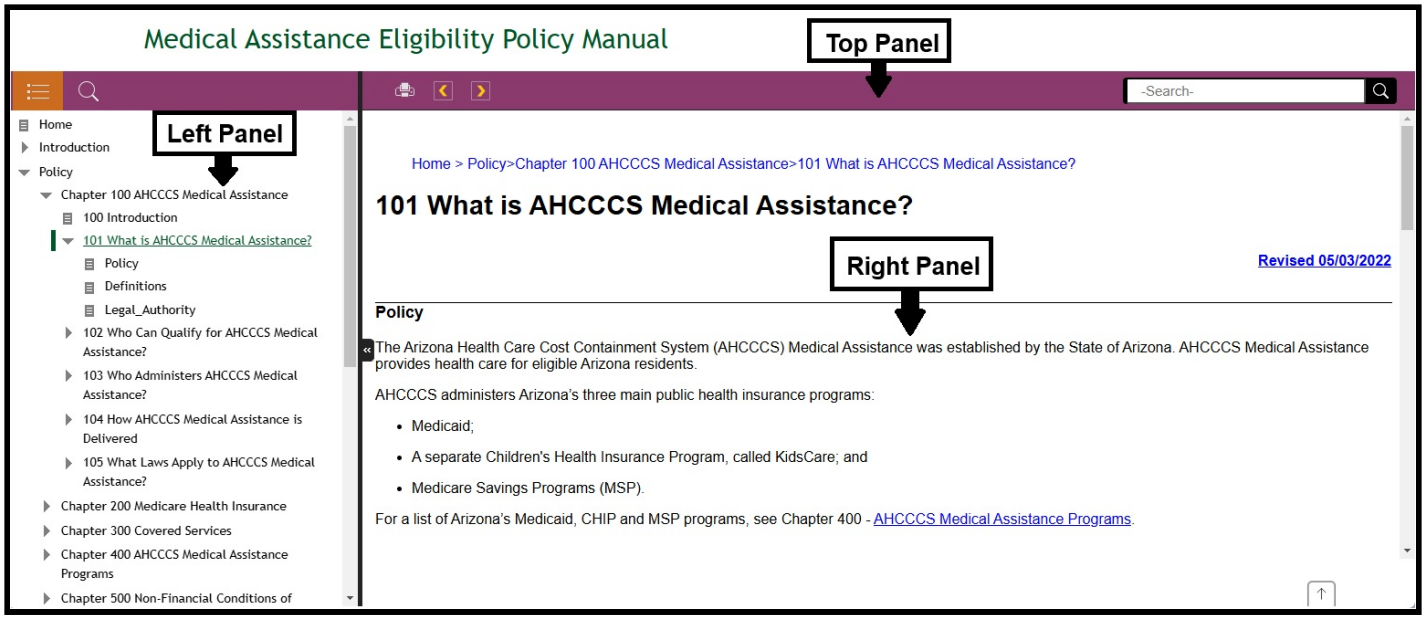
- Click on Policy
- Click on Chapter 100 - AHCCCS Medical Assistance
- Click to open subchapter 101 - What is Medical Assistance



For more instructions on navigating this manual, click on the topic "Navigating This Manual" from the Table of Contents on the left.

Navigating this manual

The window of the Arizona's Medical Assistance Eligibility Policy Manual is divided into three panels: top panel, left panel and right panel.



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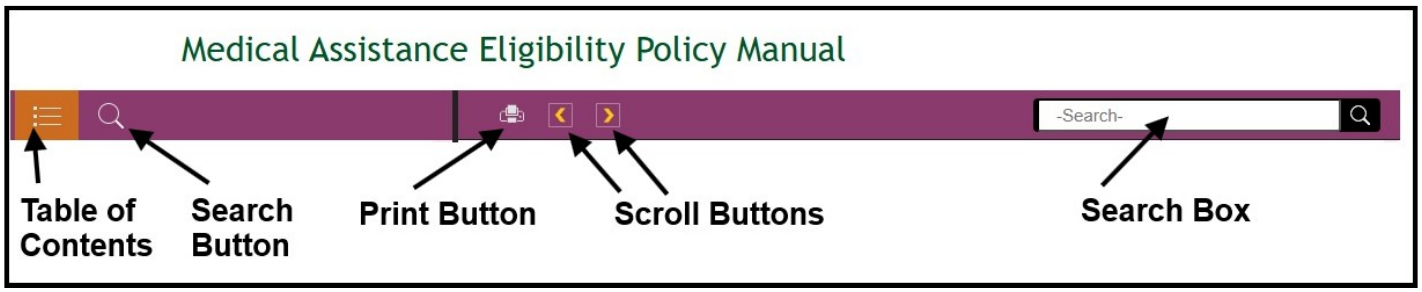
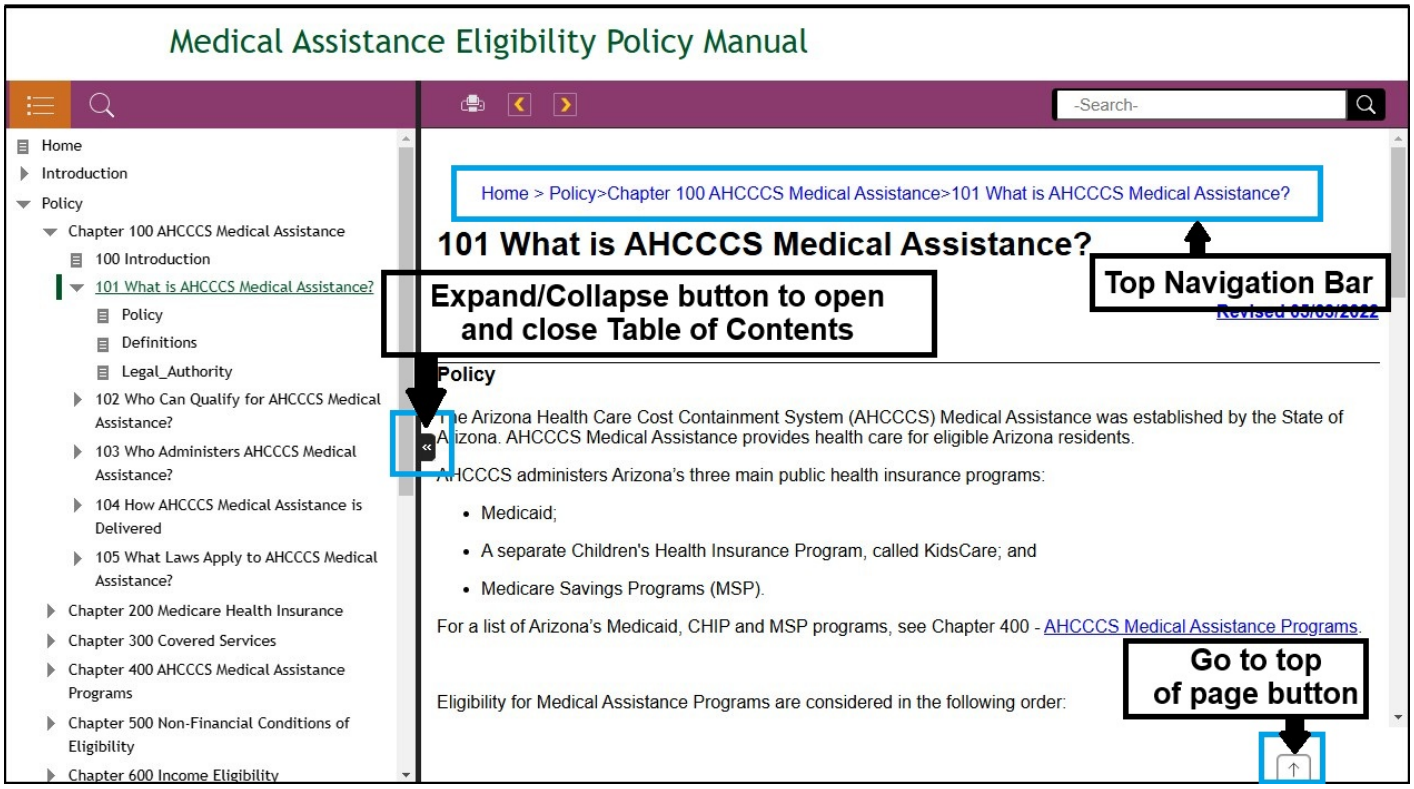


The **left panel** of the manual contains the table of contents and the search button.

The **right panel** is the main display window for the Eligibility Policy Manual.

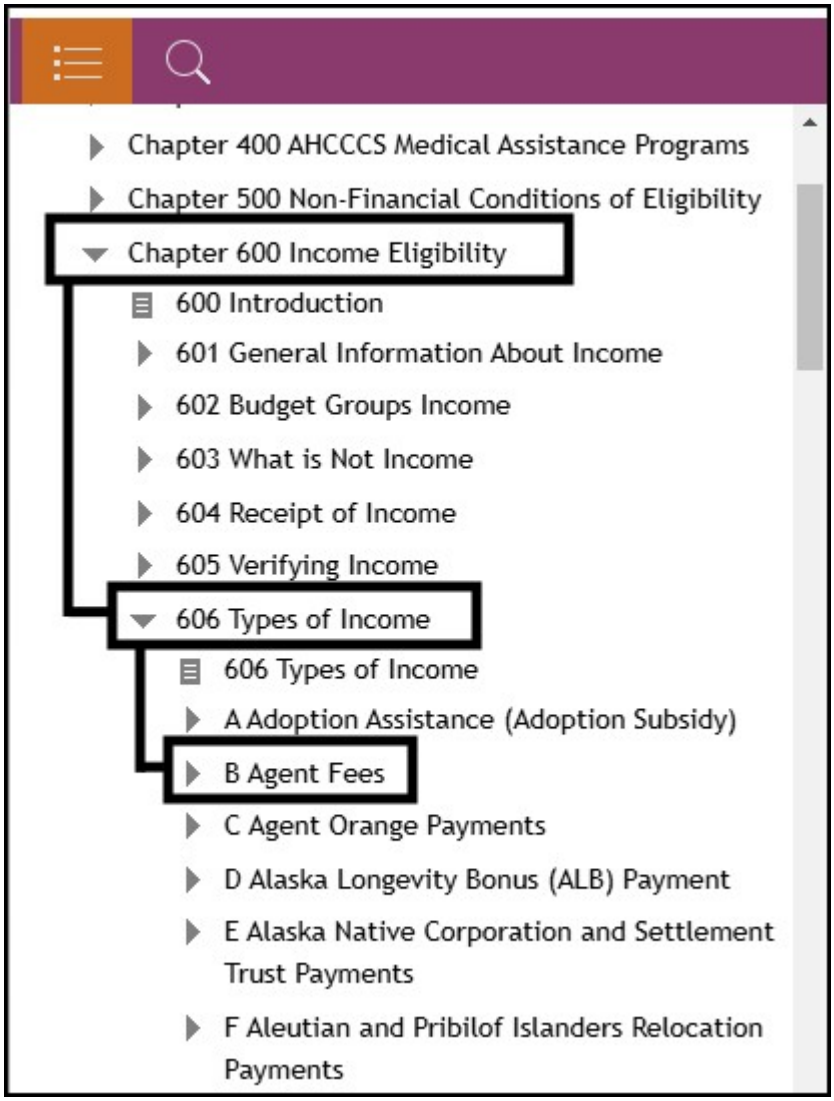


The expand and collapse button allows the user to hide, open, or resize the table of contents. This page also provides a secondary navigation at the top of the page.

At the bottom of the page there is a cursor arrow to navigate to the top of the page.

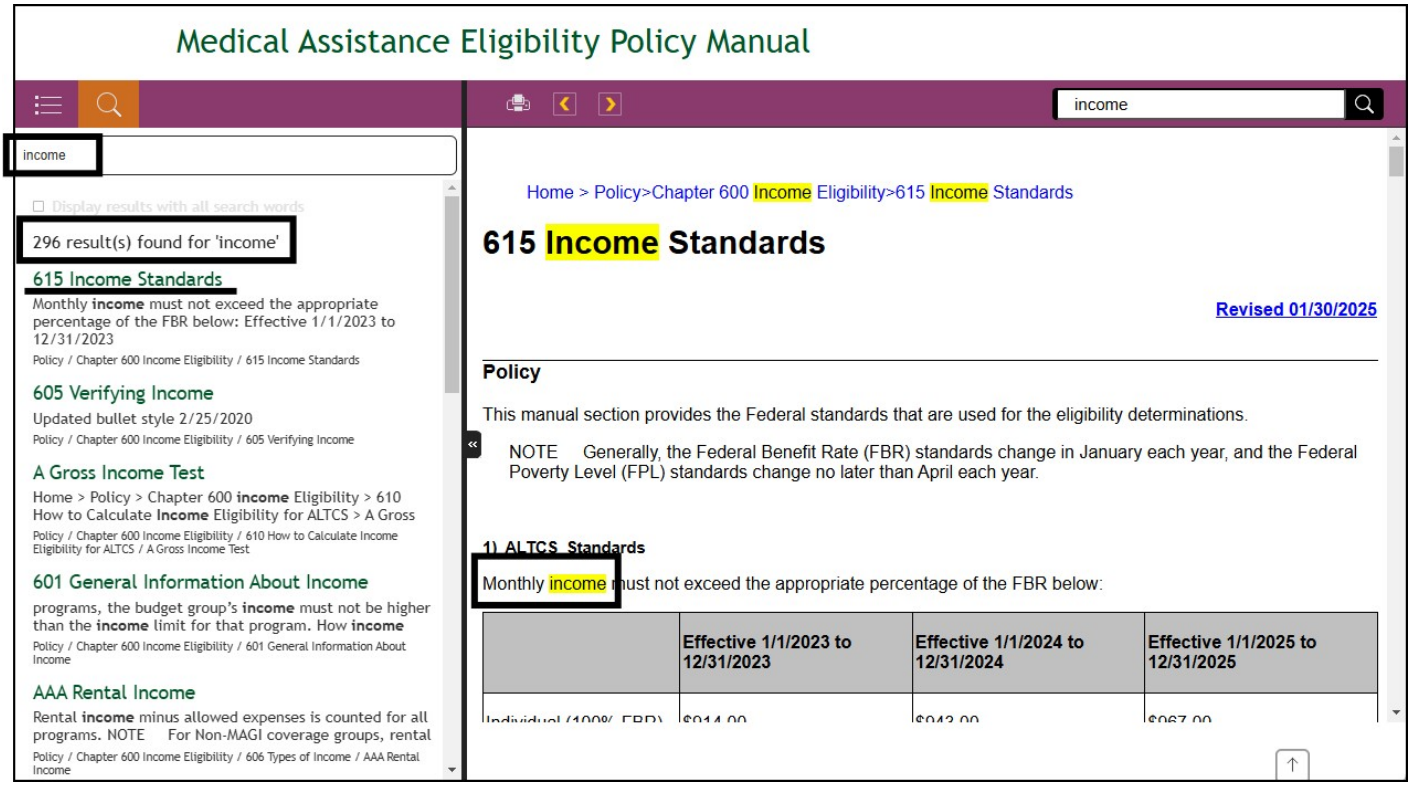
Table of Contents

The Table of Contents can be accessed by clicking the “Contents” button, if it’s not already displayed. It is organized into three levels. The first two levels are “books” and the third level contains “pages”. Books organize content by chapters (1st level) and subchapters/topics (2nd level), while pages contain the actual policy. Clicking on a book will load the pages related to that section of the chapter.



Search

The search option allows you to find all policy sections that contain a word or phrase. You can use the search button on the left of the screen of the search box. Type the word or phrase you are looking for in the Search field and click enter. (When you start typing a word or topic, a set of suggestions will start appearing and you may not have to enter the full search string).



The results of the search is displayed below the search box. A ranking system displays the most relevant sections first. Click on the title of results you want to look at and the manual section will open in the right panel. The search term will be highlighted wherever it appears on the page.

Cash Assistance and Nutrition Assistance Policy

Please see the Cash and Nutrition Assistance Policy Manual located at https://DBMEFAAPolicy.azdes.gov for policy and procedures.

Chapter 100 AHCCCS Medical Assistance

100 Introduction

In this chapter, you will learn about:

- What is AHCCCS Medical Assistance;
- Who can qualify for AHCCCS Medical Assistance;
- Who administers AHCCCS Medical Assistance;
- How AHCCCS Medical Assistance is delivered; and
- What laws apply to AHCCCS Medical Assistance.

For each section in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply to the requirement by program.

101 What is AHCCCS Medical Assistance?

Revised 05/03/2022

Policy

The Arizona Health Care Cost Containment System (AHCCCS) Medical Assistance was established by the State of Arizona. AHCCCS Medical Assistance provides health care for eligible Arizona residents.

AHCCCS administers Arizona's three main public health insurance programs:

- Medicaid;
- A separate Children's Health Insurance Program, called KidsCare; and
- Medicare Savings Programs (MSP).

For a list of Arizona's Medicaid, CHIP and MSP programs, see Chapter 400 - AHCCCS Medical Assistance Programs.

Eligibility for Medical Assistance Programs are considered in the following order:

ALTCS

SSI-Cash

Title IV-E Categories

Caretaker Relative

Continued Coverage

Transitional Medical Assistance (TMA)

Pregnant Woman

Deemed Newborns

Child

YATI

SSI-MAO Specialty

SSI-MAO

Adult

Effective until 2025-04-25

BCCTP

Freedom to Work (FTW)

QI-1 QMB/SLMB

KidsCare

Definitions

Term	Definition
Medicaid	A jointly funded, Federal-State health insurance program. Medicaid provides medical assistance for certain low-income and needy persons.
KidsCare	Arizona's Children's Health Insurance Program (CHIP). This program is for low-income, uninsured children under age 19.
Medicare Savings Program (MSP)	Provides help with Medicare expenses for customers entitled to Medicare Part A.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Medicaid	42 USC 1396a 42 CFR Part 435
Medicare Savings Program	42 USC 1396d(p)
CHIP (KidsCare)	42 CFR Part 457

Effective until 2025-04-25

102 Who Can Qualify for AHCCCS Medical Assistance?

Policy

Anyone can apply for AHCCCS Medical Assistance. Customers can qualify for AHCCCS Medical Assistance by meeting certain requirements. Requirements include, but are not limited to:

- Non-financial (Chapter 500);
- Income (Chapter 600); and
- Resources (Chapter 700).

See Chapter 400 for individual program requirements.

Definitions

Please refer to Chapter 400 for program specific definitions.

103 Who Administers AHCCCS Medical Assistance?

Revised 09/14/2021

Policy

AHCCCS Administration works with several agencies in the State of Arizona. Together, we provide services and assistance in the eligibility process to customers. The following agencies work with AHCCCS Administration to coordinate and determine eligibility:

- The Department of Economic Security (DES);
- The Department of Child Safety; and
- The Social Security Administration (SSA).

NOTE The following sections describe specific programs administered by these agencies, but does not provide a full list of each agency's responsibilities.

1) AHCCCS Administration

AHCCCS Administration responsibilities include:

- Oversight of the AHCCCS health care system;
- Administering some health insurance programs;
- Monitoring and coordinating other agencies, which are responsible for determining eligibility for AHCCCS Medical Assistance programs;
- Contracting with health plan networks and providers;
- Monitoring the quality of care provided by participating health care providers; and
- Maintaining the state's database of eligible members.

2) Department of Economic Security (DES)

There are several divisions within DES that participate with AHCCCS programs. The table below describes the main functions of each division:

Administration	Function
Family Assistance Administration (FAA)	Determines eligibility for: • AHCCCS Medical Assistance; • Cash assistance; • Kinship Foster Care; • Tuberculosis Control; • Refugee Cash Assistance; • Refugee Medical Assistance Programs; and • Nutrition Assistance.
Division of Developmental Disability (DDD)	The ALTCS program contractor for all developmentally disabled persons statewide. DDD is responsible for: • Providing a variety of services to persons who have specific disabilities; • Making eligibility determinations for DDD services on referrals from ALTCS; and • Screening and referring developmentally disabled participants to AHCCCS for an ALTCS eligibility determination.
Disability Determination Services Administration (DDSA)	The Arizona State agency authorized to make disability determinations for the Social Security Administration and AHCCCS.
Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP)	Contracts as an AHCCCS Complete Care (ACC) plan to provide medical services to foster children who meet the Title IV-E or Medicaid eligibility criteria.
Division of Child Support Services (DCSS)	DCSS is committed to helping children receive the support they are due. When a child does not

	receive financial support from one or both parents, the DCSS helps by: • Locating the non-custodial parent; • Establishing legal paternity; • Establishing a legal support order; • Enforcing support orders; and • Collecting child support and medical support payments.

3) Social Security Administration (SSA)

SSA is responsible for determining eligibility for SSI-Cash benefits. People that qualify for SSI-Cash automatically qualify for AHCCCS Medical Assistance. However, if ALTCS services are needed, they must also be determined medically eligible. The SSA also determines eligibility for Medicare and helps identify persons eligible for the Medicare Savings Program (MSP).

4) Department of Child Safety (DCS)

DCS is responsible for:

- Determining eligibility for foster assistance payments to children in the care and custody of the state;
- Determining eligibility for Adoption Subsidy payments;
- Coordinating Medicaid application and eligibility processes; and
- Providing healthcare coverage to children in state foster care through the Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP).

NOTE Children that qualify for Adoption Subsidy or Title IV-E foster care payments automatically qualify for AHCCCS Medical Assistance. However, if ALTCS services are needed, they must also be determined medically eligible.

Definitions

Term	Definition

Department of Economic Security (DES)	The state agency responsible for determining AHCCCS Medical Assistance eligibility for: • Adults • Caretaker Relatives; • Pregnant Women; • Children; • Transitional Medical Assistance; and • 4-month Continued Coverage. NOTE This includes children in the custody of a Tribal Foster Care agency.
Department of Child Safety	The state agency responsible for administering the state's foster care and adoption subsidy programs.
Social Security Administration (SSA)	The federal agency responsible for determining eligibility for SSI Cash assistance. The SSA also determines eligibility for Medicare.

104 How AHCCCS Medical Assistance is Delivered

Policy

Customers receiving AHCCCS Medical Assistance are enrolled with a health plan or Indian tribe to receive services. AHCCCS allows customers to choose a health plan from those available in the geographic service area (GSA) in which they reside.

See MA1102 for details about enrollment with a health plan.

Customers receiving ALTCS are enrolled with a program contractor. Depending on where in the state the service is to be provided, ALTCS program contractors can be:

- Counties;
- Private entities;
- The Department of Economic Security (for the developmentally disabled);
- Certain American Indian tribes;
- Native American Community Health; or
- The Arizona Healthcare Cost Containment System.

See MA1104 for details about enrollment with an ALTCS program contractor.

Definitions

Term	Definition
Health Plans	AHCCCS Complete Care (ACC) plan is defined by state statute and regulated and monitored by AHCCCS. AHCCCS delivers medical services through prepaid, capitated health plans. See MA301 for details about the AHCCCS medical services package.
Program Contractors	For ALTCS customers, all covered services are integrated into a single delivery package, coordinated and managed by the program contractors.

Capitation	AHCCCS prospectively pays fixed monthly capitation, which is based on the age, sex, and Medicare status of each customer.
Payor of Last Resort	As a Medicaid agency, AHCCCS is the payor of last resort. AHCCCS requires that other responsible parties pay before AHCCCS pays. Thus, AHCCCS collects information about Third Party Liability (TPL) to identify anyone else that might be responsible for paying the customer's medical expenses. Under State law, a customer automatically assigns rights to medical care support to the state when the customer signs the application.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
All	42 CFR Part 438

105 What Laws Apply to AHCCCS Medical Assistance?

Revised 11/24/2020

Policy

AHCCCS develops the policy contained in this manual using the following authorities:

- Federal and State laws and regulations;
- Waivers; and
- The Medicaid and Children's Health Insurance Program (CHIP) State Plans.

1) Federal Authorities

The federal authorities are the major framework for Medicaid and CHIP programs. The CHIP program in Arizona is called KidsCare.

Federal laws provide for mandatory programs and requirements, but also include options that states may choose in administering these programs. States use these options to individualize the programs for each state.

Federal authorities used to develop eligibility policy for the Medicaid and KidsCare programs include:

- Public Laws;
- Social Security Act (the Act);
- United States Code (USC);
- Code of Federal Regulations (CFR);
- Federal Register;
- State Medicaid Manual (SMM);
- SSA's Program Operations Manual System (POMS); and
- CMS guidance and letters to State Medicaid Directors (SMDL).

2) State Authorities

State laws are developed based on the Federal laws and regulations made by Congress and the Federal government. State authorities include:

- Arizona Revised Statutes (ARS);
- Arizona Administrative Code (AAC);
- Arizona Administrative Register (AAR); and
- Eligibility Policy and Procedure Manual (EPM).

3) AHCCCS Waiver Authorities

Medicaid and CHIP programs must comply with Title XIX and Title XXI of the Social Security Act. Since AHCCCS began on October 1, 1982, the agency has been exempt from specific provisions of the SSA under an 1115 Research and Demonstration Waiver. The number 1115 refers to section 1115 of the Act.

The AHCCCS 1115 Waiver contains:

- Provisions in the Act from which AHCCCS is waived;
- Expenditure authority for certain items under section 1903 of the Act;
- Terms and conditions that AHCCCS must fulfill, which includes documents and reports that must be submitted during the year;
- Approved federal budget amounts; and
- Attachments that outline financial, legislative, and budget neutrality requirements.

See http://www.azahcccs.gov/reporting/federal/waiver.aspx for Arizona's 1115 Waiver.

4) The State Plans

Arizona has a Medicaid State Plan and a KidsCare State Plan. The State Plans assure that Arizona will administer the Medicaid and KidsCare programs according to federal requirements, and include any federal options the state has chosen.

AHCCCS is Arizona's state agency with the responsibility for the State Plans. AHCCCS submits amendments to reflect changes in federal law, regulation, policy, or court decisions.

Definitions

Term	Definition
Arizona Administrative Code (AAC)	The AAC is commonly referred to as the Rules. The AAC is developed by the responsible state agency and approved by the Governor's Regulatory Review Council (GRRC). The AAC provides more detail than the ARS. The AHCCCS-related rules are located in Title 9: • Chapter 22 Medicaid; ◦ Article 15 - SSI MAO ◦ Article 19 - Freedom to Work ◦ Article 20 - BCCTP • Chapter 28 ALTCS; • Chapter 29 QMB, SLMB and QI-1; • Chapter 31 KidsCare; and • Chapter 34 Grievance System. See http://www.azsos.gov/rules/arizona-administrative-code to view the AAC.
Arizona Administrative Register (AAR)	The AAR is the official publication of the State of Arizona. The AAR contains rules approved by the GRRC but not yet published in the AAC. See http://www.azsos.gov/rules/arizona-administrative-register to view the AAR.
Arizona Revised Statutes (ARS)	The ARS are made by the Arizona legislature. The following AHCCCS-related statutes are located in Title 36, Chapter 29: • Article 1 Medicaid and Healthcare Group; • Article 2 ALTCS; • Article 3 QMB; and • Article 4 Children's State Health Insurance Program (KidsCare);

	See https://www.azleg.gov/arstitle to view the ARS.
Centers for Medicare and Medicaid Services (CMS) Guidance	Guidance and directives issued as: • State Medicaid Director letters (SMDL) to all Directors of State Medicaid agencies. • State Health Official (SHO) letters to state health officials. • CMS Rulings are final decisions of the Administrator that clarify complex or unclear provisions of the law or regulations relating to Medicaid or SCHIP. See http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html to search and view SMDL and SHO guidance by type and topic. See http://cms.hhs.gov/rulings/ to view CMS Rulings.
Code of Federal Regulations (CFR)	A collection of general and permanent rules (regulations) that have been previously published in the Federal Register. The CFR provides more detail about conditions of eligibility than the USC. Medicaid and CHIP programs are covered in: • 42 CFR - Public Health; • 20 CFR - Supplemental Security Income; and • 45 CFR - Public Welfare. See http://www.ecfr.gov/cgi-bin/ECFR?page=browse to view the CFR.
Federal Register	The Federal Register is the official daily publication of the U.S. government. It contains: • New regulations; • Changes to regulations; and

	• Legal notices issued by Federal agencies and the President. See https://www.federalregister.gov/ to view the Federal Register.
Public Law	A printing of the full text of a new law or an amendment to an existing law after it has been enacted by Congress and signed by the President. Public laws are later codified (collected and arranged) in the US Code (USC) along with all other Federal Laws. See http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=PLAW to view Public Laws.
Social Security Act (SSA)	A collection of federal laws that cover all areas of Social Security. The laws authorizing and governing the Medicaid and CHIP programs are contained in three titles of the Act: • Title XVI of the Act - Supplemental Security Income (SSI). The SSI program is for aged, blind and persons with disabilities that have low income. AHCCCS also uses this Title to develop policy for SSI-MAO and ALTCS. • Title XIX - Medicaid. This Title identifies the mandatory and optional coverage groups and the basic conditions of eligibility for each. • Title XXI - Children's Health Insurance Program. Provides funds and the basic conditions of eligibility for CHIP. Arizona's Title XXI program is called KidsCare. See http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm to view the Social Security Act.
SSA's Program Operations Manual System (POMS)	Policy Manual for programs administered by the Social Security Administration. Some legal rules dictate that the agency use similar or less restrictive rules than the policies used by the Social Security Administration.

	See https://secure.ssa.gov/apps10/ to view Social Security's Policy Manual.
State Medicaid Manual (SMM)	Policy guidance for the Medicaid requirements contained in the CFR developed by the Centers for Medicare and Medicaid Services (CMS). See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html to view the State Medicaid Manual.
State Plan	A written contract between AHCCCS and the Centers for Medicare and Medicaid Services (CMS). The State Plan describes the nature and scope of the Medicaid or KidsCare program. See https://azahcccs.gov/Resources/StatePlans/ to view Arizona's Medicaid and CHIP State Plans.
United States Code (USC)	A collection of the federal laws made by Congress sorted by subject matter. See https://uscode.house.gov/ to view the USC.

Chapter 200 Medicare Health Insurance

200 Introduction

In this chapter, you will learn about:

- What is Medicare Health Insurance;
- What are beneficiaries' medical cost responsibilities;
- How Medicare and Medicaid work together;
- Medicare entitlement;
- Medicare enrollment; and
- State Buy-In and Buy-Out.

For each section in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply to the requirement by program.

201 What is Medicare Health Insurance?

Revised 03/01/2021

Policy

Medicare is a Federal health insurance program that is available to most US citizens and legal residents who are:

- Age 65 or over;
- Persons of any age with permanent kidney failure; and
- Certain individuals with disability.

The Medicare program has four benefit packages:

- Hospital Insurance (Medicare Part A);
- Supplementary Medical Insurance (Medicare Part B);
- Medicare Advantage (Medicare Part C); and
- Medicare Voluntary Prescription Drug Coverage (Medicare Part D).

The local Social Security Administration offices take applications for Medicare and the Part D Extra Help program.

Definitions

Term	Definition
Medicare Part A	Medicare benefit that assists with inpatient care including critical access hospitals, hospice care, some home health care and skilled nursing facility services. More information on what is covered by Medicare Part A can be found on Medicare.gov.

Medicare Part B	Medicare benefit that assists with doctor's services, outpatient care and some medical services not covered by Part A. More information on what is covered by Medicare Part B can be found on Medicare.gov.
Medicare Part C	Medicare Advantage Plans are health plan options approved by Centers for Medicare & Medicaid Services . They are sometimes called "Part C" or "MA Plans". Medicare Advantage plans provide both Medicare Part A and Part B covered services. More information on Medicare Advantage plans can be found on Medicare.gov.
Medicare Part D	Medicare Part D is a voluntary program that provides prescriptions drug coverage. Part D covers most classifications of prescription drugs. Medicare offers prescription drug coverage (Part D) for everyone with Medicare. A beneficiary who is entitled to Medicare Part A or enrolled in Part B is entitled to Part D. To get Medicare drug coverage, the beneficiary must join a plan run by an insurance company or other private company approved by Medicare. More information on Medicare Part D plans can be found on Medicare.gov.

202 What Are Beneficiaries' Medical Cost Responsibilities?

Revised 05/09/2018

Policy

Beneficiaries may have medical cost responsibilities under:

- Medicare Part A;
- Medicare Part B;
- Medicare Part C; and
- Medicare Part D.

The following sections provide an overview about costs under each Part. For more detailed information, see www.medicare.gov.

1) Medicare Part A Costs

There are three fees that may be charged in association with Medicare Part A coverage:

Fee	Description
Premiums	• A premium for Medicare Part A is only charged to people who: • Are age 65 or older; • Do not have Social Security coverage or other entitlement; • Want to apply for Medicare hospital and medical insurance; and • Are willing to pay, or when eligible for the QMB program have the State pay, the monthly premium.
Deductibles	Amounts a beneficiary must pay for health care before Medicare or other insurance begins to pay. A deductible is charged for each benefit period for Medicare Part A.

	Medicare pays for the majority of covered hospital services after the annual deductible is met.
Coinsurance (Co-payments)	Coinsurance or co-payments are for: • Inpatient hospital; • Skilled nursing facility; and • Some home health care services. Exceptions: Medicare does not pay: • The Medicare Part A deductible during the first 60 days of the benefit period; and • Coinsurance amounts for hospital stays that last more than 60 days but less than 150 days.

2) Medicare Part B Costs

There are three costs associated with Part B coverage:

- A monthly premium;
- An annual deductible; and
- A coinsurance amount (co-payment) a person may be required to pay once their annual deductible has been met.

Beneficiaries are responsible for “excess charges”. An excess charge is any amount above the maximum charge allowed by Medicare.

Many people purchase supplemental or Medigap insurance to protect against excess charges and co-payments.

Sometimes doctors can choose to accept the Medicare allowable charge as payment in full. In other situations, doctors are required to accept the Medicare payment as payment in full.

3) Medicare Part C (Medicare Advantage Plan) Costs

Medicare Advantage Plans can charge different out-of-pocket costs. They may charge:

- A monthly premium in addition to the Part B premium;
- Co-insurance (co-payments); and

- Deductibles.

NOTE When the beneficiary chooses to enroll with a Medicare Advantage plan, the Medicare Advantage plan chosen receives the monthly Part B premium.

Beneficiaries also must contact their plan before they get a service. This is to find out whether the plan will cover the service and what the beneficiary's costs may be. The beneficiary must follow the plan rules to avoid higher costs.

The beneficiary does not need to buy (and cannot be sold) a Medigap (Medicare Supplement Insurance) policy. Medigap plans will not cover the Medicare Advantage Plan's premiums, deductibles, co-payments or co-insurance.

4) Medicare Part D Costs

There are several fees associated with Part D:

- Monthly premiums;
- An annual deductible;
- Co-payments or co-insurance;
- Prescription drug costs while in the coverage gap; and
- Late enrollment penalties (if any).

5) The Medicare Part D Extra Help Program

The Extra Help program helps low-income beneficiaries with the following costs of Medicare Part D:

- Helps pay the Medicare drug plan's monthly premium by a premium subsidy. The beneficiary may pay a reduced premium or no premium for a basic plan depending on:
    - The beneficiary's income and resources;
    - The plan's premium amount; and
    - The Part D premium subsidy amount for the region in which the beneficiary lives.

    NOTE For an enhanced plan, the beneficiary must pay the difference between the premium and the Part D premium subsidy amount.
- Helps pay any yearly deductible.

- Helps pay coinsurance and co-payments for covered prescription drugs. In most cases, with Extra Help, the beneficiary will pay only a small amount for each covered prescription. The beneficiary generally pays all costs for drugs that are not on the plan's formulary.
- Removes the coverage gap.

A beneficiary can automatically qualify for Extra Help when the beneficiary meets one of the following conditions:

- Has full Medicaid coverage;
- Is eligible for the Medicare Savings Program; or
- Receives Supplemental Security Income (SSI) benefits.

A person who does not automatically qualify for Extra Help can apply for Extra Help online through the Social Security Administration at https://secure.ssa.gov/i1020/start.

The beneficiary must be enrolled with a Medicare Part D plan to get Extra Help. Medicare will enroll the beneficiary in a plan when the beneficiary does not enroll. Medicare notifies beneficiaries when coverage begins. However, the beneficiary has the right to change to another plan at any time.

The exact amount the beneficiary pays depends on the level of Extra Help the beneficiary is eligible for. The beneficiary should contact their Medicare Part D plan to find out their exact premium, deductible, and co-insurance or co-payment amounts.

Beneficiaries who lose their AHCCCS, ALTCS or MSP coverage are no longer automatically eligible for Extra Help. When their Extra Help ends depends on when during the calendar year they lose their eligibility.

- People who lose their AHCCCS, ALTCS or MSP eligibility on or before June 30th of a calendar year will be eligible for Extra Help through December 31st of that year but will not be eligible in the following calendar year. However, when they become eligible again, the Extra Help will continue through December 31st of the next calendar year.
- People who lost their AHCCCS, ALTCS or MSP eligibility on or after July 1st of a calendar year will stay eligible for Extra Help through December 31st of the next calendar year.

CMS sends out notices in September of each year to customers who were discontinued before July 1st of the year to let them know that their Extra Help will be ending at the end of the year. These mailings will include a Social Security Extra Help Application form and return envelope so that the person can apply for Extra Help through the Social Security Administration.

Definitions

Term	Definition

Medicare Part A	Part A helps pay for inpatient hospital care, skilled nursing care, hospice care and other services.
Medicare Part B	Part B helps pay for doctors' fees, outpatient hospital visits, and other medical services and supplies that are not covered by Part A.
Medicare Part C	Part C (Medicare Advantage) plans allow persons to choose to receive all of health care services through a provider organization. These plans may help lower a person's costs of receiving medical services or help a person get extra benefits for an additional monthly fee. To enroll in Part C, a person must have both Parts A and B.
Medicare Part D	Part D (prescription drug coverage) is voluntary and the costs are paid for by the monthly premiums of enrollees and Medicare. Unlike Part B, in which a person is automatically enrolled and must opt out if not wanted, with Part D a person has to opt in by filling out a form and enrolling in an approved plan.
Medicare Part D Extra Help Program	The Extra Help program provides assistance with Medicare Part D prescription costs for persons with limited income and resources.
Coverage Gap	A temporary limit on what the drug plan will cover for drugs. The coverage gap starts once the beneficiary has spent a certain out-of-pocket amount on covered drugs, and ends when the beneficiary reaches the Catastrophic Coverage Limit. The out-of-pocket amount is subject to change annually.
Catastrophic Coverage limit	The amount of out-of-pocket expenses a beneficiary must spend in order to leave the Coverage Gap. This amount is subject to change annually. After the Catastrophic Coverage Limit is reached, the enrollee pays only a small coinsurance amount for covered drugs for the rest of the year.
Premium	An amount to be paid for an insurance policy.

Deductible	A specified amount of money that the insured must pay before an insurance company will pay a claim
Co-insurance	A type of insurance in which the insured pays a share of the payment made against a claim.

203 How Do Medicare and Medicaid Work Together?

Policy

AHCCCS Medical Assistance is a joint Federal and State program that helps pay medical costs for beneficiaries with limited income and resources. What is covered depends on whether a person is a full dual eligible or a deemed dual eligible.

People with Medicaid may get coverage for services that are not fully covered by Medicare. For example, a person may get coverage for nursing home and home health care.

> NOTE Prescription drugs are not covered by Medicaid when the customer is entitled to or enrolled in a Medicare Part D plan.

For details on how Medicare and AHCCCS Health Insurance work together see Chapter 200 of the AHCCCS Contractor Operations Manual (ACOM).

Definitions

Term	Definition
Full Dual Eligible	A person who receives both Medicare and Medicaid benefits.
Deemed Dual Eligible	A person who only receives benefits through a Medicare Savings Program (QMB-only, SLMB or QI-1).

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
All	ARS 36-2946

204 Medicare Entitlement

Policy

Entitlement for Medicare begins with the first day of the month the beneficiary:

- Turns age 65;
- Receives their 25th Social Security Disability Insurance (SSDI) payments,
- Applies for Medicare and is diagnosed with end-stage renal disease (ESRD) as explained in this section, or
- If a beneficiary has been diagnosed with Amyotrophic Lateral Sclerosis (ALS), the month disability benefits begin.

A person is entitled to Medicare under the following circumstances:

If the person...	And is...	Then the person is entitled to…
Is eligible for Social Security or Railroad Retirement	Age 65 or older and in one of the following groups: • Eligible for monthly Social Security benefits; • Qualified Railroad Retirement beneficiaries; • Would be eligible for monthly Social Security benefits if their Federal, State, or local government (or government of Guam, American Samoa, or the District of Columbia) employment was covered work under the Social Security Act; or • Not eligible for monthly Social Security benefits or Railroad Retirement benefits, but voluntarily	Medicare Part A

	enrolls and pays a monthly premium.		
	Under age 65 and is in one of the following groups: • Received Social Security Disability Insurance (SSDI) benefits for more than 24 months; • Would be entitled to Social Security Disability Insurance benefits for more than 24 months because of a disability if their Federal, State, Guam, American Samoa, District of Columbia, or local government employment were covered work under the Social Security Act; or • Under specified circumstances, entitled to Railroad Retirement benefits because of disability.		

	Any age and has ESRD and meets both of the following conditions: • Has chronic kidney failure requiring a regular course of dialysis or a kidney transplant; and • Is either fully or currently insured or entitled to monthly insurance payments because of work covered by the Social Security Act or the Railroad Retirement Act. This includes the spouse or dependent child of a person who is insured or entitled to monthly benefits payable under these acts.	
Receives benefits from Social Security or the Railroad Retirement Board.		Medicare Part B
Is under age 65 and disabled	Receives disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board for 24 months.	
Has Amyotrophic Lateral Sclerosis (ALS), also called Lou Gehrig's disease	Has been determined disabled	
Has Medicare Part A and Part B	• Applies for coverage with the plan; • Lives in the service area of the plan; and • Does not have ESRD	Medicare Part C
• Entitled to Medicare Part A; or	Enrolled in a Part D plan operated by an insurance company or other private	Medicare Part D

• Enrolled in Medicare Part B	company approved by Medicare	

Definitions

Term	Definition
End Stage Renal Disease (ESRD)	Permanent kidney failure requiring dialysis or a kidney transplant.
Amyotrophic Lateral Sclerosis (ALS)	Also called Lou Gehrig's disease.

205 Medicare Enrollment

Revised 06/04/2021

Policy

People who qualify for Medicare benefits are automatically enrolled in Part B when they first become entitled to Medicare Part A.

People who qualify for Medicare, but do not want to be enrolled in Part B, are given an opportunity to reject this coverage.

Medicare enrollment can occur at various times as described below:

- Initial enrollment;
- General enrollment;
- Special enrollment; and
- Conditional enrollment.

1) Automatic Enrollment in Part A

Most people who get Medicare are automatically enrolled. When enrollment is not automatic, certain time frames apply. The following chart shows which groups of people are automatically enrolled in Medicare and which are not. The chart also gives information about situations where the Part A coverage is not free.

Coverage Groups	Automatic Enrollment	Free Part A
Age 65 or Over		
• Receives SSA/RR retirement benefits including spouses and widow/widowers	Yes	Yes
• Insured government worker for Medicare	No	Yes

• Nor receiving SSA/RR benefits	No	Yes
• Eligible for SSA and still working	No	Yes
• Uninsured and no SSA or RR benefits (premium – up)	No	No
Under Age 65 and Disabled for 25 months		
• Receives SSA/RR disability benefits based on disability as a worker, widow/widower, age 50 – 59, adult child of any age disabled prior to age 22.	Yes	Yes
• Disabled widow/widower, age 60 – 64 or widow receiving SSA benefits.	No	Yes
• Insured government worker	No	Yes
Any Age with Kidney Failure		
• Insured or receives SSA or RR benefits	No	Yes
• Dependent spouse or child of a worker who is insured or receives monthly benefits.	No	Yes

2) Initial Enrollment Period

The initial enrollment period is based on when a person is first eligible to enroll.

There is a 7-month Initial Enrollment Period to sign up for Part A or Part B. If the person is eligible for Medicare when they turn 65, they can sign up during the 7-month period that:

- Begins 3 months before the month the customer turns 65;
- Includes the month the customer turns 65; and
- Ends 3 months after the month the customer turns 65.

3) General Enrollment Period

A person may only enroll during a later general enrollment period if:

- The person fails to enroll during the initial enrollment period; or
- The person terminates enrollment.

The general enrollment period occurs each year from January 1st through March 31st. The coverage period of a person who enrolls during a general enrollment period begins on the following July 1st.

The person may be required to pay a late enrollment penalty if they did not have creditable coverage during the time they declined to enroll in Part B.

4) Special Enrollment Period for Part A

There are two special enrollment periods:

If a person is...	And is...	Then the special enrollment period is...
Age 65 or older	Covered under an employer group health plan from an employer of any size	Seven full calendar months beginning with the first day of the first month in which the person is no longer enrolled in an employer group health plan based on current employment.
A disabled person under age 65	Covered under a large employer group health plan (100 or more employees)	Seven full calendar months beginning with the first day of the first month in which the person is no longer enrolled as an active individual in a large group health plan.

The coverage period of a person who enrolls during a special enrollment period begins on either of the following:

- The first day of the first month of the special enrollment period if enrollment occurs in that month; or
- The first day of the month following the month of enrollment if enrollment occurs in a month after the first month of the special enrollment period.

5) Special Enrollment Period for Part B

A person is eligible for the Part B special enrollment period if:

- The person or their spouse is currently working and the beneficiary is covered by a group health plan based on that work; or
- The person is disabled and the person is covered by a group health plan based on employment.

The person can enroll in Part B anytime while the person has group health plan coverage based on current employment or during the 8-month period that begins the month after the employment ends, or the group health plan coverage ends, whichever happens first.

If the person has COBRA coverage, they must enroll during the 8-month period that begins the month after the employment ends. This Special Enrollment Period does not apply to people with End Stage Renal Disease.

If the person waited to enroll in Part B because they had health insurance while volunteering outside of the U.S. for a tax exempt organization for at least a year, the person can enroll during the 6-month period that begins the first month that any one of the following happens:

- The person is no longer volunteering outside the US;
- The sponsoring organization is no longer tax exempt; or
- The person no longer has health insurance coverage outside the US.

6) Application for Conditional Part A Enrollment

Enrollment for Conditional Part A under QMB may occur at any time. When a monthly premium is required, some Part A applicants apply for Part A on the condition that their applications are deemed valid only if QMB eligibility is later approved.

After filing a conditional Part A application with SSA, the person must apply for the Medicare Savings Program with the SSI MAO Office.

Conditional Part A enrollment and entitlement does not apply to any Medicare Savings Program other than QMB. The Buy-In of Part A is not a benefit for the other Medicare Savings Programs. After QMB approval, the Part A premium is paid by the State (AHCCCS) through the Buy-In process.

7) Verification of Conditional Part A Enrollment

Conditional Part A enrollment for a QMB applicant can be verified by a letter or interface from the Social Security Administration. This information is also found on the WTPY, in the Medicare ENTITLED Field; as code Z99.

8) Enrollment Penalties

If a person does not enroll in Medicare when they are first entitled, an enrollment penalty is applied when the person applies for Medicare at a later date.

Medicare	Penalty
Medicare Part A With a Premium	A penalty is assessed for the person who enrolls late in Premium Part A. This penalty is a premium surcharge. The premium surcharge for late enrollment will never be more than 10%. This 10% surcharge will be payable for twice the number of months in full 12-month periods during which the beneficiary could have, but did not enroll in Premium Part A. At the end of the penalty period, the premium amount reverts to the non-penalty rate.
Medicare Part B	A penalty is assessed for late enrollment in Part B. The penalty is an increase in the monthly premium by 10% for each 12-month period after the time the beneficiary was first eligible to enroll. Once the penalty amount is established, it is ongoing for as long as the beneficiary is enrolled in Part B. The penalty may be waived if the person has creditable coverage.
Medicare Part D	The person will be charged a late enrollment penalty (higher premiums) if they choose to enroll later when: • The person decides not to join a Medicare drug plan when they are first eligible; and • The person does not have other creditable prescription drug coverage. The penalty assessed for late enrollment in Medicare Part D is currently 1% for each full month that the person did not have creditable

	coverage after the person was eligible to join a Medicare drug plan. Part D penalties are waived for people enrolled in the Part D Extra Help program.

Definitions

Term	Definition
Conditional enrollment for Medicare Part A	The person who must pay a monthly Part A premium applies for Medicare Part A on the condition that they only want Part A if they are approved for QMB.
Creditable Coverage	Health insurance coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). Examples of creditable coverage include: • Group health plans including Qualified Health Plans; • Health insurance coverage through a hospital or medical service policy, certificate or plan contract; or • Armed forces insurance (i.e. Tricare).
Medicare Enrollment	For Medicare purposes, enrollment is the process where people who meet Medicare eligibility criteria sign up for Medicare Part A and B.
Medicare Part D	Medicare Part D is a voluntary program that provides prescription drug coverage. Part D covers most prescription drugs.
Medicare Part D Extra Help Program	The Extra Help program provides assistance with Medicare Part D prescription costs for people with limited income and resources.

206 State Buy-In and Buy-Out

Revised 05/09/2018

Policy

When a person qualifies for the state to pay his or her Medicare Part B premium, AHCCCS sends a request to the Center for Medicare and Medicaid Services (CMS) to start paying the person's Part B premium. This is the buy-in process.

When a person no longer qualifies, AHCCCS sends a request to CMS to stop paying the person's Part B premium. This is the buy-out process.

1) Buy-in

It normally takes three months after a person is approved for an AHCCCS program that gets the Part B buy-in for the Social Security Administration (SSA) to stop taking the Part B premium amount out of the customer's SSA check.

AHCCCS sends buy-in requests to CMS once a month. The file goes to CMS on the 24th or 25th of each month. CMS processes the file and responds by the 5th of the following month with an acceptance or rejection for each individual request.

If the buy-in is accepted, the premium change will occur within a one month cycle. Delays may occur when there is a difference in the customer's identifying information between CMS' records and AHCCCS' records. Once the discrepancy has been resolved, the request is resubmitted to CMS the following month and the buy-in is processed.

Once the Social Security Administration (SSA) has been notified of the state buy-in, the regular SSA check will be increased to repay the customer for any premiums that were deducted after AHCCCS requested the buy-in.

The rebate may come in the form of a separate check depending on when the change is processed by SSA or if the individual does not receive Social Security benefits.

> NOTE If another state is paying the customer's Medicare premiums, Arizona residency is questionable. See MA531 Resident of Arizona for more information.

2) Buy-out

When a person no longer qualifies to have the State pay the Medicare Part B premium or other costs associated with Medicare, the customer is responsible for those costs. AHCCCS sends a letter to the customer explaining that buy-in will stop and the date Arizona will stop paying the Medicare costs for the customer.

AHCCCS sends notification of all buy-outs to CMS on the 24th or 25th of each month.

Since it may take one to three months for the buy-out to be processed, the customer may have two or three month's premiums withheld from one month's Social Security benefits when SSA completes the buy-out process.

Definitions

Term	Definition
Buy-in	State payment of a customer's Medicare Part B premium. In some instances, the State may also pay the customer's Medicare deductibles and co-payments.
Buy-out	The process of a State stopping the payment for a customer's Medicare Part B premiums or other Medicare costs.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Medicare Savings Program (MSP)	42 USC § 1396a(a)(10)(E) ARS § 36-2971 – 2976

Chapter 300 Covered Services

300 Introduction

In this chapter, you will learn about:

- Types of AHCCCS Medical Assistance services;
- Types of AHCCCS Medical Assistance service packages; and
- Who pays for AHCCCS Medical Assistance Services.

For each section in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement by program.

301 Types of AHCCCS Medical Assistance Health Services

Revised 09/11/2020

Policy

AHCCCS Medical Assistance covers the services listed below. Click here to go to the AHCCCS Medical Policy Manual. Go to the chapter listed for each service to read a full description of the coverage provided under that service.

Service	AHCCCS Medical Policy Manual Chapter
Medical services	300
Behavioral health services	300
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services	400
Family planning services	400
Long Term Care services	1200
Case management	1600

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	AAC R9-28-201 to 206
Adults	AAC R9-22-201 to 217

Caretaker Relatives Child Family Planning Freedom to Work Breast & Cervical Cancer Treatment Program Deemed Newborns Pregnant Women SSI Cash SSI MAO Title IV-E Foster Care & Adoption Subsidy Young Adult Transitional Program	
KidsCare	AAC R9-31-201 to 216

302 Types of AHCCCS Medical Assistance Service Packages

Revised 03/25/2025

Policy

AHCCCS Medical Assistance coverage is provided through the following service packages:

- AHCCCS Medical Assistance Service Package;
- ALTCS Service Package;
- Federal Emergency Service (FES) Package provided through the Federal Emergency Services Program (FESP);
- Medicare Savings Programs Service Packages; and
- Transplant Extended Eligibility Program Medical Assistance Service Package.

See Chapter 1200 for information on customer costs.

1) AHCCCS Medical Assistance Service Package

The AHCCCS Medical Assistance Service Package includes:

- Medical services;
- Behavioral health services;
- EPSDT Services for customers under age 21;
- Family Planning Services; and
- Payment of the Part B Medicare premium for most AHCCCS programs.

Most customers receive all medically necessary services from an AHCCCS Complete Care Plan.

American Indians may choose to receive services by enrolling in an AHCCCS Complete Care Plan or through the American Indian Health Program (AIHP).

2) ALTCS Service Packages

ALTCS customers may be eligible for a:

- Full ALTCS service package; or
- Limited ALTCS service package.

The full ALTCS service package includes the following services:

- Case Management;
- Medical Services;
- Behavioral Health Services;
- Family Planning Services;
- Long Term Care Services;
- EPSDT Services for Medicaid eligible children under age 21; and
- Payment of the Part B Medicare premium, except for some customers that qualify for ALTCS Freedom to Work).

NOTE The limited ALTCS service package includes all the services listed above EXCEPT Long Term Care Services.

See MA521, MA705K, and MA900 for details about what can result in a customer getting only the limited ALTCS service package.

3) Federal Emergency Service (FES) Package

The Federal emergency service (FES) package is limited to services that are needed to treat an emergency medical condition. These services are provided through the Federal Emergency Services Program (FESP)

4) Medicare Savings Program Packages

There are three Medicare Savings Plan (MSP) programs and two service packages, one for QMB and one for SLMB or QI-1:

Program	Benefits Paid
QMB	Medicare Part A premiums; Medicare Part B premiums; Medicare deductibles; and

	Medicare coinsurance
SLMB or QI-1	Medicare Part B premiums

5) Transplant Extended Eligibility Program – Medical Service Package

Customers eligible for the Transplant Extended Eligibility Program have two options for the extension of coverage. The option chosen determines the amount and duration of services that will be provided:

- Option One – The customer can choose to receive one 12-month extension of full MA services. The period begins the day after the previous AHCCCS program coverage ends. These customers receive the full AHCCCS Medical Assistance Services package listed in section 1) of this policy.
- Option Two – The customer can choose to postpone the AHCCCS coverage extension until the time the transplant is performed. If the customer is found to still be ineligible for any other AHCCCS program due to excess income, the customer will receive the eligibility extension, which covers only transplant-related surgery and services. This includes up to 100 days of post-transplantation care.

Definitions

Term	Definition
AHCCCS American Indian Health Program (AIHP)	AIHP is responsible for paying fee-for-service claims submitted for American Indians who have chosen not to enroll in an AHCCCS Complete Care plan. If the American Indian member does not choose a plan and lives within the bounds of a tribal nation, the member will be automatically enrolled in AIHP.
Federal Emergency Services (FES)	Medically necessary services, including labor and delivery, to treat a medical or behavioral health condition that in the absence of immediate medical attention is reasonably likely to result in: • Placing the individual's health in serious jeopardy; • Serious impairment to bodily functions;

	• Serious dysfunction of any bodily organ or part; or • Serious physical harm to another person.
Federal Emergency Services Program (FESP)	Federal program that provides emergency services for qualified and non-qualified aliens who meet all requirements for assistance except for citizenship.

Chapter 400 AHCCCS Medical Assistance Programs

400 Introduction

For each AHCCCS Medical Assistance program discussed in this chapter, you will find:

- The policy for each program;
- Any definitions needed to explain the policy;
- Which health service package it has;
- General information on enrollment;
- Any customer costs; and
- The federal and state laws that authorize the program.

401 Adults

Revised 03/25/20205

Policy

The conditions of eligibility for the Adult program are:

- Valid application (MA533);
- Age 19 to 64 (MA501);
- Resident of Arizona (MA531);
- Provide or apply for a valid Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524);
- Does not qualify for Medicare (MA523);
- Children for which the individual is the primary caretaker must have insurance coverage (MA518);
- Assignment of rights to medical benefits and cooperation (MA503); and
- Income at or below 133% of the FPL (MA615.7).

Definitions

Term	Definition
Adult Program	The Adult group is for people who do not qualify for AHCCCS Medical Assistance (MA) in any of the following programs: • Caretaker Relative; • Pregnant Woman; • SSI-MAO; and • Young Adult Transitional Insurance (YATI).

Service Package

Customers who meet all of the requirements for the Adult program receive full AHCCCS Medical Assistance services package. Customers who meet all requirements except U.S. citizenship or qualified noncitizen status receive Federal emergency services (FES) only through the Federal Emergency Services Program (FESP). See MA302 for details about the service packages.

Enrollment

Customers approved for full coverage under the Adult program are enrolled in AHCCCS Complete Care (ACC) plan (Chapter 1100).

Emergency Services are paid for by AHCCCS on a fee-for-service basis.

Customer Costs

Customers do not pay a premium for coverage under the Adult program. Customers in the Adult program temporarily do not have co-payments.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Adults	42 USC 1396a(a)(10(A)(1)(XIII) 42 CFR 435.119 Title 9, Chapter 22, Article 14 of the AAC AAC R9-22-305

402 Freedom to Work (FTW)

Revised 12/17/2024

Policy

The conditions of eligibility for the AHCCCS Freedom to Work program are:

- Valid application (MA533);
- At least age 16 to 64 (MA501);
- Resident of Arizona (MA531);
- Provide or apply for a valid Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524);
- Assignment of rights to medical benefits and cooperation (MA503); and
- Meet the Basic Coverage Group or Medically Improved Coverage Group definitions for disability (MA509)
- Employed (MA510);
- Monthly countable income under 250% FPL (MA615.6);
- Pay the AHCCCS FTW premium, if required (MA528); and
- Not eligible for any other Medicaid program (MA522).

Definitions

Term	Definition
Freedom to Work (FTW) Program	The FTW program is for people with disabilities who are working. There are two FTW coverage groups: • The Basic Coverage Group; and • The Medically Improved Group.

Medically Improved Coverage Group	Means customers who meet all the following conditions: • Employed; • While receiving benefits under the FTW Basic Coverage Group was determined by SSA to no longer have a disability; and • Determined by SSA to still have a severe impairment

Service Package

Customers eligible for AHCCCS Freedom to Work program receive AHCCCS Medical Services.

Customers can receive an ALTCS services package. Customers may be eligible for an ALTCS service package if they:

- Are medically in need of long term care services (MA509); and
- Reside in a setting (living arrangement) where long term care services can be provided (MA521).

Enrollment

Customers approved for coverage under AHCCCS Freedom to Work are enrolled with:

- AHCCCS Complete Care (ACC) plan; or
- Program Contractor (for ALTCS).

Customer Costs

Customers who qualify for AHCCCS Medical Services or ALTCS services under a FTW coverage group may have to pay a:

- Premium (MA1203); OR
- Share of Cost (MA1201).

Customers who pay a premium may have co-payments for certain services (MA1202).

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Freedom to Work	42 USC 1396a(a)(10)(A)(ii)(XV) 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 ARS 36-2950 AAC R9-22-1901 through R9-22-1904 AAC R9-22-1919

403 Arizona Long Term Care System (ALTCS)

Revised 12/17/2024

Policy

The conditions of eligibility for the Arizona Long Term Care System (ALTCS) are listed in the following chart:

If the customer...	Then the conditions of eligibility are...
Is eligible for SSI Cash, Title IV-E Foster Care or Title IV-E Adoption Subsidy (MA502)	• Valid application (MA533); • Interview (MA519); • Resident of Arizona (MA531); • Assignment of rights to medical benefits and cooperation (MA503); and • Transfers (see Chapter 900); • Does not have a trust which causes the resources or income to exceed the limit (see Chapter 800); and • Medical need for long term care (MA509).
• Is not receiving or deemed to be receiving SSI Cash; or • Is not receiving Title IV-E Foster Care or Adoption Subsidy	• Valid application (MA533); • Interview (MA519); • Categorical element; ◦ Aged (MA501); ◦ Blind (MA504); or ◦ Disabled (MA509); • Resident of Arizona (MA531); • Social Security number (MA532); • US Citizen (MA507) or appropriate noncitizen status (MA524);

	• Not incarcerated (MA525); • Reside in an appropriate ALTCS living arrangement (MA521); • Assignment of rights to medical benefits and cooperation (MA503); • Resources (MA701): ◦ $2,000 for individual; or ◦ $3,000 for couple; • Resource Assessment (Community Spouse only) (MA707); • Income (MA615.1): ◦ 300% of FBR for an Individual; or ◦ 100% of the FBR for persons who are only eligible for limited AHCCCS Medical Assistance benefits and • Medical need for long term care (MA509).

The AHCCCS ALTCS local offices throughout the State determine eligibility for ALTCS.

Definitions

Term	Definition
Arizona Long Term Care System (ALTCS) Program	ALTCS is an AHCCCS Medical Assistance program. ALTCS provides long term services to customers who: • Are medically and financially eligible; • Are elderly, physically disabled or developmentally disabled; and • Have a medical need for long term care services.

Service Package

The table below describes the type of service package an ALTCS customer may receive based on the customer's circumstances.

If the customer...	Then the service package is...
Is in a living arrangement where long term care services can be received (MA521A)	Full ALTCS service package
Is in a living arrangement where long term services cannot be received (MA521A)	Limited ALTCS service package (ALTCS Acute Care)
Refuses the home and community based services (HCBS) offered by the case manager (MA521)	
Has made an uncompensated transfer that makes the customer ineligible to receive long term care services (Chapter 900)	
Owns home property in which the equity value exceeds the limit (MA705K)	

For a description of the AHCCCS Medical Assistance service packages, see (MA302).

Enrollment

Customers approved for coverage under ALTCS are enrolled with an ALTCS Program Contractor (MA1104).

Customer Costs

Some ALTCS customers have to pay a share of the cost for their ALTCS health insurance (MA1201).

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS	Title 42, Chapter 7, Subchapter XIX of the USC Title 42, Chapter IV, Part 435 of the CFR Title 36, Chapter 29, Article 2 of the ARS Title 9, Chapter 28 of the AAC

404 Breast and Cervical Cancer Treatment Program (BCCTP)

Revised 10/01/2024

Policy

The conditions of eligibility for the Breast and Cervical Cancer Treatment Program (BCCTP) are:

- Valid application (MA533);
- Screened and diagnosed as needing treatment for breast cancer, cervical cancer or a pre-cancerous lesion. (MA505);
- Under age 65 (MA501);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or qualified noncitizen status (MA524);
- Not incarcerated (MA525);
- No creditable insurance or insurance that does not cover treatment of breast and/or cervical cancer (MA515); and
- Ineligible for any other AHCCCS Medical Assistance coverage groups (MA522).

The AHCCCS BCCTP Unit in the SSI MAO Office determines eligibility for BCCTP.

Definitions

Term	Definition
Breast and Cervical Cancer Treatment Program (BCCTP)	The BCCTP is for women who need treatment for: • Breast cancer; • Cervical cancer; or • Pre-cancerous cervical lesion.

Service Package

Customers eligible for the BCCTP receive AHCCCS Medical Services (MA302.1).

Enrollment

Customers approved for coverage under BCCTP are enrolled in AHCCCS Complete Care (ACC) plan.

Customer Costs

Customers do not pay a premium for coverage under the BCCTP. Customers enrolled in BCCTP do not have co-payments.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Breast and Cervical Cancer Treatment Program (BCCTP)	42 USC 1396a(a)(10)(A)(ii)(XVIII) 42 USC 1396a 42 USC 1396a(a)(10)(G)(XIV), as amended by Pub. L. 106-354 ARS 36-2901.05 Title 9, Chapter 22, Article 20 of the AAC

405 Caretaker Relative and Extended Coverages

Revised 03/25/2025

Policy

The conditions of eligibility for the Caretaker Relative program are:

- Valid application (MA533);
- Deprived child in the household (MA506);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524);
- Not incarcerated (MA525);
- Assignment of rights to medical benefits and cooperation (MA503); and
- Income at or below the limit in (MA615.8).

The following programs are an extension of coverage due to a customer losing Caretaker Relative eligibility:

- Transitional Medical Assistance; and
- Continuous Coverage.

1) Transitional Medical Assistance (TMA)

Caretaker relatives and the children they live with may become ineligible for Medical Assistance due to excess earned income. TMA allows these customers to have up to 12 months of additional coverage.

Customers can receive six months of TMA eligibility if:

- At least one member of the household received Medical Assistance as a Caretaker Relative in three of the last six months;

- At least one month of the Caretaker Relative coverage was received immediately preceding the month they became income ineligible; and
- The household is ineligible for Medical Assistance because of earned income of the Caretaker Relative.

NOTE The caretaker relative and the children they live with must be currently receiving AHCCCS as a Caretaker Relative or Child to be eligible for TMA.

In addition to the conditions of eligibility listed above, TMA customers can receive an additional six months of TMA eligibility if:

- The customer whose earned income caused ineligibility continues to work; and
- The household has income at or below 185% of the FPL.

NOTE The MAGI 5% FPL Disregard does not apply to TMA.

2) Continued Coverage (CC)

Caretaker relatives and the children they live with may lose eligibility due to an increase in alimony or spousal support payments. Continued Coverage (CC) allows these customers to have up to four months of additional coverage.

CC customers can receive up to four months of coverage if:

- At least one member of the household received Medical Assistance as a Caretaker Relative in three of the last six months;
- At least one month of the Caretaker Relative coverage was received immediately preceding the month they became income ineligible; and
- The household is ineligible for Medical Assistance because of increased alimony or spousal support payments received by the Caretaker Relative.

Definitions

Term	Definition
Caretaker Relative	A Medicaid program for customers who are: • An adult relative; and

	• Living and caring for a deprived child.
Transitional Medical Assistance (TMA)	TMA provides transitional coverage for Medicaid customers who become ineligible due to the increased earnings of a caretaker relative.
Continued Coverage (CC)	CC provides coverage for Medicaid customers who become ineligible due to an increase in alimony payments.

Service Package

Customers eligible for the Caretaker Relative program receive full AHCCCS Medical Assistance services. Customers who meet all requirements except U.S. citizenship or qualified non-citizen status receive Federal emergency services (FES) only through the Federal Emergency Services Program (FESP). See MA302 for details about the AHCCCS Medical Assistance service packages.

Enrollment

Customers approved for full coverage under the Caretaker Relative program are enrolled in AHCCCS Complete Care (ACC) plan (MA1102).

Emergency Services are paid for by AHCCCS on a fee-for-service basis (MA1103).

Customer Costs

Customers do not pay a premium for coverage under the Caretaker Relative program. However, the customer may have co-payments for certain services (MA1205).

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Caretaker Relative	42 USC 1396u-1 42 CFR 435.110, 42 CFR 435.115

	ARS 36-2901(6) AAC R9-22-1427

406 Child

Revised 04/15/2025

Policy

The conditions of eligibility for the Child program are:

- Valid application (MA533);
- Under age 19 (MA501);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524);
- Assignment of rights to medical benefits and cooperation (MA503); and
- Income at or below the limits in MA615.10, 11 and 12.

Service Package

Customers eligible for the Child program receive full AHCCCS Medical Assistance coverage. Customers who meet all requirements except U.S. citizenship or qualified non-citizen status receive Federal emergency services (FES) only through the Federal Emergency Services Program (FESP).

For a description of AHCCCS Medical Assistance service packages, see MA302.

Enrollment

Customers approved for full coverage under the Child program are enrolled in an AHCCCS Complete Care (ACC) plan (MA1102).

Emergency Services are paid for by AHCCCS on a fee-for-service basis (MA1103).

NOTE Customers enrolled in the Child category for full coverage are guaranteed a 12-month continuous period of eligibility.

See Guaranteed Enrollment Periods for more information. Customers receiving Emergency Service only are not eligible for guaranteed enrollment periods.

Customer Costs

Customers do not pay a premium for coverage under the Child program. Customers in the Child program also are exempt from co-payments.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Child	42 USC 1396a(a)(A)(10)(A)(1)(III) 42 CFR 435.118ARS 36-2901 to 2930AAC R9-22-1401 to 1443 42 CFR 435.926

407 Deemed Newborns

Policy

The conditions of eligibility for the Deemed Newborn program are:

- The child's mother is determined eligible for MA for the day the baby is born; and
- The child resides in Arizona.

Newborns are automatically approved for benefits when an AHCCCS Complete Care (ACC) plan or ALTCS program contractor informs AHCCCS that a mother eligible for AHCCCS Medical Assistance or ALTCS has given birth.

Definitions

Term	Definition
Deemed Newborn Program	Deemed Newborn coverage is for children through the month of the child's 1st birth date. The child must: • Be born to a mother eligible for ALTCS, SSI Cash, SSI MAO, Adult, Caretaker Relative, Pregnant Woman, Children or KidsCare; and • Live in Arizona.

Service Package

Customers eligible for the Deemed Newborn program receive AHCCCS Medical Services (MA302.1).

Enrollment

Customers approved for coverage under Deemed Newborn program are enrolled in AHCCCS Complete Care (ACC) plan.

NOTE Deemed Newborns are guaranteed a 12 month eligibility period unless the child does not remain an Arizona resident.

Customer Costs

There are no premiums or copayments for the Deemed Newborn Program

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Deemed Newborns	42 USC 1396a(e)(4) 42 CFR 435.117 AAC R9-22-1429

408 KidsCare

Revised 08/20/2024

Policy

The conditions of eligibility for KidsCare are:

- Valid application (MA533);
- Under age 19 (MA501);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or appropriate non-citizen status (MA524);
- Not incarcerated (MA525);
- Not in an institution for mental disease (IMD) (MA514);
- Ineligible for Medicaid (MA522)
- Assignment of rights to medical benefits and cooperation (MA503);
- Cooperation with Medicaid requirements (MA522);
- No current health insurance coverage (MA515);
- Not eligible for the State employees' health benefits plan (MA517);
- Income under 225% of the FPL (MA615.13); and
- Payment of a premium, if required (MA1204).

Definitions

Term	Definition
KidsCare	Arizona's Children's Health Insurance program for uninsured children under age 19 who are not eligible for Medicaid.

Service Package

Customers eligible for KidsCare receive AHCCCS Medical Services (MA302.1).

Enrollment

Customers approved for coverage under KidsCare are enrolled in an AHCCCS Complete Care (ACC) plan.

NOTE KidsCare customers are guaranteed a 12-month continuous eligibility period. See Guaranteed Enrollment Periods for more information. See Premiums During 12-Month Guarantee and Appeals Process for information about premiums during the guarantee period.

Customer Costs

Some customers may be required to pay a premium but are exempt from co-payments.

NOTE American Indians and Alaskan Natives are not required to pay a premium or co-payment.

Legal Authority

This policy applies to the following program:

Program	Legal Authorities
KidsCare	42 U.S.C. 1397aa 42 CFR 457.300 through 457.380, 457.570, and 457.805 42 CFR 435.926 ARS 36-2981 through 36-2998 AAC R9-31

409 Medicare Savings Program (MSP)

Revised 12/17/2024

Policy

The conditions of eligibility for the Medicare Savings Program (MSP) are:

- Valid application (MA533);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524);
- Assignment of rights to medical benefits and cooperation (QMB only) (MA503); and
- Income at or below QMB, SLMB or QI-1 requirements (MA615.3, MA615.4 and MA615.5).

Definitions

Term	Definition
Medicare Savings Program (MSP)	The MSP provides help with Medicare expenses for customers who are entitled to Medicare Part A. NOTE There is no categorical element (i.e., aged, blind or disabled) requirement for the MSP. Persons with End Stage Renal Disease (ESRD) can be eligible, provided they have Medicare Part A. The MSP offers the following programs: • Qualified Medicare Beneficiary (QMB); • Specified Low-Income Beneficiary (SLMB); and • Qualified Individual-1 (QI-1).
Qualified Medicare Beneficiary (QMB)	For customers who:

	• Meet the general conditions of eligibility; • Are entitled to Medicare Part A (MA523); • Have income less than or equal to 100% FPL.
Specified Low-Income Medicare Beneficiary (SLMB)	For customers who: • Meet the general conditions of eligibility; • Receive Medicare Part A (MA523); and • Have income greater than 100% FPL but less than or equal to 120% FPL. NOTE To be eligible for SLMB, a person does not have to be receiving Medicare Part B.
Qualified Individual-1 (QI-1)	For customers who: • Meet the general conditions of eligibility; • Receive Medicare Part A (MA523); and • Have income greater than 120% FPL but less than or equal to 135% FPL. NOTE To be eligible for QI-1, a person does not have to be receiving Medicare Part B.

Service Package

Customers eligible for the Medicare Savings Program (MSP) receive the Medicare Savings Program Service Package (MA302).

Enrollment

Customers approved for coverage under the Medicare Savings Program (MSP) are enrolled as follows:

If the customer is...	Then the customer is enrolled in...

QMB	Fee-for-Service (FFS)
• QMB and: • SSI Cash; • SSI MAO; • AHCCCS Freedom to Work; • Caretaker Relative; • Pregnant Women; • Children; • YATI; or • State Adoption Subsidy	AHCCCS Complete Care (ACC) plan
QMB and: • ALTCS; or • AHCCCS Freedom to Work – ALTCS	Program Contractor
SLMB	Not enrolled
• SLMB and: • SSI Cash; • SSI MAO; • AHCCCS Freedom to Work; • Caretaker Relative; • Pregnant Women; • Children; • YATI; or • State Adoption Subsidy	AHCCCS Complete Care (ACC) plan

Dual SLMB and AHCCCS Freedom to Work – ALTCS	Program Contractor
QI-1 NOTE An individual cannot be eligible for QI-1 and any other Medical Assistance program.	Not enrolled

Customer Costs

AHCCCS does not charge MSP customers. MSP customers who are not QMBs are responsible for paying to their health care provider:

- Medicare co-payments;
- Medicare deductibles; or
- Medicare co-insurance.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Medicare Savings Program (MSP)	42 USC 1396a(a)(10)(E) Title 36, Chapter 29, Article 3 of the ARS Title 9, Chapter 29 of the AAC

410 Pregnant Woman

Revised 04/15/2025

Policy

The conditions of eligibility for the Pregnant Woman program are:

- Valid application (MA533);
- Pregnant (MA527);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524);
- Assignment of rights to medical benefits and cooperation (MA533); and
- Income at or below the limit in MA615.9.

Definitions

Term	Definition
Pregnant Women Program	The Pregnant Woman program is for women who are pregnant or in the postpartum period.
Post Partum Period	A 12-month period starting the day the pregnancy ends and stops the last day of the month in the 12th month after the pregnancy ends. Customer must be enrolled in AHCCCS while pregnant to be in the postpartum period as it applies to this group. NOTE Women receiving emergency services only are not eligible for the Post Partum Period. See Pregnancy and Postpartum for examples.

Service Package

Customers eligible for the Pregnant Woman program receive full AHCCCS Medical Assistance coverage. Customers who meet all requirements except U.S. citizenship or qualified non-citizen status receive Federal emergency services (FES) only through the Federal Emergency Services Program (FESP).

For a description of AHCCCS Medical Assistance service packages, see MA302.

Enrollment

Customers approved for coverage under the Pregnant Woman program are enrolled in AHCCCS Complete Care (ACC) plan (Chapter 1100).

Emergency Services are paid for by AHCCCS on a fee-for-service basis.

Customer Costs

Customers do not pay a premium or co-payments for coverage under the Pregnant Woman program.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Pregnant Woman	Title 42, Chapter 7, Subchapter XIX of the USC Title 42, Chapter IV, Part 435 of the CFR ARS 36-2901(6) Title 9, Chapter 22, Article 14 of the AAC

411 [REMOVED]

Revised 11/12/2015

412 SSI Cash

Policy

The Social Security Administration determines eligibility for Supplemental Security Income (SSI) Cash. Persons who are approved for SSI Cash are automatically eligible for AHCCCS Medical Assistance and do not have apply for it separately.

Definitions

Term	Definition
SSI Cash Program	A customer is automatically eligible for Medicaid if he: • Is aged, blind or disabled; and • Receives SSI Cash from the Social Security Administration (SSA).

Service Package

Customers eligible for the SSI Cash program receive AHCCCS Medical Services (MA302).

Enrollment

Customers approved for coverage under the SSI Cash program are enrolled in an AHCCCS Complete Care (ACC) plan.

Customer Costs

Customers in the SSI Cash program do not pay a premium for AHCCCS Medical Services. However, the customer may have co-payments for certain services (MA1202).

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
SSI Cash	Title 42, Chapter 7, Subchapter XIX of the USC Title 42, Chapter 7, Subchapter XVI of the USC Title 42, Chapter IV, Part 435 of the CFR Title 20, Chapter III, Part 416 of the CFR

413 Supplemental Security Income Medical Assistance Only (SSI MAO)

Revised 03/25/2025

Policy

The general conditions of eligibility for the Supplemental Security Income Medical Assistance Only (SSI MAO) program are:

- Valid application (MA533);
- Categorical element:
  - Age 65 or older (MA501);
  - Blindness (MA504); or
  - Disability (MA509);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or qualified noncitizen status (MA524);
- Assignment of rights to medical benefits and cooperation (MA503); and
- Income at or below 100% of the FBR or 100% of the FPL (MA615.2).

Specialty Categories

In addition to the general conditions of eligibility listed above, a customer may be eligible for SSI MAO under one of the following categories:

- Disabled Adult Child (DAC);
- Disabled Widow/Widower (DWW); or
- Pickle.

1) Disabled Adult Child (DAC)

To qualify under this category, a customer must also meet the following:

- Age 18 or older (MA501);

- Received SSI Cash benefits on the basis of blindness or disability before reaching age 22 (MA529);
- Lost SSI Cash benefits due to getting new or increased Title II Social Security benefits for an adult child with a disability (MA529);
- Have countable income less than or equal to 100% of the FBR (MA615.2).

2) Disabled Widow/Widower (DWW)

To qualify under this category, a customer must also meet the following:

- Be at least age 50, but under age 65 (MA501);
- Not entitled to Medicare Part A (MA523);
- Not currently married;
- Have a Social Security claim number with a “D” or “W” Beneficiary Identification Code (BIC);
- Have countable income less than or equal to 100% of the FBR (MA615.2); and
- Have met ALL of the following conditions at any time since January 1, 1991:
    - Received SSI Cash or State Supplementary Payments (SSP);
    - Received an SSI or SSP benefit for the month before the customer began receiving Title II (SSA) payments as a disabled widow/widower (MA529); and
    - Became ineligible for the SSI or SSP benefit due to the amount of the Title II SSA payment as a disabled widow/widower (MA529).

3) Pickle

To qualify under this category, a customer must also meet the following:

- Receive Title II Social Security payments (MA530);
- Have countable income less than or equal to 100% of the FBR (MA615.2); and
- At any time since April 1, 1977:
    - Have received both SSI Cash or SSP benefits AND Title II Social Security payments at the same time for at least one month; AND
    - Have become ineligible for the SSI Cash or SSP benefits while receiving both Title II Social Security payments AND SSI Cash or SSP benefits.

Definitions

Term	Definition
State Supplementary Payments (SSP)	Payments made by a state to supplement SSI Cash benefits. Arizona does not have an SSP program, but the person may have received the payment in another state.

Service Package

Customers who meet all requirements for the SSI MAO program receive full AHCCCS Medical Assistance coverage.

Customers who meet all requirements except U.S. citizenship or qualified noncitizen status receive Federal emergency services (FES) only through the Federal Emergency Services Program (FESP).

For a description of the AHCCCS Medical Assistance service packages, see MA302.

Enrollment

AHCCCS enrolls customers approved for coverage under the SSI MAO program in an AHCCCS Health Plan (MA1102).

AHCCCS pays for Emergency Services on a fee-for-service basis (MA1103).

Customer Costs

Customers do not pay a premium for coverage under the SSI MAO program. However, the customer may have co-payments for certain services (MA1202A).

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

SSI MAO	42 USC 1396a(a)(10)(A)(ii)(I) 42 CFR 435.201 42 CFR 435.210 ARS 36-2901(6)(a) AAC R9-22-1501 to 1505
Disabled Adult Child (DAC) Disabled Widow or Widower (DWW)	42 USC 1383c 42 USC 1396a(a)(10)(A)(i)(I) 42 CFR 435.138 (DWW) ARS 36-2901(6)(a) AAC R9-22-1505
Pickle	42 USC 1396a(a)(10)(A)(i)(I) 42 CFR 435.135 ARS 36-2901(6)(a) AAC R9-22-1505

414 Title IV-E Foster Care and Adoption Subsidy

Revised 07/02/2024

Policy

Persons who receive Title IV-E Foster Care or Title IV-E Adoption Subsidies are automatically eligible for AHCCCS Medical Assistance and do not have apply for it separately. For information about the agencies that administer these programs and other programs for children in foster care see MA103.

There are three tribes with an approved Title IV-E program:

- Navajo Nation, Window Rock, Arizona
- Pascua Yaqui Tribe, Tucson, Arizona
- Salt River Pima-Maricopa Indian Community, Scottsdale, Arizona

Definitions

Term	Definition
Title IV-E Foster Care and Adoption Subsidy Program	Program for children who receive foster care maintenance or adoption assistance payments under Title IV-E of the Social Security Act

Service Package

Customers eligible for the Title IV-E foster care and adoption subsidy program receive full AHCCCS Medical Assistance coverage (see MA302 for more details).

Enrollment

Customers approved for coverage under the Title IV-E foster care are enrolled in the Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP).

Customer's approved for the Adoption Subsidy program are enrolled in an AHCCCS Complete Care (ACC) plan.

Customer Costs

Customers do not pay a premium or co-payments under the Title IV-E foster care and adoption subsidy program.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Title VI-E Foster Care and Adoption Subsidy	42 USC 1396 (a)(10)(A)(i)(I) 42 CFR 435.145

415 Transplant Extended Eligibility Program

Revised 09/07/2018

Policy

The Transplant Extended Eligibility Program is totally State funded and is not supported by any federal funding. The program is for people who are currently eligible for a medically necessary transplant under ARS § 36-2907 and are losing their AHCCCS Medical Assistance (MA) because their income is over the limit for the program.

Transplant Extended Eligibility Program eligibility is determined by AHCCCS.

The conditions of eligibility for the Transplant Program are:

- Was receiving full services MA in a group other than KidsCare, but MA is ending because of income over the program's income limit;
- Have too much income to qualify for any other MA program;
- Were approved for a medically necessary transplant and placed on a transplant waiting list before their MA eligibility ended;
- Enter into a contract with the transplant facility to pay the amount of income that is over the AHCCCS eligibility standards. This amount is called the Transplant share of cost (MA1205);
- Resident of Arizona (MA531);
- Social Security number (MA532);
- U.S. citizen (MA507) or eligible, qualified noncitizen (MA524);
- Not in a penal institution (MA525); and
- Assignment of rights to medical benefits and cooperation (MA503).

Definitions

Term	Definition
Transplant Extended Eligibility Program	The Transplant Extended Eligibility Program covers persons who need a transplant, but are losing their AHCCCS Medical Assistance coverage due to excess income.

Service Package

Customers eligible for the Transplant program have two service package options (MA302.5).

Enrollment

Customers approved for coverage under the Transplant Extended Eligibility Program are enrolled in an AHCCCS Complete Care (ACC) plan.

Customer Costs

The customer must pay a share of cost if transplanted while on this program. See MA1205 for more information on customer costs for the Transplant Extended Eligibility Program.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Transplant Extended Eligibility Program	ARS §§ 36-2907.10 and 36-3907.11

416 Young Adult Transitional Insurance (YATI)

Revised 03/25/2025

Policy

As of January 1, 2023, the conditions of eligibility for the Young Adult Transitional Insurance (YATI) program are:

- Valid application (MA533);
- Age 18 to 26 (MA501);
- Was in the custody of any United States government foster care system or a Tribe on the day the person turned age 18 (MA513);
- Was receiving Medicaid on the day the person turned age 18;
- Resident of Arizona (MA531);
- Social Security number (MA532);
- US citizen (MA507) or appropriate noncitizen status (MA524) and
- Assignment of rights to medical benefits and cooperation (MA503).

Definitions

Term	Definition
Young Adult Transitional Insurance (YATI) Program	The YATI program provides transitional medical care for children leaving foster care.

Service Package

Customers who meet all requirements for the YATI program receive full AHCCCS Medical Assistance coverage.

Customers who meet all requirements except U.S. citizenship or qualified noncitizen status receive Federal emergency services (FES) only through the Federal Emergency Services Program (FESP).

For a description of the AHCCCS Medical Assistance service packages, see MA302.

Enrollment

Customers approved for coverage under YATI are enrolled in an AHCCCS Complete Care (ACC) plan (MA1102).

Emergency Services are paid for by AHCCCS on a fee-for-service basis (MA1103).

Customer Costs

Customers do not pay a premium for coverage under the YATI program. However, the customer may have co-payments for certain services (MA1202).

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
YATI	42 USC 1396a(a)(10)(A)(i)(IX) 42 CFR 435.150 AAC R9-22-1432

417 Hospital Presumptive Eligibility

Revised 09/18/2020

Policy

Hospital Presumptive Eligibility (HPE) is a streamlined process that qualified hospitals can use to immediately enroll patients who are likely eligible under Arizona's Medicaid eligibility guidelines for a temporary period of time.

The conditions of eligibility for the HPE program are based on the categories listed below; a customer must fall into one of these categories and meet all of the requirements within that category:

- Adult (MA401)
- BCCTP (MA404)
- Caretaker Relative (MA405)
- Child (MA406)
- Pregnant Woman (MA410)
- Young Adult Transitional Insurance (MA416)

Definitions

Term	Definition
Hospital Presumptive Eligibility (HPE)	Temporary coverage for people who are likely to qualify for AHCCCS Medical Assistance. NOTE Eligibility for HPE is determined by qualified hospitals

Service Package

Customers who meet all of the requirements for the HPE program receive full AHCCCS Medical Assistance services package. See MA302 for details about the service packages.

Enrollment

HPE services are paid for by AHCCCS on a fee-for-service basis.

Customer Costs

Customers do not pay a premium for coverage under the HPE program. Customers in the HPE program do not have co-payments.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Hospital Presumptive Eligibility (HPE)	42 USC 1396r-1 42 USC 1396r-1a 42 USC 1396r-1b 42 CFR 435.1102 42 CFR 435.1103 AAC R9-22-1601

Chapter 500 Non-Financial Conditions of Eligibility

500 Introduction

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement by program.

501 Age

Revised 11/24/2020

Policy

A person must meet an age requirement to qualify for some AHCCCS programs. See the table below for the age requirements by program.

Age	Program
Under age 65	Breast & Cervical Cancer Treatment Program (BCCTP) Adults
At least age 16, but under age 65	AHCCCS Freedom to Work (FTW)
Age 50 through 64	Disabled Widow Widower (DWW)
Age 18 or older	Disabled Adult Child (DAC)
Under age 19	KidsCare, Children's Program
Under age 1	Deemed Newborns
Under age 26	YATI
Age 65 or older	SSI-MAO NOTE This condition only applies if the person is not blind or disabled.

Definitions

Term	Definition
Turns age ___	The policy on when a person turns a certain age is different depending on the AHCCCS program. For the ALTCS, SSI-MAO, MSP, FTW, and BCCTP programs: • A person is considered that age as of the day before their birthday. • A person meets the age requirement for the full month even when the day is not the first day of the month. For the Children's, Pregnant Women, Caretaker Relatives, and KidsCare programs: • A person is considered that age as of the day of their birthday. • A person meets the age requirement for the full month even when the birthday is not the first day of the month.

Proof

Accept the customer's statement for proof of age unless it is questionable, and the conflicting information would affect eligibility.

The following documents can be used as proof of age:

- Electronic verification from the Social Security Administration or Arizona Vital Statistics;
- Passport;
- Tribal record listing the person's name and date of birth;
- Birth record issued by a US or a foreign country's government agency;
- Religious record that shows age or date of birth;
- Hospital birth record or notification of birth registration;
- Delayed birth record;
- Driver's license or State identity card;

- Voter registration card;
- Statement listing the person's date of birth signed by a physician or midwife who was in attendance at the time of birth;
- School record;
- Military record;
- Insurance policy;
- Marriage record;
- Applicant's child's birth certificate showing the applicant's name and age; or
- Any other record which shows age or date of birth; for example, hospital treatment record, labor union or fraternal organization record, permits, licenses, or poll tax receipts.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Breast & Cervical Cancer Treatment Program (BCCTP)	42 USC 1396a(a)(10)(A)(ii)(XVIII) ARS 36-2901.05 AAC R9-22-2003
Freedom to Work (FTW)	42 USC 1396a(a)(10)(A)(ii)(XV) and (XVI) ARS 36-2929; ARS 36-2950
Disabled Widow Widower (DWW)	42 USC 1383c(d) AAC R9-22-1505
Disabled Adult Child (DAC)	42 USC 1383c(c) AAC R9-22-1505
KidsCare	42 USC 1397jj(c)(1)

	42 CFR 457.10 ARS 36-2981.6 AAC R9-31-303(1)
Adults	42 USC 1396a(a)(10)(A)(i)(VIII) 42 CFR 435.119
Children	42 USC 1396a(a)(10)(A)(i)(IV); (VI); and (VII) 42 CFR 435.118 ARS 36-2901(6)(a)(ii) AAC R9-22-1427
Deemed Newborns	42 USC 1396a(a)(10)(A)(i) AAC R9-22-1429
YATI	42 U.S.C. 1396a(a)(10)(A)(IX)
SSI-MAO	42 USC 1396d(a)(iii) AAC R9-22-1505

502 ALTCS Categorical Eligibility

Revised 10/22/2020

Policy

People who receive payments from Title IV-E Foster Care, Title IV-E Adoption Subsidy or Supplemental Security Income (SSI Cash) already qualify for AHCCCS Medical Assistance.

To qualify for ALTCS, they ONLY have to meet the conditions in the following chapters:

- Medical (Chapter 1000);
- Trusts (Chapter 800); and
- Transfers (Chapter 900).

Definitions

Term	Definition
Title IV-E Adoption Subsidy	Payments funded under Title IV-E of the Social Security Act to encourage the adoption of children with special needs. The payments help families with the extra costs that might be a barrier to adoption of a child with special needs.
Title IV-E Foster Care	Foster care payments funded under Title IV-E of the Social Security Act to help reimburse foster families for the costs of caring for a child placed in their care.
SSI-Cash	Payments from the Social Security Administration under Title XVI of the Social Security Act to low-income people who are at least age 65, blind or disabled. NOTE Some people do not receive a cash payment because their work income is too high, but SSA determines that it is not enough to replace both their SSI-Cash and the services they get through AHCCCS. These people are still considered to be receiving SSI-Cash.

Proof

Proof that a person is receiving any of these payments includes:

- AHCCCS records that show the person is currently receiving medical assistance related to SSI-Cash or Title IV-E;
- Copies of check stubs for an SSI-Cash or Title IV-E payment;
- A letter from the agency providing the payment;
- Contact by telephone with the agency providing the payment; or
- For SSI-Cash payments, an electronic record from SSA.

Legal Authority

This policy applies to the following program:

Program	Program
ALTCS	42 USC 1396a 42 CFR 435.120, 122, and 135 ARS 36-2934 AAC R9-28-401.01(C)

503 Assignment of Rights to Medical Benefits and Cooperation

Revised 08/13/2024

Policy

The requirement to cooperate with DCSS in establishing the identity of a child's parents and in obtaining medical support is suspended under a temporary waiver from 09/01/2023 through 06/30/2025.

A person's rights to medical support and to payment for medical care from any third party are assigned to AHCCCS when the person is approved for AHCCCS Medical Assistance (MA) or KidsCare.

- To qualify for or to keep getting AHCCCS, a person must:
- Turn in any payments for medical support or medical services to AHCCCS;
- Provide information about any sources of medical coverage or third-party liability (TPL);
- Take any actions needed to get payment for medical services from a source of TPL; and
- Cooperate with the Division of Child Support Services (DCSS) to:
    - Determine the paternity of a child in the home who is receiving MA, and
    - Take any actions needed to get medical support from an absent parent, unless the person has good cause not to cooperate.

NOTE While she is pregnant, a woman does not have to cooperate with DCSS for any children she had when she was not married. Cooperation with DCSS is also not required for people on KidsCare.

Definitions

Term	Definition
Assignment of rights	Transfers rights to medical benefits and payment for medical services from the member to the AHCCCS Administration.
Division of Child Support Services (DCSS)	Division of the Department of Economic Security responsible for getting medical support orders in place and enforcing those orders.

Good cause not to cooperate with DCSS	Good cause includes: • Cooperation in determining paternity or getting a support order is reasonably expected to result in physical or emotional harm to the child or the person with whom the child is living; • Legal proceedings for the child's adoption are pending before a court; • The parent is working with a public or licensed private agency to give the child up for adoption, and discussions have not gone on for more than three months; or • The child was conceived as a result of incest or rape.
Third-party liability (TPL)	Responsibility of a person, entity or program to pay for any of a person's medical costs. • Third-party liability includes: • Health and dental insurance; • Payments from insurance; • Payments from lawsuits; • Other medical settlements, claims, or benefits; and • Medical support for a child from an absent parent.

Proof

Proof of good cause for not cooperating with DCSS includes:

- Birth certificate that shows the child was conceived through incest;
- Medical or law enforcement records that show the mother was raped;
- Court or other legal documents showing that adoption proceedings are pending before a court;

- Written statement from the adoption agency that they have been working with the customer on giving up the child for adoption and for how long;
- Court, medical, criminal, child protective services, psychological, social services or law enforcement records showing that the absent parent might physically or emotionally harm the child or caretaker relative; or
- Sworn statements from friends, neighbors, clergy or other people who know the about the situation and can support the good cause claim.

When none of the above is available, ask the person to provide any information that would support further investigation.

Good cause must be reviewed at renewal and any time there is a change that shows good cause no longer exists.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	42 CFR 435.610 ARS 36-2903(F) AAC R9-22-306(B) AAC R9-28-401.01 AAC R9-29-208 AAC R9-31-303

504 Blind

Revised 11/25/2019

Policy

Blindness is one of three conditions (aged, blind, or disabled) that allow a person to qualify for SSI-MAO. A person must be determined blind under the rules for the Supplemental Security Income (SSI-Cash) program.

Definitions

Term	Definition
Blind	A customer is considered blind if there has been a medical determination of the following conditions: • Central visual acuity not more than 20/200 in the better eye with use of a correcting lens; or • Tunnel vision, which is a limited visual field of 20 degrees or less at the widest diameter.

Proof

Proof of blindness is limited to:

- A medical determination of blindness by the Disability Determination Services Administration (DDSA); or
- Records showing that the person is receiving SSA or SSI benefits based on blindness.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities

SSI MAO	42 USC 1396d(a)(iv), 42 USC 1396d(a) (vii) 42 CFR 435.530 AAC R9-22-1501

505 Cancer (Breast or Cervical) Diagnosis

Revised 02/25/2020

Policy

To qualify for the Breast and Cervical Cancer Treatment Program (BCCTP), a woman must have been screened and diagnosed as needing treatment for breast cancer, cervical cancer, or a pre-cancerous cervical lesion by one of the following programs:

- A provider recognized by the Well Woman Health Check Program (WWHP) administered by the Arizona Department of Health Services (ADHS);
- The Hopi Women's Health Program; or
- The Navajo Nation Breast and Cervical Cancer Prevention Program.

Definitions

Term	Definition
Well Woman Health Check Program (WWHP)	A program run by the Arizona Department of Health Services (ADHS) to help low-income, uninsured, and underinsured women get access to breast and cervical cancer screening and diagnostic services, including: clinical breast exams, mammograms, pap tests, and pelvic exams.
Hopi Women's Health Program	A program offered to women living on and near the Hopi Indian Reservation at the Hopi Health Care Center and Tuba City Indian Medical Center.
Navajo Nation Breast and Cervical Cancer Prevention Program	A program run by the Navajo Division of Health offered to women living on and near the Arizona portion of the Navajo Nation.

Proof

A Breast and Cervical Cancer Treatment Program Referral Worksheet and Document Requirements (BC-100) form completed by the WWHP, Hopi Women's Health Program or Navajo Nation Breast and Cervical Cancer Prevention Program is proof that the person meets this requirement.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Breast and Cervical Cancer Treatment Program (BCCTP)	42 USC 1396a(a)(10)(A)(ii)(XVIII) ARS 36-2901.05 AAC R9-22-2003

506 Caretaker Relative

Policy

To qualify for the Caretaker Relative group, a person must be an adult relative living with and caring for a deprived child.

Exception: A person under the age of 18 can qualify as a Caretaker Relative when the person meets any of the following:

- Does not have any living parents
- The parents cannot be located
- Does not have a legal guardian
- Is legally emancipated
- The person's health or safety could be harmed by living with his or her parents.

If either parent is living with the deprived child, the parent is the caretaker relative, even if another relative is also in the home.

Exception: If the parent in the home is incapacitated and cannot care for the child, another relative can be the caretaker relative.

Definitions

Term	Definition
Child	• A person under the age of 18, or • An 18-year old who is a full-time student in high school or a trade school and expected to graduate before turning 19.
Deprived child	A child is deprived when the budget group's income is not over the income limit for the number of people in the budget group.
Incapacitated	Unable to care for the child because of a physical or mental condition.

Relative	Means any of the following: • Parent (including step-parents) • Grandparent (including great-grandparent) • Brother or sister (including stepbrother or stepsister) • Uncle or aunt (including great-aunt or great-uncle) • Cousin (includes 1st and 2nd cousins) • Nephew or niece • The spouse of any of the relatives listed above, even after the marriage is ended by death or divorce.

Proof

Deprivation:

If the caretaker relative passes the income test the child is deprived. No further proof is needed unless the list of people living with the child is questionable. For example, the application lists one parent in the home, but other records show both parents are in the home.

Student Status:

If the only child living with the caretaker relative is 18 years old, proof of full-time student status and expected graduation date is needed. Use any of the following as proof:

- Written statement from the school
- Telephone contact with the school
- Completed “Verification of School Attendance” form
- Other documents that clearly indicate the child student status and graduation date.

Relationship:

Accept the relative’s statement of their relationship to the child unless it is questionable.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Caretaker Relatives	42 U.S.C 1396u-1 42 CFR 435.110 AAC R9-22-1427

507 Citizen of the United States

Revised 04/22/2025

Policy

To qualify for AHCCCS Medical Assistance (MA), a U.S. citizen or national must declare his or her U.S. citizenship. To declare U.S. citizenship, the customer must be listed as a U.S. citizen on the application, and the application must be signed by the customer or other person listed in MA1301.

U.S. citizens or nationals must also provide proof of citizenship, except for customers who:

- Receive Social Security Disability Insurance benefits (MA606DDD);
- Receive SSI Cash (MA606III);
- Qualify for Medicare (MA523);
- Are Deemed Newborns (MA407); or
- Receive Title IV-E foster care or adoption assistance payments (MA606A).

NOTE When a person claims U.S. citizenship, but additional proof is needed, the person must provide proof within 90 days from the date it is requested. During this time, when the person meets all other eligibility requirements, MA is approved.

Definitions

Term	Definition
U.S. Citizen	A person may be a U.S. citizen by: • Birth in the U.S. or a U.S. territory; • Having a U.S. citizen parent; • Marriage to a U.S. citizen; or • Naturalization. NOTE People born in some U.S. territories may have to meet other conditions (see Citizen by Birth below).

Citizen by Birth	A person is a U.S. citizen by birth when the person was born in the United States, or in the following U.S. territories: • American Samoa; • District of Columbia; • Guam (on or after April 10, 1899); • Northern Mariana Islands (on or after November 4, 1986); • Panama Canal Zone (between February 26, 1904 and September 30, 1979, AND a parent was a U.S. citizen employed by the U.S. government or the Panama Railroad Company); • Puerto Rico (on or after January 13, 1941); • Swain's Island; • U.S. Virgin Islands (on or after January 17, 1917); and • Wake Island. **Exception:** A person born to foreign diplomats living in the U.S. or one of the territories above is not a U.S. citizen.
Citizenship through a U.S. citizen parent – Customer was born on or before February 27, 1983	The person is a U.S. citizen when either of the following are met: • Both parents are U.S. citizens and at least one parent lived in the U.S. or its territories before the person's birth; or • One parent is a U.S. citizen and lived in the U.S., its possessions, or its territories for a total of five years before the customer's birth. At least two of the five years must be after the parent reached age 14. NOTE Count any period of time that the parent lived outside of the U.S as a U.S. government employee, serving in the U.S.

	military or working for an international organization as living in the U.S.
Citizenship through a U.S. citizen parent – Customer was born after February 27, 1983	The person is a U.S. citizen when ALL of the following are met before the person reached age 18: • At least one biological or adoptive parent is a U.S. citizen by birth or naturalization; • The child is admitted to the U.S. on an immigrant visa or as a lawful permanent resident; • The child lives in the legal and physical custody of the U.S. citizen parent; and • For an adopted child, the final adoption is completed.
Citizenship through Marriage	A woman who married a U.S. citizen before September 22, 1922 established U.S. citizenship. This does not apply to a man who married a U.S. citizen.
Citizenship by Naturalization	Persons who are not U.S. citizens by birth or adoption may go through the naturalization process to become U.S. citizens. A person born outside the U.S. to noncitizen parents is a U.S. citizen when both parents (or the sole custodial parent) were naturalized as U.S. citizens before: • The person's 21st birthday when naturalization was before October 14, 1940; or • The person's 18th birthday when naturalization was on or after October 14, 1940.
Dual Citizenship	A person may be a U.S. citizen and a citizen of another country. A person claiming dual citizenship can lose U.S. citizenship only when the person voluntarily abandons it. Dual

	citizenship status does not affect the individual's U.S. citizenship.
Enhanced Driver's License	A driver's license issued by a state that requires proof of citizenship and verification of Social Security Number before issuing the license. Enhanced driver's licenses have the word "Enhanced" printed on the front.

Proof

Citizenship is verified electronically through matches with federal and state data sources when possible.

When citizenship cannot be verified electronically, the customer must provide proof of citizenship.

The following documents can be used by themselves as proof of citizenship:

U.S. passport or passport card, regardless of its expiration date, as long as it is not a limited-validity passport;

- Certificate of Naturalization;
- Certificate of U.S. Citizenship;
- Enhanced drivers license;
- Any of the following documents issued by a federally recognized Indian Tribe:
    - Tribal enrollment card;
    - A Certificate of Degree of Indian Blood;
    - A Tribal census document; or
    - Other document on tribal letterhead signed by a tribal official that includes the name of the Tribe issuing the document and confirms the customer's membership, enrollment, or affiliation with the Tribe.

NOTE When another State Medicaid agency or a Federal agency has verified the customer's U.S. citizenship on or after July 1, 2006, the other agency's decision can be accepted as proof.

When the person does not have one of the documents in the list above, proof of citizenship must include one document from List A and a different document from List B below:

List A	**List B**

- U.S. Birth Certificate showing birth in one of the 50 states, the District of Columbia, Guam, American Samoa, Swain's Island, or the U.S. Virgin Islands;
- Certification of Report of Birth, issued to a citizen born outside the U.S.;
- Report of Birth Abroad of a U.S. Citizen;
- Certification of birth in the United States issued by the Department of State;
- U.S. Citizen ID card;
- Northern Marianas Identification Card issued by the U.S. Department of Homeland Security;
- A U.S. birth certificate showing birth in Puerto Rico on or after January 13, 1941;
- Proof of birth in Puerto Rico and the person's statement that he or she was living in the U.S. or a U.S. possession, or Puerto Rico on January 13, 1941;
- A U.S. birth certificate showing birth in the Northern Mariana Islands after November 4, 1986;
- Final adoption papers listing the child's name and a U.S. place of birth

NOTE When the adoption is not yet final, a statement from a State-approved adoption agency with the child's name and U.S. place of birth.

- Evidence of U.S. Civil Service employment before June 1, 1976
- U.S. Military Record showing a U.S. place of birth;
- Proof of birth in the Northern Mariana Islands; Trust Territory of the Pacific Islands citizenship; and residence in the U.S. or a U.S. possession on November 3, 1986, AND the person's statement that he
- A WTPY or SOLQI if it indicates that the social security number is verified.
- Driver's license or ID card with a photo or identifying information issued by a federal, state or local government
- School ID card with photograph
- U.S. military draft card or draft record
- Military dependent's ID card
- Native American tribal document
- U.S. Coast Guard Merchant Mariner Card
- Court documents
- Three or more documents that confirm the person's identity, including:
    - Employee ID card
    - High school or college diploma
    - Marriage license or divorce decree
    - Property deed or title
- For children under 16, medical, school or daycare records can be used if they were not already used for list A

or she did not owe allegiance to a foreign State on November 4, 1986

- Proof of Trust Territory of the Pacific Islands citizenship; continuous residence in the Northern Mariana Islands since before November 3, 1981, voter registration before January 1, 1975 and the person's statement that he or she did not owe allegiance to a foreign State on November 4, 1986
- Proof of continuous residence in the Northern Mariana Islands since before January 1, 1974 AND the person's statement that he or she did not owe allegiance to a foreign State on November 4, 1986
- Proof of birth in the Republic of Panama between February 26, 1904 and September 30, 1979, AND proof that a parent was a U.S. citizen employed by the U.S. government or Panama Railroad Company at the time of birth
- Proof that a woman was married to a U.S. citizen before September 22, 1922
- U.S. consular official's statement
- Extract of U.S. hospital record of birth on hospital letterhead
- One of the following documents if it was created at least 5 years before the person first applied and shows birth in the U.S. For children under 16 it must have been created near the time of birth or 5 years before the date of application
    - Life, health or other insurance record
    - Medical record
    - Admission papers from a nursing home or other institution
    - Bureau of Indian Affairs tribal census record of the Navajo Indians

◦ U.S State Vital Statistics official notification of birth registration ◦ A delayed U.S. public birth record ◦ Statement signed by the physician or midwife in attendance at the birth ◦ Roll of Alaska Natives maintained by the Bureau of Indian Affairs • Federal or State census records with the person's name, U.S. citizenship, a U.S. place of birth, and date of birth or age • An official religious record recorded in the U.S. or its territories within three months of the birth with the birthplace and the person's date of the birth, or age at the time the record was made • Early school records that show ALL of the following: name, date admitted to the school, date of birth, a U.S. place of birth, and the parent's name and birthplace	

Exception:

A person who became a citizen through the Child Citizenship Act (CCA) may not have the documents listed above. To determine the proof needed for customers who became citizens through the CCA, see the table below:

If...	**Then proof is needed that:**
The customer was under 18 or not yet born on February 27, 2001	• Before the customer turned 18: • At least one parent was a U.S. citizen (by birth or naturalized); and • The customer was admitted to the U.S. as a Lawful Permanent Resident and was in the legal and physical custody of a U.S. citizen parent.
Both of the customer's parents were U.S. Citizens	• Both parents were U.S. citizens;

	• The parents were married at the time of the customer's birth; and • At least one parent lived in the U.S. or its territories before the customer was born.
The customer was born to a U.S. citizen AND Was born on or after November 14, 1986	• One parent was a U.S. citizen; • The parents were married at the time of the customer's birth; and • The U.S. citizen parent lived in the U.S. or its territories for a total of at least five years before the customer's birth. Two of the five years must have been after the customer's parent turned 14. NOTE Any time the parent was outside the U.S. serving in the U.S. Armed Forces, employed by the U.S. government or employed by certain international organizations is counted toward the five years. Also, count any time the U.S. citizen parent was abroad as the unmarried child of a person who meets any of these three conditions.
The customer was born to a U.S. citizen AND Was born before November 14, 1986 but after October 10, 1952	• One parent was a U.S. citizen; • The parents were married at the time of the customer's birth; and • The U.S. citizen parent lived in the U.S. or its territories for a total of at least ten years before the customer's birth. Five of the ten years must have been after the customer's parent turned 14. NOTE Any time the parent was outside the U.S. serving in the U.S. Armed Forces, employed by the U.S. government or employed by certain international organizations is counted toward the ten years. Also, count any time the U.S. citizen parent was abroad as the unmarried child of a person who meets any of these three conditions.

Customer was not born to a U.S. citizen AND Was born on or after December 24, 1952	Before the customer turned 18, he or she was living in the U.S. as an Lawful Permanent Resident and met any one of the following: • Both parents naturalized; • When one parent died, the surviving parent naturalized; • When the parents legally separated, that the parent maintaining legal and physical custody naturalized before the child turned 18; • When the child was born out of wedlock and paternity has not been established by legitimation, the mother naturalized. NOTE The order in which the customer meets the conditions does not matter so long they are met before his or her 18th birthday.
Customer was adopted by a U.S. citizen AND Was under age 18 on February 27, 2001 or was not born yet	Before the customer turned 18, he or she was living legally in the U.S. in the legal and physical custody of a U.S. citizen parent AND Met any one of the following: • The citizen parent adopted the child before his or her 16th birthday (or, in some cases, 18th birthday) and had legal custody of the child and resided with the child for at least two years; • The child was admitted to the U.S. as an orphan (IR-3) or Convention adoptee (IH-3) and the adoption was fully completed abroad; or • The child was admitted to the U.S as an orphan (IR-4) or Convention adoptee (IH-4) to be adopted and the adoption was completed before his or her 18th birthday.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	8 USC 1431 42 USC 1396b 42 CFR 435.406, 407 and 911 ARS 36-2903.03 AAC R9-22-305.4,5,6
SSI MAO	AAC R9-22-1505.A.1
Medicare Cost Sharing	AAC R9-29-204.3
KidsCare	42 CFR 457.320(b)(6) and (d) ARS 36-2983.E AAC R9-31-302

508 Community Spouse

Revised 01/15/2020

Policy

1) Overview

Community Spouse policy allows a spouse who remains in the community to keep a greater share of the couple's income and resources. AHCCCS refers to this special treatment of resources, income, and share of cost as community spouse policy.

NOTE When both spouses are receiving or intend to receive HCBS, each is considered the other's community spouse.

To be able to use these special income and resource rules, all of the following must be met:

- The couple must be legally married (see MA520);
- The customer must be considered institutionalized; and
- The customer's spouse must be living in the community.
- For community spouse resource rules only, the customer's current continuous period of institutionalization started on or after September 30, 1989.

NOTE Community spouse rules must be used even if the spouse does not want to provide income or resource information. The law does NOT provide an undue hardship exception for a non-cooperative spouse.

Community spouse rules cannot be used when:

- The customer is not legally married or has no proof of legal marriage;
- The customer's spouse is in a medical institution for more than 30 days and has not lived in the community for at least one day in a month; or
- The customer is potentially eligible for ALTCS-Acute only because he or she has refused HCBS or lives in a setting where ALTCS services cannot be provided;
- The whereabouts of the customer's spouse are unknown; or
- For community spouse resource rules only, the current continuous period of institutionalization began before 9/30/89 (MA707).

2) When to Use Community Spouse Policy

Community spouse policy may apply for some months and not others depending on living arrangements or changes in marital status:

If…	Then Community Spouse Policy…
Customer Marries	Applies beginning with the month of marriage.
Customer Divorces	Applies for the month in which the divorce is granted. It stops in the following month.
Community Spouse Dies	Applies for the month in which the community spouse dies. It stops in the following month
Community spouse is in a medical facility for more than 30 consecutive days	Stops the first full month in which the community spouse has not lived in the community for at least one day.
Community spouse returns to the community from a medical institution	Applies when the community spouse resides in the community for at least one day during the month (see Community Spouse for examples).

The income, resources and share-of-cost policies for Community Spouse are located in the following sections:

- Income – MA610;
- Resources - MA707; and
- Share-of-cost - MA1201.

Definitions

Term	Definition

Institutionalized	A customer is considered institutionalized if the customer: • Has lived in a medical institution for a period of at least 30 days; • Has received HCBS for at least 30 days in a row and these services kept the person from being in a nursing facility; or • Intends to get HCBS and is at risk of being placed in a nursing facility as determined by an ALTCS Medical Eligibility Specialist.
Legally Married	Married in accordance with Arizona law (see MA520).
Medical Institution	Means any of the following: • Nursing facility; • Hospital; • Institution for Mental Disease (IMD); • Behavioral Health Inpatient Facility; • Rehabilitation center, • Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); • Free-standing hospice.
Living in the community	The customer's spouse is considered to be residing in the community when he or she is living: • At home; • In an approved alternative residential setting; • In a commercially operated, non-medical facility; or • In a penal institution.

	For more information see MA521 - Living Arrangements

Proof

Accept the customer's statement for where their spouse is living unless it is questionable. For example: The customer says his spouse lives at home, but the spouse applied two months ago and was in a nursing facility at that time.

See MA520 for proof of legal marriage.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC. § 1396r-5 ARS § 36-2932(L)(2) ARS § 36-2933(D) AAC R9-28-410

509 Disability

Revised 11/25/2019

Policy

Disability is a condition of eligibility for three Medical Assistance (MA) categories.

SSI-MAO

Disability is one of three conditions (aged, blind, or disabled) that allow a person to qualify for SSI-MAO. To meet the disability condition, a person must be:

- Determined disabled under the rules for the Supplemental Security Income (SSI-Cash) program, or
- Diagnosed with a serious mental illness (SMI) by the Arizona Department of Health Services (ADHS).

ALTCS and ALTCS-FTW

A person must be medically in need of long-term care services as determined by the Pre-Admission Screening (PAS).

Freedom To Work

The customer must be determined to have a disability by the Disability Determination Services Administration (DDSA) to qualify for Freedom To Work under the Basic Coverage Group (MA402).

A person must be determined to have a severe impairment by the Disability Determination Services Administration (DDSA) to qualify for Freedom To Work under the Medically Improved Coverage Group (MA402).

Definitions

Term	Definition
Disabled	Unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment, which can be expected to result in death or last for a continuous period of 12 months or more.

Severe impairment	A medical condition that significantly limits a person's physical or mental abilities to do basic work activities.

Proof

For ALTCS or FTW-ALTCS:

A Pre-Admission Screening (PAS) decision showing that the customer has been determined to be medically in need of long-term care.

For SSI-MAO:

Records from SSA showing the person is receiving Social Security Disability payments, or has been determined to have a disability.

An SMI Determination Summary Report or SMI Eligibility Outcome form that includes a SMI determination of functional inability to live in an independent setting or risk of serious harm to self or others.

For FTW:

Records from SSA showing the person is receiving Social Security Disability payments, or has been determined to have a disability.

Records from DDSA showing the person has been determined to have a Severe Impairment.

Legal Authority

Program	Legal Authorities
ALTCS SSI-MAO FTW	42 CFR 435.540; 42 CFR 435.541 AAC R9-28-402 (ALTCS) AAC R9-22-1501 (SSI-MAO) 42 USC 1396a(a)(10)(A)(ii)(XV) (FTW) ARS 36-2950 (FTW) AAC R9-28-1320 (FTW only)

Effective until 2025-04-25

510 Employed

Revised 02/27/2024

Policy

A person must be employed to qualify for Freedom to Work (FTW).

The customer must:

- Be earning wages; and
- Pay Social Security and Medicare taxes.

With the exception of Medically Improved customers, FTW customers do not have to work a minimum number of hours during the month or earn a minimum rate of pay. Medically Improved customers must be earning an amount equal to 40 hours per month at the federal minimum wage. To determine if the customer's earnings meet this requirement use:

- The customer's gross earnings; or
- The gross receipts less business expenses for a self-employed customer.

Employed usually means working and receiving earned income during the month. However, the customer does not need to receive earned income during the month to meet this requirement. For example, a customer who works during the month, but will not be paid until the following month, meets the employment requirement.

When the customer stops working, FTW eligibility ends the month after the customer stops working, even when he or she continues to get paychecks in following months.

Exceptions:

- A school employee who does not work during the summer months meets the work requirement during the summer when he or she has a signed contract to return to work in the fall.
- A person who is not currently working because of vacation or medical leave, but remains an employee is considered to meet the work requirement.

Definitions

Term	Definition

Medically Improved	The person's medical condition has improved to the point where he or she no longer meets the DDSA's definition of disabled; but DDSA determines that the person still has severe impairment (MA509).

Proof

Employment:

Proof of employment includes:

- Proof of employment is collected from the Federal and State Data Services Hubs when available. When proof is not available electronically, other sources of proof include: Pay stubs;
- Letter from employer;
- A Request for Verification of Employment (DE-206) completed by the employer;
- Phone call with the employer;
- If self employed, a copy of the most current tax return; or
- If self employment just started, copies of current business records such as a business ledger or business account statements.

Payment of Social Security and Medicare taxes:

Proof a person is paying taxes includes:

- Electronic Verification from Federal and State Data Services Hubs;
- Pay stubs showing tax withholding;
- A Request for Verification of Employment (DE-206) with the question about tax withholding completed by the employer;
- Letter from employer or a phone call with the employer verifying that Social Security and Medicare taxes are withheld from wages or paid by the employer; or
- If self-employed, the previous year's tax return showing payment of Medicare and Social Security taxes, copies of forms, cancelled checks, bank statements or online transactions along with electronic email/text confirmations used to make quarterly payments to the IRS.

Employment status during an absence:

Proof that a person remains employed between contracts or while on leave includes:

- Paystubs showing the customer is currently receiving leave pay;
- Written statement from the employer that the customer remains an employee during the absence;
- Employment contract for the upcoming school year;
- Collateral contact with the employer to confirm the customer is still considered an employee while on leave or has accepted a new contract for the upcoming year;
- Other documents showing the customer remains employed during the absence.

Legal Authority

Program	Legal Authorities
Freedom to Work (FTW)	42 USC 1396a(a)(10)(A)(ii)(XV) and (XVI) ARS 36-2950 and ARS 36-2928 AAC R9-22-1918; R9-22-1919; R9-28-1320

511 Entitled to Title II DAC Payments

Revised 11/25/2019

Policy

To qualify for the SSI-MAO Disabled Adult Child (DAC) category, the person must be entitled to disabled adult child's benefits from Social Security.

See MA529 for more policy related to DAC.

Definitions

Term	Definition
Disabled adult child's benefit	Title II Social Security benefits paid to a person who was determined disabled before age 22, and whose parent is deceased or receiving retirement or disability benefits.

Proof

Proof that the customer is entitled to Disabled Adult Child's benefits from Social Security includes:

- Social Security records that show the person is entitled to Social Security benefits as a disabled adult child; or
- Collateral contact with the Social Security Administration that confirms the person is entitled to benefits as a disabled adult child.

Legal Authority

Program	Legal Authorities
Disabled Adult Child (DAC)	42 USC 1383c(c) AAC R9-22-1505

512 Entitled to Title II DWW Payments

Revised 11/25/2019

Policy

To qualify for SSI-MAO in the Disabled Widow/Widower (DWW) category, the person must be entitled to Disabled Widow/Widower benefits from Social Security.

See MA529 for more policy related to DWW.

Definitions

Term	Definition
Disabled Widow/Widower (DWW) benefits	Title II Social Security benefits paid to a person who: • Has a disability; • Was married to a someone for at least 10 years; and • The spouse (or former spouse) has started collecting Social Security benefits or is deceased.

Proof

Proof that the customer is entitled to Disabled Widow/Widower benefits from Social Security includes:

- Social Security records that show the person is entitled to Social Security benefits as a Disabled Widow/Widower.
- A call to SSA that confirms the person is entitled to benefits as a Disabled Widow/Widower.

Legal Authority

Program	Legal Authorities

Disabled Widow Widower (DWW)	42 USC 1383c (d) AAC R9-22-1505

513 Former Foster Care

Revised 01/04/2023

Policy

As of January 1, 2023, to qualify for the YATI program, the person must have met two conditions on the day he or she turned age 18:

- Aged out of any United States government foster care system; and
- Was receiving Medicaid.

Definitions

Term	Definition
In Foster Care	In the legal custody of any United States government foster care system or a Tribe's foster care agency.

Proof

Aged out of any government foster care system:

Foster care information is often accessed automatically, and other proof may not be needed. However, if no record is found automatically that the person was in Foster Care or Tribal Foster Care when he or she turned 18, other proof includes:

- PMMIS records showing the person was enrolled in Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP) as of the person's 18th birthday
- Written statement from the Foster Care or the Tribe's foster care agency.
- Telephone call to the Foster Care or the Tribe's foster care agency.
- A copy of the YATI Turn-Around Document (TAD) or YATI Exparte Referral Form submitted when the child aged out of care.

Receiving Medicaid when aged out of care:

Effective until 2025-04-25

AHCCCS Medical Assistance information is accessed automatically, and other proof should not be needed. However, if proof is not found and the customer says that he or she was covered by Medicaid, or there is other evidence in the file that the person had Medicaid, the issue is elevated to AHCCCS for research.

Legal Authority

Program	Legal Authorities
YATI	42 USC 1396a(a)(10)(A)(i)(IX) 42 CFR 435.150 AAC R9-22-1432

514 Institution for Mental Disease (IMD)

Revised 11/24/2020

Policy

To qualify for KidsCare, a person cannot be living in an IMD.

Exception:

Customers who are on KidsCare when they are admitted to an IMD can stay on KidsCare until their annual renewal. If they are still in the IMD when their renewal is due, they do not qualify for KidsCare.

Definitions

Term	Definition
Institution for Mental Disease (IMD)	Medical facility primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

Proof

Proof that the customer is living in an IMD is obtained through a collateral contact with the facility. The collateral contact should determine:

- Whether the facility is an IMD; and
- Whether the customer is living in the facility.

Legal Authority

Program	Legal Authorities
KidsCare	42 CFR 457.310(c)(2)(ii) ARS 36-2983(G)(4) AAC R9-31-303(5)

Effective until 2025-04-25

515 Insurance Coverage (No Creditable Coverage)

Revised 06/08/2015

Policy

People who have creditable health insurance coverage do not qualify for:

- Breast and Cervical Cancer Treatment Program (BCCTP);
- KidsCare.

Exception:

A woman who has creditable coverage may qualify for BCCTP if:

- The insurance company will not cover the breast or cervical cancer treatment, because it is a pre-existing condition;
- She has exhausted her lifetime limit for all benefits under the insurance. This includes coverage for breast or cervical cancer treatment; or
- She is in a mandatory waiting period before she can get medical services through the policy. BCCTP eligibility ends once the waiting period is over

Definitions

Term	Definition
Creditable Coverage	Health insurance coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). NOTE Eligibility for services through Indian Health Service (IHS) or a tribal organization is not considered creditable coverage for BCCTP. Examples of creditable coverage include: • Medicare; • Group health plans including Qualified Health Plans;

	• Health insurance coverage through a hospital or medical service policy, certificate or plan contract; or • Armed forces insurance (i.e., Tricare).
Non-Creditable Coverage	The following types of policies are considered non-creditable coverage: • Coverage only for accidents (including accidental death and dismemberment); • Liability insurance, including general liability and automobile liability insurance; • Free medical clinics at a work site; • Benefits with limited scope such as dental benefits, vision benefits or long term care benefits; • Coverage for a specific disease or illness (including cancer policies); • Insurance that pays a set amount a day when the person is hospitalized or unable to work.

Proof

Accept the customer's statement on the application that he or she has no health insurance unless there is evidence to the contrary.

Evidence to the contrary may include but is not limited to:

- Social Security records showing the person has Medicare;
- Pay stubs that show deductions for group health insurance.
- The customer reported insurance coverage on a recent application.
- Health insurance listed in AHCCCS' PMMIS database on the RP 155 screen.

NOTE Health insurance on this screen may be out of date. Always call the insurance carrier to confirm the coverage is current and if there are any limits.

Proof of whether coverage is creditable and what is covers includes:

- A telephone call with the insurance company to confirm the coverage type and any limitations;
- A copy of the insurance policy.

Legal Authority

Program	Legal Authorities
Breast and Cervical Cancer Treatment Program (BCCTP)	42 USC 1396(a)(10)(A)(ii)(XVIII) ARS 36-2901.05 AAC R9-22-2003
KidsCare	42 USC 1397jj(b)(1)(C) 42 CFR 457.310(b)(2)(ii) ARS 36-2983(G)(2) AAC R9-31-303(6)

517 Insurance - State Employee Health Plan

Revised 04/09/2020

Policy

A child does not qualify for KidsCare if a parent, the child, or the child's spouse is a state employee and can get state employee health insurance.

This requirement applies even when the child, child's spouse, or parent chooses not to enroll.

NOTE Some state employees do not qualify for state employee health insurance. When the person cannot get state employee health insurance, the child can qualify for KidsCare.

Even though they participate in the Arizona State Retirement System (ASRS), employees of school districts and charter schools are not state employees. Employees of school districts and charter schools cannot get state employee health insurance.

Exception:

Employees of the Arizona State Schools for the Deaf and the Blind are state employees, and can get state employee health insurance.

Definitions

Term	Definition
State employees who do not qualify for State Employee health insurance.	• Employees who work less than 20 hours per week; • Seasonal, temporary, emergency, and clerical pool employees; • Patients or inmates employed in state institutions; • Employees in positions created for rehabilitation only; and • Employees of a state college or university who are hired to work for less than six months, or are not part of a state retirement plan.

Proof

When the person lists coverage through state employee health insurance on the application or verbally, accept the statement as proof.

When the person is a state employee but does not list coverage on the application, proof of coverage includes:

- Pay stubs showing any deduction for health coverage. Dental and vision plans are deductions for health coverage.
- Work Number records showing the person has medical, dental or vision insurance.
- Phone call to the personnel office at the agency, department or university where the person works to confirm whether the employee qualifies for state employee health coverage.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
KidsCare	42 USC 1397jj(b)(2)(B) 42 CFR 457.310(c)(1) ARS 36-2983(G)(3) AAC R9-31-303(12)

518 Insurance Coverage for Dependent Children

Policy

This policy only applies to the Adult group. When a parent or other relative is living with a child and is the child's main caretaker, the child must have minimum essential coverage for the person to qualify for the Adult group.

Parents are always considered the main caretaker when living with the child, even if another relative is also in the home.

Definitions

Term	Definition
Child	• A person under the age of 18, or • An 18-year old who is a full-time student in high school or a trade school and expected to graduate before turning 19.
Minimum Essential Coverage	Means any of the following kinds of health insurance coverage: • Full AHCCCS Medical Assistance benefits; • Medicare Part A; • TriCare for Life; • Veterans health program; • Government health plan for Peace Corps volunteers; • Group and Individual health plans, including Qualified Health Plans purchased on the Federally Facilitated marketplace; • Employer-sponsored coverage; or • Other health benefits coverage, such as a State health benefits risk pool. Minimum Essential Coverage does NOT include:

	• Coverage only for accident, or disability income insurance; • Liability insurance, including general liability insurance and automobile liability insurance; • Workers' compensation or similar insurance; • Automobile medical payment insurance; • Coverage for on-site medical clinics; • Dental- or vision-only benefits; • Coverage only for long-term care services; • Coverage only for a specified disease or illness; or • Hospital indemnity or other fixed indemnity insurance.
Parent	Means a natural, adoptive or step-parent.
Relative	Means any of the following: • Grandparent (including great-grandparent) • Brother or sister (including stepbrother or stepsister) • Uncle or aunt (including great-aunt or great-uncle) • Cousin (includes 1st and 2nd cousins) • Nephew or niece • The spouse of any of the relatives listed above, even after the marriage is ended by death or divorce.

Proof

Proof that a child has minimum essential coverage includes any of the following:

- Health-e-Arizona plus system or records showing the child has full MA coverage;
- Current documents showing the child is enrolled in a group or individual health plan; or
- Telephone call to the insurer confirming the child has minimum essential coverage.

Legal Authorities

Program	Legal Authorities
Adult	42 USC 1396a(a)(10)(A)(i)(XIII) 42 CFR 435.119

519 Interview

Revised 08/16/2022

Policy

A personal interview is required for ALTCS financial and medical eligibility.

A personal interview is not required for any other MA program.

Definitions

Term	Definition
Financial Interview	A personal interview is required for ALTCS financial eligibility. In most cases, a telephone interview may be scheduled in place of a face-to-face interview. Either the customer or the customer's representative may attend the interview.
Medical Interview	The PAS Assessor must meet with the customer to complete the medical assessment required for ALTCS eligibility. The medical interview can be: • Face-to-face; • By telephone; or • Virtual.
Face-to Face Interviews	A face-to-face interview may be conducted in any of the following locations: • An ALTCS office; • The customer's home; • Any other location that helps the customer or representative attend the interview.
Virtual Interview	An interview that takes place using electronic devices rather than an actual meeting space.

Proof

Interviews may be scheduled by phone or mail. Interview information is entered into the case file.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 CFR 435.907; 42 CFR 435.916 ARS 36-2934.G AAC R9-28-303; R9-28-401

520 Legal Marriage

Revised 07/10/2020

Policy

To have ALTCS eligibility determined using community spouse policy, the person must be legally married. A couple remains legally married when separated.

NOTE See MA602 for marital status policy for all other programs.

Definitions

Term	Definition
Legal Marriage	Arizona recognizes the following as legal marriages: • A marriage that took place in Arizona, when both of the following are true: ◦ A marriage license was obtained; and ◦ The marriage ceremony was performed by a person authorized by law. People authorized by state law to perform marriages include licensed or ordained clergy, judges, and justices of the peace; • A marriage recognized as legal in the state or country where it was established, including common law marriages; and • A common law marriage established under American Indian tribal law.
Common Law Marriage	A marriage without a civil or religious ceremony. A common law marriage may be created by mutual agreement, or by living together for a certain period of time.

	NOTE A common law marriage can only be created in Arizona under American Indian tribal law.

Proof

Require proof based on the marital relationship claimed:

Type	Proof
Legal Marriage	Proof of legal marriage includes any of the following: • An official marriage license; • Court or church records; • Marital Status and Family Profile Document issued by the Navajo Nation; • Tribal Family Census Card issued by the Bureau of Indian Affairs; • Marriage license issued by the Navajo Office of Vital Records; or • Phone contacts with an official Agency or Court. NOTE SSA or SSI benefit records cannot be used for proof of legal marriage.
Common Law Marriage	A completed Customer Statement – Common Law Marriage (DE-119) form.
Death or Divorce	Accept the person's statement unless it is questionable. For example, when a customer previously claimed to be married but later claims to be divorced or widowed, ask for proof of the divorce or death.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 25-111, 25-112 AAC R9-28-401 20 CFR 404.726

521 Living Arrangements

521 Living Arrangements

Revised 02/19/2021

The customer's living arrangements can affect the services received, the customer's Share of Cost, and how income eligibility is determined. This section discusses the following:

- Long Term Care services
- ALTCS Acute Care
- Acute Hospitals

Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Long-Term Care Services

Revised 11/05/2024

Policy

To get the full ALTCS services package, including long-term care services, the customer's living arrangements must meet the requirements in the table below.

Customer lives…	And…
In a Long-Term Care (LTC) Medical Facility	The living arrangement is both: • Licensed, and • Registered with AHCCCS.
In a Home and Community Based Services (HCBS) setting	• The customer intends to get Home and Community Based Services (HCBS) • The HCBS setting is licensed or certified, and • The HCBS setting is registered with AHCCCS.
At home	The customer intends to get Home and Community Based Services (HCBS)

When the living arrangement does not meet one of the requirements above, the person cannot get long-term care services while in that living arrangement. See MA521B ALTCS Acute Care.

Definitions

Term	Definitions
HCBS settings other than the customer's home	HCBS settings include:

	• Adult Developmental Homes; • Adult Foster Care Home; • Assisted Living Facility (ALF); • Behavioral Health Therapeutic Homes; • Behavioral Health Residential Facility; • Child Development Foster Care Homes; • Group Homes for Developmentally Disabled; • Large Group Settings for Adults and Children; and • Substance Abuse Transitional Facility.
Customer's home	The customer's home means any of the following: • A house; • A mobile home or trailer; • An apartment; • A room rented in someone else's home, or in a boarding house; • Any similar shelter; or • For a child in foster care, the foster home. A setting that is unregistered, unlicensed and uncertified is considered the customer's "home".
Long Term Care Medical Facility	A facility that provides medical, nursing, convalescent, hospice care or Level I behavioral health services. LTC medical facilities include: • Nursing facilities; • Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);

	• Free-standing hospice; • Residential Treatment Facility; • Institution for Mental Disease (IMD); • Behavioral Health Inpatient Facility; and • Long term care bed in a hospital.

Proof

1) Intends to receive HCBS

A submitted ALTCS application is proof of the customer's intent to receive ALTCS services at the time of application.

2) Living arrangement

If the customer or spouse lives…	Then the living arrangement is verified by…
At home	Contact with the customer, the spouse, another household member or the customer's authorized or legal representative.
In any other setting	Contact with a staff member of the HCBS setting or LTC medical facility to confirm actual admission and discharge dates.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities

ALTCS	42 CFR 435.1005 ARS §36-2939 AAC R9-28-406
FTW- ALTCS	ARS §36-2950 AAC R9-28-1315

Revised 12/10/2024

Policy

Customers whose living arrangements do not allow them to get long-term care services only get the limited ALTCS service package described in MA302.

When there is a change to a customer's living arrangement that allows for long-term care services to be approved, the long term care services start the date of the change.

These changes may include any of the following:

- The customer moves home;
- The customer moves to a different facility; or
- The current facility becomes certified, gets registered with AHCCCS, or contracts with a program contractor.

When the ALTCS customer is only eligible for the limited ALTCS service package, income eligibility is determined using either the:

- Gross Income Test; or
- Net Income Test.

1) Gross Income Test

The Gross Income Test is used when a customer is in any of the following living arrangements for at least one day in the month:

- Non-certified medical facility;
- Long term care facility that is not registered with AHCCCS;
- Long term care bed in a VA hospital; or
- Medical facility that does not have a contract with the program contractor.

2) Net Income Test

The Net Income Test is used when the customer meets any of the following for every day in the month:

- Lives in an HCBS setting that is licensed or certified, but is not registered with AHCCCS;
- Lives at home or in an HCBS setting and refuses HCBS services; or
- Refuses to move from a non-contracted HCBS setting to a contracted setting.

Definitions

Term	Definition
Gross Income Test	Gross countable income is compared to 300% of the Federal Benefit Rate (FBR).
Net Income Test	Countable income minus allowable deductions is compared to 100% of the FBR.

Proof

Proof that a facility is licensed and registered with AHCCCS is generally obtained through an electronic data match.

When proof is not available through this match or the facility is not listed in the electronic records, other sources of proof include:

Contact with the facility to determine:

- The name and address of the facility;
- Whether the facility is licensed or certified.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-2939 AAC R9-28-406

Effective until 2025-04-25

C Hospitals

Revised 02/19/2021

Policy

When the customer is in an acute care hospital during the month, the customer's living arrangement immediately before entering the hospital is used to determine eligibility and share of cost.

For example, the customer was living in a nursing facility before entering the hospital. The time in the hospital is treated the same as living in the nursing facility. There is no change to the customer's eligibility or share of cost.

Exception:

A customer in a long-term care bed in a hospital is considered to be living in a long-term care medical institution when determining eligibility and share of cost.

Definitions

Term	Definition
Acute Hospital	A medical institution licensed as a hospital by the Arizona Department of Health Services and certified as a provider under Title XVIII of the Social Security Act.

Proof

Proof that a hospital is licensed and registered with AHCCCS is generally obtained through an electronic data match.

When proof is not available through this match or the facility is not listed in the electronic records, other sources of proof include:

Contact with the facility to determine:

- The name and address of the facility;
- Whether the facility is licensed or certified.

Legal Authority

Program	Legal Authorities
ALTCS	AAC R9-28-406(B)

522 Medicaid (Ineligible For)

Revised 03/22/2018

Policy

A person can only qualify for the following programs if the person is not eligible for full services in any other AHCCCS Medical Assistance (MA) category:

- AHCCCS Freedom to Work (FTW)
- Breast and Cervical Cancer Treatment Program (BCCTP);
- KidsCare;
- Transplant Extended Eligibility.

The person must also cooperate and provide any proof needed to see if they qualify for any other full services category.

Definitions

Term	Definition
Full services	The full range of benefits listed in MA301

Proof

- Records showing current eligibility for a full service MA category.
- An application in Health-e-Arizona Plus that is waiting for proof, but has screened the person as potentially eligible for a full MA coverage category.

Legal Authority

Program	Legal Authorities

AHCCCS Freedom to Work (FTW)	ARS 36-2929 ARS 36-2950; AAC R9-22-1901; R9-28-1301
Breast and Cervical Cancer Treatment Program (BCCTP)	42 USC 1396a(a)(10)(A)(ii)(XVIII) AAC R9-22-2003
KidsCare	42CFR 457.310 ARS 36-2983(G) AAC R9-31-303

523 Medicare

Revised 04/09/2021

Policy

A customer must be entitled to Medicare Part A to qualify for the Medicare Savings Program (MSP):

- Qualified Medicare Beneficiary (QMB);
- Specified Low-Income Beneficiary (SLMB); or
- Qualified Individual-1 (QI-1).

A customer who is entitled to Medicare Part A or Part B cannot qualify for the Adult Group.

Definitions

Term	Definition
Medicare	A federal health insurance program run by the Social Security Administration (SSA) for: • People age 65 years old and older; • Some people under age 65 with disabilities; and • People with End-Stage Renal Disease. For more information about Medicare go to http://www.medicare.gov
Medicare Part A	Hospital insurance that pays for covered hospital care, limited skilled nursing facility care, hospice care, and some home health services. Most people do not have to pay a monthly premium for Medicare Part A. People who must pay a premium to get Part A can apply for conditional enrollment in Medicare Part A.

Medicare Part B	Medical insurance that pays for certain physician's services, including surgery, outpatient hospital care, home health services, and some other items and services not covered under Medicare Part A. There is a monthly premium for Medicare Part B coverage.
Conditional enrollment for Medicare Part A	An application for enrollment in Medicare Part A on the condition that QMB eligibility is approved. If QMB is not approved, the customer is not enrolled in Medicare Part A.

Proof

Use Social Security records to see if the customer is entitled to or receiving Medicare Part A and Medicare Part B.

Legal Authority

Program	Legal Authorities
Medicare Savings Program (MSP)	42 USC 1396d(p)(1)(A) AAC R9-29-204(7)
Adult	42 CFR 435.119(b)(3)

524 NonCitizen Status

524 Noncitizen Status

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A Overview

Revised 04/22/2025

Policy

To qualify for full AHCCCS Medical Assistance (MA) coverage, a noncitizen must:

- Be in a qualified noncitizen status;
- For certain qualified noncitizens, meet conditions in MA524B; and
- Declare his or her qualified noncitizen status. The customer must be listed as having a qualified noncitizen status on the application, and the application must be signed by the customer or other person listed in MA1301A.

Otherwise, the noncitizen can only get coverage for Federal emergency medical services (FES) through the Federal Emergency Services Program (FESP), and cannot qualify for the following categories:

- AHCCCS Freedom to Work (FTW)
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Arizona Long Term Care System (ALTCS)
- Medicare Savings Program (MSP)
- KidsCare
- Continued Coverage (CC)
- Transitional Medical Assistance (TMA)

Reasonable Opportunity Period

When a customer claims a qualified noncitizen status, but more proof is needed to verify it through SAVE VIS or VLP, the person has a reasonable opportunity period of 90 days from the date the proof is requested to provide the proof or resolve the issue with USCIS. During this time, when the person meets all other eligibility requirements, MA is approved as a conditional approval.

NOTE The child's coverage can be terminated if they do not supply the required citizenship/ non-citizenship status documentation within the reasonable opportunity period. If the status is verified, the child's continuous eligibility period will be effective with the effective date of coverage.

Definitions

Term	Definition
Noncitizen	A person who is not a citizen or national of the United States (U.S.).
Non-qualified noncitizen	A noncitizen who does not have a qualified immigration status.
Qualified noncitizen	A person admitted to the U.S. in one of the immigration statuses in the list below: • Afghan and Iraqi Special Immigrant Visa • Deportation Withheld or Removal Withheld (this does not include Deferred Action for Childhood Arrivals or “DACA” status) • Amerasian Refugee • Asylee • Battered noncitizen (must also meet conditions in section B) • Citizens of the following Compact of Free Association (COFA) countries: ◦ Republic of the Marshall Islands ◦ Federated States of Micronesia ◦ Republic of Palau • Conditional Entrant • Cuban-Haitian Entrant • Hmong or Laotian Highlander • Lawful Permanent Resident (LPR) (must also meet conditions in section B) • Parolee for at least one year (must also meet conditions in section B) • Refugee

	• Victims of Trafficking (as of the eligibility date in the certification letter issued by the Office of Refugee Resettlement).
Parolee	A noncitizen who has received a grant of parole into the United States for a temporary period of time because of urgent humanitarian needs or significant public benefit.
Reasonable Opportunity Period (ROP)	A 90-day period where individuals can provide documentation to verify their citizenship or immigration status if it's not initially verified through electronic means, allowing them to maintain eligibility while the verification is pending.
American Indian Born in Canada	An American Indian with at least 50% Indian ancestry born in Canada is considered a qualified noncitizen. NOTE A person in this group may choose to become an LPR. This does not affect the status as an American Indian born in Canada. The person does NOT need to meet the other conditions in section B.
Foreign Born Member of U.S. Indian Tribe	A member of a federally recognized U.S. Indian Tribe who does not claim U.S. citizenship. People in this group are considered qualified noncitizens. NOTE For federally recognized U.S. Indian Tribes see the annual list published in the Federal Register.

Proof

For most qualified statuses, a SAVE VIS or VLP response showing a qualified status. If unable to verify the person’s status through the initial SAVE VIS or VLP response, the following documents can be used to resubmit the SAVE or VLP request:

- Permanent Resident or Resident Alien Card, I-551;
- Alien Registration Receipt Card, I-151;

- Departure Record, I-94;
- Employment Authorization Card, I-766;
- Foreign Passport;
- Parole Notice;
- Form I-512L, Authorization to Transport for Parole of an Alien Into the United States
- Approved Petition for Amerasian, Widow(er), or Special Immigrant, Form I-360;
- Certificate of Residency or Naturalization for citizens of the Marshall Islands;
- Certificate of Residency or Naturalization for citizens of the Federated States of Micronesia;
- Certificate of Residency or Naturalization for citizens of the Republic of Palau

Additional proof is needed when:

1) The customer is a spouse, child, parent, or legal guardian of an Afghan paroled between 7/31/2021 and 9/30/2023.

- Expired or unexpired Afghan passport that lists the person's place of birth as being Afghan; or
- Afghan birth certificate
- Nationality certificate
- Citizenship letter

2) The customer is a spouse, child, parent, legal guardian, or primary caretaker of a Ukrainian paroled between 2/24/2022 and 9/30/2024.

- Expired or unexpired Ukraine passport that lists the person's place of birth as being Ukraine; or
- Ukraine birth certificate
- Nationality certificate
- Citizenship letter

Exception:

The following exceptions cannot be verified through SAVE VIS or VLP and will require additional proof.

If the customer is...	Then the required proof is...
Victims of Trafficking	Victim of Trafficking Certification Letter or Eligibility Letter
Battered Noncitizen	A notice of "prima facie" approval of a pending self-petition under the Violence Against Women Act (VAWA)
Deportation/removal withheld under Section 243(h) of the Immigration and Nationality Act (INA) or whose removal was withheld under Section 241(b)(3) of the INA	• Form I-766 annotated "A10." • A copy of the order from an immigration judge showing deportation withheld under Section 243(h) of the INA as in effect prior to 4/1/97 or removal withheld under Section 241(b)(3) of the INA. • A letter from an asylum officer granting withholding of deportation under Section 243(h) of the INA as in effect prior to 4/1/97 or withholding of removal under Section 241(b)(3) of the INA.

Legal Authority

Program	Legal Authorities
All programs	8 USC 1611, 1612, 1613, and 1641 42 CFR 435.406(a) 42 CFR 435.911(c) and 956(b)(2) 42 CFR 435.949 and 956(a)(1)(i) AAC R9-22-305.4 AAC R9-28-401.01(B)1 AAC R9-29-204.3

	AAC R9-31-302(A) 42 CFR 457.320(b)(6)

B Other Conditions for Lawful Permanent Residents (LPRs), Parolees and Battered Noncitizens

Revised 12/17/2024

Policy

Noncitizens who have the status of Lawful Permanent Resident (LPR), Parolee or Battered noncitizen must also meet one of the additional conditions below to get full services MA:

- Has been a qualified noncitizen for at least five years. The five-year period includes:
  - The amount of time a customer has been in their current status; and
  - Any time the customer had the status of LPR, Parolee or Battered noncitizen before adjusting to their current status.

  See Qualified Noncitizen for at Least Five Years Examples

- Before becoming an LPR, Parolee or Battered noncitizen, the customer had a qualified noncitizen status other than LPR, Parolee or Battered noncitizen;
- Entered the U.S. before August 22, 1996, and remained in the U.S. continuously until becoming a qualified noncitizen; or
- Has one of the following connections to the military:
  - Is a member of the U.S. Armed Forces on active duty;
  - Is an honorably discharged veteran of the U.S. Armed Forces;
  - Is the spouse or dependent child of a member or honorably discharged veteran of the U.S. Armed Forces; or
  - Is the widow or surviving dependent child of a member or honorably discharged veteran of the U.S. Armed Forces.

Exceptions:

1) Parolees from Afghanistan who meet either of the following conditions are exempt from the 5-year waiting period until September 30, 2023 OR until the end of their parole period, whichever is later:

- Were paroled into the US between July 31, 2021 and September 30, 2023; or
- Were paroled into the US after September 30, 2022 AND is the spouse, child, parent, or legal guardian of a person paroled into the US between July 31, 2021 and September 30, 2023.

2) Humanitarian Parolees from Ukraine who were paroled into the US between February 24, 2022, and September 30, 2024 are exempt from the 5-year waiting period until September 30, 2024 OR until the end of their parole period, whichever is later.

- Were paroled into the US between February 24, 2022, and September 30, 2024; or
- Were paroled into the US after September 30, 2023, AND is the spouse, child, parent, or legal guardian of a person paroled into the US between July 31, 2021 and September 30, 2024.

NOTE Parolees from Ukraine may include non-Ukrainian individuals who last habitually resided in Ukraine due to urgent humanitarian reasons or for significant public benefit.

Definitions

Term	Definition
Dependent child	• A child under age 18; or • A child aged 18-21, who is a full-time student and claimed as a dependent on the parent's tax return.
Remained in the U.S. continuously	The customer was not out of the U.S. for longer than 30 days at a time AND the total of all time out of the U.S. since 8/22/1996 is not more than 90 days.
Military connection	• Is a member of the U.S. Armed Forces on active duty; • Is an honorably discharged veteran of the U.S. Armed Forces; • Is the spouse or dependent child of an honorably discharged veteran or active-duty member of the U.S. Armed Forces; or • Is the widow or surviving dependent child of an honorably discharged veteran or active-duty member of the U.S. Armed Forces.

Prima facie approval of Battered noncitizen status	An approval of a battered noncitizen application based on meeting the minimum requirements needed for approval. This approval is granted pending a full review of the Battered noncitizen application.

Proof

Proof of qualified noncitizen status for at least 5 years:

- SAVE VIS or VLP records showing a qualified noncitizen status and an entry date at least 5 years in the past;
- Documents showing approved Victim of Trafficking status showing a date at least 5 years in the past;
- Documents showing approval or prima facie approval, whichever is earliest, of Battered noncitizen status with a date at least 5 years in the past; or
- A combination of SAVE VIS or VLP records and other documents showing the customer has held one or more qualified statuses for at least five years.

Proof of a prior qualified noncitizen status other than LPR, Parolee or Battered noncitizen:

If the person has a Permanent Resident or Resident Alien (I-551) Card, the three-digit Class of Admission (COA) code from the SAVE response or the LPR card can be used as proof of a prior qualified status. When the customer's COA code does not indicate a prior qualified status, the customer must provide proof of the prior status.

See the table below for the COA codes that prove entry under a status that is not subject to the 5-year bar:

Prior Qualified Status	**COA code on the I-551**
Refugee or Amerasian Refugee	4A, 4C, A11, A12, A16, A17, A31, A32, A33, A36, A37, A38, A41, A42, A43, A46, A47, A48, AM-1, AM-2, AM-3, AM-6, AM-7, AM-8, AR-1, AR-6, IC-6, IC-7, M8, M83, P-7, P75, P76, R86, RE, RE-1, RE-2, RE-3, RE-4, RE-5, RE-6, RE-7, RE-8, RE-9, REF, REP, RF, RRA, Y11, Y12, Y13, Y16, or Y64

Asylee	AS-1, AS-2, AS-3, AS-6, AS-7, AS-8, AY, ASP, GA6, GA7, GA8, SY6, SY7, SY8
Afghan or Iraqi special immigrant	CQ1, CQ2, CQ3, DT, OAR, PAR, SI-1, SI-2, SI-3, SI-6, SI-7, SI-8, SI-9, SQ-1, SQ-2, SQ-3, SQ-4, SQ-5, SQ-6, SQ-7, SQ-8, SQ-9, SW1, SW2, or SW3
Cuban-Haitian entrant	C7P, CB1, CB2, CB6, CB7, CC, CH-6, CNP, CU-0, CU-6, CU-7, CU-8, CU-9, CUP, HA6, HA7, HA8, HA9, HB6, HB7, HB8, HB9, HC6, HC7, HC8, HC9, HD6, HD7, HD8, HD9, HE6, HE7, HE8, HE9, HF, HH6, NC6, NC7, NC8, NC9, RCU, or RHT
Citizens of Compact of Free Association (COFA) countries: • Federated States of Micronesia • Republic of the Marshall Islands • Republic of Palau	CFA/FSM, CFA/MIS, or CFA/PAL
Victim of Trafficking	ST-0, ST-1, ST-6, ST-7, ST-8, ST-9, T-3, T-4, or C-40
American Indian born in Canada	S13 or may provide verification that the applicant is an American Indian born in Canada.
Deportation or Removal Withheld	There is no specific COA code for this status. The customer will need to present other proof that deportation or removal is withheld as well as the I-551 card.
Ukraine Parolees	DT, PAR, UHP, UKR, UP
Western Hemisphere Parolee	WHP

Proof that the customer has remained in the U.S. continuously since before August 22, 1996:

There are two parts to this proof. First, the customer must provide a written statement listing the dates of any of absences from the U.S. or that they have not left the U.S. Second, the customer must provide any combination of the following documents and records that show the customer has lived in the U.S. since before 08/22/1996:

- Rental or lease agreements listing the customer as a tenant,
- Utility bills or payment records,
- School records,
- Employment records,
- Social Security wage records,
- Church attendance records,
- Public benefits records,
- Medical records, and
- Any other official document or record that shows the customer was residing in the U.S. during the required period.

Proof that the customer has a military connection:

Military records (like a DD-214) showing current active duty or honorable discharge.

When the customer is the spouse, widow, or dependent child of an active duty or honorably discharged member of the U.S. Armed Forces, that customer must also provide proof of their relationship to the Armed Forces member or veteran. Proof of relationship includes:

- Birth certificate;
- Marriage records;
- Court documents;
- Military ID showing relationship;
- Other official records that show relationship;
- A copy of their electronic Form I-94, Arrival/Departure Record, from the U.S. Customs and Border Protection website at i94.cbp.dhs.gov, which will include a COA of MIL;
- Paper Form I-94 with a COA of MIL; or
- Form I-766, Employment Authorization Document, also known as an EAD, with a C11 parole category.

Legal Authority

Program	Legal Authorities
All programs	8 USC 1611, 1612, 1613, and 1641 42 CFR 435.406(a) 42 CFR 435.949 and 956(a)(1)(i) AAC R9-22-305.4 AAC R9-28-401.01(B) 1 AAC R9-29-204.3 AAC R9-31-302(A) 42 CFR 457.320(b)(6)

525 Not an Inmate

Revised 12/17/2024

Policy

A customer who is an inmate of a public institution may apply and qualify for AHCCCS while incarcerated. Generally, the customer cannot receive AHCCCS covered services until they are released. Enrollment and services are suspended during any time the customer is considered an inmate.

Exception:

Eligible juveniles may receive certain AHCCCS services in the 30 day period prior to release, see MA1302D for more information.

When a customer is already receiving MA benefits and is incarcerated, see MA1502V for more information.

Definitions

Term	Definition
Inmate of a Public Institution	A person who is: • An inmate of a federal or state prison; • An inmate of a county, city, or tribal jail; • An inmate of a prison or jail, prior to arraignment, conviction, or sentencing; • Incarcerated but can leave prison on work release or work furlough, and must return at specific intervals; • A child in a juvenile detention center due to criminal activity or held as a material witness; • A person involuntarily placed in a secure treatment facility that is part of the criminal justice system.

Not an Inmate of a Public Institution	A person who is: • After arrest, but before booking, escorted by police to a hospital for medical treatment and held under guard; • Voluntarily living in a public institution; • Released on probation, parole, or a release order with the condition of home arrest, work release, community service, or medical treatment; or • Admitted as an inpatient to a medical institution; • A child held in a juvenile detention center for the care, protection, or in the best interest of the child, if there is a specific plan for that person that makes the stay at the detention center temporary; • A child on intensive probation with the condition of home arrest, treatment in a psychiatric hospital, or a residential treatment center, or outpatient treatment; • A child in a juvenile detention center after disposition when there is a plan to release the child to the community, and the release is only pending arrangements suitable to the child's needs.
Public Institution	An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does NOT include: • Medical institutions; • Intermediate care facilities; • Publicly operated community residence that serves no more than 16 residents; or • State-licensed child care institutions for foster children that house no more than 25 children.

Voluntarily living in a public institution	Means living in a public institution by choice, not as an extension of incarceration. The person is free to leave the institution if they choose to.

Proof

If the customer is listed as an inmate on the application, accept the statement. No further proof is needed.

If current information or data matches show that the customer is an inmate, but the customer claims they are no longer an inmate, proof of release from incarceration is needed. Proof includes:

- Release papers;
- The customer shows up in person to a local office; and
- A telephone call to the jail, prison or detention facility confirming the person's release.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS SSI-MAO MSP FTW Child Caretaker Relative Pregnant Woman Adult	42 CFR 435.1009 - 1010 AAC R9-22-310 AAC R9-28-406 AAC R9-22-1915 AAC R9-22-2003
KidsCare	42 USC 1397jj(b)(2)(A) 42 CFR 457.310 (c)(2)(i)

	ARS 36-2983(G)(4) AAC R9-31-303(9)

526 Potential Benefits

Revised 10/01/2024

Policy

The requirement to apply for potential benefits for new and existing customers has been removed. While it is no longer an eligibility requirement, customers may ask about a potential benefit and how to apply for it. The following table provides common federal benefits and describes the most common reasons a customer may qualify:

If the benefit is…	**Then the customer may qualify when he or she…**
Veteran's pension or compensation	• Is a wartime veteran who meets one of the following: ◦ Is age 65 or older; or ◦ Has a disability. • Is a person with a military service-connected injury or illness. • Is the surviving spouse (and not remarried) of a wartime veteran. • Is the surviving spouse (and not remarried) or a dependent parent of a veteran who died in active service or from a service-connected injury or illness. • Is unmarried and has a parent who died in active service or from a service-connected injury or illness and is one of the following; ◦ Under the age of 18; ◦ Between the ages of 18 and 23 and is attending a VA-approved school; ◦ Over age 18 and was determined to have a disability before turning 18.

Social Security Disability, Retirement, or Survivor	• Has 40 qualifying quarters of work credit (Social Security Retirement only); • Has a disability and has earned enough qualifying quarters of work credit, based on the person's age; • Is at least 62 years old and has a spouse or ex-spouse that receives Social Security retirement or disability benefits; • Has a parent who is deceased or who is receiving Social Security retirement or disability benefits, and the child meets one of the following: ◦ Is under the age of 18; or ◦ Is between the ages of 18 and 19 years old, and a full-time high school student; or ◦ Is age 18 or older and has a disability that started before age 22.

Customers may apply for the following benefits online using these links:

Benefit	**Link**
Railroad Retirement	The Railroad Retirement Board does not accept applications online. For more information regarding Railroad Retirement and Survivor Benefits, contact the RRB at https://www.rrb.gov, or the RRB Mesa, AZ office at (877) 772-5772.
Social Security Disability	https://www.ssa.gov/benefits/disability/
Social Security Retirement	https://www.ssa.gov/benefits/retirement/
Social Security Survivors Benefits	https://www.ssa.gov/benefits/survivors/

Unemployment benefits	https://des.az.gov/content/apply-ui-benefits
Veteran's benefits	Veterans can apply online: • Veteran's pension https://www.va.gov/pension/application/527EZ/introduction • Veteran's disability compensation https://www.va.gov/disability/file-disability-claim-form-21-526ez/introduction
	Surviving spouses and dependents cannot apply online. See https://benefits.va.gov/BENEFITS/Applying.asp for how to apply or call the VA at (800) 827-1000 for assistance.
Veteran's benefits - apportionment	A spouse or child cannot apply online for an apportionment. The application can be found online at https://www.va.gov/vaforms/form_detail.asp?FormNo=21-0788. Deliver the application to the VA by: • Mailing it to the Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444; • Faxing it to 844-655-1604; or • Taking it to your local regional office.
Workmen's Compensation	https://www.azica.gov/forms/claims0407

Definitions

Term	Definition

Cash benefits	Means money payments to qualified individuals. These benefits include: • Social Security benefits; • Railroad Retirement; • Worker's Compensation; • Short- or long-term disability benefits; • US Armed Forces benefits; • Pension or retirement funds; and • Unemployment Insurance benefits.
Dependent Parent (for the purpose of compensation when the veteran died in active service or from a service-related injury or illness)	A natural, adoptive, or foster parent of the Veteran or service member and the parent's income is below a certain amount based on federal law.
Qualifying Quarters of Work Credit	A calendar quarter that meets the minimum amount of earnings as determined by the Social Security Administration (SSA). A person can earn up to four qualifying quarters each year.
Wartime Veteran	A person who served in the U.S. Armed Forces (Army, Marine Corps, Navy, Airforce, or Coast Guard, Space Force Commissioned Corps of the United States Public Health Services, National Oceanographic and Atmospheric Administration, National Guard, and any Military Reserve Unit of any Branch of the Armed Forces of the United States), who was discharged under any condition EXCEPT dishonorable, and had active service during one of the following periods: • 04/06/1917 to 11/11/1918 (World War I) • 12/07/1941 to 12/31/1946 (World War II) • 06/27/1950 to 01/31/1955 (Korean Conflict) • 02/28/1961 to 05/07/1975 (Vietnam War) • 08/02/1990 to present (Persian Gulf War)

Programs and Legal Authority

Program	Legal Authorities
All programs	42 CFR 435.608

527 Pregnant

Revised 12/19/2023

Policy

For the Pregnant Woman group, a woman must be pregnant.

Definitions

Term	Definition
Pregnant	A woman expecting the birth of one or more children.
60-day Postpartum Period	A 60-day period starting the day the pregnancy ends. This period applies to a customer who was not enrolled in AHCCCS while pregnant. A customer who is applying for AHCCCS and was pregnant or in their 60-day postpartum period in any of the 3 months before their application month, may be eligible for Prior Quarter Coverage.
12-month Postpartum Period	A 12-month period starting the day the pregnancy ends. This period ends on the last day of the 12th month. Customer must be enrolled in AHCCCS while pregnant to be in the postpartum period as it applies to this group. See Pregnancy and Postpartum for examples.

Proof

Accept the woman's statement that she is pregnant unless there is strong reason to question the statement.

When the statement is questionable, proof of pregnancy from a health care professional is requested. Eligibility staff do not assume that the woman cannot be pregnant. Proof may be written or received over the phone, and must including the following information:

- Name of the pregnant woman;

- Statement that she is pregnant;
- Estimated date of delivery;
- Number of babies expected;
- For written proof, the date, and the health care professional's signature;
- For proof received over the phone the name and type of health care professional (for example Nurse Practitioner, Physician, Registered Nurse).

Legal Authority

Program	**Legal Authorities**
Pregnant Woman	42 USC 1396a(a)(10)(A)(i)(III) and (IV); 42 USC 1396a(a)(10)(A)(ii)(IX); 42 USC 1396u-1 42 CFR 435.116 ARS 36-2901(6)(a)(ii) AAC R9-22-1427(C)

528 Premium Payment

528 Premium Payment

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Premium Payment for Freedom to Work

Revised 06/14/2018

Policy

To continue getting MA through the Freedom to Work (FTW) program, the customer must pay a premium based on their income. See MA1203 for premium amounts.

Exception: American Indians enrolled in a federally recognized tribe do not have a premium.

If payments fall more than one month behind, MA is stopped effective the first day of the following month. Benefits are not re-approved until the customer pays all past due premiums.

Definitions

Term	Definition
Freedom to Work (FTW)	An AHCCCS FTW premium is calculated for all customers who qualify for: • AHCCCS Medical Services under an AHCCCS FTW coverage group; or • AHCCCS FTW – ALTCS HCBS services.

Proof

AHCCCS records showing premium payments made.

Legal Authority

Program	Legal Authorities
AHCCCS Freedom to Work (FTW)	42 USC 1396a(a)(10)(A)(ii)(XV)

	42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2950 ARS 36-2928 AAC R9-22-1913; R9-28-1313

B Premium Payment for KidsCare

Revised 11/28/2023

Policy

To get MA through the KidsCare program, the customer must pay a premium based on their income. See MA1204 for premium amounts.

Exception: American Indians enrolled in a federally recognized tribe do not have a premium.

Customers with a financial hardship may qualify to have the KidsCare premium waived. See MA1204D for further details.

Definitions

Term	Definition
KidsCare Premium	A premium is calculated for all customers who qualify for KidsCare.

Proof

AHCCCS records showing premium payments made.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397cc(e) 42 USC 1397gg(e)(1) 42 CFR 457.510 ARS 36-2982(5); 36-2982(E) AAC R9-31-303(5); R9-31-1402; R9-31-1403(A)(9); R9-31-1405(c)

Effective until 2025-04-25

529 Prior Receipt of SSI Cash

Revised 12/18/2020

Policy

Persons who received SSI Cash in the past may be eligible for SSI MAO in the Disabled Adult Child (DAC), Disabled Widow/Widower (DWW), or Pickle category. Use the table below to see if the person meets the requirement for any of these groups:

To qualify for…	The person must have…
Disabled Adult Child (DAC)	• Received Supplemental Security Income (SSI) benefits on the basis of blindness or disability before reaching age 22; and • Become ineligible for SSI Cash because of the amount of their Social Security DAC benefit (see MA511).
Disabled Widow/Widower (DWW)	At any time since January 1, 1991: • Received SSI or State Supplementary Payments (SSP); • Received an SSI or SSP benefit for the month before the Social Security DWW benefit began; and • Become ineligible for the SSI or SSP benefit because of the amount of the Social Security DWW benefit (see MA512).
Pickle	At any time since April 1977: • Received SSI or SSP benefits AND Social Security benefits at the same time for at least one month; and

	• While receiving both Social Security and SSI or SSP, become ineligible for the SSI or SSP benefit.

Definitions

Term	Definition
SSP	Payments made by a state to supplement SSI Cash benefits. Arizona does not have an SSP program, but the person may have received the payment in another state.

Proof

Accept either of the following as proof that a person has received SSI Cash or SSP in the past:

- Written or electronic Social Security records; or
- AHCCCS records showing the person was eligible for SSI Cash.

Legal Authority

Program	Legal Authorities
SSI-MAO	42 USC 1383c 42 CFR 435.135, 435.137, 435.138 AAC R9-22-1505

530 Receiving Social Security Title II

Revised 07/10/2020

Policy

To qualify for SSI-MAO in the Pickle coverage group, the customer must be receiving Social Security Title II benefits.

Definitions

Term	Definition
Social Security Title II benefits	Includes the following benefits: • Social Security Disability • Social Security Retirement • Social Security Survivors

Proof

Accept any of the following that show a person is receiving Social Security Title II benefits:

- Written or electronic Social Security records;
- Current award letter; or
- Current check stub.

Legal Authority

Program	Legal Authorities
SSI MAO (Pickle)	42 CFR 435.135 AAC R9-22-1505

Effective until 2025-04-25

531 Resident of Arizona

531 Resident of Arizona

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 04/22/2025

Policy

A person must be a resident of Arizona to qualify for AHCCCS Medical Assistance (MA).

Residency policy is covered in four sections:

- Special rules for state residence;
- General rules for state residence;
- Temporary absence from the state; and
- Customers moving into the state.

1) Special Rules for State Residence

The following rules are used first when determining a customer's state of residence:

- A customer getting a State Supplementary Payment (SSP) is a resident of the state paying the SSP.
- A customer getting Title IV-E Foster Care or Adoption Subsidy payments is a resident of the state where he or she is living.
- When a state agency places a customer in an institution in another state, the customer remains a resident of the original state.
- A customer is considered a resident of the state where their home property is located when all of the following conditions exist:
    - The customer is institutionalized in Arizona;
    - The customer has a home property located out of state; and
    - The customer's spouse or dependent still lives in the out-of-state home property.

2) General Rules for State Residence

For all other people, use the rules in the table below.

If the customer is…	And is…	Then …
An adult (18 or older) OR Under age 18, but is married, divorced or emancipated	Able to say in what state he or she intends to live	The customer is a resident of the state where he or she is living when the customer: • Intends to live in the current state (even without a fixed address); or • Entered the state with a job offer or looking for work.
	Unable to indicate intent	The state of residence is where the customer is living.
A child under age 18 who is not emancipated and never married	Not in an institution	The state of residence is: • The state of residence of the parent or caretaker with whom the child lives; or • The state where the child is physically living when not living with a parent or caretaker.
	In an institution placed by a state agency	The state of residence is: • The parent's or legal guardian's state of residence at the time the child was placed in the institution; or • The parent’s or legal guardian’s current state of residence if the customer is institutionalized in that state; or • The state of residence of a customer who files an application, if the child has

		been abandoned by the parents, does not have a legal guardian, and is in an institution in that state.

3) Temporary absence from the state

A customer who is only temporarily absent from the state is still a resident of that state. A customer is considered temporarily absent when he or she intends to return to the state when the reason for the absence is completed and has not become a resident of another state.

NOTE Unless the customer was placed in an out of state institution by AHCCCS, the customer can only get Federal emergency services (FES) through the Federal Emergency Services Program (FESP) when absent from Arizona.

4) Customers Moving into the State

A person can apply for AHCCCS MA before becoming an Arizona resident but must become an Arizona resident before the application can be approved. When a person moves to Arizona, the earliest date benefits can start is the date the person arrived in the state.

When a person applying for AHCCCS moved to Arizona but is receiving benefits in another state, the benefits must be discontinued in the other state.

5) Customers Moving out of the State

A customer is no longer an Arizona resident when they have moved out of state permanently and have not been placed in an out of state institution by AHCCCS.

Definitions

Term	Definition
Emancipated	A minor freed from control by his or her parents or guardians. The parents or guardians are also freed from all responsibility for the child.

Institution	A place that provides food, shelter, and some treatment or services to four or more people who are not related to the owner.
Medical Institution	An institution that is licensed by the state to provide professional medical services.
State Supplementary Payments (SSP)	Payments made by a state to supplement SSI Cash benefits.
Unable to indicate intent	Meets any of the following: • Has an I.Q. of 49 or less or has a mental age of 7 or less; • Is judged legally incompetent; or • Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of intellectual disability.

Proof

For ALTCS, the customer's declaration on the application is accepted as proof of Arizona residency, unless there is evidence to the contrary.

For all other programs, when Arizona residency is not verified electronically, the customer must provide proof.

Proof of Arizona residency includes:

- Rent or mortgage receipts;
- Landlord statements;
- A statement from the nursing facility or other institution;
- An Arizona driver's license or state ID card;
- Arizona vehicle registration;
- A statement from an employer; or

- Utility bills or receipts.

Legal Authority

Program	Legal Authorities
All programs (except KidsCare)	42 CFR 435.403 42 CFR 435.952 42 CFR 435.956 ARS 36-2933 AAC R9-22-304(B) and (C) AAC R9-22-305(3)
KidsCare	42 CFR 457.320(e)

B Temporary Absence

Revised 05/21/2018

Policy

Customers who are temporarily absent from Arizona are still Arizona residents. A customer is considered temporarily absent from Arizona if the customer:

- Intends to return to Arizona when the reason for the absence is completed; and
- Has not become a resident of another state.

NOTE Unless the customer was placed in an out of state institution by AHCCCS, the customer can only get Federal emergency services (FES) through the Federal Emergency Services Program (FESP) when absent from Arizona.

If the customer does not intend to return to Arizona, or moves out of state to become a resident of another state or country, the absence is not temporary and the person is no longer an Arizona resident.

Definitions

Term	Definition
Institution	A place that provides food, shelter, and some treatment or services to four or more people who are not related to the owner.
Medical Institution	An institution that is licensed by the state to provide professional medical services.

Proof

Accept the customer's statement that the absence is temporary unless there is evidence that the person has become a resident of the other state or country.

Evidence that the customer has become a resident of another state or country includes:

- Buying a home;
- Getting a job;
- Getting a driver's license; or

- Applying for Medical Assistance or other public benefits.

If there is evidence that the person has become a resident of another state or country, the person must provide proof that they have not given up Arizona residency. Proof includes:

- Mortgage or current residential rental agreement showing that the person is maintaining a home in Arizona;
- Statement from the employer that the job is temporary or has a set end-date;
- Mortgage or title documents showing that the home is not the person's primary residence;
- Written or telephone confirmation from the other state or country that the person has not obtained a driver's license;
- Written or telephone confirmation from the other state or country that the person has not applied for or has withdrawn their application for public benefits.

Legal Authority

Program	**Legal Authorities**
All programs (except KidsCare)	42 CFR 435.403
KidsCare	42 CFR 457.320(e)

532 Social Security Number

Revised 11/24/2020

Policy

To qualify for benefits, a person must either:

- Give a valid Social Security number (SSN); or
- Give proof that the person has applied to the Social Security Administration (SSA) for an SSN or a replacement card.

Exception:

A person does not have to give a valid SSN or apply for one if any of the following apply:

- Cannot legally get an SSN
- Is an active member of a recognized religious group that objects to getting an SSN
- Is not applying for benefits

NOTE A person may voluntarily give the SSNs of family members who are not applying to help verify family income.

Definitions

Term	Definition
Social Security Number (SSN)	A unique number assigned by the United States Social Security Administration (SSA) to persons living in the United States and to persons who work in other countries for United States companies. A person must have an SSN to be employed, pay taxes, collect Social Security benefits and to qualify for credit accounts.

Proof

Proof of a person's SSN includes:

- An electronic response from SSA that says the SSN is assigned to that person

- An official Social Security card issued by the SSA
- An official document from SSA that contains the person's name and SSN

Proof that the person has applied for an SSN or replacement card includes:

- Receipt for an Application For an SSN (SSA-5028) form
- A Referral for Social Security Number (DE-129) form, completed by SSA
- For a newborn, a Message from Social Security (SSA-2853-OP4) form

Legal Authority

Program	**Legal authorities**
All programs except KidsCare	42 CFR 435.910 AAC R9-22-305(2)
KidsCare	42 CFR 457.340

533 Valid Application

Revised 08/15/2023

Policy

A customer must submit a valid application. A valid application contains at least the following information:

- Applicant's name;
- Address or location where the applicant can be reached;
- Date the application was signed.
- Signature under penalty of perjury (MA1301A.2)

Definitions

Term	Definition
Application	A method for a person to apply for MA benefits. The application may be written, online or telephonic, and must be approved by AHCCCS.
Monoymous person	A person who has one name.

Proof

An application is submitted containing all of the required information.

Programs and Legal Authority

Program	Legal Authorities
All programs	42 CFR 435.907

534 Verifying Non-Financial Conditions of Eligibility

Revised 07/12/2022

Policy

Non-financial conditions of eligibility must be verified for most AHCCCS Medical Assistance (MA) programs.

The agency uses information from electronic sources and other information in previous records before asking for proof from the customer.

Definitions

Term	Definition
Electronic Sources	Connections to common federal and state data sources. These data sources are used to verify a customer's application information such as age, employment, citizenship, and immigration status.
Previous records	Information or proof provided to the agency for a prior application.

Programs and Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	42 CFR 435.945(k) 42 CFR 435.949 42 CFR 435.952 42 CFR 435.956

Chapter 600 Income Eligibility

600 Introduction

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement by program.

601 General Information About Income

Revised 03/22/2022

For some AHCCCS Medical Assistance (MA) programs, the budget group's income must not be higher than the income limit for that program. How income is calculated and the income limits are not the same for all programs.

The income of budget group members may be considered available to the customer when determining eligibility. (See MA602 for information about income budget groups.)

Policy

1) Programs with Income Eligibility Requirements

The MA programs that have an income limit to qualify are:

- ALTCS;
- SSI-MAO;
- Medicare Savings Program (MSP);
- Freedom to Work (FTW);
- Adult;
- Caretaker Relative;

NOTE Including an income limit for the second six-month Transitional Medical Assistance (TMA) extension.

- Pregnant Woman;
- Child;
- KidsCare.

Some MA programs have an income limit, but income eligibility is determined by another agency (see MA400):

- SSI Cash;
- Breast and Cervical Cancer Treatment Program (BCCTP); and
- Title IV-E Foster Care and Adoption Subsidy.

2) Income Categories

Income is divided into two categories, earned and unearned:

- Earned income is received from employment or self-employment. It may be received as wages, salaries, commissions or profits.

NOTE Earned income may also be received as goods or services other than cash in return for work. Goods and services received in return for work are also known as bartering income or in-kind income. The value of the goods or services received is considered the income amount received.

- Unearned income is cash income received from sources other than employment or self-employment.

Within each category there are many types of income.

NOTE Some unearned incomes may receive a Cost-of-Living Adjustment (COLA) increase.

3) Treatment of Income

Depending on the program, each type of income is either counted or excluded. See MA606 for treatment of each type of income.

NOTE Always use the gross amount of USD when determining eligibility and entering amounts into the system. The gross amount of income paid in foreign money can be converted to USD using the online calculator at http://www.xe.com/currencyconverter/.

4) Modified Adjusted Gross Income

Modified Adjusted Gross Income (MAGI) is a method for determining:

- How income is counted;
- Whose income is counted (the budget group); and
- The income limit based on the size of the budget group.

Beginning January 1, 2014, the following programs will use MAGI to determine income eligibility:

- Adult;
- Caretaker Relative;

NOTE Including Transitional Medical Assistance (TMA) and Continuous Coverage (CC).

- Pregnant Woman;
- Child; and

- KidsCare.

NOTE The programs that do not use MAGI rules are referred to as “Non-MAGI” throughout this Chapter.

Definitions

Term	Definition
Budget Group	The people whose income is considered when determining eligibility.
Gross Income	Income before taxes or other deductions.
Modified Adjusted Gross Income (MAGI)	MAGI is based on federal tax rules for determining adjusted gross income (AGI), with some modification. MAGI includes the following sources of income that are not included in AGI: • Certain foreign investment income excluded from AGI by § 911 of the tax code; • Tax exempt interest income; and • Social security benefits excluded from AGI by § 86 of the tax code. In addition to these modifications, for Medicaid purposes only, MAGI will exclude the following income even if it is included in AGI: • Scholarships, fellowship grants and awards used for educational purposes; • Certain American Indian/Alaska Native income; and • Lump sum income (will only be counted in month of receipt).
Adjusted Gross Income (AGI)	A measure of income used to determine how much of income is taxable. The AGI is gross

	income from taxable sources minus allowable deductions.
Non-MAGI Programs	The following programs will not use MAGI methodology for determining household composition and income eligibility: • ALTCS; • SSI-MAO; • Medicare Savings Program (MSP); and • Freedom to Work (FTW).
Self-Employment	Income from a person's own business, including: • Independent contracting; • Taking in roomers or boarders, and other rental income; • Ranching or farming; • Can and bottle recycling collections; • Baby-sitting; • Blood and plasma sales; • Providing services, like cleaning or accounting; • Any wholesale or retail sales.

Proof

The Agency uses the reasonable compatibility standard to verify income. Income information for the members of the budget group is collected through the Federal and State Data Services Hubs, if available, and then compared to the income information reported on the application to see if it is reasonably compatible. See MA605.1 for details.

602 Budget Groups Income

602 Budget Groups Income

Overview

When applying for or receiving AHCCCS Medical Assistance, the income and needs of other people may need to be counted. The people whose income and needs are counted make up the budget group.

Who is included in a person's budget group may depend on:

- The AHCCCS program a person is applying for or receiving;
- The age of the person;
- Whether or not the person is married;
- Who lives with the person; and
- Whether the person files taxes or is claimed as a tax dependent.

If needed, the customer must provide proof of income for everyone in the budget group.

NOTE Sometimes the customer may need to provide proof of income for people who are not in the budget group to:

- See if they can get an income deduction (MA609); or
- Determine Share of Cost (MA1201A).

If information about who is in the budget group is questionable or does not match other available information, the customer must explain and provide any proof needed for the difference. See Example - Conflicting Tax Information for more details.

A ALTCS Budget Groups

Revised 07/10/2020

Policy

The people who must be included in the ALTCS budget group depend on several things, including age, marital status and where the customer lives.

ALTCS Budget Group Chart

If the customer is...	And...	Then the Budget Group includes...
An unmarried child under age 18	Lives in a setting where long-term care services can be provided	The child.
	• Lives in a setting where long-term care services cannot be provided; or • Refuses HCBS	The child, and all of the following, if living with the child: • Ineligible parents; • Other children of an ineligible parent; and • The child's children. **EXCEPTION**: The stepparent is not included when the natural or adoptive parent is not in the home.
An unmarried person age 18 or older	Lives in a setting where long-term care services can be provided	The person.
	• Lives in a setting where long-term care services cannot be provided; or	The person.

	• Refuses HCBS	
A married person	Has a Community Spouse (MA508)	• The person; and • The spouse.
	Lives in a setting where long-term care services can be provided, but does not have proof of legal marriage.	The person.
	• Refuses HCBS; or • Lives in a setting where long-term care services cannot be provided	• The person; and • If living with them, the spouse.

Definitions

Term	Definition
Child	A person who: • Is not married (including divorced); and • Is under age 18; or • For child allocation deductions only, is under age 22 and is a student regularly attending a school, college or university, or a course of vocational or technical training to prepare for gainful employment.
Common Law Marriage	A marriage that is not based upon a license, ceremony, or other legal formality. Most states that recognize common law marriage require that the couple consider themselves married, live together, and publicly present themselves as spouses.

	Common law marriages cannot be established in Arizona. However, a common law marriage established in a state where the marriage is considered legal can be considered legal in Arizona. Exceptions: • Some American Indian tribes recognize common law marriages. A common law marriage established under American Indian tribal law is considered legal in Arizona. • If a resident of Arizona moves to another state or country to evade the laws of Arizona relating to marriage, the marriage is no longer legal in Arizona.
Eligible Parent	A natural or adoptive parent or stepparent who is receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.
Holding Out As Married	Two persons who live in the same household and who are not legally married under Arizona law but hold themselves out to the public as being married.
Ineligible Parent	A natural or adoptive parent, or stepparent who is NOT receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.
Legally Married	A legal union that meets one of the following: • Performed by a person authorized by law (licensed or ordained clergyman, judges or justices of the peace), and a marriage license was issued; or • A common law marriage recognized as legal in Arizona.
Married	Means any of the following: • Legally married;

	• Married under common law; or • "Holding out as married" (a couple presenting themselves to the public as spouses).

Proof

Proof of Income

If needed, the customer must provide proof of income for everyone in the budget group. See MA605 for more details on proof of income.

Sometimes the customer may need to provide proof of income for people who are not in the budget group to:

- See if they can get an income deduction (MA609); or
- Determine a Share of Cost (MA1201).

Proof of Legal Marriage

The customer must provide proof of legal marriage for community spouse policy. See MA520 - Legal Marriage for the type of proof needed for marriage.

Proof of Parent/Child Relationship

A person's statement is accepted unless there is evidence to the contrary. A person's statement includes a completed application listing a relationship of parent or child.

When there is conflicting information or the relationship is questionable, the person is asked for other proof of relationship. Some items that show proof of relationship between a parent and child are:

- The child's birth certificate or other birth record;
- Court records; and
- Religious records.

Legal Authorities

Program	Legal Authorities
ALTCS	42 USC 1396(a)(10)(A)(ii)(V)

	42 USC 1396r-5 AAC R9-28-408 and 410

B Freedom To Work Budget Groups

Policy

The budget group includes only the person applying for or receiving Freedom to Work.

NOTE If the applicant or recipient qualifies for long-term care services, the income of other household members may be used to determine their share of cost. See MA1201 for more information on Share of Cost.

Proof

Only the earned income of the applicant is used to determine income eligibility. A person will be asked to provide proof of income as needed. See MA605 for more details on proof of income.

Legal Authorities

Program	Legal Authorities
Freedom to Work	R9-22-1909 and 1919

C SSI-MAO and MSP Budget Groups

Revised 07/10/2020

Policy

The people who must be included in the budget group depend on several things, including age, marital status, and who lives with the customer.

SSI-MAO and MSP Budget Group Chart

If the applicant is…	Then the Budget Group includes…
An unmarried child under age 18	The child, and any of the following who live with the child: • Ineligible parents; • Other children of an ineligible parent; and • The child's children. **Exception:** The stepparent is not included when the natural or adoptive parent is not in the home.
Unmarried and age 18 or older	The person.
Married	The person, and when living together, the person's spouse.

Definitions

Term	Definition
Child	A person who:

	• Is not married (including divorced); and • Is under age 18; or • For child allocation deductions only, is under age 22 and is a student regularly attending a school, college or university, or a course of vocational or technical training to prepare for gainful employment.
Common Law Marriage	A marriage that is not based upon a license, ceremony, or other legal formality. Most states that recognize common law marriage require that the couple consider themselves married, live together, and publicly present themselves as spouses. Common law marriages cannot be established in Arizona. However, a common law marriage established in a state where the marriage is considered legal, can be considered legal in Arizona. **Exceptions**: • Some American Indian tribes recognize common law marriages. A common law marriage established under American Indian tribal law is considered legal in Arizona. • If a resident of Arizona moves to another state or country to evade the laws of Arizona relating to marriage, the marriage is no longer legal in Arizona.
Eligible Parent	A natural or adoptive parent or stepparent who is receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.
Holding Out As Married	A couple who live in the same household and who are not legally married under Arizona law but hold themselves out to the public as being married.

Ineligible Parent	A natural or adoptive parent, or stepparent who is NOT receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.
Legally Married	A legal union that meets one of the following: • Performed by a person authorized by law (licensed or ordained clergyman, judges or justices of the peace), and a marriage license was issued; or • A common law marriage recognized as legal in Arizona.
Married	Means any of the following: • Legally married; • Married under common law; or • “Holding out as married” (a couple presenting themselves to the public as spouses).

Proof

Proof of Income

A person will be asked to provide proof of income for everyone in the budget group as needed. See MA605 for more details on proof of income.

NOTE Sometimes proof of income for people who are not in the budget group may be needed to see if the customer can get an income deduction (MA609).

Proof of Marriage

A person’s statement of marital status is accepted unless there is evidence to the contrary.

Proof of Parent/Child Relationship

A person’s statement is accepted unless there is evidence to the contrary. A person’s statement includes a completed application listing a relationship of parent or child.

When there is conflicting information or the relationship is questionable, the person is asked for other proof of relationship. Some items that show proof of relationship between a parent and child are:

- The child’s birth certificate or other birth record;
- Court records; and
- Religious records.

Legal Authorities

Program	Legal Authorities
SSI MAO	AAC R9-22-1503
Medicare Savings Program	AAC R9-29-212

D Budget Groups for Modified Adjusted Gross Income (MAGI) Programs

Revised 01/15/2021

Policy

This policy applies to the following MA groups:

- Adult;
- Caretaker Relative (including TMA and CC);
- Pregnant Woman;
- Child; and
- KidsCare.

When a person's income is too high using the MAGI budget group and income rules, the Premium Tax Credit budget group and income rules are used. See section 2 below.

1) MAGI Budget Group

The people who must be included in the budget group depend on if the customer:

- Files taxes;
- Is claimed as a tax dependent; and
- Is living with a spouse, child, parent or sibling.

The person's income limit is based on the number of people in the MAGI Budget Group with one exception. The unborn children a pregnant woman is expecting are counted as part of her MAGI budget group only.

See Example – Pregnant Woman Budget Group

MAGI Budget Group Chart

NOTE In the following table, any reference to a parent, child or sibling includes step-parents, step-children and step-siblings.

If the person is…	And…	Then the Budget Group is…

A taxpayer	Is not claimed as a tax dependent by someone else.	• The taxpayer; • Everyone the taxpayer expects to claim as a tax dependent; and • Taxpayer's spouse, when living together. Exception: If the taxpayer is under age 19 and lives with a parent, the parent must be included in the taxpayer's budget group. See Taxpayer Budget Group for examples.
A tax dependent under age 19	Any of the exceptions below apply: • Will be claimed by a non-custodial parent. • Will be claimed by a parent, lives with more than one parent, but the parents do not expect to file a joint return. • Will be claimed by someone other than a spouse or parent.	Use the "Not a taxpayer or tax dependent" rules below for the person's age.
	None of the tax dependent exceptions in the row above apply.	• The taxpayer; • Everyone the taxpayer expects to claim as a tax dependent; • Taxpayer's spouse when living together; and • The tax dependent's spouse, when living together.

		See Tax Dependent Under Age 19 Budget Group for examples.
A tax dependent age 19 or older	Is being claimed by a parent	• The taxpayer; • Everyone the taxpayer expects to claim as a tax dependent; • The tax dependent's spouse, when living together. See Tax Dependent Age 19 or Older Budget Group for examples.
	Is being claimed by a spouse	• The taxpayer; and • Everyone the taxpayer expects to claim as a tax dependent.
	Is being claimed by someone OTHER than a spouse or parent	Use the "Not a taxpayer or tax dependent" rules below for the person's age.
Not a taxpayer or tax dependent	Is under age 19	The child and if living with the child, the child's: • Spouse; • Children (natural, adopted or stepchildren); • Parents (natural, adoptive or stepparents); and • Siblings (natural, adoptive or stepsiblings) under the age of 19. See Not a Taxpayer or Tax Dependent (under age 19) Budget Group for examples.

	Is age 19 or older	The person and if living with them, the person's: • Spouse; and • Children (natural, adopted or stepchildren). See Not a Taxpayer or Tax Dependent (age 19 or older) Budget Group for examples.

2) Premium Tax Credit Budget Group

If the income of the customer's MAGI budget group is higher than the income limit for the MAGI program, Premium Tax Credit rules are used.

The people who must be included in the budget group depend on if the customer:

- Files taxes; or
- Is claimed as a tax dependent.

The customer's income limit is based on the number of people in the budget group.

Premium Tax Credit Budget Group Chart

If the customer expects to…	**Then the budget group includes…**
File a tax return	• The tax filer; • The tax filer's spouse when living together OR filing a joint return; and • Everyone the tax filer expects to claim as a tax dependent.
Be claimed as a tax dependent	• The tax filer; • The tax filer's spouse when filing a joint return; and

	• Everyone the tax filer expects to claim as a tax dependent.
Not file a tax return and not be claimed as a tax dependent	Premium Tax Credit rules do not apply. The person does not qualify.

Definitions

Term	Definition
Child	A person under the age of 19.
Custodial Parent	• A parent who has a court order or binding separation, divorce, or custody agreement giving physical custody of the child, and maintains physical custody of the child; or • When there is no custody agreement or there is a shared custody agreement, the parent with whom the child spends most nights.
Living With, or Living Together	People who occupy the same home or other residence. This includes people who are temporarily away from home but are expected to return. Some examples of reasons a person may be temporarily away from home include: • Away at school, • Visiting friends or relatives; and • Hospitalized or in a medical institution.
Parent	A natural or adoptive parent or stepparent.
Sibling	Full, half, natural, step or adopted brother or sister.
Tax Dependent	A person claimed as a dependent on someone else's tax return. This can include a person who chooses to or must file a tax return of their own.

Taxpayer	• A person who: • Expects to file a tax return for the current year, and • Will not be claimed as a tax dependent by someone else. NOTE Spouses who file a joint return and are not claimed as tax dependents by someone else are both considered tax payers.

Proof

Proof of Income

A person will be asked to provide proof of income for everyone in the budget group as needed. See MA605 for more details on proof of income.

Proof of Marriage

A person's statement of marital status is accepted unless there is evidence to the contrary.

Proof of Parent/Child Relationship

Accept a person's statement unless there is evidence to the contrary. A person's statement includes a completed application listing a relationship of parent or child.

When there is conflicting information or the relationship is questionable, ask for other proof of relationship. Some items that show proof of relationship between a parent and child are:

- The child's birth certificate or other birth record;
- Court records; and
- Religious records.

Proof of Tax Filing Status

A person's statement about whether or not they are a taxpayer or a tax dependent is accepted unless there is evidence to the contrary. A person's statement includes a completed application listing:

- Taxpayers and their tax dependent; and
- Household members who are not taxpayers or tax dependents.

When there is conflicting or questionable taxpayer or tax dependent information, the person is asked for proof that supports the person's statement. Supporting information may include but is not limited to:

- Court records;

- Statement from the other parent of a tax dependent; and
- Prior years' tax records.

See Example - Conflicting Tax Filing Information for more details.

Legal Authorities

Program	Legal Authorities
Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.4 42 CFR 435.110, 116, 118 and 119 42 CFR 435.603
KidsCare	42 CFR 435.4 42 CFR 457.10, 300, 301 and 315 42 CFR 435.603

603 What is Not Income

Revised 07/06/2017

Policy

The following are not considered income when determining eligibility:

- Money from the sale of a resource;
- Money transferred between financial accounts that belong to the same person;
- Money a person receives to cover someone else's expenses and then uses to pay the expenses is not considered income to the customer;
- Replacement income;
- Return of incorrect payments; and
- Vendor payments.

Exceptions for vendor payments:

- Payments made directly to a vendor when the money is legally owed to the person (such as alimony) are considered income. For example, the person's ex-husband pays her rent with the alimony that he normally sends her. This is income; not a vendor payment.
- For ALTCS, payments made directly to a vendor from a Special Treatment Trust for food and shelter expenses are considered income, not a vendor payment. See MA803E for details.

Definitions

Term	Definition
Replacement Income	A payment that replaces income which was lost or stolen. NOTE The original payment would be counted as income when received.

Return of incorrect payments	A payment returned by a person who is aware that he is not entitled to the payment. If there is a delay in the return of an incorrect payment beyond the month following the month of receipt, the reason for the delay must be documented. See Example – Return of an incorrect payment
Vendor Payments	Payments for a customer's expenses made directly to the vendor by a third party. See Example - Vendor Payment

Proof

Proof may be needed if the transaction appears questionable. Types of proof include, but are not limited to:

- Receipts;
- Bills; and
- Phone call to the source of the payment.

Legal Authority

Programs	**Legal Authority**
ALTCS SSI-MAO MSP FTW	20 CFR 416.1103 AAC R9-22-1503(A)
Caretaker Relative Pregnant Woman Child Adult	42 USC 1396a(e)(14) 42 CFR 435.603

KidsCare	42 U.S.C. 1397bb(1) 42 CFR 457.315

604 Receipt of Income

604 Receipt of Income

There are many ways in which a person may receive income that can affect how it is counted. This section discusses the following:

- Income received outside of the regular schedule (advanced dated checks and deferred wages);
- Constructively received income;
- Electronic fund transfers and deposits to financial accounts;
- Frequency;
- Garnishments and overpayments; and
- Contract or seasonal income.

A Income Received Outside of the Regular Schedule

Revised 06/14/2018

Policy

A person may receive income outside of the regular pay schedule. Income may be received as:

- Advance dated checks; and
- Deferred wages.

1) Advance Dated Checks

The income received from an advance dated check is considered available in the month it would normally have been received.

2) Deferred Wages

When the deferred wages are counted for eligibility depends on whether or not the deferred payment is due to circumstances beyond the control of the employee.

If the wages are deferred...	Then the income is counted as earned income in the month...
Due to circumstances beyond the control of the employee	Received.
At the employee's request or by mutual agreement with the employer	It would have been received had it not been deferred.

Definitions

Term	Definition

Advance Dated Checks	A check dated earlier than the normal payment date because the regular payment date falls on a weekend or holiday. This results in a check being received in advance of the month of normal receipt.
Deferred Wages	Wages are considered deferred if received later than the normal payment date.

Legal Authority

Program	Legal Authorities
ALTCS SSI-MAO MSP FTW	42 USC 1382a(a) and (b) 20 CFR 416.1102, 1110, 1111, and 1120
Caretaker Relative Pregnant Woman Child Adult KidsCare	42 CFR 435.603

B Constructively Received Income

Revised 06/14/2018

Policy

How constructively received income is counted depends on whether:

- The assignment of income to another person is revocable or irrevocable; and
- If the income is assigned on a periodic or permanent basis:

If the income is…	Then…
Revocably assigned	Income is counted in each month it would have normally been received. Example – Revocably Assigned Income
Irrevocably and permanently assigned (all future payments are assigned)	Irrevocably assigned income is not counted. NOTE For ALTCS, the assignment is evaluated as a transfer (see Chapter 900). Example – Irrevocably and Permanently Assigned Income
Irrevocably assigned on a periodic basis (not all future payments are assigned)	For ALTCS: Count the income in each month it would have normally been received is counted (constructively received). Example – Irrevocably and Periodically Assigned Income
	For all other programs, the income for months it is irrevocably assigned is not counted.

Definitions

Term	Definition
Constructively Received Income	Income that a person is entitled to or has unrestricted control of before refusing or assigning the income to someone else.
Irrevocable Assignment	The person cannot legally take back the assigned income or taking back possession requires action by a third party who is not under the person's control.
Revocable Assignment	The person has the right to get back if he or she chooses.

Proof

Proof of the assignment includes legal documents, contracts and agreements listing the length and terms of the assignment.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO MSP FTW	42 USC 1382a(a) and (b) 20 CFR 416.1102, 1110, 1111, and 1120
Caretaker Relative Pregnant Woman	42 CFR 435.603

Child Adult KidsCare	

C Deposits to Financial Accounts

Revised 08/27/2024

Policy

With a few exceptions, deposits to a financial account are assumed to be countable income in the month of deposit. See the following sections for more information on these exceptions.

1) Direct Deposit

When a person has income deposited directly to a bank account, the funds may be posted before or after the month in which they are payable. The funds are considered income in the month they would normally be received.

2) Treatment of Other Deposited Income

The following describes how other deposits to a person's financial account are treated:

If deposits are made...	Then...
By the customer or their spouse	All deposits are assumed to be countable income to the budget group unless proof is provided to show that the deposited money is: • From an excluded income type, • A transfer of funds from another resource owned by the customer or spouse, or • Money from the sale of a resource. Exception: An ALTCS customer's deposits are not counted as income to the spouse when the spouses are not living together. Instead, only the allocated amount is counted as unearned income to the spouse. See MA606.H for details about allocated income.

Into a person's joint account by a co-owner of the account or a third party	The deposits are considered contributions to the person unless proof is provided that the income is not available to, or used by the person. See MA705I for details on rebutting ownership of a joint account.
On behalf of another person	Payments a person receives as an agent for a minor child or incapacitated adult is considered income to the child or incapacitated adult. For example, this would include receipt of child support as a guardian or Social Security as a representative payee. The deposit must be clearly identified as the child or incapacitated adult's income. The child or incapacitated adult's name does not need to be on the account. Example - Income received on behalf of another person
To a Medicare Flex Card	Funding of the prepaid debit card by the Medicare Advantage Plan is excluded income to the owner of the Medicare Flex Card in the month it is received for both MAGI and Non-MAGI programs.

3) Agent's Misuse of Ward's Funds

Moneys misused by an agent are considered unearned income to the agent in the month received unless restitution is made.

When the agent restores misused funds to the ward, the restored funds are not considered income to the ward.

Exception:

When the agent misused the ward's income and that income was not counted for the ward's eligibility because it was not available to the ward, the restored funds are counted as income to the ward in the month they are restored.

Definitions

Term	Definition
Agent	A person or organization acting in a fiduciary capacity on behalf of another person. An agent includes a power of attorney, representative payee, conservator, or guardian
Fiduciary	A person legally appointed and authorized to manage the income and resources for the benefit of the other person rather than for his or her own profit.

Proof

Proof that a deposit was a transfer from another financial account or the conversion of a resource includes:

- Documentation showing the withdrawal of the funds from another account;
- Electronic data sources showing a decrease in one account that matches a deposit or increase in another account; or
- A bill of sale for a resource.

Proof that the deposit was from an excluded income type or belongs to a child or incapacitated adult includes

- Copies of check stubs;
- Letter from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO MSP FTW	42 USC 1382a(a) and (b) 20 CFR 416.1102, 1110, 1111, and 1120
Caretaker Relative Pregnant Woman Child Adult KidsCare	42 CFR 435.603

D Frequency of Payment

Revised 06/14/2018

Policy

Income eligibility is based on the income received during a calendar month or the monthly equivalent. In order to calculate the amount of income received during a specific month, the frequency of the payment must be determined. Income received other than monthly may be treated differently depending on the MA program. See the following table for how income is counted based on how often it is received:

If income is received…	**Then…**
Weekly	MAGI coverage groups The weekly amounts received are averaged then multiplied by 4.3 to account for the four extra pay periods per year. This prorates the extra pay periods over the year and provides a consistent monthly equivalent.
	Non-MAGI coverage groups The amounts actually received in the month are totaled. NOTE There are months when a person may receive a fifth paycheck. Each month needs to be determined separately. The person may be denied the month the five paychecks are received due to excess income.However, the person may qualify for the months that only four paychecks are received. See Example - Five weekly payments received in a month
Every other week	MAGI coverage groups The bi-weekly amounts received are averaged then multiplied by 2.15 to account for the two extra pay periods per year. This prorates the

	extra pay periods over the year and provides a consistent monthly equivalent.
	Non-MAGI coverage groups The amounts actually received in the month are totaled. NOTE There are months when a person may receive a third paycheck. Each month needs to be determined separately. The person may be denied the month the three paychecks are received due to excess income. However, the person may qualify for the months that only two paychecks are received. See Example - three bi-weekly payments received in a month
Semi-monthly	The two amounts received for the month are added together.
Monthly	The amount received in the month is the counted amount.
Quarterly	MAGI coverage groups The quarterly amount is divided by 3 to get a monthly equivalent, which is counted in each month.
	Non-MAGI coverage groups The quarterly amount is counted in the month it is received.
Regularly scheduled, but less often than monthly	MAGI coverage groups The amount is divided by the number of months it is intended to cover to get a monthly equivalent, which is counted in each month.

	Non-MAGI coverage groups The amount is counted in the month it is received.
Yearly	MAGI coverage groups The yearly amount is divided by 12 to get a monthly equivalent, which is counted in each month.
	Non-MAGI coverage groups The yearly amount is counted in the month it is received.
One-time (lump sum)	MAGI coverage groups The lump sum amount is counted only in the month received. **Exception:** Lottery or gambling winnings of more than $80,000.00 are prorated over more than one month (see MA606UU).
	Non-MAGI coverage groups The lump sum amount is counted only in the month received.
Irregularly or infrequently	MAGI coverage groups The total amount received in the last 30 days is the counted amount.
	Non-MAGI coverage groups • Exclude the first $30.00 of all earned income received infrequently or irregularly in the calendar quarter. Count the remaining amount.

	• Exclude the first $60.00 of all unearned income received infrequently or irregularly in the calendar quarter. Count the remaining amount.

Definitions

Term	Definition
Semi-monthly	A payment received twice a month. This results in 24 payments in a year.
Bi-weekly	A payment received every other week. This results in 26 payments in a year.
Weekly	A payment received every week. This results in 52 payments in a year.
Infrequent Income	Income that is received no more than once in a calendar quarter from a source. For example, a cash gift from an adult child every six months to help pay living expenses.
Irregular Income	Income that cannot reasonably be expected to be received. This is income that is: • Not subject to scheduling; or • Is unpredictable so that it cannot be counted on.
Calendar quarter	A calendar year is divided into four calendar quarters as follows: • January 1 to March 31 • April 1 to June 30 • July 1 to September 30

	• October 1 to December 31
Lump Sum	A lump sum payment is a one-time only payment like an insurance or lawsuit settlement, inheritance, lottery winnings or retroactive cash benefits.
Monthly equivalent	Monthly countable income amount determined by averaging, prorating, or converting a person's income.

Legal Authority

This requirement applies to the following programs:

Program	**Legal Authorities**
ALTCS SSI-MAO MSP FTW	42 USC 1382a(a) and (b) 20 CFR 416.1102, 1110, 1111, and 1120
Caretaker Relative Pregnant Woman Child Adult KidsCare	42 CFR 435.603 R9-22-1422, 1423 and 1424

E Garnishments and Overpayments

Revised 06/14/2022

Policy

A person's gross income is used to determine eligibility and share of cost even when a garnishment or overpayment is being deducted from the income.

Exception:

The amount withheld to recover an overpayment is excluded when BOTH of the following apply:

- The person received AHCCCS Medical Assistance the entire time the other income was being overpaid; and
- The overpaid amount was included in the customer's counted income.

When a customer reports that his or her income is being garnished, the customer is asked to contact the source of the garnishment. The source may be willing to reduce or waive the garnishment.

See Examples - Garnishments and Overpayments

One common type of garnishment is made by the IRS to collect a tax penalty. VA also places a garnishment to recover an overpayment. Both IRS and VA have processes for waiving or deferring garnishments.

Definitions

Term	Definition
Garnishment	A process that directs money or property of a third party be seized to satisfy a debt owed by a debtor to a creditor.
Overpayment	Payments of income made in excess of the sum due.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO MSP FTW	20 CFR 416.1123
Caretaker Relative Pregnant Woman Child Adult KidsCare	42 CFR 435.603 R9-22-1421

F Contract or Seasonal Income

Revised 06/14/2018

Policy

How contract or seasonal income is treated depends on the coverage group:

Non-MAGI groups:

Contract or seasonal income is counted in the month received.

MAGI groups:

- When the income is received at least monthly and will not fluctuate over the 12-month period starting with the month of application or renewal, the income is counted based on how often it is received. See MA604D for details.
- When the income is expected to fluctuate, use the tables in sections 1 and 2 below to determine how to count the income.

1) Treatment of Contract Income for MAGI Groups

If the contract is...	Then...
A one-time contract that ends between the application or renewal month and the end of the calendar year	Divide the income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent.
For contracts that extend into the next calendar year, contracts that are anticipated to be renewed	Divide the income that will be received in the 12-month period beginning with the application or renewal month by 12 to get a monthly equivalent. Example Contract periods that cover more than one calendar year Example Contract anticipated to be renewed

2) Treatment of Regular Seasonal Income for MAGI Coverage Groups

When seasonal income is anticipated to be about the same as in the past, the total anticipated amount for the year is divided by 12 to get a monthly equivalent.

Example Seasonal income

Definitions

Term	Definition
Contract Income	A set income amount or payment schedule received under the terms of a contract.
Seasonal Income	Regular seasonal income is income that: • Fluctuates based on season or is only received during a certain season; and • Can reasonably be anticipated based on history or other proof.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS	20 CFR 416-1111 42 CFR 435.945, 948,and 952
SSI MAO MSP FTW	20 CFR 416-1111
Caretaker Relative	42 CFR 435.603

Pregnant Woman Child Adult KidsCare	R9-22-1422, 1423 and 1424

G Projecting Income

Revised 03/25/2025

Overview

This section discusses how to project income when current proof does not reflect ongoing income due to any of the following:

- Pay rate has increased or decreased;
- Work hours have increased or decreased;
- A person does not get paid every pay period (zero pay); or
- Income has just started or stopped.

Policy

When all income for the budget month is known, it must be used for that month. When all income for the month is not known, the income received in the last 30 days is used when it is normal and expected to continue.

For future months, if the income received in the last 30 days is not the usual amount or there has been a recent change, the customer's income must be projected. Projecting income is predicting the future income based on the past or known information. Income received from at least the last 30 days and any known changes are reviewed to determine the income to be budgeted for future months.

1) Pay rate has increased or decreased

When the person's new rate of pay is not included in all pay received in the past 30 days, project the income for the future months. When the person's work hours do not normally vary, multiply the numbers of hours worked by the new rate to get the projected pay amount. If the person's work hours normally vary, complete the following to project the income:

- Add up the number of hours from all the normal pay periods in the last 30 days;
- Divide the total hours by the number of pay periods used to get an average number of hours; and
- Multiply the average hours by the new pay rate to get the projected income amount per pay period.

See Changes in Pay Rate for examples.

2) Work hours have increased or decreased

When a person's new work hours are not reflected in all pay received in the past 30 days, project the income for the future months.

When the person's work hours normally vary, determine the range of hours the person may be expected to work. For example, the person's employer may state that the person will work between 20 and 30 hours per week.

If the person is paid…	And…	Then…
Weekly or bi-weekly	Work hours are not expected to vary	Multiply the expected hours per pay period by the pay rate to get a projected pay amount.
	Work hours are expected to vary	• Determine the range of hours the person is expected to work per pay period; • Add the highest and lowest number of hours expected to work and divide by two to get an average; and • Multiple the average hours by the pay rate to get a projected pay amount.
Semi-monthly	Work hours are not expected to vary	• Determine the number of hours the person is expected to work per week; • Multiply the expected hours per week by 2.15 to get the average hours per pay period; and • Multiply the average hours per pay period by the pay

		rate to get a projected pay amount.
	Work hours are expected to vary	• Determine the range of hours the person is expected to work per week; • Add the highest and lowest number of hours expected to work during a week and divide by two to get the average hours per week; • Multiply the average hours worked per week by 2 to get the average hours per pay period; and • Multiply the average hours per pay period by the pay rate to get a projected pay amount.

See Changes in Work Hours for examples

3) Zero Pay Period

A zero-pay period is when a person is still employed but does did not earn any income for the scheduled pay period. This can happen when:

- The person is out sick or on vacation but does not get paid for the time off work.
- The person works only as needed. For example, the person is employed with a temporary service.

When the person normally receives income every pay period, and the zero-pay was an unusual event, only include it in the month it occurred. When the person works as needed and a zero-pay is not an unusual event, also include the zero-pay when projecting income for future months.

The table below shows how monthly income that includes a zero-pay period is calculated for MAGI and non-MAGI programs.

If the MA program type is…	Then
Non-MAGI	All of the pay amounts received during the income period are added together to get the monthly income.
MAGI	Add up all of the pay amounts received during the income period. Divide the total by the number of pay periods there were in the income period to get an average amount per pay period; and Multiply the average amount by one of the following depending on how often the person is paid: • 4.3 for weekly; • 2.15 for bi-weekly; or • 2 for semi-monthly.

See Zero Pay Periods for examples.

4) Income has just started or stopped

How income that has just started or stopped is calculated depends on whether or not a full month's income will be received in the budget month. See the table below for details:

If…	Then
A full month's income will be received.	The standard policy applies based on frequency of payment. See MA604D.
Less than a full month's income will be received	All of the pay amounts that will be received during the budget month are added together to get the monthly amount.

5) Unusual low-high income payments

Unusual low-high income payments are when there is an unusual variation in the income that is not projected to continue or recur.

This can happen when the person has work hours outside the normal range that is expected by their employer, receives a bonus, or some type of incentive pay.

Projecting unusual low-high income for Future Months:

If...	Then...
The unusual pay is not expected to continue	• Remove the check with the unusual High-low income. • Multiple the average remaining checks by the pay frequency to get a projected pay amount.
If the unusual pay is due to a one-time bonus or incentive pay and it is not expected to continue	• Subtract the bonus or incentive pay from the check. • Multiple the average the checks by the pay frequency to get a projected pay amount.
The unusual pay is not an unusual event and is expected to continue	• Include when projecting income for future months.

See Unusual Low-high Income Payments for examples.

Definitions

Term	Definition
Income period	• When all pay amounts for the budget month are known, the income period is the same as the budget month.

	• When all pay amounts for the budget month are not known, the income period is the last 30 days. NOTE When all pay amounts for the budget month are not known AND all pay amounts in the last 30 days are unusual, the income period can be extended further back to include usual pay amounts.

See Unusual Low-high Income Payments for examples.

Proof

Proof of an income change or unusual pay amounts can include one or more of the following:

- Data from state and federal hubs;
- Written or verbal statement from the employer;
- Written job offer that includes details about pay rate and frequency or amount;
- Written termination letter that includes details about the date and amount of the final pay;
- Telephone call to the employer or income source confirming the income change details.

Legal Authority

Program	Legal Authority
ALTCS SSI-MAO MSP FTW	42 USC 1382a(a) and (b) 20 CFR 416.1102, 1110, 1111, 1112, 1120, and 1124
Caretaker Relative Pregnant Woman Child Adult	42 CFR 435.603 R9-22-1422, 1423 and 1424

KidsCare	

605 Verifying Income

Revised 09/27/2022

Policy

The customer's income and income of financially responsible relatives must be verified for most AHCCCS Medical Assistance (MA) programs.

1) Reasonable Compatibility for Income

When verifying income, the reasonable compatibility standard is used before asking the customer for other proof. If the income reported by the customer is reasonably compatible with the income information found in the hub, the customer does not have to provide any further proof.

Income information is first collected from the Federal and State Data Services Hubs, if available, and compared to the income reported by the customer.

When the customer reports income that is over the income limits for AHCCCS Medical Assistance (MA), it is reasonably compatible. No further proof is needed.

When the customer reports income below the MA income limits, see the table below:

If the customer reports...	And...	Then...
Total income below the MA income limit	• Information was available for each reported income source from the hubs; and • The total is below the MA income limit	The information is reasonably compatible and considered verified. No further proof is needed.
	Information was not available for each reported income source from the hubs	The customer must provide proof of income.
	The hubs show total income above the MA income limit	The customer is asked clarifying questions to see if more proof is needed based on: • The reason why the income is different, and

		• How eligibility, premiums, or share of cost may be affected. When the answers do not account for the difference, the customer must provide proof of income.
No income	There is no information available from the hubs	The customer must provide a verbal or written statement about how living expenses are being met. The customer statement is enough proof unless it is questionable or inconsistent with other information. See Expenses Exceed Income Examples for when information is questionable or inconsistent.
	The hubs show current income information.	The customer must provide: • Information about how living expenses are being met; and • If not already verified, proof that the income shown in the hubs has ended.

NOTE A customer may report the earned income does not belong to them. When it appears to be a case of identity theft, the customer may call the Identity Theft Complaints Hotline at 877-438-4338 or use the internet site identitytheft.gov to report the issue.

See Examples - Reasonable Compatibility

2) Other Methods of Proof

When the reasonable compatibility method cannot be used (or if the customer must provide proof), income may be verified using one of the following methods:

Method	Description
Physical Evidence	Physical evidence includes: • Electronic records; • Award letters • Check stubs; • Signed contracts; • Signed statements from the income source, including completed agency forms. NOTE Always use the gross amount of USD when determining eligibility and entering amounts into the system. The gross amount of income paid in foreign money can be converted to USD using the online calculator at http://www.xe.com/currencyconverter/.
Collateral contact	Verbal statements to the Benefits and Eligibility Specialist from an employer or income source providing details of the customer's income. A collateral contact is generally made by phone. The details of the collateral contact must be documented and include: • The name, title and phone number of the person who provided the information; and • Date of the collateral contact.

The proof should include at least the following items:

- Name of the income source (also address and phone number when possible);
- Name of the person receiving the income;
- The Date paid;
- Gross amount of the income; and

- How often the income is received.

Definitions

Term	Definition
Federal Data Services Hub	A hub that connects to common federal data sources. These data sources are used to verify a customer's application information such as income, benefits, citizenship, and immigration status.
State Data Services Hub	A hub that connects to common state data sources. These data sources are used to verify a customer's application information.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	42 CFR 435.940 42 CFR 435.948 42 CFR 435.949 42 CFR 435.952 AAC R9-22-304

606 Types of Income

606 Types of Income

Overview

There are many types of income within each category of income. Different policy applies to each type of income.

Income definitions, income types, treatment, proof, expenses and calculations are addressed individually in this section for each type of income.

> NOTE The Freedom to Work (FTW) program does not consider any unearned income types when determining income eligibility. The unearned income types described in this section will not include FTW in how they are counted or in the legal authorities.

A Adoption Assistance (Adoption Subsidy)

Revised 03/25/2025

Policy

A child receiving Title IV-E adoption assistance is automatically eligible for AHCCCS Medical Assistance (MA).

How adoption assistance payments are treated depends on the following:

If the adoption assistance is funded through…	And the assistance is...	Then the treatment is...
Title IV-E		Since the child customer automatically gets MA (MA414), this income is only counted as unearned income to the customer for: • The ALTCS Share of Cost (MA1201B); and • The Child Allocation for SSI-MAO (MA611A) and MSP (MA612). NOTE Customers who receive Title IV-E are categorically eligible for ALTCS (MA502).
Title IV-B or Title XX		Excluded for all programs.
State Funded (except Connecticut, Florida, Illinois, Michigan, New Mexico, New York, Pennsylvania, Tennessee, Vermont, and Wyoming)		Since the customer automatically gets MA (MA414), the income is only counted as unearned income to the customer for: • The ALTCS Share of Cost (MA1201B); and • The Child Allocation for SSI-MAO (MA611A) and MSP (MA612).
Other	Based on need	Excluded for all programs.

	Not based on need	Counted as unearned income for: • ALTCS • SSI-MAO • MSP Exception: Any part of the payment intended for the parent as an incentive or service payment, and not to support the child, is counted to the parent.
		Excluded for: • Adult • Caretaker Relative • Child • Pregnant Woman • KidsCare

Definitions

Term	Definition
Adoption Subsidy	Payments to encourage the adoption of children with special needs. The payments help families with the extra costs that might be a barrier to adoption of a child with special needs.
Based on Need	The person must demonstrate financial need to qualify for the payment.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copies of check stubs;
- Written statement or record from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 CFR 435.145 42 CFR 435.227 42 CFR 435.403(g) and (k)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315 42 CFR 435.403(g) and (k)

B Agent Fees

Policy

Agent fees are considered as countable income for all programs. The income is counted towards the agent.

> NOTE Agent fees are categorized as unearned income for non-MAGI coverage groups.

Definitions

Term	Definition
Agent Fees	Income that a person has been authorized to keep as a: • Payee; • Guardian; or • Other agent for another person.

Proof

Proof of the amount of fees includes:

- Accounting statements;
- Copies of check stubs; or
- Legal document that authorizes the payment.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a) 20 CFR 416.1120 and 1123 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

C Agent Orange Payments

Policy

Agent Orange payments are made annually by the U.S. government. These payments are excluded for all MA programs.

Definitions

Term	Definition
Agent Orange Payments	The payments for veterans to settle Agent Orange death or disability claims.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Copies of check stubs;
- Letter from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	P.L. 101–201, Section 103 42 USC 1382a(b)

	Title 20 of the CFR, Appendix to Subpart K of Part 416, Section V(d)
Adult Caretaker Relative Pregnant Woman Child KidsCare	P.L. 101–201, Section 103 42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

D Alaska Longevity Bonus (ALB) Payment

Policy

Alaska Longevity Bonus payments are counted as unearned income.

Exception:

For non-MAGI programs, Alaska Longevity Bonus payments are excluded when the customer met both of the following conditions before October 1, 1985:

- Met the 25-year Alaska residency requirement; and
- Was eligible for SSI.

NOTE These payments will not continue a once a person is no longer a resident of Alaska. However, the person may receive a final payment in the same month that he or she moved to Arizona or soon after.

Definitions

Term	Definition
Alaska Longevity Bonus (ALB) Payment	ALB payments are made by the State of Alaska to residents age 65 or older based on how long they have been a resident of the state.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copies of check stubs;
- Letter from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b) 20 CFR 416.1124(c)(7)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603(e)(3) 42 CFR 457.10, 300, 301 and 315

E Alaska Native Corporation and Settlement Trust Payments

Policy

Alaska Native Corporation and Settlement Trust payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Alaska Native Regional and Village Corporation Payments	Distributions of cash or dividends on stock received from a Native Corporation to an: • Individual Alaska Native; or • Descendant of an Alaska Native.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include:

- Copies of check stubs;
- Letter from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b) 20 CFR § 416.1124(b) Title 20 of the CFR, Appendix to Subpart K of Part 416, Section IV(a)(3)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603(e)(3) 42 CFR 457.10, 300, 301 and 315

F Aleutian and Pribilof Islanders Relocation Payments

Policy

Aleutian and Pribilof Islanders Relocation payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Aleutian and Pribilof Islanders Relocation Payments	Relocation payments paid to the Aleutian and Pribilof Islanders relocated during World War II.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Copies of check stubs;
- Letter from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	P.L. 100–383 Title 20 of the CFR, Appendix to Subpart K of Part 416, Section IV (c)

	20 CFR § 416.1124(b)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.4 42 CFR 435.603(e)(3) 42 CFR 457.10, 300, 301 and 315

G Alimony and Spousal Maintenance

Revised 05/13/2020

Policy

Alimony or spousal maintenance payments are counted as income for:

- ALTCS
- SSI-MAO
- MSP

For the MAGI programs, see the table below to determine when to count alimony or spousal maintenance payments:

If the alimony or spousal maintenance agreement ...	Then the payments are...
Is created on or before 12/31/2018; AND Has NOT been modified after 12/31/2018 to specifically state that the Tax Cuts and Jobs Act treatment of spousal support now applies.	Counted as unearned income.
Is created **after** 12/31/2018; OR Has been modified after 12/31/2018 to specifically state that the Tax Cuts and Jobs Act treatment of spousal support now applies.	Excluded.

Definitions

Term	Definition
Alimony or Spousal Maintenance Payments	Court ordered support amount paid to a legally separated or divorced spouse.
MAGI programs	Means any of the following programs: • Adult;

	• Caretaker Relative, including TMA and Continuous Coverage; • Pregnant Woman; • Child; and • KidsCare

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Divorce or separation documents;
- Copies of check stubs;
- Collateral contact with the Clerk of the Court; or
- Signed statement from the individual providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(2)(E) 20 CFR 416.1121(b) R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	26 CFR 1.61-10 42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Effective until 2025-04-25

H Allocated Income

Revised 11/07/2023

Policy

Allocated income is income provided by an ALTCS customer living in an institution or residential facility to a spouse living at home. This income amount is also called the Community Spouse Monthly Income Allowance (CSMIA) and is calculated during the ALTCS customer's "share of cost" determination. Because the CSMIA calculation is based on standards, the spouse living in the institution may not have enough income available to pay the full CSMIA amount calculated. So, while the amount of allocated income is never more than the calculated CSMIA, it may be less.

Since the allocated income is not court ordered, this income is treated as a gift to the spouse living at home following the policy at MA606AA.

NOTE Allocated income is only considered as income to the spouse at home when the ALTCS customer gives the income to the spouse.

When the ALTCS customer is giving the allocated amount to the spouse, it is treated as income to the spouse as shown in the table below:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income.
• FTW • ALTCS FTW	Unearned income: • Not counted for income eligibility • Not counted for FTW premiums • Counted for ALTCS FTW Share of Cost
• Adult • Caretaker Relative • Pregnant Woman • Child	Excluded.

• KidsCare	

See Allocated Income Calculation Examples for more information.

Definitions

Term	Definition
Allocated Income	An amount of an ALTCS customer's income that is set aside specifically or "allocated" for a spouse living at home.
Share of cost	An amount of an ALTCS customer's income that the customer must pay toward the cost of long term care services.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- ALTCS form; or
- Collateral contact with the Benefits and Eligibility Specialist.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS	42 USC 1382a(a)
SSI-MAO	42 USC 1396r-5(d)
Medicare Savings Program	20 CFR 416.1102, 1120 and 1123

Freedom to Work	R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	26 USC 71 26 CFR 1.61-10 42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

I AmeriCorps Network Program

Policy

All AmeriCorps Network Program payments are excluded for:

- ALTCS;
- SSI-MAO
- MSP

For the MAGI programs, see the table below for how each type is treated:

If the payment is for…	Then the payment is...
Stipend or living allowance	Counted as earned income
Educational award	Amounts used for education expenses are excluded. Amounts used for living expenses are counted earned income.
Food or shelter	Excluded.
Clothing allowance	

Definitions

Term	Definition
AmeriCorps Network Programs	The program includes, but is not limited to: • Arizona Conservation Corps;

	• Arizona Council of Centers for Children and Adolescents (ACCCA); • Border Volunteer Corps (BVC); • Mesa AmeriCorps Community Services Partnership; • Rural Health Office, University of Arizona; and • Youth in Action, Learn and Serve (NAU). NOTE AmeriCorps and AmeriCorps-VISTA are different programs. See MA606.TTT for AmeriCorps-VISTA.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copies of check stubs showing the income source;
- Document from the agency providing the income; or
- Collateral contact from the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(b)(25) 20 CFR 416.1124(c)(23) 20 CFR 416.1112(c)(10) AAC R9-22-1909
Adult	42 CFR 435.603

Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 457.10, 300, 301 and 315

J Annuity Payments

Revised 03/04/2025

Policy

How annuity payments are counted depends on whether the annuity is revocable or irrevocable; and the MA program.

If the annuity is...	And the program is...	Then...
Revocable	All programs	For interest earned on the annuity see MA606KK - Interest and Dividends. For withdrawals from the principal, the payment is not counted as income. It is the conversion of a resource.
Irrevocable	• ALTCS • SSI-MAO • MSP	The full amount of the annuity payment is counted as unearned income.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	The taxable part of the payment is counted as unearned income. Any part of the payment that is not taxable is not counted.

See Special Treatment Trusts and ALTCS Eligibility for instructions on how to count annuities that are irrevocably assigned to a Pooled or Disabled Under 65 Special Treatment Trust.

Definitions

Term	Definition
Annuity Payments	Fixed payments received for a person's lifetime or a specified number of years from the investment of a person's income or resources. There are two general categories of annuity income: • Payments received according to a contract purchased from a life insurance or other investment company. • Payments based on past employment. This includes pensions or retirement benefits. They may be based on the individual's age, years of service or disability.
Revocable annuity	The contract can be surrendered and the funds in the account withdrawn. Also called a "deferred" annuity.
Irrevocable annuity	The annuity has been converted from a resource to a stream of income and cannot be cashed in. Also called an "immediate" annuity.

Proof

Proof of the annuity's revocability, payments and the taxable amount of the payment includes:

- Copies of check stubs;
- Letter from company providing the income;
- Year-end tax statements;
- Copy of annuity contract;
- Collateral contact with the company providing the income; or
- Copies of court documents for Court Settled Irrevocable Annuities.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1396p(c)(1)(G) 42 USC 1382a(a)(2)(B) ARS 36-2934.02 20 CFR § 416.1121(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

K Austrian Social Insurance

Policy

Payments to people who were imprisoned, unemployed, or forced to flee Austria during the period from March 1933 to May 1945 for political, ethnic, or religious reasons.

The treatment of Austrian Social Insurance payments depends on the basis of the payment.

If the payment is...	Then the treatment is...
Based in whole or in part on wage credits granted under paragraphs 500-506 of the Austrian General Social Insurance Act.	Excluded.
Not based in whole or in part on wage credits under paragraphs 500-506	Counted as unearned income.

Definitions

Term	Definition
Austrian Social Insurance	Pension payments made by various Austrian pension insurance agencies.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- A copy of the award letter; and
- The individual's declaration regarding the basis for the payment.

If the payment is excluded, the award letter will include the following language:

DIE BEGUENSTIGUNGSVORSCHRIFTEN FUER GESCHAEDIGTE AUS POLITISCHEN ODER RELIGIOESEN GRUENDEN ODER AUS GRUENDEN DER ABSTAMMUNG WURDEN ANGEWENDET (§ 500ff ASVG).

TRANSLATION: "The regulations which give preferential treatment for persons who suffered because of political or religious reasons or reasons of origin were applied (§ 500ff ASVG)."

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416. 1124(b) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	Pub. L. 107-16, Section 803 42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

L Black Lung Benefits

Policy

How Black Lung benefits are treated depends on the following:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income. NOTE The full amount of the payment, including any amounts added for dependents is counted as income to the beneficiary.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
Black Lung Benefits	Payments made under the Federal Coal Mine Health and Safety Act of 1969, to coal miners who are totally disabled due to pneumoconiosis. Survivor's benefits may be paid to certain family members of the miner.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copies of check stubs;
- Award letter from the Social Security Administration (SSA); or
- Collateral contact with SSA.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1121(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

M Bureau of Indian Affairs (BIA) General Assistance

Policy

How BIA General Assistance is treated depends on the following:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income. NOTE This is a needs-based payment.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
BIA General Assistance Payments	Federally-funded general assistance payments based on need that are paid to eligible Native Americans by the BIA.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Check stubs;
- Letter from BIA; or
- Collateral contact with BIA.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program (MSP)	20 CFR 416.1124(c)(2)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

N Census Income

Revised 02/05/2021

Policy

The treatment of census income depends on whether the person is:

- An employee of the Census Bureau; or
- A temporary census taker.

If the person is...	And the program is...	Then the treatment is...
An employee of the Census Bureau	All programs	Counted as earned income
A temporary census worker	ALTCS SSI-MAO MSP FTW	Excluded.
	Adult Caretaker Relative Pregnant Woman Child KidsCare	Counted as earned income.

Definitions

Term	Definition
Census worker	A person employed to assist the U.S. Census Bureau with collecting data during the census.

Census	The U.S. Census Bureau gathers and analyzes data on the U.S. population every ten years.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Pay stubs;
- Notification of Personnel Action (SF-50) from the employer;
- Written statement from the employer; or
- Collateral contact with the employer.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 CFR 416.1121 and 1124 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	45 CFR 435.603 42 CFR 457.10, 300, 301 and 315

O Child Support

Policy

Voluntary or court ordered payments made by a parent for the support of a child. Child support income is treated as follows:

Programs	Treatment
• ALTCS • SSI-MAO • MSP	Counted as unearned income
• Caretaker Relative • Child • Pregnant Woman • Adult • KidsCare	Excluded

Child support may be received:

- Directly from the absent parent;
- Through the court;
- Through a private collection agency; or
- From the Division of Child Support Services.

For the ALTCS, SSI-MAO and MSP programs, how child support is counted depends on the age of the child and who gets the payment. See the table below:

If the child is...	AND the child support is...	Then the treatment is...

Under age 18; or Age 18 and still in high school	Received by the child; or Received by a parent or responsible adult living with the child	Counted as the child's income.
	Received by a parent or responsible adult who is not living with the child; and Is not giving the payment to the child	Counted as income for the person who is getting the payments.
Age 18 or older	Back payments (arrearages) that are not given to the adult child	Counted as income for the person who is getting the payments.
	Back payments that are given to the adult child	Counted as the adult child's income.

When a single support payment is made for more than one child, count the amount listed in the court documents for each child. If there is no court document or the document does not list an amount per child, the payment is divided equally for all the children for whom it is intended.

> NOTE Private collection agencies may keep a percentage of the income as a collection fee. Count the entire gross amount. Do not deduct the amount that is kept by the collection agency

Definitions

Term	Definition
Arrearages	Also known as back payments. These are late payments for child support that was not paid in the month that it was owed.

Division of Child Support Services (DCSS)	Division of the Department of Economic Security responsible for getting support orders in place and enforcing those orders.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Court documents (If child support is court ordered there is usually also an order for health insurance coverage);
- Division of Child Support Services (DCSS) documents;
- Signed statement from the absent parent;
- Phone call with DCSS; or

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(E) 20 CFR 416.1121(b)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

P Clinical Trial Compensation

Revised 01/07/2016

Policy

Clinical Trial Compensation is payment received for taking part in a clinical trial researching and testing treatment of rare diseases or conditions that meets all of the following:

- Has been reviewed and approved by an Institutional Review Boards (IRB);
- It involves research and testing of medical treatments; and
- It targets a rare disease or condition.

Clinical trial compensation is treated as follows:

If the MA Program is...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	The first $2,000 paid during a calendar year is excluded.
All other MA programs	Counted as unearned income.

NOTE Reimbursements for costs related to the clinical trial are not considered Clinical Trial Compensation. They are treated like any other reimbursement (MA606.YY)

Definitions

Term	Definition
Clinical Trial Compensation	Income received for participation in a clinical trial researching and testing treatment of rare diseases or conditions as defined in Section 5(b)(2) of the “Orphan Drug Act”.

Institutional Review Boards (IRB)	An IRB is a committee of persons responsible for ensuring that a clinical trial is ethical and protects the participants.
Rare disease or condition	Generally refers to any disease or condition that affects less than 200,000 people in the United States.

Proof

Proof that the income meets the requirements to exclude the first $2,000 includes:

- The “informed consent form” from the clinical trial, which provides most of the information needed to determine whether the income exclusion applies.
- An official letter from the administrator of the clinical trial that provides all the relevant information of the informed consent in a summarized format.

Proof of the income amount and frequency of payment includes:

- Check stubs;
- Payment receipts;
- Informed consent form; and
- Other documents from the clinical trial administrator.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b)(26) AAC R9-22-1909

Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Q Corporation

Revised 10/24/2014

Policy

How income received from a corporation is counted depends how it is paid. The corporation may withhold taxes from the payments, the payments may be self-employment (no taxes withheld), or the payments may be interest or dividends.

> NOTE A Limited Liability Company (LLC) may be self-employment or a corporation. If the LLC elected to be classified as a corporation by filing an Entity Classification Election, IRS Form 8832, it is a corporation. If the LLC has not filed an IRS Form 8832, it is a self-employment (see MA606CCC)

See the table below for details on how each kind of corporation income is counted:

If...	Then the income is...
Taxes are withheld from the payments	Wages (see MA606.VVV)
Taxes are not withheld from the payments	Self-Employment (see MA606.CCC)
The payments are dividends	Interest and Dividends (see MA606.KK)

> NOTE S Corporations are required to report each person's share of profits on their tax forms (Schedule E) even if the corporation did not give the money to the person. Only the income actually received is counted.

Definitions

Term	Definition
Corporation	A corporation is a legally registered group of people that own a business. A corporation is considered a separate entity from its owners.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Income tax documents;
- Copy of check stubs;
- Written statement from treasurer of corporation; or
- Collateral contact with treasurer of corporation.

The Arizona Corporation Commission maintains a list of all corporations that have filed documents with the commission. This list is published on the State of Arizona Public Access System (STARPAS) website at: https://azcc.gov/

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(26) 20 CFR 416.1102, 1110(a) and 1121(c) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

R Crime Victim Payments

Policy

Crime victim payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Crime Victim Payments	Payments received from a fund established by a State to aid victims of crime.

Proof

Because this income is excluded, the only proof needed is that the income came from a State-established fund to aid victims of crime.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b)(17) 20 CFR 416.1124(c)(17) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Child KidsCare	

S Disability Insurance Payments

Revised 03/03/2014

Policy

How the disability insurance payments are treated depends on the following:

If the program is...	Then...
ALTCS SSI-MAO MSP	The payments are counted as unearned income. NOTE If the insurance payment is reduced because the person has other disability benefits like Social Security Disability or Worker's Compensation, count only the reduced amount. See Example of reduced disability insurance amount
Adult Caretaker Relative Pregnant Woman Child KidsCare	All or part of the payments may be counted depending on who paid the premium for the policy: • If the employee paid any part of the premium with after-tax income, the same percentage of the disability insurance payment is excluded. For example, if the person paid half of the premium with after-tax income, then half of the payment is excluded. • If any part of the premium was paid with pre-tax income OR was paid by the employer, the same percentage of the disability insurance payment is counted. See Taxable Disability Insurance Example

Definitions

Term	Definition
Disability Insurance Payments	Payments from group or individual insurance policies to help pay the living expenses of a person who becomes disabled. Group disability insurance through employers is the most common type. Short-term disability coverage provides benefits for a specified length of time. Long-term disability coverage may provide benefits up to age 65, or normal retirement age.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Letter from the agency providing the benefit;
- Copies of check stubs; or
- Collateral contact with the company providing the payment.

NOTE If counting the full benefit amount does not impact eligibility, specific proof of the taxable portion is not needed.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(B) 20 CFR 416.1121(b) AAC R9-22-1909
Adult Caretaker Relative	26 USC 104 42 CFR 435.603

Pregnant Woman Child KidsCare	42 CFR 457.10, 300, 301 and 315

T Disaster Assistance

Policy

Disaster assistance provided to victims of a presidentially declared disaster is excluded for all MA programs.

Exception:

For MAGI groups, disaster assistance payments for unemployment assistance or to replace loss of income are counted as unearned income.

Federal programs and agencies, joint Federal and State programs, State or local government programs, or private organizations may provide these payments.

Definitions

Term	Definition
Disaster Assistance Payments	Payments provided to victims of natural disasters through the Federal Disaster Relief Act or similar state or local assistance programs.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Letter from the agency providing the benefit;
- Copies of check stubs; or
- Collateral contact with the agency providing the information.

Presidential declarations of disaster are public information and can be verified by newspapers, television, radio announcements or the Federal Register.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(b)(11) 20 CFR 416.1124(c)(5) 20 CFR 416.1150 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	26 USC 139 42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

U Educational Assistance

Revised 12/30/2019

Policy

How Educational Assistance is treated depends on the following:

If the payment is...	And the customer is eligible for...	Then the treatment is...
Financial assistance, including work study, received under Title IV of the Higher Education Act of 1965	Any program	Excluded.
Educational Assistance, including work study, received under BIA student assistance programs.	Any program	Excluded.
Empowerment Scholarship Agreement received from the AZ Department of Education	Any program	Excluded.
For any other type of educational award or gift	Any program	Excluded when used for educational expenses. Counted as unearned income when used for living expenses.
Veteran's Administration (VA) Educational Benefits	• ALTCS • SSI-MAO • MSP	Excluded if paid under a program for vocational rehabilitation. If not part of vocational rehabilitation, counted after deducting educational expenses.
	• Adult	Excluded.

	• Caretaker Relative • Pregnant Woman • Child, or • KidsCare	
State funded student loans and other loans	Any program	Excluded.
Work study that is not paid under Title IV or a BIA program.	Any program	Counted as earned income.

Definitions

Term	Definition
Educational expenses	Includes tuition, books, lab fees and other required expenses to enroll in a course.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Request for Verification of Student Information (DE-209) form;
- Award letter;
- Empowerment Scholarship Agreement
- Loan documentation;
- Written statement from the school; or
- Collateral contact with the school.

Types of proof for education gifts include, but are not limited to:

- Written statement from the person or entity providing the educational gift; and
- Collateral contact with the person or entity providing the educational gift.

Expenses must be verified to deduct the expense from the income. Proof of expenses is only needed if the educational income is countable. Types of proof include, but are not limited to:

- Request for Verification of Student Information (DE-209) form;
- Receipts;
- Written statement from the school; or
- Collateral contact with the school.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(b)(7) 20 CFR 416.1124(c)(3) 20 CFR, Appendix to Subpart K of Part 416, Section III AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603(e) 42 CFR 457.10, 300, 301 and 315

V Emergency Assistance

Policy

How emergency assistance payments are treated depends on the following:

- The AHCCCS Medical Assistance program; and
- Whether the payment can be used for food or shelter or if the payment is specifically designated for a medical service or a social service.

If the emergency assistance payment is...	And the program is...	Then the treatment is...
Issued to the budget group member to pay for food or shelter	• ALTCS • SSI-MAO • MSP	Counted as unearned income.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.
Issued as a vendor payment on behalf of the budget group member	All programs	Excluded.
Specifically designated for a medical service or a social service		

Definitions

Term	Definition
Emergency Assistance	Emergency assistance is state-funded or tribal assistance to alleviate or prevent homelessness.
Vendor Payment	Money payments made on behalf of the household to another by a third party.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Award letters or other proof of payment;
- Statement from the agency making the payment; or
- Collateral contact with the source of the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(2) 20 CFR 416.1102, 1120 and 1123 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.603(d) 42 CFR 457.10, 300, 301 and 315

KidsCare	

W Energy Assistance

Policy

How the Energy Assistance payments are treated depends on the following:

If the assistance is ...	Then the treatment is...
Provided under LIHEAP	Excluded for all programs.
Not provided under LIHEAP	Excluded for all programs. (If it is certified by the appropriate state agency to be based on need and provided in kind by a private non-profit organization, or a supplier of home heating oil or gas or a municipal utility.)

Definitions

Term	Definition
Low-Income Energy Assistance Program (LIHEAP)	Federal energy assistance to low income families. It may be provided by a variety of agencies and known by a variety of names. Payment is usually provided in the form of a voucher or a direct payment to the vendor.

Proof

Because this income is excluded, only the source of the income is verified.

The type of verification required for energy assistance depends on whether the assistance is received as in-kind or in cash payment:

If energy assistance is received as...	Then proof is...

In-kind	The customer's statement
Cash payment	• Letter from the agency providing the income; • Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	**Legal Authorities**
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(b)(13) 20 CFR 416.1103(i) 20 CFR 416.1157(c) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

X Federal Housing Assistance

Policy

Federal housing assistance payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Federal Housing Assistance	Payments from the Office of Housing and Development (HUD) or Farmer's Home Administration (FMHA). Forms of federal housing assistance include: • Section 8 and other public housing; • Cash towards utilities; • Loans for renovations; • Guaranteed loans or mortgages.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Copy of HUD or FMHA contract, whichever is applicable; or
- Collateral contact with the source of the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b)(14) 20 CFR 416.1124(c)(14) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Y Foster Care and Guardianship Subsidy Payments

Revised 10/12/2021

Policy

How foster care and guardianship subsidy payments are treated depends on the following:

If payment is under...	And the program is...	Then the treatment is...
Title IV-E Foster Assistance	ALTCS	• The customer is categorically eligible (MA502); and • The income is counted as unearned income to the customer for the ALTCS Share of Cost (MA1201B). Exception: Any part of the payment intended for the foster care provider as an incentive or service payment, and not to support the child, is counted to the foster care provider.
	• SSI-MAO • MSP	Since the customer automatically gets AHCCCS Medical Assistance (MA414), this income is only counted as unearned income to the customer when determining the Child Allocation amount: • For SSI-MAO (MA611A); and • For MSP (MA612). Exception: Any part of the payment intended for the foster care provider as an incentive or service payment, and not to support the child, is counted to the foster care provider.

	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.
Title IV-E Independent Living Initiatives payments from the Transitional Youth or Adult Living Programs.	All programs	Excluded.
Title IV-B or Title XX Foster Assistance	All programs	Excluded.
State Funded Foster Assistance	All programs	Excluded.
Guardianship Subsidy Payments	• ALTCS • SSI-MAO • MSP	Counted as unearned income to the person in care.

	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.
Grandparent Kinship Payments	All programs	Both the one-time payment of up to $300 and the monthly payment of $75 are excluded.

Definitions

Term	Definition
Foster Care Payments	A payment made to a foster care provider for the purpose of meeting the needs of the person in care.
Grandparent Kinship Payments	Payments to a grandparent responsible for raising grandchild(ren) in the grandparent's home. There are two types of payments available: • A one-time payment of up to $300 per child to help cover the cost of additional furniture and other expenses related to moving the child into the home; and • A clothing and personal allowance of $75 per month per child.

Guardianship Subsidy Payments	Subsidy payments provided by the Arizona Department of Child Safety (DCS) for children who are placed in the care of a Legal Permanent Guardian.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Check stubs;
- Written statement from the agency providing the money; or
- Collateral contact with the agency providing the money.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1102 and 1123 20 CFR 416.1124(c)(8) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Effective until 2025-04-25

Z German Reparation Payments

Policy

German Reparation Payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
German Reparation Payments	Payments made to certain survivors of the Holocaust by the German Government.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Award letter;
- Copy of check stub; or
- Collateral contact with the agency providing the income; or
- By contacting the German embassy in Los Angeles at:

The Consulate General of the Federal Republic of Germany

6222 Wilshire Blvd. Suite 500

Los Angeles, CA 90048

Tel: (323) 930-2703

Fax: (323) 930-2805

Legal Authority

This requirement applies to the following programs:

Effective until 2025-04-25

Program	Legal Authorities
All Programs	Public Law 103.286 Title 20 of the CFR, Appendix to Subpart K of Part 416, Section V(g)

AA Gifts and Contributions

Revised 06/29/2021

Policy

Money received as a gift or as a contribution from a person or agency may be counted depending on MA program and the reason for the gift or contribution. Money from crowdfunding is considered a gift or contribution (see Crowdfunding for examples).

How cash gifts and contributions are treated depends on the following:

If the money is...	And the program is...	Then the income is...
A gift, and not intended for the person's education expenses.	• ALTCS • SSI-MAO • MSP	Counted as unearned income.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.
Received as a result of another person's death	All programs	An inheritance. See MA606.HH for how it is counted.
A gift intended to pay for the person's education expenses	All programs	Educational assistance. See MA606.U for how it is counted.
A contribution from an agency to cover living expenses like food, shelter and personal items	• ALTCS • SSI-MAO • MSP	Counted as unearned income.

	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.
Received as a result of panhandling or begging	All programs	Counted as unearned income

Definitions

Term	Definition
Gift	Something a person receives which: • Is not payment for goods and services provided by the person; and • Is not paid because of a debt owed to the person.
Contributions	Contributions are money received to cover expenses such as: • Food; • Rent or mortgage payments; • Utilities; • Household; • Public transportation; • Clothing; and • Personal care items like soap and toothpaste.
Panhandling	When a person stays in a public place and asks for free money from others including:

	• Begging • Asking for money using signs

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Written statement from the individual or agency providing the money;
- Telephone contact with the person or agency providing the money.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b)(22) 20 CFR 416.1121(g)
Adult Caretaker Relative Pregnant Woman Child KidsCare	26 USC 102 26 CFR 1.102-1 42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

BB Hemophiliacs Infected with HIV

Policy

Payments to persons with hemophilia who were infected with HIV are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Payments for Persons with Hemophilia Infected with HIV	Payments for persons with hemophilia who were infected with HIV are: • Payments from any fund established by manufacturers of blood plasma pursuant to a class settlement in the case Susan Walker vs. Bayer Corporation; or • Payments made pursuant to a release of all claims in case entered into in lieu of the class settlement. The release must be signed on or before the later of 12/31/1997 or 270 days after the release is first sent to the person to whom payment is to be made.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Court document; or
- Copy of check stub.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	P.L. 105-369 20 CFR 416.1124(b) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 USC 435.603 42 CFR 457.10, 300, 301 and 315 AAC R9-22-1420(C)(18) (2013)

CC Income Tax Refunds

Revised 10/12/2021

Policy

Federal income tax refunds are excluded for all Medical Assistance (MA) programs. Most state income tax refunds are also excluded for all MA programs.

Exception:

For MAGI programs, a state income tax refund is counted as unearned income when both of the following are met:

- The person itemized deductions on their federal tax return; and
- Claimed a deduction for state and local income taxes paid, instead of claiming state and local sales tax paid.

Advance refundable tax credits are considered tax refunds and are excluded for all MA programs.

Definitions

Term	Definition
Advance refundable tax credit	A tax credit that is both: • Paid by a tax agency to the customer before the customer files taxes to claim it; and • Not limited by the customer's income tax liability.
Income Tax Refunds	Any money paid to a customer in the form of a refund of taxes paid.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Federal income tax return; or
- Bank statements that clearly identify the deposit.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b)(19) 20 CFR 416.1103(d)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315 AAC R9-22-1420(C)(15) (2013)

DD Indian Gaming Profit Distribution

Revised 04/26/2022

Policy

Indian gaming profit distributions are counted as unearned income for all Medical Assistance programs.

As the amount of these payments may vary, the most recent payment amount is used to anticipate the next payment amount. See Indian Gaming Payment Example for more information.

Definitions

Term	Definition
Indian Gaming Profit Distributions	Money distributed by the tribe to its individual members based on revenue produced by Indian gaming within the bounds of a tribal nation.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Check stubs;
- Written statement from the Tribe; or
- Collateral contact with the Tribe.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	P. L. 98-64 20 CFR 416.1102, 1120 and 1127 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

EE Indian Payments Excluded Under Public Law

Policy

Certain payments and income of American Indians and Alaska Natives are not counted when determining eligibility for Medical Assistance programs.

1) Excluded payments

Payments made to American Indian Tribes or groups under Public Laws. See the Definitions section of this policy for a list of these payments.

2) Excluded income

Income derived from resources and usage rights that are excluded under federal law, including:

- Indian Land Lease or Royalty Payments
- Income earned from the sale of products gathered or harvested under federally protected rights or from land held in trust by the Tribe or Secretary of the Interior.
- Income earned from the lease or use of resources that have unique religious, spiritual, traditional, or cultural significance, or the sale of products gathered from the resource.
- Income earned from rights that support subsistence or a traditional lifestyle according to tribal law or custom.

See Indian Income from Protected Rights and Resources for examples of these income types.

If the payment is for...	And the program is...	Then the treatment is...
Land held in trust by a Tribe or under supervision of the Secretary of the Interior	All programs	Excluded.
Land held by the person	• ALTCS • SSI-MAO • MSP • AHCCCS FTW	Counted as unearned income.

	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
Payments made to American Indian Tribes or groups under Public Laws	Payments made to tribes throughout the United States under a variety of Public Laws. These payments include: • Settlement Fund payments to members of the Hopi and Navajo Tribes under Section 22 of Public Law 93-531 as amended by Public Law 96-305 (effective December 22, 1964). • Judgment funds to members of the San Carlos Apache Indian Tribe of Arizona under Section 6 of Public Law 96 – 134 and Public Law 96 – 95 (effective December 16, 1981). • Per capita distributions of judgment funds to members of the Tohono O'odham (Papago) Tribe of Arizona under Sections 6 and 8(d) of Public Law 96 – 408 (effective January 3, 1983). • Settlement Fund payments under the Claims Resettlement Act of 2010, Public Law 111-291 (effective December 7, 2009) • Settlement Fund payments under Elouise Cobell et al. v. Ken Salazar et al., United States District Court, District of Columbia, Civil Action No. 96-1285

Indian Land Lease or Royalty Payments	Payments for the lease of land held in trust by the Secretary of the Interior. Some individuals own or are allotted part of the trust lands that they may lease to others for use or to harvest or extract natural resources. Sources of these leases or royalty payments include but are not limited to: • Grazing rights; • Fishing rights; • Mineral rights; • Oil rights; • Timber rights; and • Water rights.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Contracts or government documents that show the source of the income is trust land or a federally protected usage rights;
- Letter from the Tribe; or
- Collateral contact with the Tribe.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	20 CFR, Appendix to Subpart K of Part 416, Section IV 20 CFR 416.1124(b)

	Public Law 103-66 Public Law 111-5, Section 5006

FF Individual Development Account (IDA)

Policy

How Individual Development Account (IDA) funds are treated depends on the following:

If the funds are...	And the program is...	Then the treatment is...
Interest earned by the IDA	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Only the interest earned on the income contributed by the IDA owner is counted as unearned income. Interest earned on the matching funds is excluded.
	• ALTCS • SSI-MAO • MSP • FTW	Excluded
Matching funds deposited to the IDA by the sponsor	All programs	Excluded
Disbursements from the IDA	All programs	Excluded
Earnings the person contributes to an IDA	All programs	Excluded.

Definitions

Term	Definition

Individual Development Account (IDA)	IDAs are special savings accounts that match the deposits of low income people. IDAs are offered through partnerships between financial institutions such as banks and credit unions, and local nonprofit organizations or program sponsors. There are two types of IDAs: • TANF IDA; and • Demonstration Project IDA.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Written statement from the sponsor;
- Collateral contact with the sponsor; or
- Statement from the financial institution.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program (MSP) Freedom to Work (FTW)	Title 20 of the CFR, Appendix to Subpart K of Part 416, Section V(i)
Adult Caretaker Relative	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Pregnant Woman Child KidsCare	

GG Industrial (Worker's) Compensation

Policy

The treatment of Industrial (Worker's) Compensation depends on the program:

If the program is...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded. Exception: If person also gets social security or railroad requirement benefits and those benefits are reduced because of the Industrial Compensation payment, the amount of the reduction is countable.

Definitions

Term	Definition
Industrial (Worker's) Compensation	Compensation paid by the Arizona Industrial Commission or similar agencies in other states to workers who are injured on the job. Industrial Compensation also may be called "Worker's Compensation".

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Written statement from the Industrial Commission;
- Payment check stubs;
- Copy of award letter; or
- Collateral contact with the Industrial Commission.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program (MSP)	42 USC 1382a(a)(2)(B) 20 CFR 416.1121(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

HH Inheritances

Revised 07/05/2022

Policy

The treatment of an inheritance depends on what the inheritance is used for:

If the inheritance is...	And the program is...	Then the treatment is...
Cash	• ALTCS • SSI-MAO • MSP	Counted as unearned income. Exception: Any part of the inheritance that will be used to pay for the deceased person's burial expenses and outstanding debts is excluded.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
Inheritance	Inheritance is cash, a right, or a non-cash item bequeathed to a person as a result of someone's death.

Proof

To verify...	Proof includes...
Amount of inheritance	• Written statement from the executor of the estate; • Collateral contact with the executor of the estate; or • Copy of the check; • A court order closing the estate; • A copy of the will; or
Burial expenses and outstanding debts	• Bills; • Receipts; or • Collateral contact with the service provider or billing agency.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(D) 20 CFR 416.1121(e) 20 CFR 416.1121(g) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Child KidsCare	

II In-Kind Income and In-Kind Support-Maintenance

Policy

How in-kind income and support-maintenance are treated depends on the following:

If...	And the program is...	Then the treatment is...
In-kind income (bartering income)	• ALTCS • SSI-MAO • MSP • FTW	Excluded.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Counted as earned income. NOTE The value of the item or service received is the counted income amount.
In-kind Support and Maintenance (ISM)	All programs	Excluded.

Definitions

Term	Definition
In-kind income	Any non-cash item including food, clothing, or shelter provided in return for labor or services rendered. This is also called bartering income. Example: A plumber does repair work for a dentist in exchange for dental services.

In-kind Support and Maintenance (ISM)	Food, clothing or shelter received by an individual that was paid or partially paid by someone else.

Proof

For ISM, the person's statement can be used for proof unless it is questionable. For In-kind income, types of proof include:

- Written statement on a from the person or source providing item or service the in-kind income;
- Receipts showing the value of the item;
- Collateral contact with source providing the in-kind income or ISM.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(2)(E) 20 CFR 416.1121(g) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Effective until 2025-04-25

JJ Insurance Awards/Legal Settlements

Policy

How insurance awards and legal settlements are treated depends on the following:

If the payment is...	And the program is...	Then the treatment is...
To replace or repair property.	All programs	Excluded up to the value of the property or damages.
Reimburse costs the person paid that were the responsibility of the insurance company.	All programs	Excluded.
Compensate the person for medical or medical-related costs related to physical illness or injury	All programs	Excluded.
For any other reason	• ALTCS • SSI-MAO • MSP	Counted as unearned income. <u>Exception:</u> Legal fees deducted from the gross award before it is paid to the person are excluded.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Counted as unearned income.

Definitions

Term	Definition
Insurance Awards and Legal Settlements	Payments for financial loss, pain and suffering, loss or earning ability or for many other reasons. Payment may be received in a lump sum, periodic payments or both.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Written statement from the insurance company;
- Copy of award letter;
- Court documents; or
- Collateral contact with the insurance company.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(C) 20 CFR 416.1121(f) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Child KidsCare	

KK Interest and Dividends

Policy

How interest and dividend payments are treated depends on the following:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Excluded.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Counted as unearned income. Exceptions: • Interest and dividend income from tax-exempt municipal and federal bonds are not counted. • Interest on matching funds in an IDA account are not counted (MA606.FF).

Definitions

Term	Definition
Interest and Dividends	Interest and dividends are returns on capital investments such as promissory notes, loans, property agreements, burial accounts, stocks, bonds, savings accounts or checking accounts.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Tax reporting forms and related schedules;
- Account statements; or
- Written statement from the financial institution.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(F) 42 USC 1382a(b)(23) 20 CFR 416.1121(c)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

LL Japanese-American Restitution Payments (Japanese Reparation Payments)

Policy

Japanese-American Restitution Payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Japanese-American Restitution payments	Payments paid by the United States Government to citizens because of the evacuation, relocation, or internment of such individuals during World War II solely on the basis of Japanese ancestry and resident Japanese aliens under the “Wartime Relocation of Civilians”.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Letter from a U.S. Department of Justice;
- Collateral contact with the U.S. Department of Justice.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO	Title 20 of the CFR, Appendix to Subpart K of Part 416, Section V(c)

Medicare Savings Program	20 CFR 416.1124(b) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

MM Job Opportunities and Basic Skills Training

Policy

How Job Opportunities and Basic Skills Training payments are treated depends on the following:

If the payment is for...	Then the treatment is...
Wages	Counted as earned income for all programs.
Reimbursement for job training related expenses	Excluded for all programs, up to the amount of the expense.

Definitions

Term	Definition
Job Opportunities and Basic Skills Training	A group of programs designed to help participants rejoin the workforce. The programs are: • On-the-Job Training; • Work Supplementation; and • Community Work Experience (CWEP).

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of paystub;
- DE-206 Request for Verification of Employment form;
- Written statement from employer; or

- Collateral contact with employer.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(1)(A) 20 CFR 416.1103(b) 20 CFR 416.1110(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

NN Jury Duty

Policy

How Jury Duty payments are treated depends on the following:

If the payment is for...	Then the treatment is...
Compensation for services	Counted as earned income. Exception: If the person must give this payment to his or her employer, the payment is not counted.
Reimbursement for mileage	Excluded up to the amount of the expense.

Definitions

Term	Definition
Jury Duty Compensation	Income received from the court for serving on a jury.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

If the payment is...	Then the types of proof include, but are not limited to...

Compensation	• Copy of check stub; or • Document from the court.
Reimbursement	Income: • Copy of check stub; or • Document from the court. Expenses: • Receipts/bills for gasoline; • Receipts/bills for public transportation; or • Receipts/bills for taxi service. NOTE If the reimbursement payment is $10.00 or less, assume that the payment does not exceed the expense. The expense does not need to be verified.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 CFR 416.1102 and 1110(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Child KidsCare	

OO Life Insurance Proceeds and Death Benefits

Policy

How life insurance proceeds and death benefits are treated depends on the following:

If...	And the program is...	Then the treatment is...
Cash surrender paid to owner	All programs	Excluded, as it is a conversion of a resource, not income.
Accelerated life insurance payments paid to insured	• ALTCS • SSI-MAO • MSP	Counted as unearned income.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded. Benefits paid per diem are excluded up to the amount of actual long-term care costs or the IRS per diem rate, whichever is higher.
Death benefits or life insurance proceeds paid directly to the beneficiary	• ALTCS • SSI-MAO • MSP	Counted as unearned income. <u>Exception:</u> Any part of the inheritance that will be used to pay for the deceased person's burial expenses and outstanding debts is excluded.
	• Adult • Caretaker Relative • Pregnant Woman	Excluded.

	• Child • KidsCare	

Definitions

Term	Definition
Death Benefits	Death benefits include, but are not limited to, the following: • Lump sum death benefits from SSA; • Railroad Retirement burial benefits; • Veteran's Administration burial benefits; • Inheritances in cash or in-kind; or • Cash or in-kind gifts given by relatives, friends, or a community group to assist with expenses related to the death.
Accelerated Life Insurance Payments	Also known as accelerated death benefits or living needs benefits, are the early payment of some or most of the proceeds to the insured during his lifetime. This occurs mainly when the insured is terminally ill or permanently confined to a nursing home.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

To Verify...	By...
Amount of Death benefit	• Written statement from the insurance company;

	• Collateral contact with the insurance company; or • Copy of check.
Last illness, Burial Expenses, and Outstanding Debts	• Bills; • Receipts; or • Collateral contact with the service provider or billing agency

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(D) and (E) 20 CFR 416.1121(e)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

PP Loan Agreements

Policy

How loan agreement payments are treated depends on the following:

If the customer...	And the program is...	Then the treatment is...
Borrows money (includes purchases made on credit)	All programs	Excluded.
Payments received from a reverse mortgage	All programs	Excluded.
Lends money and receives repayment of the loan	• ALTCS • SSI-MAO • MSP	Excluded.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	The part of payment toward the principal is excluded. Interest paid on the loan is counted as unearned income.

Definitions

Term	Definition
Reverse mortgage	A special type of agreement that allows a home owner, age 62 or older, to borrow against the value of the equity of his or her home.

	NOTE All payments received from a reverse mortgage represent the conversion of a resource from equity in home property to cash and are not considered income.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of loan agreement; or
- Written statement of both the borrower and lender.

The proof must include:

- The date the loan was received;
- Terms of repayment;
- Amount of payments;
- Frequency of payments; and
- Names of the borrower and the lender.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(F) 42 USC 1382a(b)(23) 20 CFR 416.1121(d)
Adult Caretaker Relative	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Pregnant Woman Child KidsCare	

QQ Medical Insurance Payments

Revised 08/31/2017

Policy

How medical insurance payments are treated depends on the following:

If medical payment is...	And the program is...	Then the treatment is...
Reimbursement received from medical insurance	All programs	Excluded unless it exceeds the actual incurred expense. The excess amount is counted as unearned income.
A reimbursement for actual costs paid directly to the health care provider	All programs	Excluded as a vendor payment.
A disbursement from a Health Savings Account (HSA) or Medical Savings Account (MSA)	All programs	Not income. It is the conversion of a resource.
A flat rate insurance policy payment paid directly to the person If the payments have been assigned to someone else, see MA604.B for special handling.	• ALTCS • SSI-MAO • MSP	Counted as unearned income.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded up to the amount of actual expenses. The excess amount is counted as unearned income.

Definitions

Term	Definition
Medical Insurance Payments	Payments from Medicare or private medical insurance policies.
Reimbursement for Medical Expenses	Reimbursement received from medical insurance (Medicare and private medical insurance policies).
Flat Rate Policy	Cash from any medical insurance policy, which pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred (ex., per diem hospitalization or disability insurance, cancer or dismemberment policies or long term care policies).

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Collateral contact with payment source;
- Check stub;
- Statement from payment source; or
- Request for Verification of Long Term Care Partnership Insurance Policy (DE-243) if payments are being made from a Long Term Care Partnership Insurance Policy.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1102 and 1123 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

RR Military Allowances

Policy

How military pay is treated depends on the following:

If the military pay type is...	Then the treatment is...
Hostile fire pay	Excluded.
Free on-base housing or Housing allowance for privatized housing paid directly to the contractor	Excluded.
All other allowances and special pay, including a housing allowance paid to the person and used to pay rent for completely private off base housing	Counted as unearned income.

NOTE A full quarter's allowance may be paid to a service member living in on-base housing, then deducted in the same month. This transaction is just for accounting purposes and the person is actually receiving rent-free shelter. A quarters allowance is excluded if the allowance is paid and deducted in the same pay period.

Definitions

Term	Definition
Military Allowances	Cash benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty.

	Basic pay or base pay is based on the service member's pay grade and rank. Basic pay is treated as wages.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Letter from the service branch;
- Pay stub; or
- Collateral contact with the service branch.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(1)(A) 20 CFR 416.1121(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

SS Netherlands WUV

Policy

Netherlands WUV payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Netherlands WUV payments	Payments to victims of persecution from 1940-1945 made under the WUV (Wet Uitkering Vervlgingsslachtoffers) program.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Award letter;
- Copy of check stub; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO	Public Law 103-286 20 CFR 416.1124(b)

Medicare Savings Program	
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

TT Pension and Retirement Income

Revised 05/11/2021

Policy

How pension and retirement income is treated depends on the type of pension or retirement income. This section describes most pension and retirement income, as well as special types like Federal, Military and Railroad Retirement.

NOTE Military retirement is not the same as VA benefits based on disability or need. See MA606RRR for VA benefits.

The table below describes how pension and retirement income is counted:

If the payment is...	And the program is...	Then...
Railroad Retirement	• ALTCS • SSI-MAO • MSP	Counted as unearned income. NOTE Any part of the pension paid to an ex-spouse as community property under a divorce decree is not counted to the retiree.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	• The Tier I - Social Security Equivalent Benefit is counted in full as unearned income. • The taxable amount of any Tier 1 - Non-Social Security Equivalent Benefit, Tier II benefit, vested dual benefit and supplemental annuity is counted. Non-taxable amounts are excluded.
All other pension and retirement payments	• ALTCS • SSI-MAO	Counted as unearned income.

	• MSP	NOTE Any part of the pension paid to an ex-spouse as community property under a divorce decree is not counted to the retiree.
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	The taxable amount of the payment is counted as unearned income. Any part that is not taxable is excluded. NOTE Most employment-based pensions are fully taxable.
Cash surrender	• ALTCS • SSI-MAO • MSP	Not income. It is the conversion of a resource (MA701.3).
	• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Pre-tax contributions, employer contributions, and interest and dividend parts of the payment are counted.

If a person gets more than one retirement payment and a payment is reduced to account for other retirement income, only the reduced amount is counted.

NOTE The Railroad Retirement Board (RRB) also offers Unemployment Insurance (UI) and Sickness Insurance (SI) benefits. RRB UI is treated as Unemployment Insurance (MA606OOO). RRB SI is treated as Disability Insurance Payments (MA606S).

A pension may be increased to pay health insurance premiums. The increased amount is not counted in the total gross income when it is less than or equal to the premium paid. See Arizona State Retirement System with Health Insurance Supplement Examples for more information.

Definitions

Term	Definition
Pension and Retirement Income	Payments based on a person's past employment including age, years of service or disability.
Federal Pension	A civil service benefit (also called an annuity) paid to a retired federal government employee.
Military Retirement	Periodic payments to a former military service member based on age, length of service or disability. For persons who served in the United States military, these payments will generally be issued by the Defense Finance and Accounting service (DFAS).
Railroad Retirement Benefits	Payments made by the Railroad Retirement Board to retired and disabled railroad employees and their spouses. The payments can include any more of the following RRB types: • Tier 1 - Social Security Equivalent Benefit (SSEB); • Tier 1 - Non-Social Security Equivalent Benefit (NSSEB); • Tier II benefit; • Vested dual benefit; and • Supplemental annuity.
Taxable amount of pension or retirement payment	Generally includes: • Employer contributions; • Pre-tax contributions; and • Interest or dividends.

Proof

Proof of income:

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Letter from the payor;
- Pay stub;
- Collateral contact with the source of the payment;
- Letter from the service branch of DFAS (for military retirement);
- Award letter; or
- Written statement from the Office of Personnel Management (OPM) for federal pensions.

Proof of taxable amount:

Proof must be provided for any non-taxable part of the payment to be excluded. In addition to the sources listed above, proof of the non-taxable amount includes:

- Most current 1099-R form or other income reporting form;
- Most current tax return;
- Letter from the payor;
- Pay stub; or
- Collateral contact with the source of the payment.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(B) 20 CFR 416.1121(a)

Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

UU Prizes and Winnings

Revised 12/18/2020

Policy

The policy for how prizes and winnings are counted is covered in the following sections:

- General rules for prizes and winnings;
- Prorating prizes and winnings over more than one month (MAGI programs only); and
- Undue hardship claims for prorated prizes and winnings (MAGI programs only).

1) General Rules for Prizes and Winnings

How prizes and winnings are treated depends on the following:

If the prize or winning is...	And the program is...	Then the treatment is...
Cash (i.e., currency, checks or money orders)	All programs	Counted as unearned income. NOTE For MAGI programs, prizes and winnings of $80,000.00 or more must be prorated over more than one month; see section 2 below.
Non-cash items	• ALTCS • SSI-MAO • MSP	Excluded.
	• Adult • Caretaker Relative • Pregnant Woman • Child	Counted as unearned income. Prizes and winnings of $80,000.00 or more must be prorated over more than one month; see section 2 below.

	• KidsCare	NOTE The fair market value of the prize or winnings is the countable income amount.

2) Prorating Income for MAGI Programs

Use the chart below to determine when prizes or winnings must be prorated:

If the prize or winnings amount is...	Then the treatment is...
Less than $80,000.00	Counted as unearned income in the month received.
$80,000.00 to $89,999.99	Prorated over two months.
$90,000.00 to $99,999.99	Prorated over three months.
Over $99,999.99	Prorated over three months plus one additional month for each additional $10,000 over $90,000, up to a maximum of 120 months.

3) Undue Hardship Claims for Prorated Prizes and Winnings

A request for undue hardship will be considered when a loss of eligibility due to prorated prize income would deprive the customer of:

- Medical care to the point that the customer's life or health would be endangered; or
- Food, clothing, shelter, or other necessities of life as shown by the fact that the customer's income excluding the prorated prize income is less than or equal to 100% of the Federal Poverty Level (FPL). See MA615.2 for the 100% FPL income standard.

To qualify for an undue hardship, ALL of the following conditions must be met:

- The customer does not have the income or resources to pay for the medical care that he or she needs;
- The customer does not have any other means of obtaining the medical care that he or she needs, including other insurance, benefits, or third-party liability; and

- The customer is otherwise eligible for AHCCCS Medical Assistance when the prorated prize income is not counted.

NOTE This is an exception to the general rule that resource information is not needed for MAGI programs.

Undue hardship decisions are made on a case-by-case basis.

Definitions

Term	Definition
Prizes and winnings	Items of value provided as a result of a contest, sweepstake, lottery or gambling. The item may be provided in cash or as a non-cash item such as goods, property or services.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of the check stub;
- Prize or winnings award letter; or
- Collateral contact with the source providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(C) 20 CFR 416.1121(f)

Adult Caretaker Relative Pregnant Woman Child KidsCare	42 USC 1396a(e)(14)(K) 42 CFR 435.603 42 CFR 457.315

VV Radiation Exposure Compensation Payments

Policy

Radiation exposure compensation payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Radiation Exposure Compensation Payment	Payments made from the Radiation Exposure Compensation Trust Fund (RECTF) to persons (or their survivors) exposed to radiation from the U.S. Government's atmospheric nuclear testing and from uranium mining.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Award letter;
- Copy of check stub; or
- Collateral contact with the U.S. Government.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO	Public Law 101-42

Medicare Savings Program	Title 20 of the CFR, Appendix to Subpart K of Part 416, Section V(e) 20 CFR 416.1124(b)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

WW Rebates and Refunds

Policy

Rebate and refund payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Rebate and Refund	A return of money already paid. NOTE This is different from a dividend or interest payment which is a return on a person's investment. Also, this is different than a reimbursement which is repayment of funds.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to

- Check stub;
- Collateral contact with the source of income; or
- DE-207 Request for Verification of Unearned Income form.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1102 and 1103
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

XX Refugee Cash Payments (Refugee Assistance)

Revised 04/26/2022

Policy

Treatment of Refugee Cash Payments depends on the following:

If the program is...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income. NOTE This is a needs-based payment.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
Refugee Cash Assistance	Federally funded needs-based payments to refugees during their first 12 months in the United States.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Check stub;
- Collateral contact with the source of income; or
- DE-207 Request for Verification of Unearned Income form.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1142(a)(3)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

YY Reimbursements

Policy

Reimbursements are excluded for all programs up to the amount of the loss or expense. Any amount that is more than the loss or expense is counted as unearned income.

Definitions

Term	Definition
Reimbursement	Repayment to the person for: • Job related expenses; • Loss of personal property; or • Money spent on behalf of another person.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

If the reimbursement is for...	Then the types of proof include...
A job related expense	• Pay stubs; • Bills and receipts; • Letter from employer; • Collateral contact with employer.
Loss of personal property	• Bills and receipts; • Statement from insurance company;

	• Collateral contact with insurance company.
Money spent on behalf of another person	• Bills and receipts; • Written agreement for the reimbursement; or • Other supporting documents

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 CFR 416.1102 and 1103 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

ZZ Relocation Payments

Policy

Relocation payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Relocation payments	Payments to persons displaced by projects that acquire real property. Relocation assistance may be provided to persons displaced by: • Any Federal or federally-funded assistance project under Title II of the Uniform Relocation Assistance and Real Property Act of 1970; or • A State or local government through a state assisted or locally assisted project.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Award letter;
- Copy of check stub; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	Title 20 of the CFR, Appendix to Subpart K of Part 416, Section II(d) 20 CFR 416.1124(c)(18)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

AAA Rental Income

Policy

1) How Rental Income Is Treated

Rental income minus allowed expenses is counted for all programs.

NOTE For Non-MAGI coverage groups, rental income is categorized as earned or unearned income as follows:

If...	Then treatment is...
The person is in the business of renting properties	Counted as earned income (self-employment).
The person is not in the business of renting properties	Counted as unearned income.

2) Expenses

What expenses may be deducted depends on the program:

If the program is...	Then these expenses are deducted before counting income...
• ALTCS • SSI MAO • MSP • FTW	• Property taxes; • Interest and escrow payments on a mortgage (payments on the principle of a mortgage is not an allowed expense); • Real estate insurance; • Repairs, such as repairing a roof or fence; NOTE Capital investments like replacing a roof or installing a fence is not an allowable expense.

	• Advertising for tenants; • Landscaping or lawn maintenance; • Snow removal; • Utilities; and • Homeowner's insurance. NOTE Expenses are deducted when paid and not when incurred.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	<u>Real Estate Rental</u> • Advertising; • Ordinary and necessary auto and travel expenses related to rental activities; • Cleaning and maintenance; • Commissions; • Insurance; • Legal and other professional fees; • Mortgage and other interest related to rental income; • Repairs; • Supplies; • Taxes; • Utilities; • Depreciation expense or depletion; and • Other ordinary and necessary expenses related to rental of real estate. NOTE For people who are in the business of renting personal property such as equipment or vehicles, see self-employment MS 606.CCC.

3) Prorating Expenses

If the person rents out only a part of a property, expenses must be prorated to determine the amount that is for the rented part of the property. The following are examples of how expenses are prorated.

Scenario	Example
Multiple Residences	The customer owns a four-unit apartment building. She lives in one unit and rents the other three. Three quarters of the allowable expense are deducted from the gross rental income.
Rooms for Rent	The customer rents one bedroom out of her six-bedroom house. One-sixth of the allowable expenses are deducted from the gross rental income.
Acreage	The customer rents one acre of the five acres of land she owns. One-fifth of the allowable expenses may be deducted from the gross rental income.

Definitions

Term	Definition
Net Rental Income	Gross rent less the ordinary and necessary expense paid in the same taxable year.
Ordinary and Necessary Expenses	Expenses necessary for the production or collection of rental income. In general, these expenses include: • Interest on debts; • State and local taxes on real and personal property and on motor fuel; • General sales taxes; and

	• Expenses of managing or maintaining property.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Federal income tax returns (Form 1040, Schedule C or C-EZ or Schedule E;
- Receipts;
- Statement from the renter;
- Statement from the property manager company;
- Bills; and
- Canceled checks.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(1)(B) 42 USC 1382a(a)(2)(F) 20 CFR 416.1110(b) and 1121(d) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Effective until 2025-04-25

BBB Royalties

Policy

Income from royalties counted for all Medical Assistance programs. If the royalties represent net earnings from self-employment, see MA606.CCC.

NOTE Income from royalties can be either earned or unearned income depending on the type of royalty.

Definitions

Term	Definition
Earned Royalties	Royalties are received by a person for: • Any publication of his work; • As part of a trade or business; or • As an investment dividend from a lease that represent net earnings from self-employment.
Royalties	Royalties are compensation paid to the owner for the use of: • Property; • Usually copyrighted material (ex., books, music or art); or • Natural resources (ex., minerals, oil, gravel, or timber). Royalties can be either earned or unearned.
Unearned Royalties	Royalties received as an investment dividend or from a lease agreement (ex., royalties paid to the owner of a mine, oil well, timber tract, etc.) are considered unearned income, unless the

	payment represents net earnings from self-employment.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Lease agreement;
- Other written contract;
- Pay stubs;
- Letter from company providing the income; or
- Collateral contact with the company providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(i)(D) 42 USC 1382a(a)(2)(F) 20 CFR 416.1121(c) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

Effective until 2025-04-25

CCC Self-Employment

Revised 04/09/2024

Policy

Income from self-employment minus allowable business expenses is counted as earned income for all programs.

Exception:

Self-employment income of American Indians or Alaska Natives that is generated from property held in trust, subject to Federal restrictions or from federally protected rights is not counted as income. Review the policy at MA606EE to determine whether self-employment of American Indian or Alaska Native customers meets the policy requirements to be excluded.

When a self-employment business is owned by more than one person, the net income or loss is divided among the partners based on each one's share of the business. Income and expenses for the year are added up and divided by 12 to get a monthly amount.

> NOTE If the self-employment was started during the current calendar year, the income and expenses are added up and divided by the number of months it has been in business to get a monthly amount.

1) Expenses

Whether a business expense is allowed or not depends on the program. The following expenses are allowed for all programs:

- Cost of stock and inventory;
- Cost of operating machinery or equipment;
- Rent for the business property;
- Taxes on the business property, such as real estate and vehicle taxes;
- Mortgage interest, vehicle loan interest, and interest on loans made to the business;
- Fire, theft, flood, or similar insurance, liability insurance, and contributions to industrial compensation and unemployment insurance;
- Wages paid to employees;
- Costs of employee benefits, such as health insurance, dependent care assistance, and life insurance;

- Business transportation, such as lease payments, license and registration, vehicle insurance, gas, oil, tires, repair costs, garage rent, tolls, parking;
- Advertising costs; and
- Utilities.

Other business expenses allowed for tax purposes are treated differently depending on the MA program. See the table below:

If the program is...	And the expenses are...	Then the expense is...
ALTCS SSI-MAO MSP AHCCCS FTW	• Depreciation; • Federal, state, or local income tax payments; • Entertainment expenses; • Business use of a personal vehicle, based on actual mileage; • Cost of purchasing capital equipment; • Payments on the principal of loans; and • Carryover of previous year's losses.	Not allowed as a deduction from gross self-employment income.
Adult Caretaker Relative Pregnant Woman Child KidsCare		Allowed as a deduction from gross self-employment income.

2) Expenses that Exceed Income

A business may report a net loss for the year. This is when the business' expenses are higher than the income earned. How a loss is treated depends on the MA program:

If the program is...	Then a loss is treated as follows...
• ALTCS • SSI-MAO	The net income is counted as $0. The excess expenses are not deducted from the budget group's other income.

• MSP • FTW	
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	The prorated amount of the loss is subtracted from the budget group's countable income for the month. See Example of Net Loss for MAGI groups NOTE If the remaining income is not enough to cover living expenses, the person must explain how these costs are being met (see MA607 - Expenses Exceed Income).

Definitions

Term	Definition
Partnership	A self-employment business owned by more than one person.
Self-employed	Means any of the following is met: • The person is directly involved in their own recognizable business, trade, or profession. This may include odd jobs or irregular and varied activities. • No employer - employee relationship exists. This occurs when the person controls the hours worked and how the work is performed. • The person works for someone else on a commission basis but pays their own federal taxes. NOTE In general, if taxes are deducted from the person's pay, the person is NOT self-employed.

Self-Employment Income	Income earned from a person's own business or trade, including: • Independent contracting; • Rental income (see MA606.AAA); • Ranching or farming; • Can and bottle recycling; • Blood and plasma sales; • Wholesale or retail sales; and • Other services like those provided through the gig economy.
Gig Economy	Activities or services done to earn income, often through an app or website (digital platforms), like but not limited to: • Drive a car for deliveries like Uber Eats and Grubhub; • Rent out property or spaces or part of a space; • Sell goods online; • Rent equipment; • Provide creative services such as crafts and handmade items sold on a marketplace like Facebook and Etsy; • Provide professional services as a Real Estate agent or Salesperson; • Provide other temporary, on-demand or freelance work; • Ridesharing services such as Uber and Lyft; • On-demand labor and repair services.

Schedule C; Profit or Loss from Business	The Schedule C is used to report income or loss from a business or profession the person operates as sole owner.
Schedule E; Supplemental Income and Loss	The Schedule E (Form 1040) is used to report the income or loss from rental real estate, royalties, partnerships, S-corporations, estates, trusts, and interests in real estate mortgage investments.
Schedule F; Profit or Loss from Farming	Schedule F (Form 1040) is used to report farm income and expenses.
Schedule K-1	The Schedule K-1 reports each partner's share of business income and expenses. It also states what percentage of the business the partner owns.

Proof

Proof of self-employment income includes:

The most recent tax return when the self-employment income is expected to be about the same for the current year. The Schedule C or Schedule C-EZ, and Schedule E or Schedule F can be used for proof of self-employment income and expenses.

> NOTE If the current tax return shows that the self-employment was not in business for the entire year, it can still be used as proof when it reflects normal, ongoing income for the months it was in business.

If the person does not have a current tax return or the tax return does not reflect what they expect to make for the current year, proof of self-employment income and expenses must be provided for at least the last 30 days. If the self-employment fluctuates from month to month, the person must provide proof for additional months as needed to support their stated annual income. Proof of self-employment income and expenses include the following:

- Business bank account statements showing income deposited and business expenses paid. The business expenses must be clearly identified and separated from any personal expense amounts.
- For expenses, receipts, bills, and electronic payment histories;
- For income, invoices, and statements from the source of the income;

- Collateral contacts with the self-employed person's customers to confirm income;
- Collateral contacts verifying expense amounts.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(1)(B) 20 CFR 416.1111(b) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

DDD Social Security Benefits

Revised 03/22/2022

Policy

These benefits are sometimes referred to as Retirement, Survivors, and Disability Insurance (RSDI) or Title II. Social security benefits are counted for all MA programs as unearned income. Ongoing benefits are paid monthly.

For back pay received as a lump sum see MA604.D.

For treatment of overpayments taken from the gross benefit see MA604.E.

1) Dual Entitlement

A person can be entitled to more than one benefit. This is called dual entitlement. When there is dual entitlement, the beneficiary receives the smaller benefit in full plus the difference between the larger and the smaller benefit. For example, a person may be entitled to payments both as a retired worker and as a spouse.

2) Annual Cost of Living Adjustment (COLA)

This policy applies to MSP and SSI-MAO only.

In years when there is a COLA increase, Social Security benefits are increased in January. The increase is not counted for SSI-MAO or MSP until the Federal Poverty Level changes are implemented, usually in April. The previous year's benefit amount is used for the month of January and ongoing until the month the FPL update put into effect.

3) Rounding Down Social Security Values

The SOLQI or WTPY may show a gross benefit that includes cents. Since SSA does not actually issue the cents, the benefit is rounded down to the next whole dollar to get the correct gross benefit.

Definitions

Term	Definition
Social Security Benefits	Paid to aged and disabled people and surviving spouses and children, based on their own or a

	family member's work history and contributions to the Social Security system.
Social Security Disability	Payments to certain disabled workers under age 65 who are determined disabled by a DDSA determination.
Social Security Retirement	A payment to a retired worker who has earned a minimum of 40 Social Security work credits (10 years of work). An individual may earn a maximum of 4 credits per year. A qualified worker may retire as early as age 62 and receive a reduced "early retirement" benefit.
Social Security Survivors and Dependents Benefits	Upon the death or disability of a qualified worker, certain family members including a surviving spouse, unmarried children or a dependent parent may be eligible for benefits. An unmarried disabled son or daughter of a qualified worker may be eligible to receive benefits as a disabled, adult child if the disability began prior to age 22. Payments may begin as early as age 18.
Cost-of-Living Adjustment (COLA)	An increase intended to ensure that income is adjusted to account for inflation. The COLA amount, if any, is determined annually.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Award letters from Social Security;
- Collateral contact to Social Security.

Legal Authority

This requirement applies to the following programs:

Effective until 2025-04-25

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 CFR 435.601 R9-22-1503 R9-28-408
Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.603 R9-22-1401
KidsCare	42 CFR 457.10 R9-31- 304

EEE Spina Bifida Payments

Policy

Spina Bifida Payments are excluded for all Medical Assistance programs.

NOTE Interest earned on unspent Spina Bifida payments is excluded income.

Definitions

Term	Definition
Spina Bifida Payments	Payments made by the Department of Veterans Affairs to children with Spina Bifida who are born to Vietnam veterans.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Award letter;
- Copy of check stub; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO	Title 20 of the CFR, Appendix to Subpart K of Part 416, Section V(k)

Medicare Savings Program	
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

FFF State Supplementary Payments (SSP)

Policy

How State Supplementary payments are treated depends on the MA program:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
State Supplementary Payments (SSP)	A payment in addition to Supplemental Security Income (SSI) paid by some states to account for variations in living costs from one state to another or for special needs. These payments vary from state to state. SSP may be paid directly by the State or combined with the SSI-Cash payment. NOTE Arizona does not have a State Supplementary Payments program.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Award letter from agency providing the SSP benefit;
- Collateral contact with the agency providing the SSP benefit.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO MSP	20 CFR 416.1124(c)(2)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

GGG Strike Pay

Policy

How strike pay is treated depends on the following:

If the program is...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Excluded.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Counted as unearned income.

NOTE Income other than strike benefits paid to union members who actually perform picket or other strike duty are wages.

Definitions

Term	Definition
Strike Pay	Strike pay is paid by labor unions to striking workers.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of pay stub;
- Letter from the union providing the income; or
- Collateral contact with the union providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1102 and 1103 AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

HHH Summer Youth Employment and Training Program

Policy

How Summer Youth Employment and Training Program payments are treated depends on the following:

If the program is...	Then the treatment is...
• ALTCS • SSI-MAO • MSP • AHCCCS FTW	Excluded.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	• Wages are counted as earned income. • Reimbursements and supportive services are excluded.

Definitions

Term	Definition
Summer Youth Employment and Training Program	The program is designed to encourage disadvantaged adults and youth to complete school and expose them to the world of work. The program is for individuals age 14 through 21. Payments are for: • Wages; • Living Allowances; and

	• Reimbursements.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of check stub;
- Letter from program providing the income; or
- Collateral contact with the program providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 USC 416.1103(b)(1) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

III Supplemental Security Income (SSI)

Revised 12/27/2022

Policy

Supplemental Security Income (SSI) Cash payments are treated as follows:

Programs	Treatment
• ALTCS • SSI-MAO • MSP	• Excluded for income eligibilty • Counted for ALTCS Share of Cost see MA1201B for details. • Counted for the child allocation for SSI-MAO and MSP NOTE An SSI-Cash recipient in Arizona who has free Medicare part A is automatically eligible for the QMB MSP without needing to apply for it separately.
• Caretaker Relative • Child • Pregnant Woman • Adult • KidsCare	Excluded NOTE An SSI-Cash recipient in Arizona is automatically eligible for MA without needing to apply for it separately.

NOTE When an ALTCS customer receives SSI-Cash and lives in a Long-Term Care (LTC) medical facility, no more than $30 of the customer's SSI-Cash payment is counted for Share of Cost. See MA1201B for details.

Definitions

Term	Definitions

Supplemental Security Income (SSI)	Need-based payments to aged and disabled individuals that meet certain income and resource eligibility requirements. These benefits are sometimes referred to as Title XVI.
SSI Aged Benefits	Payments to individuals or couples age 65 years or older who have limited resources and income. The maximum amount payable is the individual or couple Federal Benefit Rate (FBR).
SSI Disability Benefits	Payments to individuals or couples who are blind or disabled and have limited resources and income. The maximum amount payable is the individual or couple Federal Benefit Rate (FBR). Children as well as adults may qualify for benefits. Disability is determined by DDSA.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Award letter from Social Security;
- Collateral contact with Social Security.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1102 and 1103
Adult	42 CFR 435.603
Caretaker Relative	42 CFR 457.10, 300, 301 and 315

Pregnant Woman Child KidsCare	

JJJ Temporary Assistance for Needy Families (TANF) Cash Assistance

Policy

How TANF Cash Assistance is treated depends on the following:

If the program is...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income. NOTE This is a needs-based payment.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
Temporary Assistance to Needy Families (TANF)	TANF is cash assistance paid to a family unit. Because TANF is partially funded by Federal block grants, it is considered income based on need.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- HEAplus notices or records;
- Collateral contact with DES Family Assistance Administration.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(b)(6) 20 CFR 416.1124(c)(2)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

KKK Trade Readjustment Assistance

Policy

Trade Readjustment Assistance is counted as income for all Medical Assistance programs.

The following describes how to treat the payment:

If the payment is for...	Then the treatment is...
Unemployment compensation	Counted as unearned income.
Mileage reimbursement	Excluded up to the amount of actual expenses. NOTE Exclude the reimbursement up the IRS business mileage rate if the person does not have proof of actual expenses.

Definitions

Term	Definition
Trade Readjustment Assistance	Payments to people laid off due to a foreign company's trade. A person may receive a general payment and payment for mileage reimbursement. A person can receive this assistance for 52 weeks and only after all other Unemployment Insurance (UI) benefits are used. DES Unemployment Insurance – Special Programs administers this program.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

If verifying...	Then the types of proof include, but are not limited to...
Income	• Statement from Arizona Department of Economic Security; or • Collateral contact with the Arizona Department of Economic Security
Mileage Expense	• Receipts/bills for gasoline; • Receipts/bills for public transportation; or • Receipts/bills for taxi service.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 USC 416.1121(a)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

LLL Tribal Work Experience Program (TWEP)

Policy

Tribal Work Experience Program (TWEP) benefits are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Tribal Work Experience Program (TWEP)	A tribal program which provides eligible General Assistance recipients with work experience and job skills to enhance the participant's potential for job placement.

Proof

Because this income is excluded, only the source of the income is verified. Types of proof include, but are not limited to:

- Written statement from the Tribe; or
- Collateral contact with the Tribe.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 CFR 416.1124(c)(2) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

MMM Trust Income

Revised 12/19/2023

Policy

For MAGI programs, only the income added to or earned by the trust is counted as income for the trust owner. Any amount distributed from the trust that is more than the income added or earned is considered paid from the trust principal and is a resource conversion, not income.

For the non-MAGI programs, how trust income is counted depends on the type of trust and the specific MA program.

- For the ALTCS program, see Chapter 800.
- For SSI-MAO and MSP, see the table below for how to count trust income:

If the trust type is...	Then the treatment is...
Medicaid Qualifying Trust	Income assigned to the trust is counted in the month it would have been received by the customer.
Testamentary trusts and non-grantor trusts	When the beneficiary cannot access the trust principal: • Any disbursements made directly to the beneficiary are counted as unearned income. Disbursements not issued directly to the beneficiary are not counted. • When the beneficiary has a right to the income produced by the trust, it is counted as it becomes available, whether it is actually paid to the beneficiary or not. When the beneficiary has no right to the income produced by the trust it is not counted.
All other trust types	Count the higher of the following amounts as unearned income: • Income received by the trust, except for interest earned by the trust, or

	• Disbursements from the trust directly to or for the benefit of the customer

Definitions

Term	Definition
Trust	Any arrangement where money or property is entrusted to one or more persons with the intent that it be used for the benefit of someone else. See Chapter 800 for more detailed information and definitions for trusts.

Proof

Proof of the terms of a trust and the person's access to the trust includes:

- A copy of the trust instrument or other document establishing the trust with all amendments or restatements to date;
- Trust instrument;
- Court records;
- Court approved injury settlement;
- Will; and
- Schedule A (can also be referred to as an attachment or a different type of schedule or exhibit. Schedule A is most common).

Proof of income received, earned, or distributed by the trust includes:

- Trust accounting records;
- Trust financial account statements showing deposits and distributions; and
- Canceled checks drawn on the trust account.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	42 USC 1396p(d) ARS 36-2934.01
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

NNN Tuberculosis Control

Policy

Tuberculosis Control Payments are excluded for all Medical Assistance programs.

Definitions

Term	Definition
Tuberculosis Control Payments	State funded cash assistance based on need. It is paid to a customer or the family of a customer who is under medical treatment for tuberculosis. The program is administered by DES Family Assistance Administration.

Proof

Because this income is excluded, only the source of the income is verified. Proof includes:

- Benefit letters from DES;
- Collateral contact with DES.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1124(c)(2)

Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

OOO Unemployment Insurance

Policy

Unemployment Insurance payments are counted for all Medical Assistance programs as unearned income.

> NOTE A person may be working part-time and still receive a reduced unemployment payment.

Unemployment Insurance payments received electronically are considered income on the date received. If mailed, payments are considered received as of the third day following the date of issue.

Definitions

Term	Definition
Unemployment Insurance Payments	Also known as unemployment compensation. A person receives these payments under a State or Federal unemployment law.

Proof

Income is first obtained through the Federal and State Data Services Hubs.

If needed, other proof includes:

- Award letter from state agency providing the unemployment insurance; or
- Collateral contact with the state agency providing the unemployment insurance.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(a)(2)(B) 20 CFR 416.1121(a)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

PPP Uniform Transfer to Minors Act (UTMA)

Policy

For MAGI programs, a gift to a minor under the Uniform Transfer to Minors Act (UTMA) is not counted as income. However, any interest or dividends earned by the UTMA account is counted as unearned income.

For the non-MAGI programs, how UTMA payments are counted depends on the type of payment and the age of the child. See the table below for details:

If the child is...	And the payment is...	Then the treatment is...
Is under age 21	A transfer to the child under UTMA	Excluded
	Disbursements from an UTMA account to the child	Counted as unearned income.
	Disbursements from an UTMA account used to make vendor payments on behalf of the minor	Excluded.
Reaches Age 21		The value of the UTMA account is counted as unearned income in the month of the child's 21st birthday.

Definitions

Term	Definition
Uniform Transfer to Minors Act (UTMA)	Also known as Uniform Gift to Minors Act (UGMA). The UTMA permits a person to make an irrevocable tax-free gift of money or other securities to a minor. The gifts are placed in accounts designated UTMA or UGMA. A custodian controls the gift, and any earnings it

	generates, until the child reaches age 21. The custodian can spend UTMA assets for the minor's support, maintenance, benefit or education. The child automatically receives control of the assets on his or her 21st birthday.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of financial account statement (checking, savings, etc.);
- Written statement from the financial institution; or
- Request for Verification of Financial Accounts (DE-203) completed by financial institution.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	The Uniform Gifts to Minors Act The Uniform Transfers to Minors Act 20 CFR 416.1102 and 1103
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

QQQ Vaccine Injury Compensation Program (VICP)

Policy

How the Vaccine Injury Compensation Program (VICP) payments are treated depends on the following:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP	Counted as unearned income.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	Excluded.

Definitions

Term	Definition
Vaccine Injury Compensation Program (VICP)	Payments made by the federal government to compensate individuals, or families of individuals, who have been injured by adverse reactions to mandated childhood vaccines.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Court document; or
- Copy of check stub.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program	20 CFR 416.1102 and 1120
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

RRR Veterans Administration (VA) Benefits

Revised 03/11/2025

Policy

The Veterans Administration (VA) has numerous programs providing payments to veterans and their dependents. The most common types of VA payments are detailed in this section, but this list does not include all possible VA benefit types.

> NOTE VA benefits are not the same as military retirement pay. See MA606TT for military retirement pay.

For MAGI programs, VA benefits are excluded as income.

For the non-MAGI programs, how VA benefits are counted depends on the type of payment. See the table below for details:

If...	Then the treatment is...
VA Compensation	Counted as unearned income. NOTE Compensation payments made to a veteran, or the veteran's spouse or child are not based on need. Compensation payments made to the parents of a veteran based on a service-connected death are based on need.
Increase for dependents	Excluded as income to the veteran. Excluded as income to the veteran and the dependent when paid directly to the veteran who is NOT living with the dependent. Counted as unearned income to the dependent when paid: • Directly to the veteran for a dependent who resides in the home with the veteran; or

	• By a separate check to the dependent (an apportionment) NOTE When the customer is the dependent, the customer must ask that the VA pay the benefit directly to him or her.
Increase for unusual medical expenses	Excluded.
VA Pension	Counted as unearned income. NOTE Most VA pension payments are based on need, except for VA pension payments due to a Medal of Honor or a special act of Congress.
VA Reduced Pension ($90)	Excluded.
Aid and Attendance and Housebound allowances	Excluded.
VA Clothing allowance	Excluded.
VA Caregivers Payments	Excluded as income to the veteran. Counted as unearned income to the caregiver.

Definitions

Term	Definition
VA Aid and Attendance and Housebound Allowance	An allowance paid to veterans, spouses of disabled veterans and surviving spouses who are in regular need of the aid and attendance of another person or who are housebound. Increases in VA benefits for aid and attendance or housebound allowances are included in the pension or compensation payment.

VA Pension	Payments made on the basis of a combination of service and an age of 65 or over, a non service-connected disability or death.
VA Reduced Pension	The VA may reduce the VA benefit to a maximum of $90.00 per month for veterans or surviving spouses of veterans who meet all three of the following criteria: • Resides in a certified nursing facility other than the Arizona State Veteran Home; • Is receiving ALTCS; and • Has no spouse or dependents.
VA Clothing Allowance	A lump sum allowance is paid in August of each year to a veteran with a service-connected disability who uses a prosthetic or orthopedic appliance, including a wheelchair. The clothing allowance is intended to help pay the increased cost of clothing due to the wear and tear caused by the appliances.
VA Increase for Dependents	A VA payment to a veteran or a veteran's surviving spouse that is increased because of a dependent. Pensions, compensation, and educational benefits can all be increased for dependents. • An augmented benefit, which includes a portion for the dependent, is issued as part of the veteran's or surviving spouse's payment. • Payment of the dependent's portion by a separate check directly to the dependent is an apportionment.
VA Increases for Unusual Medical Expenses	The VA considers unusual medical expenses when determining some needs-based pension and compensation payments.

	Unusual medical expenses may result in a lump sum payment, an increase in the ongoing VA pension or compensation payment, or both.
VA Caregiver Payment	Payments made to a family member for providing caregiver services to a veteran who has: • Been medically discharged from service; • A serious injury that was aggravated in the line of duty on or after September 11, 2001; • Need of personal care because of the inability to perform one or more activities of daily living; and • Been Enrolled in VA Health Services

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Benefit pay stub benefit explanation if it lists the types of benefits included in the gross payment;
- Letter from the VA;
- A printout of the customer’s compensation from the customers’ online VA account;
- A collateral contact using the VA Automated Payment Line;
- A Request for Verification of VA Information (DE-210) form completed by the VA;
- VA PARIS Report using the current DE-210W VA Worksheet for Renewals.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

ALTCS SSI-MAO Medicare Savings Program	42 USC 1382a(2)(B) 20 CFR 416.1103(b)(1) 20 CFR 416.1121(a)
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

SSS Vocational Rehabilitation

Policy

How Vocational Rehabilitation payments are treated depends on the following:

If the customer is eligible for...	Then the treatment is...
• ALTCS • SSI-MAO • MSP • AHCCCS FTW	Excluded.
• Adult • Caretaker Relative • Pregnant Woman • Child • KidsCare	• Wages are countable. • Other stipends and supports are excluded.

Definitions

Term	Definition
Vocational Rehabilitation	Paid by the Department of Economic Security. It may include Training Related Expenses (TRE), subsistence and maintenance allowances, and incentive payments. This does not include payments made from the Veteran's Administration for vocational rehabilitation.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of check stub;
- Letter from the agency providing the income; or
- Collateral contact with the agency providing the income.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 USC 416.1103(a)(3) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

TTT Volunteer Service Program Payments

Policy

How Volunteer Service Program payments are treated depends on the following:

If the payment is...	Then the treatment is...
A reimbursement or a stipend for services performed as a volunteer.	Excluded.
Wages for services the person performed for the agency.	Counted as earned income.

Definitions

Term	Definition
Volunteer Service Program Payment	Payments to volunteers in the following programs: • The Service Corps of Retired Executives (SCORE); • The Active Corps of Executives (ACE); • Foster Grandparents; • Retired Senior Volunteer Program (RSVP); • Volunteers in Service to America (VISTA); • University Year for ACTION (UYA); • Senior Companion Program; • Senior Community Service Employment Program (SCSEP) (Title V Program);

	• Older Americans Community Service Programs; and • Special and Demonstration Volunteer Programs.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of check stub;
- Written statement from the income source;
- Collateral contact with the income source.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	20 CFR 416.1124(c)(23) 20 CFR 416.1102 and 1110(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315 -

Effective until 2025-04-25

UUU Wages

Revised 03/12/2024

Policy

How wage payments are treated depends on the following:

If the payment is...	Then the treatment is...
Wages	Counted as earned income
Difficulty of Care Payments	• Excluded from income for MAGI programs. • Counted as earned income for non-MAGI programs.
Tips	Under $20 per month are counted as unearned income for the non-MAGI programs.
U.S. Census Wages	For wages from temporary work for the U.S. Census, see MA606N.
Flex Income Credits	Any part of the credits paid to the person in their wages instead being used to purchase benefits is counted as earned income.
On call, standby or non-work pay	On call, standby or non-work pay Counted for all Medical Assistance programs as earned income.

Definitions

Term	Definition
Wages	The amount paid to a person for services provided as an employee. Wages include:

	• Advances • Back pay • Bonuses • Commissions • Paid time off, including sick pay • Military basic pay • Overtime pay • Severance pay • Sheltered Workshop or Work Activities Center payments NOTE An employer's contributions toward an employee's insurance, retirement or Unemployment Insurance are not counted as income for the employee.
Advances	Amounts paid to the employee as an advance before the scheduled pay date.
Back Pay	Amounts to make up the difference between what the employee was paid and what he or she should have been paid.
Difficulty of Care Payments	Wages received by providing Personal Care or attendant services to an ALTCS customer. Difficulty of Care payments must meet the following conditions: • The earnings are for Personal Care, Attendant Care, or habilitation services; • The services are covered by the ALTCS program; • The caregiver is providing the services to an ALTCS customer living at home with them. See Difficulty of Care payments examples

Flex Income Credit	An amount of money provided by the employer to purchase benefits like life, health, and disability insurance through the employer's offered plans.
On Call, Standby or Non-work Pay	Payment for duty that requires the employee to be available and able to report to duty if called.
Severance Pay	Payment made by an employer to an employee after employment has ended.
Sheltered Workshop or Work Activity Center Payment	Payments for services performed in a sheltered workshop or a work activity center under a program designed to help the person become self-sufficient.
Tips	Gifts from customers for the employee's service. The employer is required to keep a record of the amount reported for IRS purposes. Types of jobs that may earn tips are: • Restaurant wait staff; • Pizza delivery; • Dancer; and • Barber and salon staff.
Work Activity Center	Work activity centers provide therapeutic activities that teach basic living skills to those whose handicap is so severe that it precludes productive employment.

Proof

Proof of income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of pay stubs;
- Letter from employer;

- Request for Verification of Employment form completed by the employer;
- Collateral contact with employer; or

NOTE Tips may be difficult to verify and is usually dependent on accurate reporting by the employee.

For Difficulty of Care Payments

Proof of wages being paid by a healthcare agency includes:

- Information from the employer's website or other reliable internet sites;,
- Collateral contact with the employer; or
- Written statement from the employer.

Proof that the person being cared for is on ALTCS and living with the customer includes AHCCCS eligibility and enrollment records.

When the customer is a paid caregiver for someone who lives with them AND someone who does not, proof of the counted amount of wages includes:

- Pay stubs if itemized for each person receiving care;
- Written statement from the employer, or
- Collateral contact with the employer

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(1)(A) 20 CFR 416.1111(a) AAC R9-22-1909

Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

VVV Workforce Innovation and Opportunity Act (WIOA)

Revised 11/07/2023

Policy

How Workforce Innovation and Opportunity Act (WIOA) payments are treated depends on the following:

If the WIOA payment is for...	Then the treatment is...
Wages	Counted as earned income.
Stipends or incentive payments	Excluded.

Definitions

Term	Definition
Workforce Innovation and Opportunity Act (WIOA)	Salaries, stipends, or incentive payments paid to the individual. The person may also receive support services such as childcare, transportation, medical care, meals, and other expenses in cash or in kind. These payments were formally known as Workforce Investment Act (WIA) payments.

Proof

Income is first obtained through the Federal and State Data Services Hubs. If needed, other proof includes:

- Copy of pay stub;
- DE-206, Request for Verification of Employment form;
- Letter from employer;
- Letter from agency providing stipend or incentive payment; or

- Collateral contact with employer or agency providing stipend or incentive payment.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Medicare Savings Program Freedom to Work	42 USC 1382a(a)(1)(a) 20 CFR 416.1110(a) AAC R9-22-1909
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.603 42 CFR 457.10, 300, 301 and 315

607 Expenses Exceed Income

Revised 09/27/2022

Policy

Expenses Exceed Income (EEI) may be indicated by one or more of the following:

- The customer reports a living expense, like a mortgage payment, that is higher than the amount of income reported;
- The customer reports little or no income and would be unable to pay for food, clothing or shelter;
- The customer reports living off savings or other resources, but proof does not show enough resources to cover the expenses.

If the EEI is...	AND the customer...	Then...
An ongoing situation, not caused by a recent loss of income or other change	Cannot or will not explain how expenses are being paid	A written statement from the customer or knowledgeable source that explains how the customer's living expenses are met. AND • Bills showing the expenses are unpaid; or • Proof of how the customer is paying the expenses. (See proof section for details)
	Explains how the living expenses are being met	The customer's statement is acceptable proof unless questionable or inconsistent with other information.
Due to a new change in circumstances	Does not know yet how expenses will be met	The customer's statement is acceptable proof. A review of

		the customer's situation will be needed in 6 months.
	Explains how the living expenses are being met	The customer's statement is acceptable proof unless questionable or inconsistent with other information.

Definitions

Term	Definition
Expenses Exceed Income (EEI)	EEI is a situation that occurs when the monthly living expenses reported are higher than the monthly income reported. This is either at the time of the initial determination of eligibility or later.

Proof

The customer's statement explaining how basic living expenses are being met is usually enough to resolve expenses exceed income. However, if the customer's explanation is questionable or inconsistent with other information received by the agency, proof of expenses and how the expenses are being paid is needed.

See Expenses Exceed Income for examples of questionable or inconsistent information.

Proof of expenses includes:

- Receipts;
- Statements;
- Bills;
- Insurance Policies;
- Payment Books;
- Contracts; and
- Collateral contacts with knowledgeable sources.

Proof of how the customer is paying the expenses includes:

- Credit card statements showing payments for expenses;
- Bank statements showing expenses being paid from savings;
- Statements from anyone giving or loaning money to the customer; and
- Statements showing that an expense has been waived or deferred and for how long.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	42 CFR 435.952

608 Income Deeming

608 Income Deeming

Overview

For some AHCCCS Medical Assistance (MA) programs, part of another person's income may count as income to a customer, whether or not that income is actually contributed to the customer.

Deeming applies to:

- Parental deeming; and
- Sponsored non-citizen deeming.

A Parental Deeming

Revised 06/08/2017

Policy

This policy only applies to the ALTCS Acute, SSI-MAO and MSP programs.

When determining eligibility for a child under the age of 18 who lives with one or more ineligible parents, a portion of the income of the ineligible parent or parents is deemed to be the income of the child.

NOTE Income is only deemed to the child for the net income test. Income is not deemed from a parent for the ALTCS gross income test.

Only counted income types are included when deeming income. Along with the income types listed as excluded in MA606, the following income types are also excluded when deeming income from an ineligible parent to a child:

- Income received by the ineligible parent that was counted to determine the amount of a public benefit based on need. Such benefits include Cash Assistance, Tuberculosis Control and payments based on need provided by the VA or the Refugee Act of 1980; and
- Income received by the ineligible parent from a Federal, State or local government program to provide the customer with chore, attendant or homemaker services.

When calculating the amount to be deemed to a customer-child from an ineligible parent, the following deductions may be allowed:

- A deduction for child support paid under the terms of a court order or as enforced by the Division of Child Support Services (MA609.B.1);
- The Student Earned Income Exclusion (MA609.B.2);
- Infrequent or Irregular Income Exclusion (MA609.B.9)
- Child allocations (MA609.B.8);
- The $20 general deduction (MA609.B.3);
- The $65 standard work expense (MA609.B.4);
- Impairment Related Work Expenses (MA609.B.5);
- One-half remaining earned income deduction (MA609.B.6); or
- Blind Work Expenses (MA609.B.7).

Definitions

Term	Definition
Deeming	Deeming is the process of considering the income of a person to be available to the customer, whether or not that income is actually given to the customer.
Child	Means a person who: • Is not married (including divorced); and • Is under age 18; or • For child allocation deductions only, is under age 22 and is a student regularly attending a school, college or university, or a course of vocational or technical training to prepare for gainful employment.
Ineligible Parent	A natural or adoptive parent, swho is NOT receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS Acute	20 CFR 416.1160
SSI-MAO	20 CFR 416.1161(a)
Medicare Savings Program (MSP)	20 CFR 416.1165 42 CFR 435.601

B Sponsored Noncitizen Deeming

Revised 03/25/2025

Policy

Noncitizens lawfully admitted into the United States for permanent residence under the Immigration and Nationality Act are qualified aliens. Some of these Lawful Permanent Residents (LPR) are sponsored by others who are responsible for their support.

A part of the sponsor's income may need to be deemed to an LPR customer when determining eligibility. If the sponsor is married and lives with his or her spouse, the spouse's income is also deemed. If the sponsor's income must be deemed, the deemed income is counted in determining:

- Income eligibility;
- ALTCS Share of Cost (SOC); and
- Premiums.

Income deemed from a sponsor is only counted toward the LPR. It is not counted for the LPR's spouse, children, or any other budget group member.

NOTE Sponsor deeming is not applied if the sponsor and the LPR customer are in the same budget group. For example, the LPR's husband is her sponsor, and they live together.

1) Noncitizens Subject to Sponsor Deeming Rules

The sponsor deeming rules apply only to customers who:

- Are Lawful Permanent Residents (LPRs);
- Are eligible for full AHCCCS Medical Assistance services.;
- Were granted LPR status on or after December 19, 1997;
- The sponsor signed a USCIS-864, Affidavit of Support.

NOTE If the sponsor signed any affidavit of support other than the USCIS-864, sponsor deeming does not apply.

2) Noncitizens NOT Subject to Sponsor Deeming

Customers who are Lawful Permanent Residents (LPRs) are not subject to the sponsor deeming rules when the LPR:

- Immigration status was adjusted to LPR from a status of refugee or asylee. Persons who adjusted from these classifications are exempt from sponsor deeming, even if they have sponsors;
- Qualifies only for Federal Emergency Services (FES) through the Federal Emergency Services Program (FSP);
- Is indigent;
- Is a victim of domestic violence or extreme cruelty; or
- Has 40 qualified quarters of coverage based on earnings.

3) When Does Sponsor Deeming Stop?

The sponsor deeming requirement stops when:

- The sponsor dies (see MA1502G for proof required);
- The customer becomes a naturalized U.S. citizen; or
- The customer qualifies for an exemption:
  - Becomes indigent;
  - Becomes the victim of battery or extreme cruelty; or
  - Can be credited with 40 qualifying quarters of coverage.

4) Sponsored Deeming Exception for Indigent Customers

A customer is indigent when the total income for the customer's budget group is less than or equal to 100% of the FPL for the size of the income group. The value of in-kind support, vendor payments, and contributions provided to the customer in cash or for food, clothing, shelter, or utilities are included in the total income.

Exception:

A customer is indigent only when he or she is unable to obtain food and shelter, therefore the customer is not indigent when:

- The customer is living with his or her sponsor. Assume that the sponsor is providing food and shelter and meeting the customer's food and shelter needs; or
- The customer is not living with his or her sponsor but is receiving free room and board.

If the customer is determined to be indigent, the sponsor's income and resources are not deemed to the customer for 12 months beginning with the application month. Only the amount of cash actually provided by the sponsor to the customer is counted. The customer must be determined indigent at renewal to continue to qualify for the sponsor deeming exception.

5) Sponsored Noncitizen Deeming Exception for Victims of Domestic Violence and Extreme Cruelty

Sponsor deeming does not apply (even when a sponsor has completed the I-864 Affidavit of Support) when a customer with Lawful Permanent Resident status is:

- A victim of domestic violence or extreme cruelty;
- The parent of a battered child; or
- The child of a battered parent.

All of the following must be met for the customer to qualify for the exemption:

- The abuser was the spouse or parent or other family member of the victim;
- The abuser was residing in the same household as the victim when the abuse occurred;
- The abuse occurred in the United States;
- The customer did not participate in the battery or cruelty; and
- The victim does not currently live with the abuser.

The exemption applies for a period of 12 months and must be re-verified at renewal.

6) Sponsor Deeming Exemption Due to Forty Qualifying Quarters of Work

When a sponsored LPR has 40 qualifying quarters of work credit, sponsor deeming does not apply.

- A person can earn up to four qualifying quarters each year: one for each calendar quarter of the year. The income must have been earned in the U.S. or a U.S. territory by a U.S. citizen or a noncitizen authorized to work in the U.S. When the customer or spouse are getting SSA retirement income, it means they have 40 qualifying quarters.
- Any of the following can be used toward the customer's 40 quarters:
- Quarters worked by the customer;
- Quarters worked by the customer's spouse during their marriage, even if the spouse is now deceased. Spouse's quarters cannot be used if the customer and spouse are divorced.
- Quarters worked by the customer's parents while the customer was under age 18.

Exception:

Beginning January 1, 1997, any quarter in which the wage-earner received a federal means-tested benefit cannot be counted as a qualifying quarter.

A person cannot get credit for future quarters. For the current year, credit can only be given for the current and past quarters, even if enough income has been earned to cover all four quarters.

Example - Counting Only Current and Past Quarters

A chart of the earnings needed by year to get credit for a qualifying quarter is available at https://www.ssa.gov/oact/cola/QC.html#qcseries

7) Deeming the Sponsor's Income

Deemed income is unearned income to the customer. The sponsor's income is deemed only to the person named on the Affidavit of Support. When the sponsor's income is deemed, actual cash contributions from the sponsor are not counted as income to the customer.

A person may sponsor more than one noncitizen. Similarly, a noncitizen may be sponsored more than one person. See the following table for treatment of multiple deeming situations:

If…	Then…
The noncitizen is sponsored by more than one person	The deeming rules are applied separately to the income of each sponsor. Then the amounts deemed from the sponsors are added together to get the total deemed income counted to the noncitizen.
A person sponsors two or more noncitizens, who are in different income groups	The sponsor deeming rules are applied as if each noncitizen were the only one sponsored. The deemed income is counted in full to each noncitizen. The sponsor's income is not divided among the noncitizens.
A person sponsors more than one person in the same income group	The deemed amount is counted only once.

Deeming Calculation

Use the steps below to determine the income amount deemed to the customer:

Step	Action
1	Add up the total gross income of: • The sponsor; and • The sponsor's spouse (if the sponsor and spouse are living together).
2	Subtract 100% of the FPL for the sponsor's family size (MA615). Include the following people living with the sponsor in the family size: • The sponsor; • The sponsor's spouse; • The sponsor's dependent children; and • The sponsor's spouse's dependent children.
3	The result is the amount of income deemed to the customer from the sponsor.

Definitions

Term	Definition
Sponsor Deeming	Sponsor deeming is the process of considering the income and resources of the sponsor to be available to the sponsored noncitizen, whether or not the income or resources are actually made available.
Federal means-tested benefit	These benefits include AHCCCS Medical Assistance (except for emergency services), KidsCare, Cash Assistance (TANF), Nutrition Assistance, and SSI-Cash.
"Battered or subjected to extreme cruelty"	Was the victim of any act or threatened act of violence, including any forceful detention, which results or threatens to result in physical or mental injury. Examples of acts of violence:

	• Psychological or sexual abuse or exploitation (rape, molestation, incest with a minor, or forced prostitution); • Physical abuse; and • Threatened acts of violence. NOTE It is not possible to identify all behaviors that could be acts of violence under certain circumstances. This is not an exhaustive list of all acts of violence and extreme cruelty.
Other Family Member	Any person related by blood, marriage, or adoption to the customer, or to the spouse or parent of the customer.
Quarter	There are four quarters to a calendar year: • January through March; • April through June; • July through September; and • October through December.
Qualifying Quarter	A qualifying quarter is a quarter that meets the minimum amount of earnings as determined by the Social Security Administration (SSA).
Lag Quarters	Lag quarters are current year or preceding year's earnings that are not yet displayed in the SSA earnings record.

Proof

Proof of sponsorship

In most cases, sponsorship is verified through the United States Citizenship and Immigration Services (USCIS) SAVE Verification Information System (VIS).

Proof of sponsorship is not needed when the customer became an LPR before 12/19/1997, or is exempt from sponsor deeming.

The Affidavit of Support Form I-864, is accepted as proof of sponsorship. If the customer has any other Affidavit of Support Form, sponsor deeming does not apply.

Proof of Domestic Violence or Extreme Cruelty

The following documents are accepted to verify that the customer is a victim or the parent or child of a victim:

Type	Description
Petition for Amerasian, Widow or Special Immigrant (I-360)	The I-360 verifies that the noncitizen filed a petition with USCIS to establish that they are victims of battery or extreme cruelty.
USCIS Form I-797	The I-797 Form indicates USCIS approval of the I-360 petition.
Other evidence	Because of the nature of abusive relationships, noncitizens may not have copies of USCIS Forms that they have filed. Any of the following may be used when a customer has little or no documentation: • Reports or affidavits from police, judges or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health providers and other social service agency employees; • Legal documents, such as an order of protection against the abuser or court records showing the abuser was convicted of committing an act of domestic violence, or other records that show evidence of abuse; • Evidence that the noncitizen asked for help from a battered women's shelter or similar refuge because of the abuse; or • Photographs of the visibly injured victim.

Proof of Qualifying Quarters

The following documentation is accepted as proof when determining qualifying quarters:

- Social Security records showing qualifying quarters earned;
- Receipt of SSA retirement when no federal means-tested benefits were received during the earnings period;

NOTE Social Security records may not include the most current qualifying quarters.

- Pay stubs;
- W-2 forms;
- Statements from employers; and
- Copy of a Federal or State tax return;
- Timely filed self-employment tax forms; or
- Union records

Proof of the Sponsor's Income

When sponsor deeming applies, the customer must provide proof of income for:

- The sponsor; and
- If living with the sponsor, the sponsor's spouse.

See MA606 for proof of income by income type.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All programs	8 USC 1631 AAC R9-22-316 AAC R9-22-317

609 Income Deductions

609 Income Deductions

For some AHCCCS Medical Assistance (MA) programs, certain expenses may be deducted to determine the amount of income used for determining a customer's:

- Eligibility;
- Share of cost; and
- Premium amount.

The deductions and amounts vary by program.

A Costs Required to Obtain Income

Revised 01/01/2018

Policy

This policy applies ONLY to the following MA programs:

- ALTCS;
- SSI-MAO;
- AHCCCS Freedom to Work (FTW); and
- Medicare Savings Program (MSP).

Some expenses that a person must pay to get a type of income can be deducted from the gross income amount.

NOTE These expenses may be allowed even if incurred or paid in a month before the income was received.

Allowable expenses include:

- Attorney fees and court costs;
- Filing fees;
- Fees for birth or death certificates;
- Medical fees;
- Guardian fees;
- Fees for converting foreign money to U.S. dollars (USD);
- Rents; and
- Contract expenses.

NOTE If the person pays a fee, but could have gotten the income whether the fee was paid or not, the expense is not allowed.

The expense is deducted from the first and any following payments of the related income until all expenses are fully deducted.

NOTE Always use the gross amount of USD when determining eligibility and entering amounts into the system. The gross amount of income paid in foreign money

can be converted to USD using the online calculator at http://www.xe.com/currencyconverter/.

Definitions

Term	Definition
Guardian fees	In certain cases where a person has a legal guardian, the person must pay a fee for the guardian's services.

Proof

Proof of expenses include, but are not limited to:

- Bills;
- Cancelled checks;
- Money orders;
- Receipts; or
- Any other evidence that proves the expense was incurred.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS SSI-MAO Freedom to Work (FTW) Medicare Savings Program (MSP)	20 CFR 416.1123(b)(3)

Effective until 2025-04-25

B Income Deductions for Non-MAGI Programs

Revised 12/18/2024

Policy

For the Non-MAGI programs, certain expenses may be deducted from gross income to determine the amount of income to count. The deductions in this section apply ONLY to the following MA programs:

- ALTCS Acute;
- SSI-MAO;
- AHCCCS Freedom to Work (FTW); and
- Medicare Savings Program (MSP).

1) Child Support Deductions

There are two different child support deductions:

- A deduction from child support income received by a child.
- A deduction for child support paid by an ineligible parent to a child who is not in the home.

Deduct…	**When…**
One-third of the child support received by the customer child.	Determining the child's countable income for MA eligibility.
A deduction for child support paid under the terms of a court order or as enforced by the Division of Child Support Services	Determining the amount of an ineligible parent's income to deem to a customer child.

NOTE This deduction does not apply to Freedom to Work (FTW)

2) Student Earned Income Exclusion

The student earned income exclusion is deducted from the earned income of a person who is considered a student. To qualify for the student earned income exclusion, the person must:

- Be under age 22; and

- A part-time or full-time student regularly attending a school (includes accredited online school or homeschool) for grades 7 - 12, college, university, or a course of vocational or technical training designed to prepare for gainful employment.

NOTE The person remains a student during a school vacation if he or she intends to return when classes resume.

If the customer qualifies for the income exclusion, the following is deducted from the customer's earned income:

For calendar year:	A monthly amount of no more than:	With a total limit per calendar year of:
2018	$1820	$7350
2019	$1870	$7550
2020	$1900	$7670
2021	$1930	$7770
2022	$2040	$8230
2023	$2220	$8950
2024	$2290	$9320
2025	$2350	$9460

3) General Income Deduction

The general income deduction of $20 can be deducted from any earned or unearned income that is not based on need. The deduction is taken from unearned income first. Any amount remaining is then applied to earned income.

The $20 General Deduction is not deducted from any payment based on need.

4) Standard Work Expense Deduction

The standard work expense deduction is $65.00. The $65.00 is deducted from earned income remaining after previous deductions.

The work expense deduction is applied to the counted earned income of:

- An individual customer;
- A couple, when one or both spouses are the customer, even when both spouses have earned income; and
- An ineligible parent of a customer child when deeming the parent's income.

5) Impairment Related Work Expenses (IRWE)

A person may get a deduction for the reasonable cost of certain impairment-related services and items that a disabled person needs in order to work.

To qualify for the IRWE deduction, the person

- Must be under age 65 and have been determined disabled (but not blind); or
- Received SSI as a disabled person for the month before the month he or she reached age 65.

To get a deduction for these costs the person must actually pay for the items or services. A deduction cannot be given for costs covered by insurance, paid by another person, or that were paid for in-kind instead of with money.

The table below lists services and items that qualify for an IRWE deduction IF they are necessary for the person to be able to work:

Payment is for…	**Description...**
Attendant care services	• Help with personal functions like bathing, dressing, and taking medications to get ready for work. • Help traveling to and from work, help at work with personal functions like eating or toileting, or help with work related functions like reading or communicating. • Costs for a family member to provide attendant care is only allowed if the family member has to reduce work hours or stop

	work for another employer to provide the services and loses income. NOTE Only the costs for attendant care services specifically related to enabling the person to work can be deducted.
Medical devices	Durable medical equipment made for repeated use and is normally used for medical purposes. Examples include wheelchairs, hemodialysis equipment, canes, crutches, and artificial limbs (prosthetic devices).
Equipment	Costs for special equipment needed for the person to do his job. Examples of special equipment include one hand typewriters, telecommunication devices for the deaf, and other tools designed to accommodate a person's impairments. Equipment not normally used for medical purposes is only deductible if there is medically verified need for the item to control the impairment and enable the person to work. If the item were not available, it would immediately affect the person’s ability to work. For example, an electric air cleaner is deductible for a person with severe respiratory disease, who cannot function in a non-purified air environment. NOTE Any cost deducted as a business expense for the self-employed in the eligibility determination process cannot be deducted as an IRWE.
Drugs and medical services	Payments made for drugs or medical services, including diagnostic procedures, needed to treat or control an impairment.
Other supplies and services	• Medical supplies like incontinence pads, catheters, bandages, elastic stockings, and face masks. • Physical and occupational therapy.

Transportation costs	Deductible transportation costs depend on whether public transportation is available to the person, and whether the person is able to use available public transportation. If the person's impairment does not prevent him or her from using public transportation and it is available, no deduction is allowed for transportation costs. If public transportation is not available or the person's impairment prevents him or her from using public transportation, the following costs may be deducted: • If the person must use their own vehicle to get to and from work, a mileage allowance for the trip to and from work is deductible. The current IRS mileage rate for business miles is used to calculate the deduction. • Modifications to a vehicle to allow the person to get to and from work. The modifications must be necessary for the person to use the vehicle and directly related to the person's impairment. Only the costs of the modifications are deductible, not the cost of the vehicle. • When the person must have someone else drive them to work, the costs of taxicabs or other hired vehicles is deductible. If the person's own vehicle is used, a mileage allowance for the trip to and from work is deductible. The current IRS mileage rate for business miles is used to calculate the deduction.
Home modifications	The location of the person's place of work determines which modifications to the home are deductible. • When employed outside the home, only the cost of changes to the exterior to allow the person to get to his means of transportation are allowed. Example: an exterior wheelchair ramp.

	• When employed at home, the costs of modifying the inside of the person's home to create a working space are deductible, but only to the extent that the changes are specifically to the space in which the person actually works. Example: enlarging the doorway into the workspace for wheelchair access.
Installing, maintaining, and repairing deductible items	When a device, equipment, or appliance would qualify as a deductible item as described in the list above, the costs directly related to installing, maintaining, and repairing these items are also deductible.

6) One-Half Work Expense Deduction

For eligibility determined using the FBR test, one-half of the remaining earned income can be deducted after the previous deductions are applied.

> NOTE MSP also receives the one-half work expense deduction, despite using the FPL test.

7) Blind Work Expenses (BWE)

Ordinary and necessary expenses related to earning income can be deducted from the earned income of a person who is blind. Expenses paid by someone else are not deductible. The person must pay the expense.

To qualify for a BWE deduction, the person:

- must be under age 65 and determined blind (but not disabled), or
- Received SSI as a blind person for the month before the month he or she reached age 65.

Expenses are deductible only in the month in which they are paid and cannot be more than the person's total earned income for any month. Unused expenses cannot be carried over to another month. Ordinary and necessary expenses reasonably necessary for the earning of income are deductible.

The expense does not need to be directly related to the person's blindness; it need only be an expense related to working. There are three major categories of expenses.

The following are some examples of types of expenses:

Type of Expense	Type of Expense Includes
Transportation to and from work	• Bus or cab fare; • Guide dog, including upkeep; and • Private vehicle mileage at IRS business miles rate.
Job performance and improvement	• Braille instruction, equipment and translation; • Other work-related instruction or training, like computer training or stenotype instruction; • Child care costs; • Equipment and tools needed on the job; • Licenses; • Meals consumed at work; • Work-related professional association dues or union dues; • Durable medical equipment, like prosthetics or wheelchairs; • Income taxes; • Uniforms, including upkeep;

Daily living expenses are not work related and cannot be deducted. The following are some examples (but by no means all) of daily living expenses:

- Food;
- Personal care (haircuts, etc.);
- General educational development; and
- Life insurance.

8) Child Allocations

A person may get a deduction from income to account for the needs of their dependent child in the home. The child allocation deduction considers the financial responsibility of a parent to his or her child when the child is not the customer.

NOTE This deduction does not apply to Freedom to Work (FTW)

The child allocation is calculated and applied to the income group members as follows:

If …	**Then…**
The customer is living with his or her child or stepchild, including a spouse's stepchild	A child allocation amount is calculated for each child and the total is deducted from the combined income of the customer and spouse.
The customer child's ineligible parent has other children or stepchildren in the home	A child allocation amount is calculated for each child other than the customer and the total is deducted from the income of the ineligible parent when deeming the parent's income to the customer child.

Maximum Child Allocation Standards:

	Effective 1/1/23 to 12/31/23	**Effective 1/1/24 to 12/31/24**	**Effective 1/1/25 to 12/31/25**
Maximum Child Allocation	$457.00	$472.00	$483.00

How to Calculate the Child Allocation:

The child allocation is determined by subtracting the child's counted income from the Maximum Child Allocation Amount. A child's income must be verified in order to deduct a child allocation.

NOTE Since the child automatically gets MA (acute care), SSI payments and Title IV-E Adoption Assistance are only countable income for the Child Allocation.

The child allocation is calculated as follows:

Step	Action
1	Counted earned income of the child - Student earned income deduction (if any) = Net earned income.
2	Counted unearned income of the child + Net earned income = Total net income.
3	Maximum child allocation - Total net income = Child allocation (if a negative number results, the deduction is zero).
4	Total the individual allocations of each child.

9) Infrequent or Irregular Income Exclusion

This deduction does not apply to Freedom to Work (FTW)

Unearned Income

The first $60 of unearned income that is received infrequently or irregularly in a calendar quarter is excluded.

Earned Income

The first $30 of earned income that is received infrequently or irregularly in a calendar quarter is excluded.

The infrequent or irregular exclusion is not applied to an income type if another exclusion has already been applied.

> NOTE Earned and unearned exclusions are determined separately, but both may be applied during the same month. As much as $90.00 can be excluded in a calendar quarter.

Definitions

Term	Definition
Ineligible parent	A natural or adoptive parent, or stepparent who is NOT receiving SSI-Cash, ALTCS, Freedom to Work, MSP or SSI-MAO.
Regular Attendance	Regular attendance means that the individual takes one or more courses of study and attends classes: • In a college or university for at least 8 hours a week under a semester or quarter system; • In grades 7-12 for at least 12 hours a week and taking standard academic or vocational courses; • In a course of study to prepare him for gainful employment for at least 15 hours a week if the course involves shop practice, or 12 hours a week if it does not involve shop practice.
Payments Based on Need	The person must demonstrate financial need to qualify for the payment.
Available public transportation	Public transportation is considered available only if it is within a reasonable distance of the individual's place of work and that it runs when the person needs it.
Child	Means a person who: • Is not married (including divorced); and • Is under age 18; or • For child allocation deductions only, is under age 22 and is a student regularly attending a school, college or university, or a course of vocational or technical

	training to prepare for gainful employment (MA610).
Ineligible Parent	A natural or adoptive parent or stepparent who is NOT receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.
Infrequent income	Income that is received no more than once in a calendar quarter from a single source (e.g., a cash gift received from the customer's adult son every six months to help the customer pay his living expenses).
Irregular income	Income that cannot reasonably be expected to be received because it is not paid on a scheduled basis or is unpredictable so that it cannot be counted on or budgeted for.

NOTE This deduction does not apply to Freedom to Work (FTW)

Proof

Federal and State Data Services Hubs are checked first for proof. If proof is not available, or more proof is needed to see if the person qualifies for a deduction, other items that can be used for proof are listed under each type of information:

Proof of child support received or paid:

Proof of child support income includes:

- Court documents;
- Division of Child Support Services (DCSS) documents;
- For child support income received, a signed statement from the absent parent; or
- Collateral contact with the DCSS.

Proof of student status

Proof of student status and school attendance includes:

- A Request for Verification of School Attendance form (DE-208) completed by the school;
- School records;

- Collateral contact with the school or program.

Proof of work expenses (for IRWE and BWE)

- Receipts;
- Bills;
- Employer statements;
- Any evidence that indicates:
    - The nature of the expense;
    - Payment of the expense; and
    - Date payment was made.

    NOTE The customer's statement of transportation expenses and meals may be accepted without proof if they are reasonable.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	**Legal Authorities**
ALTCS Acute	20 CFR 416.1112(c)
SSI-MAO	20 CFR 416.1124(c)
Medicare Savings Program (MSP)	20 CFR 416.1166(b)
Freedom to Work (FTW)	AAC R9-22-1909

C Income Deductions for MAGI Programs

Revised 01/30/2025

Policy

For the programs that use Modified Adjusted Gross Income rules for income eligibility, certain expenses may be deducted from gross income to determine the amount of income to count. The deductions in this section apply ONLY to the following MA programs:

- Caretaker Relative;
- Pregnant Woman;
- Child;
- Adult; and
- KidsCare.

There are three types of deductions for the MAGI programs:

Deduction type	Description
Pre-tax deductions from gross income	Deductions taken from income before taxes are deducted. Common pre-tax deductions include deductions for health insurance premiums, contributions to 401(k) retirement plans, and life insurance premiums.
Adjustments to gross income	Expenses and adjustments allowed for tax purposes to determine Adjusted Gross Income (AGI) are also allowed when determining income eligibility using MAGI rules.
MAGI 5% FPL Disregard	A deduction equal to 5% of the Federal Poverty Level (FPL) for the size of the income group.

NOTE Pre-tax deductions and adjustments to gross income that occur more or less often than monthly are budgeted the same way as income for MAGI programs. See the table in MA604D for details.

1) Pre-tax Deductions from Gross Income

Verified deductions taken out of a person's income before taxes are allowed as a deduction from income for eligibility. The amount and the fact that it was taken out before taxes must be verified.

2) Adjustments to Gross Income

While proof of the expense or cost must be provided, the person does NOT have to file a tax return to get the deduction. Only "adjustments from gross income" are allowed as a deduction. While there are other credits and deductions allowed when filing a tax return, they are not allowed as a deduction from income. The following table gives an overview of each adjustment to gross income that may be allowed for MA:

> NOTE The table does NOT include all of the IRS requirements for each adjustment. See IRS Publication 17 for full list of the requirements for each adjustment at http://www.irs.gov/publications/p17/index.html

Adjustment type	Description
Educator Expenses	Eligible educators can deduct up to $250 of qualified expenses paid in the tax year. The maximum deduction is $500 for spouses who are both educators and filing jointly.
Business Expenses of Reservists, Performing Artists, and Fee-Basis Government Officials	These expenses include: • Certain business expenses of National Guard and reserve members who traveled more than 100 miles from home to perform services as a National Guard or reserve member; • Performing arts-related expenses as a qualified performing artist; and • Business expenses of fee-basis state or local government officials.
Health Savings Account Deduction	A deduction for contributions made from a person's income to a qualified HSA during the year.

Moving Expenses	For members of the Armed Forces, the costs of moving are because of military orders. The new work site must be at least 50 miles further from the person's old home than the old home was from the former workplace.
Deductible Part of Self-Employment Tax	A deduction for the employer-equivalent portion of self-employment tax.
Self-Employed SEP, SIMPLE and Qualified Plans	A deduction for contributions to a qualified retirement plan for the self-employed and clergy members.
Self-Employed Health Insurance Deductions	A deduction for the amount paid a self-employed person paid for health insurance for him or herself, spouse, and dependents.
Penalty on Early Withdrawal of Savings	A deduction for penalties paid for early withdrawal of savings from certain financial accounts.
Alimony Paid	A deduction for payments to or on behalf of a spouse or former spouse under a spousal support agreement only when they meet both of the following conditions: • Created on or before 12/31/2018; and • It has not been modified after 12/31/2018 to specifically state that the Tax Cuts and Jobs Act treatment of spousal support now applies.
IRA Deduction	Contributions made to a traditional IRA during the tax year may be deducted. The person must have earnings in the year to qualify for the deduction.
Student Loan Interest Deduction	A person may take this deduction if all of the following apply: • The person paid interest in the tax year on a qualified student loan;

	• The person is not married filing separately; • The person's modified adjusted gross income is less than $95,000 if single, head of household or qualified widow(er), or $195,000 if married filing jointly; and • The person is not claimed as a dependent on someone else's tax return.

3) MAGI 5% FPL Disregard

When a customer meets the non-financial requirements for a MAGI program but is over the income limit, a deduction equal to 5% of the FPL for the customer's budget group size is given.

When the customer could qualify for more than one MAGI program, the deduction is only applied when the customer does not meet the income limit for any of those MAGI programs. The deduction is applied in the income test for the MAGI program with the highest income limit.

NOTE The MAGI 5% FPL Disregard does not apply to the TMA program.

For examples, see Modified Adjusted Gross Income (MAGI) Deductions Examples.

The following table lists the MAGI 5% FPL Disregard by budget group size:

Number of people in the Budget Group	5% Disregard Amount Effective 2/1/2024	5% Disregard Amount Effective 2/1/2025
1	$63	$66
2	$86	$89
3	$108	$112
4	$130	$134
5	$153	$157
6	$175	$180

7	$198	$203
*Each additional person, add:	$23	$23

* “Each Additional” Approximate Amounts Only.

Definitions

Term	Definition
Adjustments to gross income	Expenses or deferred income subtracted from gross taxable income to determine a person’s Adjusted Gross Income (AGI). Also known as “above the line deductions” because they are listed above the line on the first page of the federal tax return where the AGI is calculated and entered.
Health Savings Account (HSA)	A tax-exempt account that is set up to pay or reimburse certain medical expenses.
Individual Retirement Account (IRA)	A form of individual retirement plan that is provided by a financial institution.
Non-Financial Requirements	The requirements to qualify for an AHCCCS Medical Assistance program that are not related to a customer’s counted income or resources.
Tax Year	It is the same as the calendar year; January 1 through December 31.

Proof

Proof for these deductions varies based on the type of deduction. Some examples of what can be used for proof include:

- Bills;
- Business records;
- Receipts;
- Bank account statements;
- Paychecks or paystubs;
- Current tax returns if the amount is anticipated to be the same; and
- Any other documents that support the expense or adjustment.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Adult Caretaker Relative Pregnant Woman Child KidsCare	42 CFR 435.4 42 CFR 435.603

610 How to Calculate Income Eligibility for ALTCS

610 How to Calculate Income Eligibility for ALTCS

Revised 04/14/2016

Policy

A customer's counted income must not be more than the income limit for ALTCS.

NOTE A customer receiving SSI-Cash, Title IV-E Foster Care or Title IV-E Adoption Assistance is considered income eligible for ALTCS unless the customer has a disqualifying trust. When a customer receives one of these payments and disbursements from a Special Treatment Trust, the disbursements are counted for eligibility as described in MA803A.8.

The table below lists the income tests and describes when each is used:

Use the...	When...
Gross income test	• The customer is living in a setting where long-term care services can be provided (MA521); and • Is not refusing HCBS services.
Net income test	• The customer is living in a setting where long-term care services cannot be provided; or • Is refusing HCBS services.

A Gross Income Test

Revised 04/14/2016

Policy

The gross test means the gross counted income, minus any costs required to obtain the income described at MA609A is used to determine the income eligibility.

If the customer...	Then...
Does not have a community spouse	Only the customer's counted income is used for the gross test.
Has a community spouse	Both the customer's and the spouse's income is used for the gross test.

1) Gross Income Test Calculation (Non-Community Spouse)

Follow the steps below to calculate income eligibility using the gross income test for a non-community spouse case:

Step	Action
1	The countable unearned income and countable earned income of the customer received in the control date are totaled.
2	The total is compared to the limit of 300% of the FBR. The customer passes the income test if the income is less than or equal to the income limit.

See Example - ALTCS Gross Test - Non-Community Spouse

2) Gross Income Test Calculation (Community Spouse)

This section describes how to calculate income eligibility for ALTCS using the gross test when the customer has a community spouse.

NOTE If the customer refuses HCBS, community spouse policy is not applicable. The net income test is used to determine eligibility.

Income eligibility for community spouse cases is determined by using one of the following budgeting rules:

Rule	Overview
Community Property Rules	One-half of the couple's total countable income is counted for the customer.
Name-on-Check Rules	Only the income that is in the customer's name or that the customer has ownership rights to is counted as income to the customer. NOTE This is used only when the customer is not eligible using the community property calculation.

Calculation Using Community Property Rules:

Step	Action
1	The gross countable unearned income of both spouses is combined.
2	The gross countable earned income of both spouses is combined.
3	The combined gross countable unearned income from Step 1 and the combined gross countable earned income from Step 2 are totaled.
4	The total calculated from Step 3 is divided by two.
5	The result from Step 4 is compared to 300% of the FBR:

	The customer passes the income test if the income is less than or equal to the income limit.

See Example - Community Property Rules Calculation

Calculation Using Name-on-Check Rules

The steps below are used to calculate income eligibility using name-on-check rules:

Step	Action
1	The countable unearned income and countable earned income owned by the customer are totaled.
2	This amount is compared to 300% of the FBR. The customer passes the income test if the income is less than or equal to the income limit.

See Examples – Name on Check rules

Important:

For the name-on-check rules, ownership of the income must be determined:

If income is paid...	AND payment is made...	Then...
With instrument	In only one spouse's name	The income is considered available to the person in whose name payment is made, unless another instrument specifies other ownership rights to the income.
	In the names of both spouses	One half of the income is considered available to each spouse, unless another instrument specifies other ownership rights to the income.

	In the names of the customer, the spouse or both, and to another person	The income is considered available to each spouse in proportion with the spouse's interest as shown by the instrument.
With no instrument	N/A	One-half of the income is considered available to the each spouse. NOTE When the customer disagrees with having the income split evenly, it can be split differently when there is proof that the amount or percentage of the income owned by each spouse is not one-half.

See Examples – Income Ownership

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 USC 1396r-5 42 CFR 435.236 Full ALTCS 42 CFR 435.210 ALTCS Acute AAC R9-28-408 AAC R9-28-410(C)

B Net Income Test

Revised 07/13/2018

Policy

The net test means the gross counted income, minus any allowable deductions described in MA609.A and MA609.B is used to determine the customer's income eligibility.

The income standard for the net income test is 100% of the Federal Benefit Rate (FBR) for either an individual or a couple, whichever is applicable (see MA615.1)

1) Net Income Calculation for the Customer Only

The following actions are taken to determine income eligibility when the customer is:

- Single; or
- Under age 18, unmarried and parental deeming does not apply because the child does not live with an ineligible parent; or
- Is married and does not live with the spouse or the legal spouse is in a medical institution.

The steps below are used to calculate income eligibility using the net income test:

Step	Action
1	To calculate the net unearned income: • The customer's counted unearned income, except needs based assistance, is totaled; • If a customer child receives child support payments, subtract 1/3 of the child support payment; • The $20.00 general income deduction is subtracted; and • Needs based assistance payments are added to get the total counted unearned income.
2	To calculate the net earned income: • The counted earned income of the customer is totaled; • Any Student Earned Income Exclusion is subtracted; • The unused portion of the $20.00 deduction is subtracted;

	• The $65.00 work expense deduction is subtracted; • Impairment Related Work Expenses are subtracted; • ½ of the subtotal of earned income is subtracted; and • Blind Work Expenses are subtracted. NOTE If any of the subtractions in this step result in a $0.00 subtotal or negative subtotal, the net earned income amount is $0.00.
3	The net unearned income from Step 1 is added to the net earned income from Step 2 to get the total net income.
4	Calculate a child allocation amount for each of the customer's children living in the home (see MA609B.8 for calculation steps). Total the child allocation amounts and subtract from the total net income from step 3.
5	The result is compared to 100% of the FBR for an individual: The customer passes the income test if the net income is less than or equal to the income limit.

See Example - Customer Only Net Calculation

Net Income Calculation for Customer and Spouse

Take the following actions to determine income eligibility when the customer lives with a spouse:

Step	Action
1	To calculate the net unearned income: • Total the customer's and spouse's counted unearned income, except needs based assistance; • If the customer is a child and receives child support payments, subtract 1/3 of the child support payment; • Subtract the $20.00 general income deduction; and • Add any needs based assistance payments to get the total counted unearned income.

2	To calculate net earned income: • Any Student Earned Income Exclusion for the customer is subtracted; • Any Student Earned Income Exclusion for the customer's spouse is subtracted; • After the Student Earned Income Exclusion has been subtracted, total the customer's and spouse's remaining earned income. • The unused portion of the $20.00 deduction is subtracted; • The $65.00 work expense deduction is subtracted; • The Impairment Related Work Expenses are subtracted; • ½ subtotal of earned income is subtracted; and • The Blind Work Expenses are subtracted. NOTE If any of the remaining subtractions in this step result in a $0.00 subtotal or negative subtotal, the net earned income amount is $0.00.
3	The net unearned income from Step 1 is added to the net earned income from Step 2 to get the total net income.
4	Calculate a child allocation amount for each of the customer's children and the customer's spouse's children living in the home (see MA609B.8 for calculation steps). Total the child allocation amounts and subtract from the total net income from step 3.
5	The result is compared to 100% of the FBR for couple (MA615.1): The customer passes the income test if the net income is less than or equal to the income limit.

See Example – Customer and Spouse Net Calculation

Calculation for Customer Child and Ineligible Parent

The income-eligibility determination for a customer child who resides with at least one ineligible parent includes three separate calculations.

- First, a child allocation is calculated for each of the ineligible parents' other children living in the home.

- Second, the amount of income to be deemed to the customer child from the ineligible parents is calculated.
- Third, the customer child's own income is calculated and added to any income deemed from the ineligible parents.

Follow the steps below to determine income eligibility when an unmarried customer child under age 18 resides with at least one ineligible parent.

1st Process: Determine Child Allocations	
Step	**Action**
1	Calculate a child allocation amount for each ineligible parent's children living in the home (see MA609B.8 for calculation steps).
2	Combine all of the child allocation amounts to get the total Child Allocation.
2nd Process: Deeming Calculation	
Step	**Action**
3	Total the gross counted unearned income of the ineligible parents and subtract the total Child Allocation from Step 2. • If the result is a negative number, this is the remaining unused Child Allocation. There is no remaining unearned income. • If the result is a positive number, this is the remaining unearned income. There is no unused Child Allocation. • If the result is exactly zero, there is no unused Child Allocation and no remaining unearned income.
4	For each ineligible parent under age 22 that meets the definition of a student, subtract the Student Earned Income Exclusion (MA609B.2).
5	Total the earned income of the ineligible parents from Step 4 and subtract any unused Child Allocation from Step 3. • If the result is zero or a negative number there is no remaining earned income.

	• If the result is a positive number, this is the remaining earned income.
5	Determine if there is any remaining unearned income or remaining earned income to be deemed. • If there is no remaining income from Step 3 or Step 5, the amount of income deemed from the ineligible parents is $0.00. Skip to step 10 • If there is remaining unearned or earned income from Step 3 or Step 5, continue to Step 6
6	Subtract the $20.00 general income deduction from any remaining unearned income to get the net unearned income.
7	Subtract the following deductions in order from any remaining earned income to get the net earned income: • Any unused portion of the $20.00 deduction; • The $65.00 work expense deduction; • Any Impairment Related Work Expenses; • ½ subtotal of earned income; and • Any Blind Work Expenses.
8	Add the net unearned income from Step 6 to the net earned income from Step 7 to get the total net income.
9	To get the total deemed income amount, take the total net income from Step 8 and subtract: • The individual FBR amount if the customer has only one ineligible parent; or • The couple FBR if the customer has two ineligible parents.
3rd Process: Net Income Test Calculation	
Step	**Action**
10	To calculate the net unearned income:

	• Add the deemed income amount to the customer child's counted unearned income except for needs based payments; • If a customer child receives child support payments, subtract 1/3 of the child support payment; • Subtract the $20.00 general income deduction; and • Add in any needs based payments.
11	To calculate the net earned income: • Total the counted earned income of the customer child; • Subtract any student earned income exclusion; • Subtract and unused portion of the $20.00 general deduction; • Subtract the $65.00 work expense deduction; • Subtract any Impairment Related Work Expenses; • Subtract ½ of remaining earned income; and • Subtract any Blind Work Expenses.
12	Add the net unearned income from Step 10 to the net earned income from Step 11 to get the total net income.
13	Calculate a child allocation amount for each customer child's children living in the home (see MA609B.8 for calculation steps) and subtract the total child allocations from the total net income from Step 12
14	Compare the result from Step 13 to 100% of the FBR for an individual: The customer passes the income test if the income is less than or equal to the income limit.

See Example – Customer Child with Ineligible Parents

Definitions

Term	Definition

Instrument	A written document that states the ownership of or right to the payment. Examples of instruments include check stubs, bank statements, contracts and trusts. There may be more than one instrument for the payment. For example, income paid by check may have another instrument, like an annuity contract, which provides more detailed information on who owns the income.
No instrument	There is no written document showing ownership of the payment. For example a cash payment made where there is no written contract or agreement.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 USC 1396r-5 42 CFR 435.236 Full ALTCS 42 CFR 435.210 ALTCS Acute AAC R9-28-408 AAC R9-28-410(C)

611 How to Calculate Income Eligibility for SSIMAO

611 How to Calculate Income Eligibility for SSI-MAO

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A How to Calculate Income Eligibility for SSI-MAO

Revised 02/13/2024

Policy

Income eligibility for all SSI-MAO programs is determined by using a “net income test.” “Net income test” means certain deductions and disregards are taken from the gross countable income.

Some SSI-MAO programs like Pickle, Disabled Adult Child (DAC) and Disabled Widow/Widower (DWW) have additional disregards to determine the amount of countable unearned income used to calculate income eligibility.

1) Net Income Test

The net income test is used to determine income eligibility under SSI-MAO.

To qualify, the customer’s counted income minus any allowable deductions cannot be more than the income standard. The income standard for SSI-MAO is either:

- 100% of the Federal Benefit Rate (FBR); or
- 100% of the Federal Poverty Level (FPL).

The income test using the 100% FBR standard is done first. If the customer is not eligible using the 100% FBR standard, the net income test is completed using the 100% FPL standard. The only differences in the tests are:

- The deduction for 1/2 of earned income does not apply when using the 100% FPL standard; and
- The 100% FPL income standard is higher than the 100% FBR standard.

2) Deductions from Net Income

The table below shows the allowable income deductions used in the net income test in the order that they are deducted:

Allowable Deduction	**Amount**
Child Support	Varies
Student Child Earned Income Deduction	Varies
General Income Deduction	$20.00

Standard Work Expense Deduction	$65.00
Impairment Related Work Expenses (IRWE)	Varies
1/2 Subtotal of Earned Income (allowed for the 100% FBR test only)	Varies
Blind Work Expenses (BWE)	Varies
Child Allocations	Varies

3) Calculation for the Customer Only

The following actions are taken to determine income eligibility when the customer is:

- Single; or
- Under age 18, unmarried and parental deeming does not apply because the child does not live with an ineligible parent; or
- Is married and does not live with the spouse.

Net Income Test Using 100% FBR Standard	
Step	**Action**
1	To calculate the net unearned income: • The customer's counted unearned income, except needs-based assistance, is totaled; • If a customer child receives child support payments, subtract 1/3 of the child support payment; • The $20.00 general income deduction is subtracted; and • Needs-based assistance payments are added to get the total counted unearned income.

2	To calculate the net earned income: • The counted earned income of the customer is totaled; • Any Student Earned Income Exclusion is subtracted; • The unused portion of the $20.00 deduction is subtracted; • The $65.00 work expense deduction is subtracted; • Impairment Related Work Expenses are subtracted; • 1/2 of the subtotal of earned income is subtracted; and • Blind Work Expenses are subtracted. NOTE If any of the subtractions in this step result in a $0.00 subtotal or negative subtotal, the net earned income amount is $0.00.
3	The net unearned income from Step 1 is added to the net earned income from Step 2 to get the total net income.
4	Calculate a child allocation amount for each of the customer's children living in the home (see MA609B.8 for calculation steps). Total the child allocation amounts and subtract from the total net income from Step 3.
5	The result is compared to 100% of the FBR for an individual (MA615.2): • If net income is less than or equal to the FBR standard, STOP. The customer is income eligible. • If net income is more than the FBR standard, continue to Step 6.
6	Take the total net income from Step 3 and add back in 1/2 of the subtotal of earned income amount from Step 2 to get the total net income for the 100% FPL test.
7	Calculate a child allocation amount for each of the customer's children living in the home (see MA609B.8 for calculation steps). Total the child allocation amounts and subtract from the total net income from Step 6.
8	Compare the result to 100% of the FPL for an individual (MA615.2): • If net income is less than or equal to the FPL standard, the customer is income eligible. • If net income is more than the FPL standard, the customer is not eligible for SSI-MAO due to excess income.

	NOTE The customer may qualify for MSP. The net test for QMB, SLMB and QI-1 allows the 1/2 of earned income deduction and uses the higher 100% FPL income standard.

See Calculation for the Customer Only Examples

4) Calculation for Customer and Spouse

The following actions are taken to determine income eligibility for a married customer who resides with his or her spouse.

First, the net test using FBR standards is completed. If the customer is not eligible using FBR standards, the net test is completed using FPL standards:

Net Income Test Using 100% FBR Standard	
Step	**Action**
1	To calculate the net unearned income: • Total the customer's and spouse's counted unearned income, except needs-based assistance; • If the customer is a child and receives child support payments, subtract 1/3 of the child support payment; • Subtract the $20.00 general income deduction; and • Add any needs-based assistance payments to get the total counted unearned income.
2	To calculate net earned income: • Any Student Earned Income Exclusion for the customer is subtracted; • Any Student Earned Income Exclusion for the customer's spouse is subtracted; • After the Student Earned Income Exclusion has been subtracted, total the customer's and spouse's remaining earned income. • The unused portion of the $20.00 deduction is subtracted; • The $65.00 work expense deduction is subtracted; • The Impairment Related Work Expenses are subtracted; • 1/2 of the subtotal of earned income is subtracted; and

	• The Blind Work Expenses are subtracted. NOTE If any of the remaining subtractions in this step result in a $0.00 subtotal or negative subtotal, the net earned income amount is $0.00.
3	The net unearned income from Step 1 is added to the net earned income from Step 2 to get the total net income.
4	Calculate a child allocation amount for each of the customer's children and the customer's spouse's children living in the home (see MA609B.8 for calculation steps). Total the child allocation amounts and subtract from the total net income from Step 3.
5	The result is compared to 100% of the FBR for a couple: • If net income is less than or equal to the FBR standard, STOP. The customer is income eligible. • If net income is more than the FBR standard, continue to Step 6.
6	Take the total net income from Step 3 and add back in 1/2 of the subtotal of earned income amount from Step 2 to get the total net income for the 100% FPL test.
7	Calculate a child allocation amount for each of the customer's children living in the home (see MA609B.8 for calculation steps). Total the child allocation amounts and subtract from the total net income from Step 6.
8	Compare the result to 100% of the FPL for a couple: • If net income is less than or equal to the FPL standard, the customer is income eligible. • If net income is more than the FPL standard, the customer is not eligible for SSI-MAO due to excess income. NOTE The customer may qualify for MSP. The net test for QMB, SLMB and QI-1 allows the 1/2 of earned income deduction and uses the higher 100% FPL income standard.

See Calculation for Customer and Spouse Examples

5) Calculation for Customer Child and Ineligible Parent

The income-eligibility determination for a customer child who resides with at least one ineligible parent includes three separate calculations.

- First, a child allocation is calculated for each of the ineligible parents' other children living in the home.
- Second, the amount of income to be deemed to the customer child from the ineligible parents is calculated.
- Third, the customer child's own income is calculated and added to any income deemed from the ineligible parents.

Follow the steps below to determine income eligibility when an unmarried customer child under age 18 resides with at least one ineligible parent.

1st Process: Determine Child Allocations	
Step	**Action**
1	Calculate a child allocation amount for each ineligible parent's children living in the home (see MA609B.8 for calculation steps).
2	Combine all of the child allocation amounts to get the total Child Allocation.
2nd Process: Deeming Calculation	
Step	**Action**
3	Total the gross counted unearned income of the ineligible parents and subtract the total Child Allocation from Step 2. • If the result is a negative number, this is the remaining unused Child Allocation. There is no remaining unearned income. • If the result is a positive number, this is the remaining unearned income. There is no unused Child Allocation. • If the result is exactly zero, there is no unused Child Allocation and no remaining unearned income.
4	For each ineligible parent under age 22 that meets the definition of a student, subtract the Student Earned Income Exclusion (MA609B.2).
5	Total the earned income of the ineligible parents from Step 4 and subtract any unused Child Allocation from Step 3. • If the result is zero or a negative number there is no remaining earned income. • If the result is a positive number, this is the remaining earned income.

6	Determine if there is any remaining unearned income or remaining earned income to be deemed. • If there is no remaining income from Step 3 or Step 5, the amount of income deemed from the ineligible parents is $0.00. Skip to Step 11. • If there is remaining unearned or earned income from Step 3 or Step 5, continue to Step 7.
7	Subtract the $20.00 general income deduction from any remaining unearned income to get the net unearned income.
8	Subtract the following deductions in order from any remaining earned income to get the net earned income: • Any unused portion of the $20.00 deduction; • The $65.00 work expense deduction; • Any Impairment Related Work Expenses; • 1/2 subtotal of earned income; and • Any Blind Work Expenses.
9	Add the net unearned income from Step 7 to the net earned income from Step 8 to get the total net income.
10	To get the total deemed income amount, take the total net income from Step 9 and subtract: • The individual FBR amount if the customer has only one ineligible parent; or • The couple FBR if the customer has two ineligible parents.

3rd Process: Net Income Test Calculation

Step	**Action**
11	To calculate the net unearned income: • Add the deemed income amount to the customer child's counted unearned income except for needs-based payments; • If a customer child receives child support payments, subtract 1/3 of the child support payment; • Subtract the $20.00 general income deduction; and

	• Add in any needs-based payments.
12	To calculate the net earned income: • Total the counted earned income of the customer child; • Subtract any student earned income exclusion; • Subtract any unused portion of the $20.00 general income deduction; • Subtract the $65.00 work expense deduction; • Subtract any Impairment Related Work Expenses; • Subtract 1/2 of remaining earned income; and • Subtract any Blind Work Expenses.
13	Add the net unearned income from Step 11 to the net earned income from Step 12 to get the total net income.
14	Calculate a child allocation amount for each customer child's children living in the home (see MA609B.8 for calculation steps) and subtract the total child allocations from the total net income from Step 13.
15	Compare the result from Step 14 to 100% of the FBR for an individual: • If net income is less than or equal to the FBR standard, STOP. The customer is income eligible. • If net income is more than the FBR standard, continue to Step 16.
Net Income Test Using 100% FPL Standard	
FPL Deeming Calculation	
Step	**Action**
16	• Take the total net income from Step 9; • Add back in 1/2 of the subtotal of earned income deduction from Step 8; and • Subtract the 100% FPL amount for one person if the customer has only one ineligible parent; or the couple 100% FPL amount if the customer has two ineligible parents. The result is the total deemed income amount from the ineligible parents.

3rd Process: Net Income Test Calculation	
Step	**Action**
17	The net unearned income is calculated as follows: • Add the counted unearned income of the customer child and the total deemed income from Step 16; • If a customer child receives child support payments, subtract 1/3 of the child support payment; • Subtract the $20.00 general income deduction; and • Add and needs-based assistance payments.
18	The net earned income is calculated as follows: • Total the counted earned income of the customer child; • Subtract any Student Earned Income Exclusion; • Subtract any unused portion of the $20.00 general income deduction; • Subtract the $65.00 work expense deduction; • Subtract any Impairment Related Work Expenses; and • Subtract any Blind Work Expenses.
19	Add the net unearned income from Step 17 to the net earned income from Step 18 to get the total net income.
20	Calculate a child allocation amount for each customer child's children living in the home (see MA609B.8 for calculation steps) and subtract the total child allocations from the total net income from Step 13.
21	Compare the result to 100% of the FPL for one person: • If net income is less than or equal to the FPL standard, the customer is income eligible. • If net income is more than the FPL standard, the customer is not eligible for SSI-MAO due to excess income.

See Calculation for Customer Child and Ineligible Parents Example

Definitions

Term	Definition
Child	Means a person who: • Is not married (including divorced); and • Is under age 18; or • For child allocation deductions only, is under age 22 and is a student regularly attending a school, college or university, or a course of vocational or technical training to prepare for gainful employment.
Ineligible Parent	A natural or adoptive parent, or stepparent who is NOT receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.

Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
SSI-MAO	42 USC 1396a(a)(10)(A)(ii)(I) 42 CFR 435.201 42 CFR 435.210 ARS 36-2901(6)(a) AAC R9-22-1501 to 1505

B How to Calculate the Special Income Disregard for Pickle

Revised 02/13/2024

Policy

The Pickle disregard excludes Title II cost of living adjustment (COLA) increases from the date the person lost their eligibility for SSI-Cash or out-of-state State Supplemental Payment (SSP) benefits.

To get the Pickle disregard, the customer must:

- Currently receive Social Security Title II benefits;
- Have received SSI-Cash or out-of-state State Supplemental Payment (SSP) benefits in the past;
- Have received SSI-Cash or SSP benefits and received or were entitled to receive Social Security Title II for the same month in at least one month since April 1977; and
- Have lost SSI-Cash or SSP benefits due to a COLA increase.

NOTE The Pickle disregard is only given for the 100% FBR net income test. It is not allowed when determining eligibility using the 100% FPL income standard.

Definitions

Term	Definition
Pickle	People who are eligible under the Pickle Amendment receive Title II Social Security payments. These individuals previously received both SSI-Cash and Title II benefits at the same time and lost their SSI-Cash.
Cost of Living Adjustment (COLA)	An increase intended to ensure that Social Security benefits are adjusted to account for inflation. The COLA amount, if any, is determined annually.

Proof

One or more of the following may be used for proof of Social Security benefits and that a person received both Social Security and SSI-Cash or SSP:

- Social Security records and data matches;
- Award letters;
- AHCCCS records showing SSI-Cash eligibility.

Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
SSI-MAO (Pickle)	42 USC 1396a(a)(10)(A)(i)(I) 42 CFR 435.135 ARS 36-2901(6)(a) AAC R9-22-1505

C How to Calculate the Special Income Disregard for DAC

Revised 02/13/2024

Policy

The Title II Social Security payment from a parent is not counted when calculating financial eligibility for a Disabled Adult Child (DAC).

NOTE The DAC disregard is only given for the 100% FBR net income test. It is not allowed when determining eligibility using the 100% FPL income standard.

Definitions

Term	Definition
Disabled Adult Children (DAC)	Disabled Adult Children (DAC) are adults who were determined disabled before age 22 and were receiving SSI-Cash payments, but their SSI-Cash stopped when they became entitled to or had an increase in Title II Social Security benefits as the dependent of a parent.

Proof

One or more of the following may be used for proof of Social Security benefits, disability onset date, and the date and reason the SSI-Cash payment stopped:

- Social Security records and data matches;
- Award letters;
- AHCCCS records showing SSI-Cash eligibility;
- Social Security income currently received.

Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities

SSI-MAO (DAC)	42 USC 1383c(c) ARS 36-2901(6)(a) AAC R9-22-1505

D How to Calculate the Special Income Disregard for DWW

Revised 02/13/2024

Policy

The Title II Social Security payment from a deceased spouse is not counted when calculating financial eligibility for a Disabled Widow/Widower (DWW).

NOTE The DWW disregard is only given for the 100% FBR net income test. It is not allowed when determining eligibility using the 100% FPL income standard.

Definitions

Term	Definition
Disabled Widow/Widowers (DWW)	DWWs are persons between age 50 and 65 who were determined disabled and received SSI-Cash benefits. The SSI-Cash payment stopped due to receipt of or an increase in Title II Widows benefits (MA512).

Proof

One or more of the following may be used for proof of Social Security benefits, disability onset date, Medicare entitlement, and the date and reason the SSI-Cash payment stopped:

- Social Security records and data matches;
- Award letters;
- AHCCCS records showing SSI-Cash eligibility;
- Social Security income currently received.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
SSI-MAO (DWW)	42 USC 1383c(b) 42 USC 1396a(a)(10)(A)(i)(I) 42 CFR 435.138 AAC R9-22-1505

612 How to Calculate Income Eligibility for Medicare Savings Program (MSP)

Policy

The net income test is used to determine income eligibility under the Medicare Savings Program (MSP) for:

- Qualified Medicare Beneficiary (QMB);
- Specified Low Income Medicare Beneficiary (SLMB); and
- Qualified Individual (QI-1).

Only the income of the customer and responsible relatives is used to determine net income. Income is counted in the month it is received, even if earned in the previous month.

The counted income available to a customer minus deductions cannot be more than the income standard.

1) Income Standard

The income standard for MSP depends on the program:

If the MSP is...	Then the income standard is...
Qualified Medicare Beneficiary (QMB)	100% of the Federal Poverty Level (FPL).
Specified Low Income Beneficiary (SLMB)	Greater than 100% but equal to or less than 120% of the FPL.
Qualified Individual- 1 (QI-1)	Greater than 120% but equal to or less than 135% of the FPL.

2) Deductions from Net Income

The table below shows the allowable income deductions used in net income budgeting for MSP:

Allowable Deduction	Amount
Child Support	Varies
Student Earned Income Exclusion	Varies
General Income Deduction	$20.00
Standard Work Expense Deduction	$65.00
Impairment Related Work Expense Deduction (IRWE)	Varies
½ Subtotal of Earned Income	Varies
Blind Work Expenses	Varies
Child Allocations	Varies

3) Calculation for the Customer Only

The following actions are taken to determine income eligibility when the customer is:

- Single; or
- Under age 18, unmarried and parental deeming does not apply because the child does not live with an ineligible parent; or
- Is married and does not live with the spouse.

Step	Action
1	The net unearned income is calculated as follows:

	• The counted unearned income of the customer is totaled; • If a customer child receives child support payments, 1/3 of the child support payment is subtracted; • The $20.00 general income deduction is subtracted; and • Needs based assistance payments are added.
2	The net earned income is calculated as follows: • The counted earned income of the customer is totaled; • The Student Earned Income Exclusion (only if under age 22) is subtracted; • The unused portion of the $20.00 deduction is subtracted; • The $65.00 work expense deduction is subtracted; • Impairment Related Work Expenses are subtracted; • ½ subtotal of earned income are subtracted; and • Blind Work Expenses are subtracted. NOTE If any of the remaining subtractions listed in this step result in a $0.00 subtotal or negative subtotal, the net earned income amount is $0.00.
3	The total net income is calculated as follows: • The subtotal obtained from Step 1 is added to subtotal obtained in Step 2; and • Child Allocations are subtracted.
4	The result is compared to the QMB, SLMB, and QI-1 income standards for an individual. If the income is: • Less than or equal to 100% of the FPL, the customer qualifies for QMB. • Greater than 100% but less than or equal to 120% of FPL, the customer qualifies for SLMB. • Greater than 120% but less than or equal to 135% of FPL, the customer qualifies for QI-1.

See Example - Customer Only

4) Calculation for Customer and Spouse

The following actions are taken to determine income eligibility for a customer who lives with a spouse:

Step	Action
1	The total gross unearned income is calculated as follows: • The counted unearned income of the customer and spouse is totaled; • If a customer child receives child support payments, 1/3 of the child support payment is subtracted; • The $20.00 general income deduction is subtracted; and • Needs based assistance payments are added.
2	The net earned income is calculated as follows: • The Student Earned Income Exclusion is subtracted from customer's counted earned income (only if under age 22); • The Student Earned Income Exclusion is subtracted from spouse's counted earned income (only if under age 22); • After the Student Earned Income Exclusion has been subtracted, the counted earned income of the customer and spouse is subtotaled; NOTE If any of the remaining subtractions listed in this step result in a $0.00 subtotal or negative subtotal, the net earned income amount is $0.00. The following are subtracted from the subtotal in this order: • The unused portion of the $20.00 deduction; • $65.00 work expense deduction; • Impairment Related Work Expenses; • ½ subtotal of earned income; and • Blind Work Expenses.
3	The total net income is calculated as follows: • The subtotal obtained from Step 1 is added to the subtotal obtained in Step 2; and

	• Child Allocations are subtracted.
4	The result is compared to the QMB, SLMB, and QI-1 income standards for a couple. If the income is: • Less than or equal to 100% of the FPL, the customer qualifies for QMB. • Greater than 100% but less than or equal to 120% of FPL, the customer qualifies for SLMB. • Greater than 120% but less than or equal to 135% of FPL, the customer qualifies for QI-1.

See Example - Customer and Spouse

5) Calculation for Customer Child and Ineligible Parent

The income-eligibility determination for a customer child who resides with at least one ineligible parent includes three separate calculations.

- First, a child allocation is calculated for each of the ineligible parents' other children living in the home.
- Second, the amount of income to be deemed to the customer child from the ineligible parents is calculated.
- Third, the customer child's own income is calculated and added to any income deemed from the ineligible parents.

Follow the steps below to determine income eligibility when an unmarried customer child under age 18 resides with at least one ineligible parent.

1st Process: Determine Child Allocations	
Step	**Action**
1	Calculate a child allocation amount for each ineligible parent's children living in the home (see MA609B.8 for calculation steps).
2	Combine all of the child allocation amounts to get the total Child Allocation.
2nd Process: Deeming Calculation	

Step	Action
3	Total the gross counted unearned income of the ineligible parents and subtract the total Child Allocation from Step 2. • If the result is a negative number, this is the remaining unused Child Allocation. There is no remaining unearned income. • If the result is a positive number, this is the remaining unearned income. There is no unused Child Allocation. • If the result is exactly zero, there is no unused Child Allocation and no remaining unearned income.
4	For each ineligible parent under age 22 that meets the definition of a student, subtract the Student Earned Income Exclusion (MA609.B.2).
5	Total the earned income of the ineligible parents from Step 4 and subtract any unused Child Allocation from Step 3. • If the result is zero or a negative number there is no remaining earned income. • If the result is a positive number, this is the remaining earned income.
5	Determine if there is any remaining unearned income or remaining earned income to be deemed. • If there is no remaining income from Step 3 or Step 5, the amount of income deemed from the ineligible parents is $0.00. Skip to step 10 • If there is remaining unearned or earned income from Step 3 or Step 5, continue to Step 6
6	Subtract the $20.00 general income deduction from any remaining unearned income to get the net unearned income.
7	Subtract the following deductions in order from any remaining earned income to get the net earned income: • Any unused portion of the $20.00 deduction; • The $65.00 work expense deduction; • Any Impairment Related Work Expenses; • ½ subtotal of earned income; and

	• Any Blind Work Expenses.
8	Add the net unearned income from Step 6 to the net earned income from Step 7 to get the total net income.
9	To get the total deemed income amount, take the total net income from Step 8 and subtract: • The individual 100% FPL amount if the customer has only one ineligible parent; or • The couple 100% FPL if the customer has two ineligible parents.

3rd Process: Net Income Test Calculation

Step	Action
10	To calculate the net unearned income: • Add the deemed income amount to the customer child's counted unearned income except for needs based payments; • If a customer child receives child support payments, subtract 1/3 of the child support payment; • Subtract the $20.00 general income deduction; and • Add in any needs based payments.
11	To calculate the net earned income: • Total the counted earned income of the customer child; • Subtract any student earned income exclusion; • Subtract and unused portion of the $20.00 general deduction; • Subtract the $65.00 work expense deduction; • Subtract any Impairment Related Work Expenses; • Subtract ½ of remaining earned income; and • Subtract any Blind Work Expenses.
12	Add the net unearned income from Step 10 to the net earned income from Step 11 to get the total net income.

13	Calculate a child allocation amount for each customer child's children living in the home (see MA609.B.8 for calculation steps) and subtract the total child allocations from the total net income from Step 12
14	The result is compared to the QMB, SLMB, and QI-1 income standards for an individual. If the income is: • Less than or equal to 100% of the FPL, the customer qualifies for QMB. • Greater than 100% but less than or equal to 120% of FPL, the customer qualifies for SLMB. • Greater than 120% but less than or equal to 135% of FPL, the customer qualifies for QI-1.

See Example - Customer Child and Ineligible Parents

Definitions

Term	Definition
Child	Means a person who: • Is not married (including divorced); and • Is under age 18; or • For child allocation deductions only, is under age 22 and is a student regularly attending a school, college or university, or a course of vocational or technical training to prepare for gainful employment.
Ineligible Parent	A natural or adoptive parent, or stepparent who is NOT receiving SSI-Cash benefits, ALTCS, Freedom to Work, MSP or SSI-MAO.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Medicare Savings Program (MSP)	42 USC 1396a(a)(10)(E) AAC R9-29-212 and 213

613 How to Calculate Income Eligibility for Freedom to Work (FTW)

Policy

The net income test is used to determine income eligibility under AHCCCS Freedom to Work (FTW). Only the customer's earned income is used. Unearned income is not counted in the FTW calculation. Income is counted in the month it is received, even if earned in the previous month.

The customer's counted earned income minus allowable deductions cannot be more than the income standard.

> NOTE Only the customer's income is counted. The income of a spouse or other family members is not counted for income eligibility.

1) The Income Standard

The income standard for AHCCCS FTW is 250% of the Federal Poverty Level (FPL).

2) Deductions from Net Income

The table below shows the allowable income deductions used in net income budgeting for AHCCCS FTW:

Allowable Deduction	Amount
General Income Deduction	$20.00
Student Earned Income Exclusion	Varies
Standard Work Expense Deduction	$65.00
Impairment Related Work Expense Deduction (IRWE)	Varies
One half of the Remainder of Earned Income	Varies

Blind Work Expenses	Varies

3) Calculation for AHCCCS FTW

The following steps are used to determine income eligibility for Freedom to Work:

Step	Action
1	For the income eligibility determination, disregard all unearned income received by the customer.
2	To calculate the net earned income: • The counted earned income of the customer is totaled; and • The following are subtracted in this order: ◦ Student Earned Income Exclusion (only if under age 22); ◦ The $20.00 general income deduction; ◦ The $65.00 work expense deduction; ◦ Impairment Related Work Expenses; ◦ ½ of subtotal of earned income; and ◦ Blind Work Expenses.
3	The result in Step 2 is compared to 250% of the FPL: The customer passes the income test if the net income is less than or equal to the income limit.

See Example: How to calculate FTW income Eligibility

Definitions

Term	Definition

Unearned income	Any income that is not received as the result of a job or self-employment.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Freedom to Work (FTW)	AAC R9-22-1909

614 How to Calculate Income Eligibility Using MAGI

Revised 01/07/2025

Policy

Modified Adjusted Gross Income (MAGI) policy is used for the following AHCCCS Medical Assistance (MA) programs:

- Caretaker Relative;
- Pregnant Woman;
- Child;
- Adult;
- KidsCare.

To qualify, the counted income of the customer's MAGI budget group minus any allowable deductions cannot be more than the income standard for the MA program and the size of the budget group.

NOTE People living in the same home may have different budget groups and MA categories. Income eligibility is determined for each person based on their budget group and category.

See MA602D for MAGI budget group policy.

See MA615 for the income limits for MAGI groups.

1) Whose Income is Counted?

In general, the counted income of everyone in the budget group is totaled and compared to the income standard for the size of the budget group. However, the income of children under age 19 and tax dependents are excluded in some situations. See the table below for details:

If...	Then...
The person meets all the following conditions: • Is age 18 or younger;	Exclude the income of the person in the budget group that includes both the child AND the child's parent or parents.

• Is included in the budget group of his or her custodial parent; AND • Has income for the current year but it is expected to be too low to have to file a tax return. See Tax Rules for Children and Dependents for who has to file a return.	See Counting Income of Children example.
The person has income for the current year, but it is expected to be too low to have to file a tax return; AND Meets one of the following conditions: • Will be claimed by a non-custodial parent; • Lives in a household where both parents are present, but they plan to file separate tax returns; OR • Will be claimed by someone other than a spouse or parent. See Tax Rules for Children and Dependents for who has to file a return.	Exclude the income of the dependent child See Income of Children and Tax Dependents for MAGI example.
The person: • Is age 19 or older; • Has income for the current year but it is expected to be too low to have to file a tax return; AND • Will be claimed as a tax dependent by a spouse or parent. See Tax Rules for Children and Dependents for who has to file a return	Exclude the income of tax dependent. See Income of Children and Tax Dependents for MAGI.

2) Income Eligibility Calculation

The MAGI income eligibility calculation may be a two-part process. If the income is too high using MAGI rules, a second income test is run using Premium Tax Credit rules. The income standard for the second test is 100% of the FPL.

The following steps are used to determine income eligibility for coverage groups that use MAGI:

Step	Action
1	Add up the monthly countable earned and unearned income of all members of the MAGI budget group whose income must be included.
2	To calculate the budget group's total countable income: • Subtract any pre-tax deductions from income. • Subtract any adjustments to gross income. NOTE See MA609C for policy about these deductions.
3	Compare the total countable income to the income standard for the budget group size and MAGI program. • If the income is less than or equal to the income standard, STOP. The customer is income eligible. • If income is more than the income standard, continue to Step 4.
4	Subtract the 5% FPL disregard amount for the budget group size from the remaining income from Step 3. See MA609C.3 for the 5% FPL Table.
5	Compare the remaining income from Step 4 to the income standard for the budget group size and MAGI program. • If the income is less than or equal to the income standard, STOP. The customer is income eligible. • If income is more than the income standard, continue to Step 6.
6	Add up the countable earned and unearned income of all members of the Tax Filing Group who expect to be required to file a tax return for the current year.

7	Any *taxable* income listed below that the Tax Filing Group got or expects to get during the current calendar year that was NOT already counted in Step 5 is added: • Lump sum payments; • Scholarships, awards, or fellowship grants; and • Taxable amounts of payments to American Indians or Alaska Natives from trusts, settlements, property rights, and use of natural resources. NOTE For any payments received less often than monthly, the total amount that will be received for the year will be divided by 12 to get a monthly amount before adding it to the total from Step 5.
8	The total monthly income from Step 7 is compared to 100% FPL for the number of people in the Tax Filing Group. If the total monthly income for the Tax Filing Group is less than 100% FPL, the person passes the income test.

Definitions

Term	**Definition**
Tax Filing Group	The taxpayer and everyone claimed by the taxpayer as a dependent.
Child	A person under the age of 19.
Parent	A natural or adoptive parent or stepparent.
Pre-tax deductions	Deductions from income that are taken before taxes are deducted from the income. Common pre-tax deductions include deductions for health insurance premiums, contributions to 401(k) retirement plans, and life insurance premiums.
Tax Dependent	A person claimed as a dependent on someone else's tax return. This includes a person who chooses to or must file a tax return of their own.

Taxpayer	A person who: • Expects to file a tax return for the current year, and • Will not be claimed as a tax dependent by someone else. NOTE Spouses who file a joint return and are not claimed as tax dependents by someone else are both considered taxpayers.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
Adult	42 USC 1396a(e)(14)
Caretaker Relative	42 USC 1397bb(b)
Pregnant Women	42 CFR 435.603
Child	42 CFR 457.300 and 301
KidsCare	

615 Income Standards

Revised 01/30/2025

Policy

This manual section provides the Federal standards that are used for the eligibility determinations.

NOTE Generally, the Federal Benefit Rate (FBR) standards change in January each year, and the Federal Poverty Level (FPL) standards change no later than April each year.

1) ALTCS Standards

Monthly income must not exceed the appropriate percentage of the FBR below:

	Effective 1/1/2023 to 12/31/2023	**Effective 1/1/2024 to 12/31/2024**	**Effective 1/1/2025 to 12/31/2025**
Individual (100% FBR)	$914.00	$943.00	$967.00
Couple (100% FBR)	$1,371.00	$1,415.00	$1,450.00
Individual (300% of the FBR)	$2,742.00	$2,829.00	$2,901.00

2) SSI-MAO Standards

Income eligibility for SSI-MAO can be determined either under FBR or FPL income limits. A person's monthly income must not exceed the appropriate income limits as set below:

100% of FBR			
	Effective 1/1/2023 to 12/31/2023	**Effective 1/1/2024 to 12/31/2024**	**Effective 1/1/2025 to 12/31/2025**

Individual	$914.00	$943.00	$967.00
Couple	$1,371.00	$1,415.00	$1,450.00

100% of FPL			
	Effective 2/1/2023	**Effective 2/1/2024**	**Effective 2/1/2025**
Individual	$1,215.00	$1,255.00	$1,305.00
Couple	$1,644.00	$1,704.00	$1,763.00

3) QMB Income Standards

Monthly income must not exceed the appropriate percentage of the FPL below:

100% of FPL			
	Effective 2/1/2023	**Effective 2/1/2024**	**Effective 2/1/2025**
Individual	$1,215.00	$1,255.00	$1,305.00
Couple	$1,644.00	$1,704.00	$1,763.00

4) SLMB Income Standards

Monthly income must not exceed the appropriate percentage of the FPL below:

Greater than 100%, Equal to or Less than 120% of FPL

Effective until 2025-04-25

	Effective 2/1/2023	Effective 2/1/2024	Effective 2/1/2025
Individual	$1,215.01-$1,458.00	$1,255.01-$1,506.00	$1,305.01-$1,565.00
Couple	$1,644.01-$1,972.00	$1,704.01-$2,044.00	$1,763.01-$2,115.00

5) QI-1 Income Standards

Monthly income must not exceed the appropriate percentage of the FPL below:

Greater than 120%, Equal to or Less than 135% of the FPL			
	Effective 2/1/2023	**Effective 2/1/2024**	**Effective 2/1/2025**
Individual	$1,458.01-$1,641.00	$1,506.01-$1,695.00	$1,565.01-$1,761.00
Couple	$1,972.01-$2,219.00	$2,044.01-$2,300.00	$2,115.01-$2,380.00

6) AHCCCS FTW Income Standards

Monthly income must not exceed the appropriate percentage of the FPL below:

250% of FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$3,038.00	$3,138.00	$3,261.00

7) Adult Group Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

Effective until 2025-04-25

133% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,616	$1,670	$1,735
2	$2,186	$2,266	$2,345
3	$2,756	$2,862	$2,954
4	$3,325	$3,458	$3,564
5	$3,895	$4,055	$4,173
6	$4,465	$4,651	$4,783
7	$5,035	$5,247	$5,393
*Each additional member add:	$570	$597	$610

*“Each additional” approximate amounts only.

8) Caretaker Relative Group Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

106% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,288	$1,331	$1,383

2	$1,742	$1,806	$1,869
3	$2,196	$2,281	$2,355
4	$2,650	$2,756	$2,840
5	$3,105	$3,232	$3,326
6	$3,559	$3,707	$3,812
7	$4,013	$4,182	$4,298
*Each additional member add:	$455	$476	$486

*“Each additional” approximate amounts only.

9) Pregnant Woman Group Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

156% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,896	$1,958	$2,035
2	$2,564	$2,658	$2,750
3	$3,232	$3,357	$3,465
4	$3,900	$4,056	$4,180

5	$4,569	$4,756	$4,895
6	$5,237	$5,455	$5,610
7	$5,905	$6,155	$6,325
*Each additional member add:	$669	$700	$7

*“Each additional” approximate amounts only.

10) Child Under Age 1 Group Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

147% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,787	$1,845	$1,918
2	$2,416	$2,504	$2,591
3	$3,046	$3,163	$3,265
4	$3,675	$3,822	$3,939
5	$4,305	$4,482	$4,613
6	$4,935	$5,141	$5,286
7	$5,564	$5,800	$5,960

*Each additional member add:	$630	$660	$674

*“Each additional” approximate amounts only.

11) Child Age 1 through 5 Group Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

141% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,714	$1,770	$1,839
2	$2,318	$2,402	$2,486
3	$2,922	$3,034	$3,132
4	$3,525	$3,666	$3,778
5	$4,129	$4,299	$4,424
6	$4,733	$4,931	$5,074
7	$5,337	$5,563	$5,717
*Each additional member add:	$604	$633	$647

*“Each additional” approximate amounts only.

12) Child Age 6 through 18 Group Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

133% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,616	$1,670	$1,735
2	$2,186	$2,266	$2,345
3	$2,756	$2,862	$2,954
4	$3,325	$3,458	$3,564
5	$3,895	$4,055	$4,173
6	$4,465	$4,651	$4,783
7	$5,035	$5,247	$5,393
*Each additional member add:	$570	$597	$610

*“Each additional” approximate amounts only.

13) KidsCare Income Limits

Monthly income must not exceed the appropriate percentage of the FPL below:

200% of the FPL prior to 3/1/2024, 225% of the FPL effective 3/1/2024			
Number of People in Household	**Effective 2/1/2023**	**Effective 3/1/2024**	**Effective 2/1/2025**

1	$2,430	$2,824	$2,935
2	$3,287	$3,833	$3,966
3	$4,144	$4,842	$4,997
4	$5,000	$5,850	$6,029
5	$5,857	$6,859	$7,060
6	$6,714	$7,868	$8,091
7	$7,570	$8,877	$9,122
*Each additional member add:	$857	$1,009	$1,032

*“Each additional” approximate amounts only.

14) Transitional Medical Assistance (TMA) Income Limit (2nd 6-month period)

Monthly income must not exceed the appropriate percentage of the FPL below:

185% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$2,248	$2,322	$2,413
2	$3,041	$3,152	$3,261
3	$3,833	$3,981	$4,109

4	$4,625	$4,810	$4,957
5	$5,418	$5,640	$5,805
6	$6,210	$6,469	$6,653
7	$7,003	$7,299	$7,501
*Each additional member add:	$793	$830	$848

*“Each additional” approximate amounts only.

15) MAGI Gap Filling Test Income Limits

If income exceeds the amounts listed for the MAGI groups in 7) through 14) above, a second income test is run using Premium Tax Credit budget group and income rules.

Monthly income must not exceed the appropriate percentage of the FPL below:

100% of the FPL			
Number of People in Household	**Effective 2/1/2023**	**Effective 2/1/2024**	**Effective 2/1/2025**
1	$1,215	$1,255	$1,305
2	$1,644	$1,704	$1,763
3	$2,072	$2,152	$2,221
4	$2,500	$2,600	$2,680
5	$2,929	$3,049	$3,138

6	$3,357	$3,497	$3,596
7	$3,785	$3,945	$4,055
*Each additional member add:	$429	$449	$459

“Each additional” approximate amounts only.

Definitions

Term	Definition
Federal Benefit Rate (FBR)	The basic benefit amount the Social Security Administration (SSA) pays to clients who are eligible for the Supplemental Security Income (SSI) program.
Federal Poverty Level (FPL)	A measure of income used to help government agencies determine eligibility levels for public assistance programs such as Medicaid.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS	42 USC 1396a(a)(10)(E)
SSI-MAO	AAC R9-22-1504 and 1505
Medicare Savings Program (MSP)	AAC R9-22-1909
Freedom to Work (FTW)	AAC R9-28-408
	AAC R9-29-212 and 213

Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.110, 116, 118 and 119 AAC R9-22-1427
KidsCare	42 CFR 457.10, 300, 301 and 315 AAC R9-31-304

Chapter 700 Resources

700 Introduction

This chapter provides information about how to determine resource eligibility for the Arizona Long Term Care System (ALTCS).

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement.

701 General Information about Resources

Revised 06/04/2021

Policy

To qualify for ALTCS, the customer's counted resources must be less than or equal to the ALTCS resource limit at any time during a calendar month (MA706). If the customer's resources are within the resource limit at any time during the month, then he or she is resource-eligible for the entire calendar month.

1) Whose Resources Count

The resources of responsible relatives may be considered available to the customer in determining eligibility. The policy in MA702 describes whose resources are counted and when.

2) Exceptions

Resource requirements do not apply or are limited in the following situations:

If the customer...	Then...
Qualifies for Freedom to Work (FTW) - ALTCS	The requirements in this chapter do not apply in the customer's eligibility determination.
Receives: • SSI Cash; • Title IV-E Foster Care; or • Title IV-E Adoption Subsidy	The only resources reviewed and considered in the eligibility determination are trusts.

3) Resource Eligibility

Resource eligibility is determined on a month-by-month basis. Generally, the equity value of a resource is used, unless an exception is noted for a specific type of resource. Equity value is the fair market value minus any liens, mortgages or other debts.

Generally, the proceeds from the sale of a resource are not income, but rather the conversion of one type of resource to another. The converted resource must be reviewed to determine its effect on eligibility.

Resources that are sold or transferred to someone else without receiving fair value in return, may result in the customer being unable to get long-term care services for a period of time. See Chapter 900 for detailed policy about transfers and how they affect ALTCS eligibility.

Definitions

Term	Definition
Resources	Items of real or personal property, including cash, which may be used to meet the customer's needs for food or shelter. Resources are sometimes called "assets." NOTE Income received during the month is never treated as a resource. Any unspent amount of the income payment is not a resource until the following month.

Proof

In general, proof includes any documents showing:

- The type of resource;
- The value; and
- Who owns the resource.

Proof must come from the institution or third party knowledgeable about the resources in question. Knowledgeable entities are those that are responsible for administering, overseeing or dispensing the resource.

Each type of resource requires specific types of proof. See MA705 for proof needed for each type of resource.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1382b 42 USC 1396a(a)(10)(A)(ii)(V) 42 USC 1396r-5 for Community Spouse

	20 CFR 416.Subpart L 42 CFR 435.601(b) ARS 36-2933, 2934, 2934.01 and 2934.02 AAC R9-28-407 and 410

702 Resource Groups

Revised 12/30/2019

Policy

To determine eligibility, the value of counted resources owned by each member of the customer's resource group is totaled and compared to the resource limit.

Resource Group Members

The following chart shows who is in the customer's resource group:

If the customer is...	And...	And...	Then the Resource Group includes...
Unmarried child <18	Lives with parents		Customer
		Refuses HCBS services	Customer and parents
	Does not live with parents		Customer
Married	Has a community spouse	During the Initial Period	Customer and spouse
		During Post-Initial Period	Customer
	Has a non-community spouse	Living together at home or in an HCBS residential setting	Customer
		The spouse is in a medical institution	Customer

		Living together in an alternative residential setting in which ALTCS services cannot be provided	Customer and spouse
		Customer refuses HCBS	Customer and spouse
	Does not live with non-community spouse		Customer
Unmarried Adult			Customer

Definitions

Term	**Definition**
Resource Group	The people whose resources are considered available to the customer, and may be counted when determining the customer's total resources.

Proof

Proof of Resources

If needed, the customer must provide proof of resources for everyone in the budget group. See MA705 for details about the proof needed for each type of resource.

Proof of Marriage

The customer must provide proof of legal marriage for eligibility to be determined using community spouse policy. See MA520 - Legal Marriage for the type of proof needed for marriage.

Proof of Parent/Child Relationship

Proof of family relationships and who lives in the household is needed only when there is information that conflicts with the customer's statement.

A customer's statement includes information provided by the customer on a signed application.

Some items that show proof of relationship between a parent and child are:

- The child's birth certificate or other birth record;
- Court records; and
- Religious records.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396a(a)(10)(A)(ii) (V) 42 USC 1396r-5 for Community Spouse AAC R9-28-407 and 410

703 Resource Treatment

703 Resource Treatment

Overview

The following sections discuss how resources are treated for ALTCS in specific situations.

A Resource Availability

Revised 04/26/2022

Policy

Resources must be reviewed to see if they are actually available to meet the customer's needs. A resource that is unavailable is not counted when determining resource eligibility. Resources that are available to the customer are either counted or excluded based on the resource type.

Resources are considered unavailable to the customer they meet any of the following conditions:

A resource is unavailable when...	Examples
The person does not have an ownership interest in it during the budget month. NOTE This does not apply to resources held by an agent for the customer (MA704.D).	There is a will or other legal document dividing a deceased person's estate, but it is being contested. The heir does not have an ownership interest until the estate is settled. Property ownership is being decided or disputed in a divorce. Neither person has an ownership interest until the ownership is awarded.
The person cannot legally transfer the title to or spend the resources for his or her own support.	A member of a tribe holds title to land within the bounds of a tribal nation that may not be sold.
There is a legal barrier to the sale of property.	A co-owner, who is not part of the resource group legally blocks sale of jointly owned property.

When a resource is unavailable to the customer, the customer's statement of why it is unavailable, and supporting proof is referred for legal review.

Definitions

Term	Definition

Have an ownership interest in a resource	• Own fully or partly. • Is listed on the title of real or personal property. • Has possession of or the legal right to use the resource.

Proof

A customer who states that a resource is not available for his or her needs must provide proof to support the statement. Proof includes, but is not limited to:

- Financial account statements;
- Request for Proof of Financial Accounts (DE-203) form or a written statement from the financial institution that has the exact language used to establish the account and a description of any legal restrictions on the customer's access to the account.
- Vehicle titles;
- Real estate titles;
- Court documents; or
- Written statements from a co-owner who refuses to allow the resource to be sold or used for the customer's needs

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b 20 CFR 416.1201(a)(1)

B Commingled Funds

Revised 06/14/2018

Policy

When a financial account contains both counted funds and excluded funds, it is known as “commingled funds”. For the excluded funds to remain excluded, they must be able to be identified separately from the other funds. However, in general they do not have to be kept in separate accounts.

Exception: Funds set aside for burial expenses must be kept separate from other non-burial-related resources and must carry a designation that the funds are to be used for burial (see MA705.D).

When withdrawals are made from an account containing commingled funds, the counted funds are considered withdrawn first, leaving as much of the excluded funds in the account as possible. See Commingled Funds for examples.

The amount of excluded funds in the account increases when either of the following happens:

- Funds that are excluded under the same rule are deposited; and
- Interest earned on the excluded funds is also excluded by law.

Definitions

Term	Definition
Commingled Funds	Excluded funds maintained in the same account, policy, or investment account as non-excluded funds.

Proof

A complete history of account transactions back to the initial deposit of excluded funds must be obtained, using the customer's own records, if possible (ex., bank statements).

The person's statement about the date and amount of a deposit of excluded funds is accepted if such statement agrees with the documents already provided showing that the customer received funds at that time.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b 20 CFR 416.1201 (a) and (a)(1) 20 CFR 416.1208

C Constructively Received Resources

Policy

A resource is considered “constructively received” and is counted as if the person has actual possession of it when any of the following are met:

- The person makes advance payments to a nursing facility for the share of cost or other medical expenses that are not due yet.
- The person has refused to accept the resource in the past, but could still accept it.
- The person assigned the resource to someone else, but could revoke the assignment and get the resource back.

If the person can no longer accept the refused resource or it is irrevocably assigned, review it as a transfer. See Chapter 900 for detailed policy about transfers.

See Constructively Received Resources for examples.

Definitions

Term	Definition
Irrevocably Assigned	A resource has been placed in another's name and only the third party can take the action needed to make the resource available to the customer.

Proof

Proof of advance payment to a nursing facility

Proof of advance payments to a nursing facility includes check stubs, invoices or other documentation of the payment amount and the currently due charges.

Proof of refused or assigned resources

The customer or representative must provide proof that the resource is no longer available or has been irrevocably assigned to someone else, or proof of the resource value. See the specific proof requirements by income type in MA705.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b 20 CFR 416.1201(a), (b) and (c)

D Sponsor Deeming

Policy

Noncitizen customers who have Lawful Permanent Resident (LPR) status may be sponsored by others who are responsible for their support.

A part of the sponsor's resources may need to be deemed to the LPR customer when determining eligibility. If the sponsor is married and lives with his or her spouse, the spouse's resources are also deemed.

Detailed policy related to sponsor deeming is found in MA608.B. Please see this section to determine:

- If the customer has a sponsor;
- If the customer is subject to the deeming rules;
- If the customer qualifies for an exemption from sponsor deeming;
- When the sponsor deeming requirement begins and ends;
- The customer's proof and reporting requirements; and
- The amount of resources deemed from the sponsor.

1) Sponsor Deeming Rules

The sponsor's resources are deemed only to the noncitizens he or she sponsors who is named on the Affidavit of Support. If the sponsor lives with a spouse, the spouse's resources are also deemed. The following table describes when to apply sponsor deeming of resources:

If the sponsor is...	Then...
The customer's community spouse	Community Spouse Rules are used to calculate resource eligibility (MA707). Sponsor-deeming is not applied.
Anyone else	The sponsor-deeming is applied unless both of the following are met: • Eligibility is being determined for ALTCS Acute Care; and

	• The sponsor's resources are already being deemed using spouse-to-spouse deeming or parent-to-child deeming (MA703D.2) or parent-to-child deeming (MA608A).

2) Resource Exclusions and Deductions for Sponsor Deeming

The resource exclusions that apply to the sponsor are the same as the resource exclusions allowed for the customer. This includes home property, household goods and personal effects, vehicles, burial funds, and burial plots.

Once the resource exclusions above have been applied, the remaining counted resources are deemed to the customer as described in the following table:

If the sponsor...	And...	Then...
Does not live with a spouse		Deduct $2,000 from the sponsor's counted resources. Any remaining amount is deemed to the customer.
Lives with a spouse	The sponsor's spouse is not the customer's co-sponsor.	Deduct $3,000 from the combined counted resources of the sponsor and the sponsor's spouse. Any remaining amount is deemed to the customer.
Lives with a spouse	The sponsor's spouse is also listed on an affidavit of support as the customer's sponsor	Deduct $4,000 from the combined counted resources of the sponsor and the sponsor's spouse. Any remaining amount is deemed to the customer.

Definitions

Term	Definition

Sponsor Deeming	The process of considering the income or resources of the sponsor (and the sponsor's spouse) to be available to the sponsored noncitizen, whether or not the sponsor's income and resources are actually made available to the noncitizen.

Proof

The proof needed depends on the type of resource. See MA705 for the proof needed by specific resource type.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b 20 CFR 416.1204 AAC R9-28-407

E Good Faith Effort to Sell

Policy

If the value of a customer's non-liquid resources is the only reason he or she does not qualify for ALTCS, the resources may be excluded on the condition that the customer or the legal representative completes all of the following:

- Completes and signs an Agreement to Sell Property (DE-165); and

NOTE If the resource is jointly owned, all owners must sign the DE-165.

- Shows that he or she is making reasonable efforts to sell the resource.

A DE-165 must be completed even if the customer can prove that reasonable efforts to sell the property began before the application date.

More than one non-liquid resource may be conditionally excluded, but a separate Agreement To Sell Property (DE-165) must be completed for each resource and reasonable efforts to sell must be reviewed separately for each conditionally excluded resource.

NOTE The conditional exclusion can only be applied to property titled to a trust if no one has the legal ability to sell the property if it is removed from the trust. For example, this could happen when the trust beneficiary is incompetent, and the trustee cannot legally sell the property if it is removed from the trust.

1) When the Conditional Exclusion Begins

The conditional exclusion starts the earlier of the following:

- The month the Agreement to Sell Property (DE-165) is completed and signed by all owners; or
- The month the customer began reasonable efforts to sell the resource if there has been no break in the efforts to sell. The customer must provide proof of the date reasonable efforts began, the types of reasonable efforts made, and proof that efforts to sell the property were made throughout the entire period before the DE-165 was signed. If reasonable efforts to sell stopped for longer than one week, the customer must have good cause (see #3 below).

2) Reasonable Efforts to Sell

To make a reasonable effort, the customer must take all necessary steps to sell the resource. Reasonable efforts include all of the following:

- Unless he or she has good cause, the customer must take all of the following actions within 30 days of getting notice that AHCCCS has accepted the DE-165:

  - List the property with an agent; or begin to advertise it in at least one of the newspapers, shoppers guides or other local media where the resource is located;
  - Place a “For Sale” sign on the property, if allowed;
  - Begin to hold open houses or otherwise show the property to interested parties on a continuing basis; or
  - Use any other suitable methods like posting notices on community bulletin boards or issuing fliers.

- Except for gaps of not more than one week, the customer must make continuous efforts to sell the property by listing it with an agent or by trying to sell it himself;
- Sell the property for as much as possible;
- Ask no more than the highest current market value (CMV) estimated by a knowledgeable unbiased third party; and
- Accept any reasonable offer to buy the property. An offer is reasonable if it is at least two-thirds of the estimated CMV unless the owner proves otherwise. The burden of proof rests on the owner to prove that a rejected offer was not reasonable.

3) Good Cause for Not Maintaining Continuous Efforts to Sell

When reasonable efforts to sell the resource are not made for more than a week, the customer must be given a chance to provide proof of good cause for not maintaining continuous efforts to sell the resource. Good cause exists when circumstances beyond the customer’s control prevent him or her from making reasonable efforts to sell.

For example, good cause exists when the customer stops efforts to sell to accept a legitimate offer to buy the property, but then the buyer does not complete the purchase.

4) Failure to Establish Good Cause

If there is a gap of more than one week in the customer’s efforts to sell the resource and the customer is unable to prove good cause, the conditional exclusion of the resource no longer applies. The value of the resource is counted when determining resource eligibility. If the customer loses ALTCS benefits because of the value of the resource, the customer must prove that he or she has restarted reasonable efforts to sell before the resource can be conditionally excluded again. The conditional exclusion can be reapplied in the month following the month reasonable efforts to sell are restarted.

5) Ending the Conditional Exclusion

The conditional exclusion ends at the earliest of the following times:

- The resource is sold;
- The customer stops reasonable efforts to sell without good cause;

- The customer's provides a written request to cancel the agreement; or
- The total value of the customer's countable resources plus the value of the conditionally excluded resource falls below the resource limit.

Definitions

Term	Definition
Non-liquid Resources	Real or personal property that generally cannot be converted to cash within 20 workdays. Examples of non-liquid resources include loan agreements, vehicles, tractors, boats, machinery, livestock, buildings and land.
Liquid Resources	Cash or other property that can be converted to cash within 20 workdays. Examples of liquid resources include stocks, bonds, mutual funds, promissory notes, life insurance policies, financial accounts and similar items.

Proof

Proof of reasonable efforts to sell the resource may include the following:

- Copies of listing agreements with real estate agencies;
- Telephone call to the real estate agency confirming the property is currently listed with then for sale;
- Dated advertisements showing the resource is for sale;
- Contracts to advertise or copies of ads showing the resource for sale;
- A photograph of the "For Sale" sign on the resource;
- Copies of fliers or posted notices; or
- Any other evidence of reasonable efforts to sell the resource.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b 20 CFR 416.1201

F Long Term Care Partnership Program Exclusion

Policy

Section 1917(b) of the Social Security Act allows states to develop Long-Term Care Partnership Programs (LTCPP) to increase the number of people buying private long-term care insurance. The Arizona Long-Term Care Partnership program began July 1, 2008.

The State Insurance Commissioner, or other state official charged with regulation and oversight of insurance policies sold in the state, determines whether a policy meets the State Insurance Department's LTCPP requirements.

1) Treatment

People with a qualifying policy get a resource exclusion equal to the amount of benefits paid out under the policy before the month the person applies for ALTCS.

- The resource exclusion is limited to the total amount of payments made by the insurance company through the month before the month of ALTCS application.
- The exclusion is not applied to resources that are already excluded under another ALTCS policy.
- The resource exclusion can be applied to any type of counted resource, including real property.
- The resource exclusion only applies to resources owned solely or jointly by the customer and community spouse. The resource exclusion is not applied to resources owned solely by a community spouse.

NOTE An amount equal to the resource exclusion is also excluded from collection by the Estate Recovery program.

See Long Term Care Partnership Program Exclusion for an example.

If the LTCPP policy is still paying for services during or after the month of the ALTCS application, the payments are treated as Medical Insurance Payments (see MA606QQ).

2) LTCPP Resource Exclusion and Transfers

The LTCPP resource exclusion is not tied to any specific resources. So, it cannot be used to exclude a resource transferred without receiving fair value and avoid a penalty period.

3) LTCPP Policies from Other States

Federal law allows states to enter into agreements to honor LTCPP policies purchased in another state. Arizona is a participating state.

Definitions

Term	Definition
Estate Recovery	Legal claim against the estate of an ALTCS customer to recover amounts paid by AHCCCS on behalf of the customer.

Proof

Proof includes:

- A copy of the long-term care insurance policy; or
- A Request for Verification of Long Term Care Partnership Insurance Policy (DE-243) form completed by the insurance company.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1396p(b)(1)(C)

704 Ownership of Resources

704 Ownership of Resources

The ownership of a resource must be reviewed to determine what part is available to the customer to meet his or her needs.

This section describes different types of ownership including:

- Sole and separate ownership;
- Joint ownership;
- Equitable ownership; and
- Ownership involving an agent.

A Sole and Separate Ownership

Revised 06/08/2017

Policy

A person with sole and separate ownership of a resource is the only person who may sell, transfer, or dispose of the property. The full value of the resource belongs to that person.

Definitions

Term	Definition
Sole and separate ownership	The resource is owned by only one person.

Proof

Proof includes:

- A copy of the account statement; or
- A copy of the title to the property.

Legal Authority

Program	Legal Authority
ALTCS	42 U.S.C. 1382b 20 CFR 416.1201 20 CFR 416.1208

B Joint Ownership

Revised 09/27/2022

Policy

There are three possible ways jointly owned property can be titled:

- “Or” between the owners’ names;
- “And/or” between the owners’ names; and
- “And” between the owners’ names

If the resource title shows “or” or “and/or” between the owner’s names, either owner can sell, transfer, or dispose of the property without the consent of the other owner. The full value of the resource is considered available to each owner.

If the title shows “and” between the owners’ names, all the owners must sign before the resource can be sold, transferred, or disposed of. If an owner who is not part of the customer’s resource group cannot be located or refuses to sell, the resource is not considered available to the customer.

Resources that are jointly owned must be reviewed as a transfer. See MA902B and MA902C.

See Creating Joint Ownership - Examples

Exception:

There are special rules that affect how jointly owned financial accounts are counted. See MA705I for detailed policy.

Definitions

Term	Definition
Joint Ownership	Joint ownership designates real and personal property owned together with one or more individuals.

Proof

Proof of joint ownership includes:

- A copy of the title to the property or a tax statement showing the owners of the property; or
- A phone contact with the appropriate county assessor's office to confirm ownership.

Proof that the resource is unavailable includes:

If the other owners can be located, proof of the following must be obtained:

- The other owner refuses to sell (via written statement or phone contact);
- The sale of the resource would create an undue hardship to the other owner in the form of loss of housing; and
- A legal barrier is preventing the customer from selling their portion of the resource.

If the other owners cannot be located, proof must be obtained of the following:

- Names of all owners;
- The reason the property is not available; and
- The reason a written statement of refusal to sell is not available from the other owners.

Legal Authority

Program	**Legal Authority**
ALTCS	42 U.S.C. 1382b 20 CFR 416.1201

C Equitable Ownership

Revised 12/30/2019

Policy

A person may have an ownership interest in a resource even when he or she is not listed as an owner on the title or ownership document. This is described as having equitable ownership. Equitable ownership may affect a customer's counted resources in either of the following situations:

- The customer holds the legal title, but claims that someone else really owns the resource through equitable ownership; or
- The customer does not hold legal title to a resource, but does have an equitable interest.

1) Customer holds legal title, but someone else has an equitable interest

The value of the other person's equitable interest in the resource is not counted in the customer's resource determination. The actual ownership interest for each person must be determined. See Equitable Ownership for an example.

2) Customer does not hold legal title, but does have an equitable interest

The value of a customer's equitable ownership interest is considered in the resource determination. Common types of equitable ownership include the following:

- Ownership interest in an unprobated estate – This may occur when a person is an heir or relative of the deceased and receives income from the property or received rights to the property due to the death.
- Beneficiary of a trust - The beneficiary does not have legal title, but does have an equitable ownership interest in the assets held by the trust. See Chapter 800 for policies and procedures for trusts.
- Real Property – A person may gain an equitable ownership interest in real property by activities like making mortgage or property tax payments, building or paying for additions to or improvements on a structure.

Definitions

Term	Definition

Beneficiary	A person for whom a trust was created, and who receives the benefits of that trust.
Equitable ownership	An equitable ownership interest is a form of ownership or right of use that exists without legal title to the property. For example, a person regarded as the real owner because of his investment in the property, but the legal title is in someone else's name has an equitable ownership interest in the property.

Proof

Proof of equitable ownership may vary depending on the reason for the equitable ownership and whether the customer or someone else has the ownership interest. See the following table for more details:

If the customer…	**Proof includes…**
Is the beneficiary of a trust	Depends on the trust type. See Chapter 800.
Has equitable ownership interest in an unprobated estate	• Court documents; • Copy of the deceased person's will; • Documents showing relationship to the deceased; • Any other documents supporting the customer's claim to the estate.
Has equitable ownership interest in real property	• Receipts; • Canceled checks; • Written agreement with legal owner; • Other documents showing the customers investment in the property.

Has legal title but claims someone else has an equitable ownership interest	• Other person's receipts, canceled checks or other documents showing the other person's investment in the resource;and • Written agreement between the parties; or • A written statement from each person regarding their agreement and the amount of the person's equitable ownership interest.

Legal Authority

Program	Legal Authority
ALTCS	42 U.S.C. 1382b 20 CFR 416.1201

D Ownership Involving an Agent

Revised 12/17/2021

Policy

Special rules may apply to how a person's resources are counted when:

- The person is a ward and the agent has access to the person's resources; or
- The person acts as an agent and has access to someone else's resources.

1) The Person is a Ward

In general, the resources are still considered the ward's, even though the agent has access to them. They are not the agent's resources, since the agent does not own them and only uses them for the ward's benefit. In many cases the ward's resources cannot legally be used for the agent's benefit. An action taken by the agent is treated the same as an action taken by the ward.

An agent may be holding resources owned by the ward. In this situation, the title must clearly show the ward's ownership interest, and that the agent is acting in a fiduciary capacity. If the title does not accurately show the ward's ownership interest, it must be corrected.

If the title is not corrected, the resource is counted as available to the ward based on the ownership interest listed on the current title. For example, if the title does not list the ward as an owner at all, the resource is not counted as available to the ward. However, the change in ownership must be reviewed as a transfer (MA900). See Ownership Involving an Agent Examples.

2) The Person is an Agent

In general, even though the agent has access to a ward's resources, they are not considered available to the agent. However, if the title of a resource belonging to the ward incorrectly lists the agent as an owner and is not corrected, the resource is counted as available to the agent based on his or her ownership interest.

Definitions

Term	Definition

Agent	A person or organization acting in a fiduciary capacity on behalf of another person. The term "agent" applies whether the authorization is formal or informal, and includes power of attorney, representative payee, conservator, or guardian.
Fiduciary	A person legally appointed and authorized to manage the income and resources for the benefit of another person rather than for his or her own profit.
Ward	The person for whom an agent has authority to act. This term is not limited to "ward" in the legal sense.

Proof

Proof of ownership or an agent's fiduciary capacity includes:

- Title documents;
- Financial account statements; and
- Receipts and other records showing how the customer's assets have been used.

The agent/ward relationship between a customer and another person or organization must be clearly proven. Proof of the agent/ward relationship includes:

- Court documents showing appointment of a guardian or conservator;
- Power of Attorney;
- Records appointing or listing a Representative Payee.

Legal Authority

Program	**Legal Authority**
ALTCS	42 USC 1382b

	20 CFR 416.1201 20 CFR 416.1208

705 Resource Types

705 Resource Types

Overview

There are many different types of resources that may be owned by a customer or their spouse. Different policy applies to each type of resource.

Policy, definitions, proof, and legal authority are addressed individually in this section for each type of resource.

A Animals

Revised 01/01/2019

Policy

Animals that meet any of the following are excluded as a resource:

- Animals used for food or to produce items used for food;
- Livestock and other animals that produce income and meet the requirements at MA705S; and
- Service animals and pets

The value of all other animals is counted as a resource.

NOTE For animals used for transportation, use the policy for vehicles at MA705AA.

Definitions

Term	Definition
Service animal	An animal trained to do work or perform tasks for the benefit of a person with a disability.

Proof

The customer's statement as to the specific use of the animal is accepted unless there is other conflicting information.

Any of the following is used to establish the value of any animal that is counted as a resource:

- Bill of Sale;
- Receipt;
- Contract;
- Any other legal document that lists the current market value of the animal; or
- Appraisal from a breeder, pet dealer or other person who is knowledgeable about the animal and its value, if the appraisal contains enough information to determine the current market value of the animal.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382a ((b)(3)(C)(8) 20 CFR § 416.1218 20 CFR § 416.1220

B Annuities

Revised 01/01/2019

Policy

The resource value of an annuity depends on the type of annuity.

If the annuity is...	Then the treatment is...
Revocable	The amount, after any penalties, the customer would get if the annuity were cashed in is a counted resource.
Irrevocable	Excluded as a resource. NOTE To evaluate the annuity as a possible transfer, see MA902G.

Definitions

Term	Definition
Annuitant	The person or people entitled to payments from an annuity.
Annuity	A contract under which an investor makes a lump-sum payment or a series of payments to an insurance company, bank or other financial institution that, in return, agrees to give the investor either a higher lump-sum payment in the future or a series of guaranteed payments.
Annuitized	When an annuity is issuing payments according to the contract and has become irrevocable. When a resource is annuitized, it changes from a resource to a stream of income.

Beneficiary	The person(s) entitled to any remaining pay-out of an annuity upon the death of the annuitant.
Irrevocable Annuity	The annuity has been converted from a resource to a stream of income and cannot be cashed in. Also called an “immediate” annuity.
Revocable Annuity	The contract can be surrendered and the funds in the account withdrawn. Also called a “deferred” annuity.

Proof

Proof that can be used to verify the annuitant, annuity beneficiary, current market value, and whether the annuity is revocable or irrevocable includes:

- A copy of the annuity application to verify the annuity beneficiary; AND
- A copy of the annuity contract and account statements from the annuity or insurance company; OR
- The AHCCCS Request for Proof of Annuity form (DE-235) form completed by the annuity company or life insurance company; OR
- A written statement from the annuity company or life insurance company with enough information to evaluate the annuity.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1396p(c)(1)(f) and (G) 20 CFR 416.1201(a)(1) ARS 36-2934.02

C Bonds

Revised 01/01/2019

Policy

For most bonds the current market value is counted as a resource, unless there is proof that the owner cannot sell the bond. Most bonds can be sold and transferred.

Exception:

U.S. Savings Bonds are excluded as a resource for the first 12 months after they are issued. After that period, the current market value is counted.

Definitions

Term	Definition
Bond	An investment in which an investor loans money to a corporation or government entity for a specific period of time at a specified interest rate. Some bond types are corporate bonds, municipal bonds and government bonds.
Minimum Retention Period	Savings bonds must be held for a minimum of 12 months after issuance before they can be converted into cash.
Maturity Date	The date on which the principal amount of the bond is due to be repaid to the investor, and the bond stops earning interest.
U.S. Savings Bonds	Debt securities issued by the U.S. Department of Treasury to help pay for the U.S. government's borrowing needs.

Proof

Ownership:

Proof of who owns the bond is usually found on the bond itself. Other proof includes an account statement from the corporation or government entity that issued the bond.

Current Market Value(CMV):

Proof of a bond's CMV includes:

- An account statement from the corporation or government entity that issued the bond;
- Collateral contact with the corporation or government entity that issued the bond; or
- Request for Proof of Financial Accounts (DE-203) completed by the bond issuer.

NOTE In addition to the proof listed above, the value of a U.S. Savings Bond may be verified by a bank or online through the U.S. Department of the Treasury's website at: http://www.treasurydirect.gov/BC/SBCPrice.

Since the CMV is the face value after it matures, do not request proof of the value of a series H or HH bond after the maturity date.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201 (a) and (b)

D Burial Funds

Revised 01/01/2019

Policy

1) Types of burial funds

The counted value of burial funds depends on the type of burial fund and whether it is revocable or irrevocable.

See the table below for details of how burial funds are treated:

Burial Fund...	**Treatment...**
Irrevocable Burial Arrangement	Resources irrevocably assigned to fund a pre-need funeral arrangement are excluded when the customer does not have access to the funds. NOTE The customer may still have access to funds in a burial arrangement even when he or she is no longer the listed owner or holder of the contract or certificate. See Irrevocable Burial Contract for an example. When the customer has access to the funds in the irrevocable funeral arrangement use the policy for **revocable** burial arrangements to determine how to count the resource.
Revocable Burial Arrangement	When a burial arrangement can be revoked or sold, the following apply: • Consider any amounts clearly identified for the purchase of burial plot items using the policy in MA705E; • Any remaining amount is counted based on the amount payable to the owner if revoked, or the current market value when the contract is not revocable but can be sold. Exception:

	When the burial arrangement cannot be revoked or sold without significant hardship to the customer, it is treated like an irrevocable burial fund and excluded. An example of a significant hardship would be if the customer has to move out of state for the contract to be revoked or liquidated.

2) Burial Fund Exclusion

If the customer does not have an irrevocable burial arrangement, up to $1,500 that is set aside to pay for the cost of a funeral is excluded as a resource. The customer and the customer's spouse are each eligible for their own $1,500 burial fund exclusion, regardless of which spouse owns the funds. To qualify for the exclusion, these funds must be designated for burial expenses and kept separate from other non-burial related resources.

Designation may be done by the title of an account or by written declaration. Written declarations should be on the Burial Fund Designation (DE-157) form, which has a penalty clause for providing false information. A written declaration must show:

- The value and owner of the resources;
- How the resources are being held (burial contract, bank account, etc.);
- For whose burial the resources are set aside; and
- The date the owner first considered the funds set aside for the burial of the person named.

3) Burial Fund Exclusion - Begin Date

The burial fund exclusion is applied to the value of the designated fund, including interest or appreciation, the month the exclusion begins. The exclusion begins the latest of the following months:

- The month the funds were first considered to have been set aside;
- The application month; or
- The month funds designated for burial are separated from other funds not related to burial.

See Examples Declaratively Designated Burial Funds.

Once a fund is separated and designated as set aside for burial, it remains a burial fund until one of the following occurs:

- The customer's ALTCS eligibility ends;

NOTE When the customer has a temporary change in circumstances that lasts three months or less, eligibility may be suspended instead of ended. In this case, the burial fund and exclusion remain in place.

- The customer purchases an irrevocable burial contract;
- The customer uses the funds for another purpose; or
- The burial funds are mixed with other resources not intended for burial.

If a fund is no longer a burial fund, any part of it that was excluded under burial fund policy is now counted.

4) Interest Earned on Excluded Burial Funds

Once the burial fund exclusion is determined, any interest earned on the designated burial funds is also excluded if not withdrawn. This applies even when only a portion of the burial fund is excluded.

When the customer loses eligibility and reapplies later, the burial fund exclusion is applied as if it were being applied for the first time, and a new designation must be provided. The current value of the fund is used. Interest earned or appreciation since the prior time the exclusion was applied are no longer excluded.

See Examples Interest Earned on Burial Funds.

5) Adding to a Designated Burial Fund

If the total amount of the designated burial funds at the time the Burial Fund Exclusion was determined is less than $1,500, the customer may add to the designated burial fund up to the maximum of $1,500. See Example - Additional Funds Placed in a Burial Account.

Definitions

Term	Definition
Burial funds	Burial contracts, burial insurance, burial trusts, other burial arrangements such as cash, financial accounts, or other financial instruments that are clearly designated for burial expenses and separated from any resources not related to burial.
Burial Insurance	An insurance policy with terms that do not allow the use of the proceeds for anything other than payment of the insured's burial expenses.

	NOTE If the policy has a cash surrender value to which the owner has access, it is considered life insurance and not burial insurance.
Declarative Designation	A statement signed under the penalty clause regarding fraud in which the person who owns the resource states the purpose for which the resource was set aside and the date it was set aside. The Burial Fund Designation (DE-157) form is used for this purpose.
Funeral Arrangement Expenses	Funeral arrangement expenses are related to preparing the body for burial and services before burial. This includes transporting the body, embalming, cremation, funeral or memorial services, flowers, clothing, the services of a funeral director and staff, benefit of clergy. NOTE These items are different than burial plot items, which are used for the deceased's remains.
Irrevocable Burial Arrangements	A burial fund with terms stating that no portion of the funds may be obtained under any circumstances except for burial expenses. NOTE When a funeral provider has been irrevocably named the beneficiary of an insurance policy to fund a pre-need burial contract, the policy is treated as an irrevocable burial fund if the policy's owner has no access to the policy's CSV and cannot cancel the policy.
Irrevocable Burial Trust	An irrevocable Burial Trust is a trust that does not fund a burial plan at a specific funeral home.
Pre-need Burial Contract	An agreement whereby the buyer pays in advance for funeral goods, services, and burial plot items that the seller agrees to furnish upon the death of the buyer or other designated individual.

Revocable Burial Arrangement	A burial fund that may be sold and some or all of the value of the contract can be used for non-burial expenses.

Proof

Contract or Trust Terms:

Proof of burial funds and burial arrangements include Burial Contract, Trust, or Arrangement papers when they contain the following information:

- The name of the contract owner or trust beneficiary;
- Date of the contract, trust, or arrangement;
- Terms of the contract, including whether or not it is it is revocable;
- Name and address of the contractor or trustee; and
- Value of the contract or trust.

Contract Value:

When there is an indication that the customer owes money on the contract or arrangement proof of the outstanding balance and payments includes:

- Billing statements;
- Written statement from contract issuer;
- Canceled checks for proof of payments;
- Collateral contact with the contract issuer.

Irrevocable Assignment of Insurance Policy:

When the burial arrangement is funded by the irrevocable assignment of the ownership of an insurance policy, proof needed includes:

- The burial contract;
- The insurance policy whose proceeds pay for the burial contract; and
- A document legally obligating the insurance policy as payment for the services specified in the burial contract.

NOTE The burial contract itself may contain a clause legally obligating the insurance policy as payment for the services.

Declarative Designation of Burial Funds:

The statement on the Burial Fund Designation (DE-157) form must contain all of the following:

- The value and owner of the resource set aside for burial;
- For whose burial the resources are set aside;
- The form in which the resource is held (for example, life insurance policy, bank account, stocks); and
- The date on which the person considered the funds set aside for burial.

NOTE The person's statement of the date he or she first considered the funds set aside for burial is accepted (even if it is before the application month) unless there is evidence that the funds were used and replaced after that date.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(a)(2)(B) 42 USC 1382b(d) 20 CFR 416.1231

E Burial Plots

Policy

Burial plot items may be counted or excluded depending on for whom they are being held and whether they serve the same purpose as another item held for the same person.

See the following table for details on when burial plot items are counted or excluded:

If…	Then the treatment is...
The burial plot items are being held for someone other than the customer or any member of the customer's immediate family	Counted.
If the burial plot item serves the same purpose as another item (for example, an urn and a casket)	The duplicate item is counted. Only one of each type of burial item can be excluded per person.
The burial plot items are held for the customer or any member of the customer's immediate family	Excluded.
Both burial plot items and funeral service purchases are included in the contract, but the type and value of the burial plot items cannot be specifically identified in the contract	The entire agreement is evaluated under the burial fund policy (MA705D).

NOTE An excluded burial plot item that is held in a contract may earn interest. The interest earned is also excluded when left on account even when the contract contains both counted and excluded items (for example, cemetery plots for the customer as well as his four cousins).

Definitions

Term	Definition
Burial Plot Items	Includes burial spaces, grave sites, crypts, mausoleums, caskets, urns, niches, or other repositories which are normally used for the remains of deceased persons.

	The term also includes needed and reasonable improvements or additions to such items like vaults, headstones, markers, plaques, burial containers, and arrangements for opening and closing the grave site for burial. Contracts for care and maintenance of the grave site, can also be excluded as a burial plot item.
Held for	An ownership situation in which the person has title to or possesses a burial plot item intended for another's use. This includes when the person has purchased a pre-need burial contract for specific burial plot items as the agreement shows the person's legal right to the items in the contract. NOTE A burial space is not held for a person when making payments under an installment sales contract since the person will not own or have the right to use the space until all payments have been made. However, it is still entitled to the conditional burial plot item exclusion if regular payments are being made as required by the contract.
Immediate Family	The immediate family includes a customer's spouse and any of the following related by blood, adoption or marriage: • Children; • Siblings; and • Parents. The person does not need to be dependent or live in the same household.

Proof

The type of proof needed depends on what the customer owns. If the customer owns more than one of a type of burial plot item, the customer must also provide a statement regarding for whom it

is being held. The statement must include the name of the person(s) and their relationship to the customer.

NOTE Only the value of non-excluded burial plot items must be proven.

Proof of the value if burial plot items includes legal documents, like sales contracts and purchase agreements or a collateral contact to the contractor when all of the following information is included:

- Name of the purchaser;
- Name and address of the seller;
- Description and location of the burial plot item;
- Date of the purchase;
- Cost of the burial plot item at time of purchase; and
- Current value of the burial plot item.
- When installment payments are still due, whether the payments are being made according to the contract terms..

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(a)(2)(B) 42 USC 1382b(d) 20 CFR 416.1231

F Cash

Revised 01/01/2018

Policy

All cash a customer has on hand is considered a counted resource. This includes coin collections.

Definitions

Term	Definition
Cash	Money on hand or available in the form of currency or coins. Foreign currency is cash if it can be exchanged for U.S. currency.

Proof

The customer’s statement of actual cash on hand is accepted as proof.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201(a) and (b)

G Continuing Care Retirement Community Entrance Fees

Revised 01/01/2019

Policy

The entrance fee a person paid to a continuing care retirement community (CCRC) or life care community contract (LCCC) is considered a resource for the eligibility determination if the person:

- Can use the entrance fee to pay for care; and
- Is eligible for a refund upon death or upon leaving the CCRC or LCCC; and
- The fee does not purchase an ownership interest in the CCRC or LCCC.

Definitions

Term	Definition
Continuing-Care Retirement Community (CCRC)	A residential community offering a choice of services and living situations, based on the person's changing needs at any point in time for the remainder of his or her life. Residents sign a long-term contract that provides for housing, services and nursing care; enabling seniors to remain in a familiar setting. CCRCs are also known as: • Continuing Care Retirement Facilities (CCRF); • Life-Care Facilities (LCF); or • Life-Care Communities (LCC).

Proof

A copy of the CCRC contract is used to determine the amount of the entrance fee and terms of the contract concerning its use.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1396p(g)

H Federal Food Assistance

Policy

The value of food provided from any of the following programs is not considered a resource:

- Nutrition Assistance (formerly known as the Food Stamp program);
- School Lunch Programs;
- Federal Child Nutrition programs;
- U.S.D.A. Food Commodities distribution programs;
- Women, Infants and Children (WIC) program.

Definitions

Term	Definition
U.S.D.A. Food Commodities	Federally donated foods distributed pursuant to Section 32 of Public Law 74-320 or Section 416 of the Agriculture Act of 1949.

Proof

Since these benefits are not considered resources, no proof is needed.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1236(a)

Effective until 2025-04-25

I Financial Accounts

Revised 08/27/2024

Policy

In general, the full amount of the funds in a financial account is counted as a resource to each person listed on the account title.

NOTE Account balances held with an electronic payment service are considered financial accounts.

Exceptions:

Specific exceptions to the general policy on financial accounts are listed in the following table:

If…	Then…
It is a pooled account	Only the customer's share of the funds is counted.
The account is owned by more than one person applying for or receiving AHCCCS	The funds in the account are divided by the number of account owners who are applying for or receiving AHCCCS to determine the customer's share.
It is a conservatorship account	Generally, counted for the ward, and not counted for the conservator or guardian. See MA704D for policy on ownership involving an agent. NOTE The funds may be counted even when withdrawals require court approval. Denial of a specific withdrawal does not mean that the funds are not available.
It is a 529 Educational Savings Account (ESA)	The funds are counted for the owner of the account. NOTE Funds in an ESA are excluded for the listed beneficiary, because the beneficiary does not have access to the money.

It is a 530 Coverdell Education Savings Account	The funds are completely excluded for the owner and the beneficiary. NOTE The funds are not counted for the owner because they are acting as an agent for the beneficiary on the account.
It is a Flexible Spending Arrangement or Flexible Spending Account (FSA)	Excluded.
It is a Health Savings Account (HSA) or Medical Savings Account (MSA)	Excluded when the funds in the account may only be used for qualified medical expenses, and receipts must be submitted to the financial institution before funds can be disbursed. Counted for the owner of the account when the owner may withdraw funds for non-medical purposes. In this case, disbursements from the account are considered conversions of a resource (MA701).
Medicare Flex Card	Counted as a resource in the month following the month the Medicare Advantage Plan funded the card. Disbursements from the account are considered conversions of a resource (MA701). NOTE The funding of the prepaid debt card by the Medicare Advantage Plan is excluded income to the owner of the Medicare Flex Card in the month it is received for both MAGI and Non-MAGI programs.
It is an ABLE account	The full amount in the account is an excluded resource. NOTE An ABLE account does not need to be opened in Arizona to be excluded. The treatment of withdrawals from an ABLE account depends on the type of expense: • Funds withdrawn for a non-qualifying expense are counted as a resource in the month of the withdrawal;

	• Unspent funds withdrawn for a qualified housing expense are counted the month following the month of the withdrawal; and • Unspent funds withdrawn for any other qualifying expense are excluded when they are identifiable from the customer's bank statement. • Do not count ABLE account distributions as income of the designated beneficiary. • Contributions made to an ABLE account are not counted as income to the designated beneficiary.
The funds in the account are unavailable	Excluded when the customer cannot legally access and use the funds for his or her own support (see MA703A for policy and proof).
The customer rebuts ownership of some or all of the funds.	Excluded when the customer provides proof that the funds belong to another person AND that the customer can no longer access those funds.

NOTE There are certain funds that are excluded by law and are excluded when determining the value of a financial account. For a detailed list and policy see MA705BB.

Definitions

Term	Definition
ABLE Account	An account that meets the requirements of the Achieving a Better Life Experience Act of 2014. ABLE accounts have tax advantages and allow an eligible person to save funds for the disability-related expenses of the account's designated beneficiary.
Agent	A person or organization acting as a fiduciary for another person. This includes a power of

	attorney, representative payee, conservator, or guardian.
Bank Statement	An official, detailed statement or online transaction listing from a financial institution that shows the person's name, account number, statement date, and all the account activity over a certain period of time (usually a month) for each bank account held by a person or business.
Conservatorship Account	An account in which a person or institution has been appointed by a court to manage the resources held in the account for a ward. The ward retains ownership of all resources placed in a conservatorship account.
Educational Savings Account (ESA)	A trust or custodial account created for the purpose of paying qualified education expenses of the account's designated beneficiary. There are two types of ESA's: • 529 Education Savings Account • 530 Coverdell Education Savings Account The account must be titled or designated as an ESA when it is established.
Electronic Payment Service	A service that allows money to be sent electronically between users. Examples include PayPal, Stripe, Google Pay, Zelle, etc.
Flexible Spending Arrangement or Flexible Spending Account (FSA)	An employer benefit used to reimburse employees for qualified medical expenses.
Fiduciary	A person legally appointed or authorized to manage a person's income and resources for the benefit of the other person.
Financial Account	Any account that holds funds that can be used to purchase food or shelter.

	These include formal accounts like bank checking and savings accounts, as well as informal accounts like a community cooperative for savings and loans.
Health Savings Account/ Medical Savings Account	A tax-exempt account used to pay for qualified medical expenses.
Medicare Flex Card	A prepaid debit card funded by a Medicare Advantage Plan is used to pay for qualified medical expenses and in some cases special supplemental benefits such as food and produce, meal delivery and nonmedical transportation.
Pooled accounts	Financial accounts containing funds for more than one person. These accounts are usually titled to an agency or institution that manages funds for several clients. Examples include patient trust, DDD and public fiduciary accounts.
Qualified Expense	Any expenses related to the eligible individual's blindness or disability which are made for the benefit of the designated beneficiary, including the following expenses: • Education; • Housing; • Transportation; • Employment training and support; • Assistive technology and related services; • Health; • Prevention and wellness; • Financial management and administrative services; • Legal fees; • Expenses for ABLE account oversight and monitoring;

	• Funeral and burial; and • Basic living expenses.
Ward	The person for whom an agent has authority to act. This term is not limited to "ward" in the legal sense.

Proof

Proof of ownership and account value is first obtained through State Data Services Hubs. When the hubs verify account ownership and value, no further proof is needed for the account unless both of the following are met:

- The customer is resource ineligible using that amount; and
- The customer is reporting resources below the limit.

Proof may be needed for deposits that indicate potential income (MA604C) or withdrawals that may be uncompensated transfers (MA901).

When proof is not available through the State Data Service Hubs; the customer must provide proof of ownership and value of the funds in each account. For excluded financial accounts, only proof of the account type is needed.

Other proof for financial accounts may include:

- Bank statements, including on-line bank statements, that includes all transactions from the 1st day of the month to the last day of the month;
- Request for Proof of Financial Accounts (DE-203) form completed by the financial institution;
- Written statement from the financial institution;
- Account ledgers from a nursing facility, DDD Account Statement or Public Fiduciary account ledgers;
- A collateral contact to the financial institution;
- An account balance slip from an ATM machine, which contains enough information to show account ownership, when combined with other proof identifying the account;
- For an ESA, the account details, and terms, contract, or IRS form 1099-Q;
- For an FSA, an account statement or a current pay stub showing a salary deduction deposited into the FSA; and
- For an HSA or MSA, a copy of the account terms.

Proof of ABLE account withdrawals

The customer must provide proof of how funds withdrawn from an ABLE account were used or are their intended use. Proof includes:

- An accounting or written statement from a state program or institution administering ABLE accounts that monitors and validates withdrawals from the account;
- Receipts;
- Estimates; and
- Written statement from the person or organization that includes all of the following:
    - Who received the funds;
    - The date of the payment; and
    - The purpose of the payment or the service that was provided.

Proof rebutting account ownership

To rebut the assumption of full or partial ownership of an account, the following information is needed for each account:

- Account records showing deposits and withdrawals for all months in which ownership is being rebutted; and
- Account records or statements from the financial institution showing the customer's portion of the funds (if any) have been removed from the account, and that the customer is no longer listed as an owner or signer, and
- The customer and each other account owner must complete and sign a Financial Account Ownership Form (DE-117), under penalty of perjury.

The DE-117 must contain all of the following:

- Who owns the funds in the account;
- Why there is a joint account;
- Whose income was deposited and withdrawn from the account; and
- How withdrawals have been spent.

NOTE If the only other account holder is incompetent or a minor, the customer must provide a statement that meets these requirements from a person who was aware of the circumstances surrounding the establishment of the account.

See Financial Account Rebuttal Examples.

Legal Authority

Program	Legal Authority
ALTCS	26 USC 529A (ABLE accounts) 42 USC 1382b(a)(15) 20 CFR 416.1201(a) and (b) 20 CFR 416.1208 20 CFR 416.1210(u)

J HCBS and Nursing Facility Refunds

Revised 01/01/2019

Policy

After ALTCS approval, the nursing facility must refund the amount of payments made by the customer while waiting for the ALTCS approval that is more than the customer's share of cost for the approved months.

ALTCS Program Contractors are able to refund payments for some HCBS services provided while an ALTCS application was pending. The reimbursement for HCBS is determined by the Program Contractor and depends on whether the services were otherwise approvable.

Any of these refunds received after ALTCS is approved are excluded for six months starting with the month the refund is received.

NOTE While the refund is excluded for the six-month period it is not an "excluded resource" as described in MA903F. When the refund is paid to anyone other than the customer or the customer's spouse evaluate it as a potential transfer.

If the refund is kept in an account with money that counts as a resource, any withdrawals made are assumed taken from the counted money first. See MA703B for more details on commingled funds.

Definitions

Term	Definition
HCBS and nursing facility refunds	Money refunded by a nursing facility for services the customer self-paid before being approved for ALTCS benefits.

Proof

Proof of the amount of the refund and the date it was received includes:

- Written statement from the payer;
- Check stub; or
- Collateral contact to payer.

Legal Authority

Program	Legal Authority
ALTCS	AAC R9-28-407(C)(4)(h)

K Home Property

Revised 12/18/2024

Policy

The policy for how a customer's home property is counted is covered in the following sections:

- General rules for home property;
- Home property equity value limit; and
- Sale of home property.

1) General Rules for Home Property

The value of real property or a life estate interest in real property is generally counted as a resource. However, the customer's home property or life estate interest in home property is excluded when any of the following conditions are met:

- The customer or spouse lives in the home property;
- The customer is absent from the home property due to institutionalization but the customer's spouse or dependent relative lives in the property as his or her principal residence; or
- The customer or spouse lived in the home property, is absent due to institutionalization, but intends to return to the home. For life estates, the customer must have lived in the home property before entering the institution.

Exceptions:

The home property exclusion does not apply when the home property is:

- In a trust (See Home Property examples);
- Located out-of-state, even when the customer's spouse lives in the property. The property is considered real property. (MA705T)

See Life Estate Interests as Home Property for examples of how home property policy applies to life estates.

NOTE When the customer purchased a life estate in another person's home, it must be evaluated as a transfer (see MA903).

2) Home Property Equity Value Limit

If the equity value of the customer's ownership interest in the home property is greater than the limit in the following table, and all other conditions of eligibility are met, the customer would only be eligible for ALTCS Acute Care services (See MA302), and cannot receive long term care services:

Home Equity Limit		
Effective 1/1/23 to 12/31/23	**Effective 1/1/24 to 12/31/24**	**Effective 1/1/25 to 12/31/25**
$688,000	$713,000	$730,000

Exceptions:

This policy does not apply to customers who meet any of the following conditions:

- Approved for ALTCS before July 1, 2006 and have had no break in ALTCS eligibility since July 1, 2006;
- The customer's spouse lives in the home;
- The customer's child under age 21 lives in the home;
- The customer's child lives in the home and is blind or disabled, as determined by Supplemental Security Income (SSI-Cash) rules (see MA504 and MA509).

Undue Hardship for Home Equity Value

Ineligibility for long term care services based on equity value of home can be waived if the customer can demonstrate undue hardship. All of the following must be met to establish undue hardship:

- The customer must be otherwise eligible for ALTCS benefits;
- The customer must be unable to obtain medical care without receipt of ALTCS;
- The customer is incapacitated, as determined by a physician;
- The customer is unable to participate in the sale of the property; and
- There is no one with the legal authority to sell the property on the person's behalf.

3) Sale of Home Property with Intent to Replace

When a customer sells his or her home property the net proceeds may be excluded for up to three months when the customer plans to use money to buy another home property. Buying another home property includes any of the following costs:

- Down payment;
- Settlement costs;
- Loan processing fees and points;
- Moving expenses;
- Necessary repairs to or replacements of the new home's structure or fixtures that are identified and documented before moving into the home;
- Mortgage payments; and
- Other costs identified and documented before buying or moving into the new home. These costs must be directly related to the purchase.

If the customer received the proceeds from the sale of home property under an installment contract, the contract is excluded for as long as the customer plans to use the entire down payment and the entire principal portion of the installment payment to buy another home, and does so within three months of receiving any payment.

The proceeds from the sale of a home are excluded until the last day of the third full month following the month they were received. If the home is not replaced within the three-month period, proceeds from the sale are counted as a resource.

If the proceeds from the sale of the original home are more than the costs of buying the new home, the excess amount is counted as a resource.

Exception:

The three-month exclusion does not apply when the home property is sold after the customer is institutionalized, unless the property was excluded because it was the principle residence of the customer’s spouse or a dependent relative.

Definitions

Term	Definition

Home Property	Property that serves as a person’s principal place of residence, and includes the shelter in which the person lives, the land on which the shelter is located and related outbuildings. It can be real or personal property, fixed or mobile, and may be located on land or water. This also includes property that is adjacent or contiguous to the home property and any other buildings located on that land. Land parcels which are joined side-by-side, corner-to-corner, or in any other fashion are considered adjacent or contiguous to each other. This means that the properties are next to or connected to each other and not separated by property owned by someone else. NOTE Easements or public rights of way (streets, roads, utility lines, etc.) are not considered to be separate land. For example, two pieces of land on opposite sides of a road are considered adjacent. In the same manner, watercourses, such as streams and rivers, do not separate land. A person does not have to own the shelter to consider the land part of the home property. For example, the customer lives on his own land in someone else's trailer.
Principal Place of Residence	The residence established as the person’s home.
Dependent Relative	A son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew or cousin, who is a dependent of the customer. Dependency may be of any kind (for example, financial, medical, etc.)

Proof

Proof of ownership:

The following may be used for proof of property ownership:

- Deed;
- Assessment notice;
- Current tax bill;
- Current mortgage statement;
- Report of title search; or
- Wills, court records, or relationship documents which show rights of an heir to the property after death of the former owner.

Proof of Home Property equity value:

If the customer is exempt from the Home Property Equity Value Limit, proof of the property value is not needed. If the customer is not exempt, the following may be used for proof of the home property's equity value:

- County Assessor's Office records;
- Assessment notice;
- Current tax bill;
- Mortgage documents showing the loan balance; or
- Court documents or County Recorder's Office records showing the balance of liens against the property.

Proof of adjacent or contiguous property:

When there is information that part of the home property is not adjacent or contiguous to the home plot, the following may be used to determine if the property is separated from the home:

- The tax assessment;
- Property title;
- Deed;
- Collateral contact with the County Assessor's Office; or
- Other official documents showing property boundaries.

Proof of intent to return home:

The customer’s statement is accepted as proof unless it contradicts itself. When the statement does not make the customer’s intent clear, proof must be obtained from other sources, such as a physician, close relative, or person in a position to know.

Proof of Home Property when more than one residence is owned:

Proof must be provided showing which residence is the home property. Proof includes:

- Voter registration or identification;
- Mailing address on recent tax forms;
- Address used by others to mail payments or benefits; or
- Address from driver's license.

Proof of customer’s spouse or dependent relative living in the home property:

A signed statement must be provided by the customer, spouse or dependent relative that the customer's spouse or dependent relative currently lives in the home. If the relative is other than the spouse, the statement must also describe the relative’s relationship to the customer and the cause of dependency. The statement is accepted without further proof unless there is reason to question it.

Proof of intent to replace home property:

When the home property has been sold but will be replaced, a signed Intention to Replace Home Property (DE-168) form is used to show the intent to use the proceeds to purchase a new home.

Proof of the amount of the proceeds and the dates and amounts of any allowable costs or deductions must be obtained. Proof includes, but is not limited to, the following:

- Contracts;
- Bills;
- Receipts; or
- Settlement sheets.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(a)(1) 20 CFR 416.1212

L Household Goods and Personal Effects

Revised 01/01/2018

Policy

The value of household goods and personal effects are excluded in the resource determination.

EXCEPTION:

Items that are kept for their value, rather than for use, are counted as a resource. This may include stored or undisplayed artworks, gems, jewelry not worn or held for family significance, and collectibles.

NOTE Items purchased after the customer is institutionalized and primarily used by someone other than the customer should be reviewed as a transfer.

Definitions

Term	Definition
Household Goods	Items of personal property customarily found in the home and used in connection with the maintenance, use and occupancy of the home. Items are considered a person's household goods when they are currently used, or in the case of an institutionalized person, were previously used by the person in his or her own residence. Examples of household goods include: • Household appliances and furnishings; • Cookware and tableware; and • Stereos and television sets.
Personal Effects	Items of personal property which are, or in the case of an institutionalized person were, worn or used by the person. Examples of personal effects include:

	• Clothing and jewelry; • Personal grooming items; • Medical equipment; • Recreational equipment; • Musical instruments; and • Hobby items.

Proof

The customer’s statement is accepted as proof.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(a)(2)(A) 20 CFR 416.1216 AAC R9-28-407(C)(2)

M Indian Tribal Land and Natural Resources

Revised 04/30/2024

Policy

The following Tribal land and natural resources are excluded:

- Property located on within the bounds of a tribal nation,
- Property held in trust,
- Property subject to Federal restrictions,
- Property under the supervision of the Secretary of the Interior.
- Indian allotments on or near the bounds of a tribal nation as designated and approved by the Bureau of Indian Affairs (BIA) of the Department of the Interior
- Ownership interests in rents, leases, royalties, or use of natural resources related to federally protected rights. This includes extracting natural resources or harvesting timber, plants and plant products, animals, fish, and shellfish.
- Ownership interests in or rights to use items that have unique religious, spiritual, traditional, or cultural significance, or rights that support subsistence or a traditional lifestyle according to Tribal law or custom.

Definitions

Term	Definition
Fishing Rights	Rights to harvest fish or shellfish from designated fishing grounds.
Grazing Rights	Ownership interests in and usage rights to land used under agreements between Tribal officials or individual members and livestock owners for grazing.
Indian Tribal Land	Restricted allotted land owned by an enrolled member of an Indian tribe.

Mineral or Oil Rights	Ownership interest in natural resources such as coal, oil, or natural gas extracted from the ground.
Within the bounds of Tribal Nation	Any federally recognized Indian Tribe's tribal land, pueblo, or colony. This includes: • Former tribal lands in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act and Indian allotments on or near tribal lands as designated and approved by the BIA; and • For other federally recognized Tribes, property located within the most recent boundaries of a prior Federal tribal lands.
Timber Rights	Ownership interest permitting someone to cut and remove free standing trees.

Proof

Because these are excluded resources, only the source is verified.

Proof of Indian Tribal land and natural resources includes the following:

- Deeds;
- Titles;
- Tribal documents;
- Land use or rights contracts and permits;
- Written statement from the Tribe or the BIA; or
- Collateral contact with the Tribe or the BIA.

Legal Authority

Program	Legal Authority

ALTCS	42 U.S.C. 1396a(ff) 20 CFR 416.1210(i) 20 CFR 416.1234

N Individual Indian Money Accounts (IIM)

Revised 04/26/2022

Policy

Treatment of Individual Indian Money (IIM) accounts depends on whether the account is unrestricted or restricted.

If the IIM Account is…	Then the treatment is…
Unrestricted	Any amount that is not specifically excluded under MA705BB is counted.
Restricted	Excluded.

Definitions

Term	Definition
Individual Indian Money Account (IIM)	Similar to regular bank accounts. Funds in an IIM account may earn interest. The Bureau of Indian Affairs (BIA) area office or agency within the bounds of the tribal nation administers these accounts which are either restricted or unrestricted.
Restricted IIM Account	A restricted account requires BIA authorization for the person to make a withdrawal.
Unrestricted IIM Account	An unrestricted account does not require BIA authorization for the person to make a withdrawal.

Proof

Acceptable proof documenting account ownership and value include, but are not limited to, the following:

- IIM account statements or ledgers;
- Request for Proof of Financial Accounts (DE-203) form completed by the BIA area office or agency administering the account;
- Written statement from the BIA area office or agency within the bounds of the tribal nation administering the account; and
- Collateral contact to the BIA area office or agency administering the account.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201(a) and (b)

O Individual Development Accounts (IDA)

Policy

Funds in an Individual Development Account (IDA) are excluded.

Definitions

Term	Definition
Individual Development Account (IDA)	IDAs are special savings accounts that match the deposits of low income people. IDAs are offered through partnerships between financial institutions such as banks and credit unions, and local nonprofit organizations or program sponsors. There are two types of IDAs: • TANF IDA; and • Demonstration Project IDA.

Proof

Proof of account ownership and type includes the following:

- Written statement from the sponsor;
- Collateral contact with the sponsor; or
- Statement from the financial institution.

Legal Authority

Program	Legal Authority

ALTCS	20 CFR 416.1236(a)(19) and (20)

P Life Insurance

Revised 04/26/2022

Policy

In general, the equity value of life insurance policies is counted as a resource. The equity value of a life insurance policy is the cash surrender value (CSV) minus any outstanding loans on the policy.

Exception:

If the total face value of all life insurance policies the customer owns on any person is $1,500 or less, the equity value of the policies is excluded.

NOTE For policy on income from life insurance proceeds or death benefits see MA606.OO.

1) Determining Total Face Value

In determining whether the total face value of life insurance policies the customer owns on a person is $1,500 or less, the face value of the following are excluded:

- Burial insurance policies and term insurance policies with no cash surrender value;
- An insurance policy that has been irrevocably assigned to fund a burial contract or irrevocably placed in a burial trust;
- An insurance policy with a funeral provider irrevocably named beneficiary when the policy owner has no access to the policy's CSV and cannot cancel the policy;
- An insurance policy revocably assigned to fund a pre-need burial arrangement; and
- An insurance policy declaratively designated as a burial fund.

NOTE Dividend accumulations left with the insurance company to accumulate interest are counted as a resource, even if the policy itself is excluded.

2) Determining Cash Surrender Value (CSV)

When an insurance policy is a countable resource, the value of any dividend additions is added to the policy's original CSV to determine the policy's current CSV.

The insurance company type determines whether the policy pays dividends. The type of company is usually identified on the face page of the policy after the firm's name.

- A policy issued by a non-participating or stock company generally does not pay dividends.

- A policy issued by a participating or mutual company usually does pay dividends.

Dividend additions are included in the CSV of the policy. Dividend accumulations that are not included in the face value or CSV of a policy and are left with the insurance company to accumulate interest, are added to the CSV of the policy.

3) Treatment Based on Insurance Type

The table below provides specific policy for certain types of life insurance:

If the policy is...	Then…
Burial Insurance	The treatment depends on whether the customer can access the CSV: • If the customer can access the CSV of the policy, it is treated as life insurance according to the policy in this section. • If the customer does not have access to the CSV, it is treated as a burial fund under MA705D.
Term Life Insurance	Term life insurance usually does not generate a cash surrender value. The face value of the term insurance policy is not included in the resource determination. The equity value is only determined when it is known that the policy has a potential CSV (such as group policies contracted through Navistar International).
Accidental Death Insurance	Accidental death policies do not have a CSV. Only the type of policy must be verified.
Assigned to fund a burial contract	If the policy's owner has no access to the policy's CSV and cannot cancel the policy, the policy is treated as an irrevocable burial fund (see MA705D).
Declaratively designated as a burial fund	The policy is treated as a revocable burial fund (see MA705D).

Demutualized life insurance	If the customer or spouse owns stock in an insurance company due to the demutualization of the insurance company, it is treated as stocks (see MA705X). If the customer or spouse received a cash payment due to the demutualization of the insurance company, any remaining cash is a countable resource.

Definitions

Term	Definition
Accidental Death Policy	Accidental death policies pay only upon the death of the insured caused by sudden, unexpected or unintended external causes.
Beneficiary	The person named in the contract to receive the proceeds of the policy upon the death of the insured person.
Burial Insurance	An insurance policy with terms that prevent it from being used for anything other than payment of the insured's burial expense is burial insurance and not life insurance.
Cash Surrender Value	The amount that the insurer will pay to the policy owner upon cancellation of the policy before the death of the insured individual or maturity of the policy.
Declarative Designation	A signed statement in which the individual who owns the resource states the purpose for which the resource is set aside and the date on which it was set aside.
Dividends	Payments of a share of any surplus company earnings to the policy owner.

	• Dividend Additions - Amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV, but not the face value. The table of CSV that comes with an insurance policy does not reflect the added CSV of any dividend additions. Dividend Additions are also called Paid-up Additional Insurance. • Dividend Accumulations - Dividends that the policy owner could have received but left in the custody of the insurer to accumulate at interest. They do not add value to the life insurance policy. The owner can obtain them at any time without affecting the policy's face value or CSV.
Face Value	The death benefit contracted for at the time the policy is purchased or maturity amount of the policy. The face value is shown on the face of the policy. Face value does not include: • The face value of any dividend addition which is added after the policy is issued; • Additional sums payable in the event of accidental death or because of other special provisions; and • The amounts of term insurance, when a policy provides whole life coverage to one family member and term coverage for others.
Life Insurance	A contract where the owner pays premiums to the company that provides the insurance. In return, the insurer agrees to pay a specified sum to a designated beneficiary upon the death of the insured.
Mutual Company	A company that has no capital stock, is owned by policy owners, is managed by a board of directors chosen by the policy owners, and usually issues participating insurance only.

Non-Participating Policy	A policy for which a fixed guaranteed premium is payable, and which makes no provision for the payment of any dividends on the policy.
Ordinary or Whole Life Insurance	A contract for which the insured individual pays premiums for a period of time, and on which the company pays the face amount of the policy to the beneficiary upon the death of the insured person. This type of insurance usually has a CSV.
Participating Policy	A policy which shares in the distribution of dividends out of the surplus earnings of the company.
Stock Company	A company that is owned by shareholders who share in the earnings of the company. Stock companies may issue participating and non-participating policies.
Term Life Insurance	A life insurance policy under which the benefit is payable only if the insured person dies during a specific period of time. No benefit is paid if the insured person survives to the end of the term. Generally, term insurance policies do not generate CSV.

Proof

Proof needed for life insurance policies is based on whether or not the policy generates a CSV:

Policies that do not generate a CSV:

Proof of the policy type for accidental death policies and most term life insurance policies includes:

- A copy of the policy;
- A collateral contact with the insurance company confirming that it is an accidental death policy, or that a term life insurance policy does not have a CSV.

<u>Policies that generate a CSV:</u>

Proof of ownership, CSV and equity value of life insurance includes:

- Request for Verification of Life Insurance Policies (DE-204) Form completed by the insurer;
- A letter of value provided by the life insurance policy; and
- Annual Dividend Statements.

A collateral contact or a life insurance policy is acceptable proof if it contains all of the following:

- Name and address of the life insurance company (insurer);
- Name of the policy owner;
- Name of the insured individual;
- Name of the beneficiary;
- Face Value;
- CSV of the policy (less any loans);
- If the policy is revocable or irrevocable;
- Policy number; and
- Date the policy was issued.

NOTE When using insurance tables to determine the CSV of a policy, some tables specify a value per $1,000 of coverage, meaning that the amount listed is multiplied by the appropriate factor.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201 20 CFR 416.1230 AAC R9-28-407

Q Mutual Fund Shares

Policy

The shares of a mutual fund are counted as a resource.

Definitions

Term	Definition
Mutual Fund	A company whose primary business is buying and selling securities and other investments.
Shares in a Mutual Fund	Represent ownership in the investments held by the fund.

Proof

Acceptable proof documenting account ownership and value include, but are not limited to, the following:

- Account statements from the firm that issued or is holding the mutual fund;
- Written statement from the firm that issued or is holding the mutual fund account;
- Collateral contact to the firm administering the account; or
- A newspaper listing showing the value of funds not traded on an exchange.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201(a) and (b) 20 CFR 416.1208

Effective until 2025-04-25

R Promissory Notes, Loans and Property Agreements

Revised 08/10/2021

Policy

The principal balance of promissory notes, loan agreements and property agreements that are negotiable (can be sold) is counted. The current market value (CMV) may be used when the customer disputes the value of the agreement and provides proof of the actual CMV.

If the note, loan, or agreement is not negotiable, it is not counted as a resource. Instead, it must be evaluated as a transfer under MA902H.

How cash proceeds are treated depends on whether the customer is the borrower or lender.

If the customer is the...	Then...
Borrower	The money is not counted in the month received, but any amount remaining in later months is counted as a resource.
Lender	Payments received from the borrower are treated as follows: The part of a payment that is applied to the loan principal is counted as a resource. NOTE The part of a payment for interest owed is income, not a resource, in the month of payment. (See MA606KK for more information on treatment of interest income.)

See Promissory Notes, Loans and Property Agreement Examples.

Definitions

Term	Definition
Negotiable	A negotiable agreement is a written order or unconditional promise to pay a fixed sum of money on demand or at a certain time. A

	negotiable instrument can be transferred from one person to another. Once the instrument is transferred, the holder obtains full legal title to the instrument. It does not contain terms which make it unmarketable. If any of these conditions are not met, the agreement is not negotiable.
Promissory Note	A written, unconditional agreement signed by an individual who promises to pay a specific sum of money at a specified time, or on demand, to the person, company, corporation, or institution named on the note. A promissory note may be given in return for goods, money loaned, or services rendered.
Loan	An agreement for one party to advance money to another party who promises to repay the debt in full, with or without interest. A loan without a written agreement is called an “oral loan”.
Oral Loan	A loan agreement without a written agreement of the terms of the loan and repayment. Because there is no written agreement, oral loans are not negotiable.
Property Agreement	Pledge or security of a particular property or properties for the payment of a debt or the performance of some other obligation within a specified time period. The following are examples of real property agreements: • Mortgages; • Installment contracts: • Land contracts; or • Contracts for deeds. The following are examples of personal property agreements (chattel mortgages): • Pledges on crops; • Pledges on fixtures; or

	• Pledges on inventory.

Proof

Proof of the loan or agreement terms:

The proof provided must include the following information:

- The amount of the loan;
- The date the loan was made;
- The date repayment is due in full, or when periodic payments start;
- Amount of payments;
- Frequency of payments; and
- Names of the borrower and the lender

A copy of the agreement or contract is the main source of proof. If there is no written agreement, then a written statement from both the borrower and the lender must be provided. The Request for Proof of Money Borrowed (DE-230) and the Request for Proof of Money Loaned (DE-231) forms should be used to ensure that complete information is received.

Proof of the unpaid principal balance:

Proof of the unpaid principal balance is only needed if the agreement is a countable resource and using the face value would put the customer over the resource limit.

If the face value of the countable agreement or contract plus the value of other countable resources is less than the resource limit, no further action is required.

Otherwise, the unpaid principal balance of promissory notes, loans or property agreements must be verified. Proof includes:

- Written statement of both the borrower and lender of payments made and remaining principal balance;
- Payment books or ledgers;
- Financial statements showing payment deposits;
- Bank statements or letters from bank officers that provide the unpaid principal balance.

Proof of CMV

Reliable proof of CMV is the appraised value obtained by the customer from a knowledgeable source, which includes any of the following:

- Banks;
- Savings and loan associations;
- Credit unions; and
- Licensed loan or mortgage brokers.

Proof of negotiability

Written agreements or contracts are assumed to be negotiable unless they obviously do not meet the definition of “negotiable”. Evidence of a legal barrier to assigning or selling the agreement is accepted as proof that it is not negotiable. If there is no written document, the agreement is not negotiable, further proof is not needed.

Legal Authority

Program	**Legal Authority**
ALTCS	20 CFR 416.1201(a) and (c) ARS 36-2934.02

S Property Essential to Self-Support

Revised 08/14/2020

Policy

Certain property that generates income and can be considered “essential to self-support” is excluded when it is currently in use.

Exception:

The property may not be in use for reasons beyond the customer's control. In this situation it may still be excluded when:

- It has been in use before: and
- There is a reasonable expectation that it will be in use again within 12 months of the last use.

There are three kinds of property that may be partly or fully excluded as essential to self-support:

- Business property used in a trade or for employment;
- Non-business property that produces at least a 6% rate of return; and
- Property that produces goods or services for the customer’s needs.

NOTE When home property is used in a trade or business, see Home Property policy in MA705K.

1) Business property used in a trade or for employment

The full value of property currently being used for a job or for self-employment is excluded. There are three main types of property covered by this policy:

- Trade or business property;
- Personal property used by a customer as an employee for work; and
- Property that represents governmental authority to engage in an income producing activity (for example a vendor’s license).

See Property Essential to Self-Support for an example.

2) Non-business property that produces a 6% rate of return

Up to $6,000 of the equity value of non-business property is excluded if the property produces at least a 6% rate of return. The rate of return is calculated by dividing the net annual income from the property by the property's equity value (see Rate of Return for an example).

Exception:

A property's rate of return for the current year may be lower than 6% for reasons beyond the customer's control. In this situation it may still be excluded when:

- The property has produced at least a 6% rate of return in one of the last two years; and
- There is a reasonable expectation that the property will again produce at least a 6% rate of return within 24 months of the last year it produced a 6% rate of return.

NOTE If there is more than one property, the rate of return requirement applies to each property separately. For example, a customer owns two small rental spaces valued at $2,500 each, each one would have to produce a 6% rate of return to be excluded.

3) Property that produces goods or services for the customer's needs

Up to $6,000 of the equity value of property used to produce goods or services for the daily living needs of the customer or the customer's spouse is excluded.

Definitions

Term	Definition
Business Property	Property used in a trade or business including: • Property and items necessary to running a business. Examples include warehouse and storage buildings, fleet vehicles, manufacturing or office equipment, or liquid resources used as part of the business. • Items like tools, safety equipment, uniforms, etc. that the customer uses as an employee; • Licenses to engage in an income producing activity that have a market value (for example, a license to sell liquor).

Non-business income-producing property	Land or non-liquid property that provides rental or other income but is not used as a part of a trade or business. Examples include: • Buildings producing rental income; • Land producing rent, mortgages, or land use fees like, timber royalties, mineral rights, or grazing fees.
Property used to produce goods or services for the customer's household needs	Property used to produce food items or for activities that produce food items. Examples, include: • Property used to grow produce or livestock solely for the customer's home consumption (for example, milk cows, chickens for meat or eggs, a garden plot for vegetables). • Property used in activities needed to produce food solely for the customer's home consumption (for example, a garden tractor or a boat used for subsistence fishing). NOTE This does not include any vehicle that qualifies as an automobile (used primarily for personal transportation).

Proof

Specific proof needed for property essential to self-support depends on the type of property. The following table lists the proof needed for each property type:

If the property is…	**The proof needed is…**
Business Property	For property used in the customer's own trade or business, a written statement with the following information: • A description of the trade or business; • A description of the resources used in the trade or business; and

	• The number of years the trade or business has been operating. For property used as an employee, a written statement with the following information: • The name and contact information for the employer; • A description of the property used on the job; and • A description of the job duties where the property is used. For property that represents governmental authority to engage in an income producing activity, a written statement with the following information: • The type of license, permit, or other property; • The name of the issuing agency; • Whether the license, permit, or other governmental authority is required for the income-producing activity; and • How the license, permit, or other governmental authority is being used. NOTE For any business property essential to self-support, contracts, invoices, and paychecks may be used to support the customer's statement that the property is currently in use for self-support.
Non-business income-producing property	The property's equity value - See the specific property type in MA705 for the proof needed. The property's annual net income - See the specific income type in MA606 for the proof needed. NOTE For property with a rate of return below 6%, the customer must also provide written statement explaining the earnings decline, and proof of the property's earnings for the last two tax years.

Used to produce goods or services for the customer's household needs	The property's equity value - See the specific property type in MA705 for the proof needed. The customer must also provide a written statement with the following information: • A description of the property; • How the property is used; and • That the property excluded as producing food for home consumption will be used for that purpose, and the food produced is for personal use and not for sale.
Not currently in use, but expected to be in use within 12 months	The customer must provide a written statement that includes all of the following: • The date the property was last used; • The reason the property is not currently in use; and • The date the customer expects it to be back in use.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(a)(3) 20 CFR 416.1220 20 CFR 416.1222 20 CFR 416.1224

T Real Property

Revised 04/26/2022

Policy

In general, the equity value of real property is counted. For situations when real property may be excluded, see the following policy sections:

- A Good Faith Effort to sell the property is being made (MA703E)
- Home Property (MA705K)
- Property Essential to Self-Support (MA705S)
- Indian Tribal Land (MA705M)

Ownership of real property can consist of an interest in the title or a right to the use of the property without title to the property, such as a life estate. To determine what part of the real property is counted as a resource, the following must be considered:

- The customer's ownership interest (MA704); and
- The availability of the resource (MA703A).

NOTE There is a separate policy for property assigned to a trust. See Chapter 800 for more information.

1) Determining Equity Value

The equity value of real property is calculated by subtracting the balance of any mortgages, loans, or liens on the property from the current market value.

2) Undue Hardship

Jointly owned real property that is available to the customer and would be counted may be excluded when sale of the property would cause an undue hardship to a co-owner. Undue hardship may exist when all of the following apply:

- The property is the co-owner's principal place of residence;
- The co-owner would have to move if the property were sold; and
- The co-owner has no other readily available housing.

The value of the customer's ownership interest in the property is excluded for as long as the undue hardship exists for the co-owner.

Definitions

Term	Definition
Current Market Value (CMV)	The CMV of real property is the amount that property can be expected to sell for on the open market in the surrounding geographic area and under existing economic conditions.
Life Estate with Powers	A life estate where the owner retains the power to sell the property, with a remainder interest to someone else. The estate holder can sell the property or revoke the Life estate with Powers.
Life Estate without Powers	A life estate without full title to the property but includes the use of the property for the life estate owner's lifetime, or for a specified period.
Life Estate Remainder Interest	When an owner of property gives it to a person in the form of a life estate but designates a second person to inherit it upon the death of the life estate holder. The second person has a remainder interest, but does not have the right to own, occupy or otherwise use the property until the life estate ends.

Proof

Proof of ownership:

Proof of ownership interest or a life estate interest may include:

- Deeds;
- Assessment notices;
- Current tax bills;
- Current mortgage statements;

- Report of title search; or
- Wills, court records, or relationship documents.

Proof of CMV:

Primary proof of a property's CMV is the assessed value from current tax bills or County Assessor records. However, these records cannot be used if the assessment meets any of the following:

- Was issued more than one year in the past;
- It is a special purpose assessment that does not include a full cash value assessment;
- It is under appeal; or
- It is based on a fixed rate per acre method.

If the assessment cannot be used or the customer disagrees with the assessed CMV, current written estimates of the property's CMV must be obtained from two knowledgeable sources. The estimates must identify the source of the estimate, the effective date and must be signed by the source. Knowledgeable sources include:

- Banks, savings and loan associations, mortgage companies, and similar lending institutions;
- An official of the local real property tax jurisdiction;
- The county Agricultural Extension Service;
- Real estate brokers; or
- The local office of the Farmer's Home Administration for rural land.

NOTE The customer may submit any additional information that supports the claim that the value of the property is different than the assessed value.

Proof for equity value:

Proof of mortgages, loans and liens on the property may include one or more of the following:

- Current mortgage statements that provide the outstanding loan amount or pay-off amount;
- County Recorder records of loans and liens on the property;
- Written statements from loan- or lienholder with the outstanding balance; or
- Other accounting or year-end statements or balance sheets.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201 20 CFR 416.1245

U Retirement Funds

Revised 10/01/2024

Policy

The value of a retirement fund, pension plan or pension annuity is a countable resource in the amount available for withdrawal.

The value of the fund counts as a resource from the first month the money in the fund is available for withdrawal. This applies even if the withdrawal is delayed for reasons beyond the customer's control, like an organization's processing time.

Determine whether the customer is eligible for defined periodic benefit payments (pension) or a lump-sum withdrawal. Use the table below to determine treatment of the retirement fund.

If the retirement fund is...	Then treat the fund as...
Partially or fully available for withdrawal	A countable resource for the amount available less any fees and loans that must be paid to get the funds. NOTE The taxes due are not subtracted from the available balance until which time the taxes are paid (usually upon withdrawal).
• Available as a defined periodic benefit payment. • Available as a lump sum or a defined periodic benefit payment.	• An income stream when the customer is receiving payments. See MA606TT for details. • A transfer when the customer elects the lump sum. See MA902E for details.
Is not available because the customer: • Must end employment to access the funds • Has not contributed and is not vested in the employer's contributions • Cannot legally access the funds • Has not reached the retirement age or criteria that makes the funds available	Not a countable resource.

• Only has access to the funds as a loan • Only has access for specific purchases or payments which cannot be used for the customer's support or maintenance. For example: education, medical bills, or a down payment on a home	
Converted to an irrevocable annuity or income stream	Not a countable resource. See MA902G for treatment of the transfer.
Unavailable and becomes available	A countable resource in the month following the month the fund became available.

Definitions

Term	Definition
Defined Benefit Retirement Plan	Also known as a pension plan. The employer guarantees a specific benefit or payout upon retirement.
Pension	Benefit payments based on a person's past employment including age, years of service or disability.
Periodic Retirement Benefits	Benefit payments made to a person at a regular interval (often monthly) due to entitlement to retirement benefits based on a defined benefit retirement plan.
Retirement Funds	Annuities or work-related plans for providing income when employment ends. This includes funds administered by an employer or union, as well as individual retirement accounts (IRAs) and Keough accounts.

Proof

Proof of a retirement fund's value includes:

- Letter from the payor;
- Pay stub;
- Collateral contact with the fund administrator;
- Written statement from the Office of Personnel Management, Retirement Operations Center (federal pensions);
- Letter from the service branch of DFAS (military retirement); or
- Award letter.

The proof must contain the following:

- Name of the fund owner;
- Name and address of the fund administrator;
- Terms and conditions of the fund, including the conditions for withdrawal; and
- Amount currently available.

NOTE The Request for Proof of Unearned Income (DE-207) form may be used to verify that the fund is paying periodic benefits and is excluded as a resource.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1201(a) and (b)

V Reverse Mortgage Payments

Revised 01/01/2018

Policy

Payments from a reverse mortgage are a conversion of a resource from equity in real property to cash and are counted resources.

When a customer has a line of credit as the result of the reverse mortgage, the conversion does not occur until the funds are actually advanced.

Definitions

Term	Definition
Reverse Mortgage Payments	A special type of mortgage which allows homeowners age 62 and older to borrow against the value of their home.

Proof

Proof of reverse mortgages and payments may include one or more of the following:

- Department of Housing and Urban Development (HUD) documents like;
  - Home Equity Conversion Deed of Trust;
  - Home Equity Conversion Note
  - Home Equity Conversion Mortgage contract.
- “Home Keeper Mortgage” contract; or
- Account statements or ledgers from the lender.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 436.1201(a) and (b) 20 CFR 416.1208

W SSI Funds in a Designated Account

Policy

Supplemental Security Income (SSI) funds, and interest earned, kept in a dedicated account are excluded. The account must contain only the retroactive SSI-Cash payments to be excluded.

Definitions

Term	Definition
Designated Account	An account established at a financial institution which contains only past due SSI benefits. • The customer must be under 18 years of age, receive SSI benefits and have a representative payee; • The customer must have received a past-due SSI benefit payment of more than six times the Federal Benefit Rate (FBR) in December 1996, or later. Any past due benefit payment amounts that total more than six times the FBR must also be deposited directly into the dedicated account.

Proof

The following documents may be used as proof of the initial direct deposit into the account and the account designation for the sole benefit of the customer:

- Bank statements;
- Request for Proof of Financial Accounts (DE-203) form completed by the financial institution;
- Written statement from the financial institution;
- A collateral contact to the financial institution.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1247

X Stocks and Digital Assets

Revised 05/21/2024

Policy

The current market value (CMV) of stock or digital assests is counted as a resource. The CMV is the closing price on the day for which it is evaluated. The “par value” or “stated value” that may be shown on some stock certificates is not the CMV.

NOTE The customer may request an exclusion for stock that is not publicly traded based on good faith effort to sell (MA703E). Stock that is not publicly traded is not considered a liquid resource because it usually cannot be converted to cash within 20 working days.

Definitions

Term	Definition
Stock	Shares of stock represent an ownership interest in a business corporation.
Digital Assests	A digital or virtual currency that has an equivalent value in real currency that can be purchased for, or exchanged into, U.S. dollars. Examples: Bitcoin, Ethereum, Tether, stable coins, and non-fungible tokens (NFTS).

Proof

Ownership and shares:

Proof of stock ownership and number of shares includes:

- The stock certificate;
- Current account statement from a brokerage or management company that is managing the customer’s investments; or
- Current statement from the firm that issued, is holding the stock, or is managing the stock portfolio.

Proof of digital assets ownership includes:

- Account statements from the financial institution managing the investment; or
- Purchase or sales receipts for the transactions.

Value:

The closing price of stock for any given day is verified as follows:

If the stock or currency is…	**Then the value is verified by...**
Publicly traded	• An account statement from the firm that holds the stock or currency; • A newspaper listing; or • Internet site for historical quotes by ticker symbol: http://finance.yahoo.com/.
Not publicly traded	A written statement from the corporation, which must include ALL of the following: • An estimate of the stock or currency's value on the date proof is requested; • The basis on which the estimate was made (most recent sales, most recent offer from outsiders, CMV of assets less debt, cessation of activity and sale of assets, etc.); and • The name, phone number, address and title of the person providing the information.

See Stocks and Digital Assets Examples.

Legal Authority

Program	**Legal Authority**

ALTCS	20 CFR 416.1201(a) and (b)

Y Trust Funds

Policy

The trust corpus may be counted or excluded as a resource depending on the type of trust.

The treatment of trusts for resource eligibility is explained in Chapter 800.

If the trust is a ...	Then follow the policy in...
Revocable Trust	MA802
Irrevocable Trust	MA802
Medicaid Qualifying Trust (MQT)	MA802
Testamentary Trust or a Trust established by another person	MA802
Special Treatment Trust	MA803

Definitions

Term	Definition
Trust	Any arrangement where money or property is entrusted to one or more people with the intent that it be used for the benefit of a specified person or people.
Trust Corpus	The income and resources that fund the trust. The trust corpus may also be called the trust principal.

Proof

Follow the instructions at MA801 in general and specific trust type sections to determine the type of proof that is required for a trust.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(e) 42 USC 1396p(d) ARS § 36-2934.01 AAC R9-28-407(E)

Z Uniform Transfers to Minors Act (UTMA) Accounts

Revised 01/01/2019

Policy

Funds in a designated UTMA account are excluded until the month after the designated beneficiary turns age 21. The account must be designated as an UTMA or UGMA account on behalf of the minor to be excluded while the beneficiary is under age 21.

Any funds withdrawn from the account as cash or used for food, clothing or shelter before the beneficiary turns 21 are considered as a resource in the month following the month of withdrawal if not spent.

Definitions

Term	Definition
Uniform Transfer to Minors Act (UTMA)	Also known as Uniform Gift to Minors Act (UGMA), permits a person to make an irrevocable tax-free gift of money or securities to a minor. The gifts are placed in accounts designated UTMA or UGMA. A custodian controls the gift, and any earnings it generates, until the child turns 21. The custodian can spend UTMA assets for the minor's support, maintenance, benefit or education. The child automatically receives control of the assets on his or her 21st birthday.

Proof

A financial account statement designating the account as an UTMA or UGMA account on behalf of the minor.

Legal Authority

Program	Legal Authority
ALTCS	20 CFR 416.1236(a)(1)

AA Vehicles

Revised 06/04/2021

Policy

In general, the equity value of vehicles is counted as a resource.

Exception:

One automobile per household is excluded regardless of its value if it is used for transportation of the customer or a member of the customer's household.

For other situations when vehicles may be excluded, see the following policy sections:

- A Good Faith Effort to sell the vehicle is being made (MA703E)
- Property Essential to Self-Support (MA705S)

If the value of the vehicle adversely affects the customer's eligibility, the customer may rebut the value of the vehicle. The customer must provide a statement, at his or her own expense, from a disinterested knowledgeable source.

A disinterested knowledgeable source may be any of the following:

- Car or truck dealer;
- Vehicle insurance company; or
- State Motor Vehicle Department.

NOTE Animals which meet the criteria of a vehicle must have their value determined by contacting a knowledgeable source in the local geographic area.

Definitions

Term	Definition
Automobile	A vehicle used to provide necessary transportation. Examples of automobiles include the following: • Passenger cars;

	• Trucks; • Animals (horses, donkeys, etc.); • Animal drawn vehicles (carts, wagons, etc.); • Motorcycles; and • Bicycles. NOTE Any vehicle used only for recreation or for a purpose other than transportation (for example, selling parts or racing) is not considered an automobile for purposes of the one vehicle exclusion.

Proof

Proof of use for transportation:

The customer's statement that an automobile is used for transportation by a household member is acceptable proof, unless there is conflicting evidence in the file.

NOTE Proof of the ownership, CMV, or equity value are not needed for the one vehicle excluded as transportation.

Proof of ownership:

Proof of ownership includes:

- Title or registration;
- Current insurance policy;
- Bill of sale or sales contract;
- Current car payment bill; or
- Wills and court records.

Proof of CMV:

Primary proof of a vehicle's CMV is the Kelley Blue Book (KBB) value. However, an estimated value from a disinterested, knowledgeable source may be used in either of the following situations:

- The vehicle is a historical or luxury vehicle and is older than the oldest KBB listing; or
- The customer disagrees with the KBB value.

The estimate must identify the source of the estimate, the effective date and must be signed by the source. A disinterested knowledgeable source may be any of the following:

- Car or truck dealer;
- Vehicle insurance company;
- State Motor Vehicle Department; or
- Other dealer of the specific vehicle type.

NOTE The customer may submit any additional information that supports the claim that the value of the vehicle is different than the KBB listed value.

Proof for equity value:

Proof of loans or liens on the vehicle may include any of the following:

- Current loan payment statements or bills that provide the outstanding loan amount or pay-off amount;
- Written statements from loan- or lien-holder with the outstanding balance; or
- Other accounting or year-end statements or balance sheets.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b(a)(2)(A) 20 CFR 416.1210(c) 20 CFR 416.1218

BB Unspent Income

Revised 12/30/2019

Policy

Any unspent part of an income payment becomes a resource in the month after the month it was received. Most types of income that remain unspent in the month after the payment was made are counted.

However, the unspent part of some income types may be excluded as a resource for a period of time beginning the month after the payment was received. The table below lists the exclusions and the unspent payment types to which they apply:

Length of time excluded…	Unspent payment type

Indefinitely	• Agent Orange Payments; • Alaska Native Corporation and Settlement Trust Payments; • Aleutian and Pribilof Islands Payments; • Austrian Social Insurance and Reparation Payments based in any part on wage credits under paragraphs 500-506 of the Austrian General Social Insurance Act; • Corporation for National and Community Service (CNCS) program payments; • Disaster Assistance, *including interest earned on these funds*; • Educational assistance, including work study, received under Title IV of the Higher Education Act or BIA Student Assistance programs; • German Reparation Payments; • Home Energy Assistance; • Housing Assistance; • Indian Judgment Fund per capita distributions; • Japanese-American Restitution Payments (Japanese Reparation Payments); • Netherlands WUV payments; • Persons with Hemophilia Infected with HIV; • Radiation exposure payments; • Payments under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
Up to 30 months	Funds to replace or repair excluded resources. NOTE The exclusion begins with nine months, which can be extended for nine months, then for twelve months, as long as the repair or

	replacement was prevented for reasons beyond the person's control.
12 months	• Settlement Fund payments under the Claims Resolution Act of 2010 (Cobell v. Salazar); • Federal refundable tax credits.
The first $2,000 paid in the calendar year.	Clinical Trial Compensation
Nine months	• Crime Victim Payments; • Educational awards or gifts NOT paid under Title IV of the Higher Education Act or BIA Student Assistance programs; • Social Security (Title II or Title XVI) retroactive payments; • State or local relocation assistance NOT paid the under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
One month	Cash inheritance that will be used to pay for the deceased person's last illness and burial expenses and outstanding debts.

If excluded payments are kept in the same account as money that does count as a resource, any withdrawals are assumed to be taken from the countable money first. To be excluded as a resource, the amount of the excluded funds must be identifiable from counted funds.

When excluded and counted payments are kept in the same account, see MA703B for policy on how they are counted.

Definitions

Term	Definition
Agent Orange Payments	Payments to veterans to settle Agent Orange death or disability claims.
Alaska Native Regional and Village Corporation Payments	Distributions of cash or dividends on stock received from a Native Corporation to an Alaska Native or descendant of an Alaska Native.
Austrian Reparation Payments	Pension payments made by the Austrian General Social Insurance Act under paragraphs 500-506.
Clinical Trial Compensation	Payment for taking part in a clinical trial research and testing for treatment of rare diseases or conditions that meets all of the following: • Reviewed and approved by an Institutional Review Boards (IRB); • Involves research and testing of medical treatments; and • Targets a rare disease or condition.
Crime Victim Payments	Payments received from a fund established by a state to aid victims of crime.
Disaster Assistance Payments	Payments provided to victims of natural disasters through the Federal Disaster Relief Act or similar state or local assistance programs.
Federal refundable tax credit	A special tax credit that reduces a taxpayer's Federal tax liability. It can result in a payment to the taxpayer, either as an advance from an employer, or as a refund from the IRS. The most common refundable tax credits are the earned income tax credit (EITC) and the child tax credit (CTC).

German Reparation Payments	Payments made to certain survivors of the Holocaust by the German Government. The German embassy in Los Angeles may be contacted at: Generalkonsulat der Bundersrepublik Deutschland Consulate General of the Federal Republic of Germany Social Affairs 6222 Wilshire Blvd. Suite 500 Los Angeles, CA 90048 Phone: (323) 930 7602; Fax: (323) 930 2805
Home Energy Assistance	Benefits to help with energy expenses. Includes Low Income Home Energy Assistance Program (LIHEAP). It may be provided by a variety of agencies and known by different names. Payment is usually provided by voucher or directly to the utility company.
Federal Housing Assistance	Payments from the Office of Housing and Development (HUD) or Farmer’s Home Administration (FMHA).
Indian Judgment Payments	Settlement Fund Payments under the Claims Resettlement Act of 2010.
Japanese-American Restitution Payments	Payments paid by the United States Government to U.S. citizens and resident aliens evacuated, relocated, or interned during World War II solely on the basis of Japanese ancestry.
Netherlands WUV Payments	Payments to victims of persecution from 1940-1945 made under the WUV (Wet Uitkering Vervlgingsslachtoffers) program.
Radiation Exposure Payments	Payments made from the Radiation Exposure Compensation Trust Fund (RECTF) to people (or their survivors) exposed to radiation from the U.S. Government's atmospheric nuclear testing and from uranium mining.

Proof

For counted unspent payments, follow the proof policy for either cash or financial accounts.

For most excluded unspent payments, only the source is verified. Types of proof include, but are not limited to:

- Copies of check stubs;
- Written statement or award letter from the source of the income;
- Federal income tax return (for refundable tax credits);
- Loan contract (for student loans);
- Written statement from the landlord (for housing assistance);
- Individual Indian Money Account Statements from BIA listing the payment type; and
- Collateral contact with the source of the income.

Some excluded unspent payments need more proof than just the source. See the table below for a list of the unspent payment type and the other proof needed for each one:

Payment type…	**Additional proof needed…**
Clinical Trial Compensation	That the clinical trial meets the requirements listed in the Definitions section above. Proof includes: • The “informed consent form” from the clinical trial, which provides most of the information needed to determine whether the income exclusion applies. • An official letter from the administrator of the clinical trial that provides all the relevant information of the informed consent in a summarized format. • Check stubs; and • Payment receipts.

Disaster Assistance Payments	Proof that the payment received is due to a federal disaster. Presidential declarations of disaster are public information and can be verified by newspapers, television, radio announcements or the Federal Register.
Cash inheritance that will be used to pay for the deceased person's last illness and burial expenses and outstanding debts	Proof of the amount of the inheritance that will be used to pay expenses related to deceased person's last illness, burial and outstanding debts. Proof of the amount of the cash inheritance: • A court order closing the estate; • A copy of the will; • Letter or written statement from the insurance company; • Collateral contact with the insurance company; • Copy of insurance check. Proof of expenses: • Bills; • Receipts; • Collateral contact with the service provider or debt-holder.

Legal Authority

Program	Legal Authority
ALTCS	Agent Orange payments P.L. 101-239 20 CFR § 416.1236(a)(16)

Alaska Native Settlement Claims 42 USC 1382b(a)(2)(A)(5) 20 CFR § 416.1236(a)(10)
Aleutian and Pribiloff Islander Reparations P.L. 100–383 20 CFR § 416.1236(a)(15)
Austrian Social Insurance and Reparations 20 CFR 416.1236(a)(18)
Cash inheritance used for a deceased person's last illness and burial expenses and outstanding debts 20 CFR 416.1201(a)(4)
Clinical Trial Compensation 42 USC 1382b(a)(17)
Corporation for National and Community Service (CNCS) 20 CFR 416.1236(a)(9)
Crime Victims Payments 42 USC 1382b (9) 20 CFR 4161210(p)
Disaster Assistance 20 CFR 416.1201(k) 20 CFR 416.1237

Refundable federal tax credits 26 USC 6409
Educational Assistance 42 USC 1382b(a)(15) 20 CFR 416.1210(u)
Funds to repair or replace excluded resources 20 CFR 416.1232
German Reparation payments 20 CFR 416.1236(a)(18)
Home Energy Assistance 20 CFR 416.1236(a)(13)
Payments for Persons with Hemophilia Infected with HIV Public Law 105-369, §201
Housing assistance 42 USC 1382b(a)(8) 20 CFR 416.1236(a)(13)
Indian Judgment funds Claims Resolution Act of 2010 (Pub. L. 111–291); Section 101(f) 20 CFR 416.1236(a)(3)
Japanese reparation payments 20 CFR 416.1236(a)(15)

	Netherlands WUV 20 CFR 416.1236(a)(18)
	Radiation Exposure payments 20 CFR 416.1236(a)(17)
	Relocation Assistance 42 USC 1382b (a)(10) 20 CFR 416.1236(a)(1)
	Retroactive TII/XVI payments 20 CFR 416.1210(m)

706 Resource Budgeting

706 Resource Budgeting

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Resource Budgeting Principles

Policy

The actual value of a resource during the budget month is used to determine resource eligibility. If counted resources are within the resource limit at any time during the calendar month, the customer is resource-eligible for that month.

When the total value of the customer's resources is higher than the resource limit in a month, the following amounts are subtracted from the customer's cash resources and financial accounts:

- Income received in the calendar month; and
- If still over the limit, the amount of any uncashed checks issued against a financial account.

B How to Calculate Resource Eligibility

Policy

To qualify, the customer's counted resources cannot more than the resource standard.

1) Customer Only Calculation

The following actions are taken to determine resource eligibility when the customer is not married and is either:

- Over age 18; or
- Under age 18 and does not live with an ineligible parent.

The customer's total counted resources are compared to the $2,000 resource limit for a single person. If the total is less than or equal to the limit, the customer is resource-eligible for ALTCS. If the counted resources are more than the resource limit, the customer does not qualify for ALTCS.

2) Customer Child Living with Parents Calculation

In general, a parents' resources are not counted when determining the child's eligibility for ALTCS, unless the parents refuse HCBS for the child.

The following table shows how to calculate a child's resource-eligibility, when a parent refuses HCBS for the child:

Step	Action
1	Determine if the child lives with at least one ineligible parent. • If YES, parent-to-child deeming applies. Continue to Step 2. • If NO, parent-to-child deeming does not apply. Skip to Step 5 and use $0 for the Parent-to-Child Deeming amount.
2	Determine the total value of countable resources owned by each ineligible parent and ineligible spouse of a parent who lives in the home. NOTE Allow any resource exclusions as if they were applying.

3	Deduct the resource standard from the result from Step 2 as follows: • If living with just one ineligible parent, deduct $2,000 from the counted resources. • If living with two ineligible parents, or with an ineligible parent and an ineligible stepparent, deduct $3,000 from the counted resources.
4	Divide the resulting amount from Step 3 by the number of eligible children in the home to get the Parent-to Child Deeming amount.
5	Add the value of all resources owned by the customer child to the Parent-to-Child Deeming amount.
6	Deduct the child's excluded resources. NOTE Do not allow a home exclusion unless there was not one given when determining the parents' resources. Only one home exclusion is allowed per family.
7	Compare the result from Step 6 to the $2,000 resource limit for a single person: • If the result is less than or equal to the resource limit, the child is eligible for ALTCS Acute Care. • If the result is more than the resource limit, the child is not eligible for ALTCS Acute Care.

3) Married with a Non-Community Spouse

In general, a spouse's resources are not counted when using non-community spouse rules, and the steps in section 1) Customer Only Calculation.

The spouse is only included in the customer's resource group and the resources counted when BOTH of the following are met:

- The spouse's are living together; and
- Eligibility is being determined for ALTCS Acute.

If the spouse is included in the resource group, then total the couple's countable resources and compare it to the $3,000 resource limit.

4) Married with a Community Spouse

When the customer has a Community Spouse the resources of the spouse may be counted even when the spouses are separated. See MA508 for policy about when Community Spouse rules apply.

There are also certain resource deductions that are only allowed when using Community Spouse rules. See MA707, Community Spouse Resource Budgeting, for detailed policy and procedures for customer with a Community Spouse.

Definitions

Term	Definition
Child	A “child” means a person under age 18. A person is considered a child through the month the person turns age 18.
Eligible Child	A child under age 18 who is applying for or receiving any of the following: • SSI-Cash • SSI-MAO • ALTCS
Ineligible Parent	A parent, including a stepparent, in the home who is not applying for or receiving any of the following: • SSI-Cash • SSI-MAO • ALTCS

Proof

Proof of a resource's value during the calendar month is used to determine resource eligibility for that month. When determining a customer's eligibility for more than one month, proof of the resource's value during each month is used.

Resources with a value that does not normally fluctuate and has not changed do not need separate proof of the value for each month. Common examples include real property and other non-liquid resources.

Resources with fluctuating values or that have had a change in value during the months being determined need proof of the value for each month of eligibility. Common examples include financial accounts and other liquid resources.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1382b42 USC 1396r-5 20 CFR 416.1201 and 1202 AAC R9-28-410

707 Community Spouse Resource Budgeting

Revised 12/18/2024

Policy

Community Spouse rules protect a certain amount of the couple's resources for the spouse living in the community.

This protected amount of the couple's resources is the Community Spouse Resource Deduction (CSRD).

NOTE The customer must meet the requirements in MA508 to qualify for the CSRD.

Under Community Spouse Initial rules, the CSRD is deducted from the couple's combined counted resources for up to 12 consecutive months when determining resource eligibility. The 12-month period:

- Begins the 1st month eligibility is determined using community spouse rules and ends after the next 11 months.
- May include months when the individual is not eligible or gets acute care only. See Ineligible Month in Initial Period for an example.

This 12-month Initial Period gives the couple time to transfer sole ownership of counted resources to the Community Spouse. The resources left in the customer's name must not be more than the $2,000 resource limit when the initial rules period ends to meet the resource limit when post-initial rules are applied.

The Initial Period may be shorter than 12 consecutive months when:

- The customer transfers all counted resources over $2,000 to the community spouse before the end of the Initial Period.
- The couple's counted resources increase during the Initial Period and the customer no longer qualifies using initial rules. The couple is given the option to switch to post-initial rules early and has10 days to transfer remaining resources over $2,000 to the Community Spouse. See Ending the Initial Period Early – Resources Increased for an example.
- Eligibility stops before the end of the 12-month period.

1) When are Initial Rules applied?

When the customer has a community spouse and is not currently on ALTCS, see the table below to determine which rules to use:

If the customer…	Then…
Has never received ALTCS benefits	Community spouse initial rules are used.
Received ALTCS in the past, but never using community spouse rules	Community spouse initial rules are used.
Received ALTCS in the past using community spouse rules but has not been continuously institutionalized since last receiving ALTCS.	Community spouse initial rules are used.
Received ALTCS in the past using community spouse rules, and remained continuously institutionalized	Post-initial rules are used; even when the customer did not get ALTCS the full 12-month initial period.

2) CSRD Standards

The following standards are used to determine the Community Spouse Resource (CSRD). These Federal standards generally change every year on January 1st.

	Effective 1/1/23 to 12/31/23	Effective 1/1/24 to 12/31/2024	Effective 1/1/25 to 12/31/2025
Minimum CSRD	$29,724.00	$30,828.00	$31,584.00
Maximum CSRD	$148,620.00	$154,140.00	$157,920.00

3) Community Spouse Resource Assessment (CSRA)

A resource assessment is often needed to determine the value of the couple's resources for the month the customer's first continuous period of institutionalization (FCPI) began. This is called the Community Spouse Resource Assessment (CSRA). The CSRA amount is then used to calculate the Community Spouse Resource Deduction (CSRD).

Exception:

A CSRA is not needed when the customer is resource eligible in the month of application using the minimum CSRD in section 2 above. The minimum CSRD amount is used for the Initial Period.

When a CSRA is needed, the steps in the table below are followed:

Step	Action
1	Information is collected about all periods of time on or after September 30, 1989, that the customer was in a hospital, nursing facility, residential facility, or received paid formal HCBS.
2	The first continuous period of institutionalization (FCPI) is determined.
3	Proof of the value of all resources the couple owned in the month the FCPI began is requested.
4	The value of all countable resources is totaled to determine the CSRA amount.

NOTE A customer can have a CSRA done without applying for ALTCS. For example, a couple thinking about moving to Arizona, may request a CSRA to see if they might qualify before they move.

4) How to calculate the CSRD

The table below describes how to calculate the CSRD:

Step	Action
1	Divide the CSRA amount by 2 to get the spouse's share of the resources.
2	Compare the spouse's share from Step 1 to the Maximum CSRD amount (MA707.2) • If the Maximum CSRD is less than the spouse's share of the resources, STOP. The Maximum CSRD amount is used. • If the Maximum CSRD is more than the spouse's share of the resources, continue to Step 3.
3	Compare the spouse's share from Step 1 to the Minimum CSRD amount (MA707.2) • If the Minimum CSRD is more than the spouse's share of the resources, the Minimum CSRD amount is used. • If the Minimum CSRD is less than the spouse's share of the resources, the spouse's share of the resources is used.

See Community Spouse Resource Deduction for examples.

NOTE Resource policy varies from state to state. A resource assessment or determination from another state cannot be used to qualify in Arizona.

5) Using the CSRD for Later Applications

Once determined, a customer's (CSRD) is used for all later applications when initial rules are applied, unless the customer was given the Minimum or Maximum CSRD.

The Minimum and Maximum CSRD amounts can increase from year to year. If the customer qualified for the Minimum or Maximum CSRD originally and applies again later, the Minimum or Maximum CSRD in effect for the month of the later application is used.

6) Undue Hardship Exception

When a customer's resources are over the limit using Community Spouse rules, the customer may still qualify for ALTCS when denying the customer would cause an undue hardship and all of the following are met:

- Except for resources, the customer meets all of the ALTCS requirements;
- The customer is unable to get medically necessary care without ALTCS benefits;
- The property is legally unavailable without the signature of the community spouse, and the community spouse has refused to make the property available to the customer; and
- There has been a break in marital ties.

7) Post-Initial Rules

Post-initial rules are used to determine resource eligibility when the initial rules period has ended. Under post-initial rules resource eligibility resources are counted as follows:

- The CSRD is not used;
- None of the community spouse's resources are considered available to the customer;
- The customer's ALTCS is not affected by community spouse transferring his or her sole property;

NOTE The transfers may affect the community spouse if he or she applies for ALTCS in the future.

- Only the customer's resources are totaled and compared to the resource limit.

8) How to Calculate Community Spouse Resource Eligibility

How resource eligibility is determined for a customer with a Community Spouse depends on whether Initial Rules or Post-Initial Rules are being used.

Community Spouse Resource Calculation – Initial Rules

Determine the customer's resource eligibility using initial rules as follows:

Step	Action
1	Total the counted resources owned by the customer and community spouse.
2	Subtract the amount of the couple's CSRD.
3	Compare the result to the ALTCS resource limit for a single person of $2,000.

See Initial Rules Calculation for an example.

Community Spouse Resource Calculation – Post-Initial Rules

Determine the customer's resource eligibility using post-initial rules as follows:

Step	Action
1	Total the counted resources owned by the customer. Do not include any resources that are only in the community spouse's name
2	Compare the total to the ALTCS resource limit for a single person of $2,000.

See Post-Initial Rules Calculation for an example.

Definitions

Term	Definition
Break in marital ties	The customer and the community spouse are physically separated and one of the following is met:

	• A dissolution or annulment petition has been filed in court, even though a final decree has not been entered yet; or • The customer and the community spouse have entered into a court-approved legal separation agreement. NOTE When one spouse is temporarily absent due to being in an institution, on vacation, or away from home for work or education, it is not a break in marital ties
First Continuous Period of Institutionalization (FCPI)	The first continuous period of 30 days or more beginning on or after September 30, 1989, that the customer: • Was in a medical institution; • Received paid formal HCBS; or • Received a combination of medical institutionalization and HCBS. Exception: When a customer does not have any continuous periods of institutionalization but intends to receive long term care services, being determined medically eligible by a Pre-Admission Screening (PAS) establishes the FCPI. In this case the FCPI begins with the month the customer applied or requested a resource assessment or private request PAS (see MA1002). See Establishing the FCPI for an example. NOTE When an ALTCS customer marries a person who lives in the community, the FCPI begins the month the couple was married.
Medical Institutions	Nursing facilities, hospitals, psychiatric hospitals, and residential treatment centers.

Paid Formal HCBS	Services that meet all of the following: • Provided by a licensed or certified person or entity that contracted with the customer to provide the services; • Is an ALTCS covered service and was billed to the customer, the customer's insurance, or another person on behalf of the customer; • Prevented the customer from being institutionalized. The customer must have needed the level of care provided in a medical institution, as determined by the AHCCCS PAS Assessor; and • Were not provided by the customer's spouse, or, if the customer is a minor child, parent.

Proof

The proof needed for Community Spouse resource budgeting depends on the specific policy.

1) Application Period Resource value

Proof of the value of all resources currently owned by the customer and community spouse.

If the customer has a copy of a resource assessment completed in another other state, this document is acceptable proof of the resources the customer owned at the time the assessment was done. However, more proof may be needed if a different FCPI is determined or the value of a resource if it is determined differently based on Arizona policy. A copy of the resource assessment completed in the other state and all related documentation must be provided. Otherwise, for proof of resource values, see the proof section for that resource type in MA705.

2) FCPI Month Resource value

When the customer does not qualify using the Minimum CSRD, he or she must also provide proof of the value of resources the couple owned during the month the FCPI began. A copy of a resource assessment completed in another state may be used as proof of the resources the couple owned in the month assessed.

However, more proof may be needed when a different FCPI month is determined, or the value of a resource type is determined differently based on Arizona policy. For proof of specific resource values, see the proof section for that resource type in MA705.

3) Post-Initial period resource value

During the post-initial period, the customer must provide the following proof:

- The value of only the resources remaining in his or her name.
- Proof that the excess resources were transferred and to whom.

4) FCPI determination

The customer must provide the following proof to establish the FCPI:

- Medical institution admission and discharge dates;
- Proof of formal paid HCBS received and when. This includes proof that the person providing the services was licensed or certified and that the services were paid.
- Proof of an FCPI month based on intent to receive long-term care services is the first eligible PAS determination made for an ALTCS application, CSRA request or Private Request PAS.

5) Undue Hardship

Some proof needed for undue hardship claims is collected during the application process. This includes proof the customer meets all other ALTCS requirements and the customer's ability to get necessary services without ALTCS.

Proof needed for the other two undue hardship conditions includes the following:

- Proof that a resource is legally unavailable without the spouse's signature and that the spouse refuses to make the resource available. This may include:
    - Court documents,
    - Titles or deeds,
    - Spouse's signed statement (for refusal to make the resource available),
    - Contracts or other documents that support the customer's claim.
- Proof of a break in marital ties includes:
    - A dissolution or annulment petition that has been filed with the court; or

- A copy of a court approved Legal Separation Agreement.

Legal Authorities

Program	Legal Authorities
ALTCS	42 USC 1382b 42 USC 1396r-5(c) AAC R9-28-410

Chapter 800 Trusts

800 Introduction

This chapter describes how trusts impact eligibility for ALTCS and explains how to identify and treat different trusts.

For each requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement.

801 Trust Overview

Policy

A trust is a legal arrangement in which a person or organization, like a bank, manages assets for someone else. There are several different kinds of trusts. Income and resources that are assigned or titled to a trust may be counted differently when determining if someone qualifies for AHCCCS.

This Chapter focuses on how trusts impact eligibility for the ALTCS program. For information on how trust income or income assigned to a trust affects other AHCCCS programs, see MA606MMM.

Trusts are created for many reasons. Trusts can be used to transfer ownership of resources to someone to avoid probate, reduce estate taxes or provide for a person's future needs. There are also a group of trusts that can allow people who would not otherwise qualify due to excess resources or income to become eligible for ALTCS. These trusts must follow strict federal and state rules to qualify for this special treatment, which is why they are often called "Special Treatment Trusts" (STT).

How the trust's income, resources and disbursements are treated when determining ALTCS eligibility depends on:

- Whether the trust qualifies as a Special Treatment Trust;
- Whose income or resources were used to fund the trust;
- Who created the trust; and
- Whether the trust is revocable or irrevocable.

The chart below describes how to identify the common types of trusts:

If the Trust...	Then the Trust Is Probably...
Created before August 11, 1993 with the income or resources of the customer, the spouse, or both	Medicaid Qualifying Trust (MA802.3)
• Created on or after August 11, 1993; • The customer or spouse is listed as the trustor, trustee, and beneficiary of the trust; and • Does not include language or terms used for STTs.	Revocable non-special treatment trust (MA802.1)

• Does not allow the person who created the trust to revoke it; and • Does not include language or terms used for STTs.	Irrevocable non-special treatment trust (MA802.2)
Is funded from the proceeds of a Will or with the income, resources or both of someone other than the customer or the customer's spouse. NOTE May be referred to as a "special needs trust".	Testamentary or Non-Grantor (MA802.4)
• Created on or after August 11, 1993; • Lists AHCCCS, Arizona or another State as a beneficiary of the trust; • References 42 USC §1396p(d)(4) or Section 1917(d)(4) of the Social Security Act; • States that disbursements must not be made for purposes other than those described in ARS §36-2934.01; and • Has conditions concerning the trust corpus, trust creator, trust manager, trust purpose, or the beneficiary's age.	Special Treatment Trust See MA803 for policy on the three types of STT.

Trusts are reviewed for impact to eligibility, and sent for a legal review if needed.

NOTE All potential Special Treatment Trusts are sent for a legal review to see if the trust qualifies for special treatment.

Important!

Some financial accounts look like trusts and even include the word "trust" in the title, but are not actual trusts. Examples include patient trust accounts and accounts maintained by a representative payee or conservator. For these accounts see MA704.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income or both from a trust.
Disbursement	A payment or distribution from the trust corpus or trust earnings.
Irrevocable	Means the grantor or the grantor's representative may not end the trust after it is made. NOTE A trust that states it is irrevocable but will end by some action taken by the grantor is a revocable trust.
Non-grantor trust	A trust funded with the assets of someone other than the beneficiary. For example, a grandparent creates a trust funded with her own money for the benefit of her grandchild. Sometimes called Special Needs Trusts.
Revocable	Means the person who set up the trust has the right to end it. A revocable trust can be ended by: • Withdrawal; • Recall; • Restatement; • Reversal or revocation; and • Transferring all trust resources out of the trust. A trust that says it can be changed or ended by a court is considered a revocable trust.
Trust Corpus	The income and resources that fund the trust. The resources or income in the trust corpus may

	be available to the customer, but are no longer owned by the customer. NOTE The trust corpus may also be called the trust principal.
Trustee	A person or organization that manages the trust resources and income for the benefit of the beneficiaries.
Trust document	The formal document that created the trust. It contains the powers of the trustees and rights of the beneficiaries. It may be a will, a deed in trust or a formal declaration of trust.
Trustor	One who creates a trust. Also called a settlor or grantor.

Proof

Proof needed to identify trusts and assets titled to the trust includes:

- The complete trust instrument or document setting up the trust. This includes all amendments, restatements and schedules to date;
- Court records relating to the trust;
- Court approved injury settlement;
- Will;
- Proof of income or resources assigned to the trust like a quit claim deed, vehicle title or bank statements showing accounts titled to the trust.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01

	AAC R9-28-407 AAC R9-28-408

802 Non-Special Treatment Trusts

Revised 01/25/2023

Policy

Trusts that were not created to qualify for special treatment or that do not qualify as a Special Treatment Trust are known as non-special treatment trusts.

The policy for counting the income and resources of these trusts applies regardless of any of the following:

- Purpose for which the trust was created;
- Whether or not the trustee has the ability to make payments to the customer, or the trustee actually makes any payments;
- Restrictions on when or if payments may be made; and
- Restrictions on the use of payments from the trust.

NOTE Trust policy in this section may be waived in cases of undue hardship. See MA804 for information about undue hardship for trusts.

Trust Ownership:

Non-special treatment trusts may be jointly owned. When a trust is jointly owned, only the percentage owned by the customer and spouse is used to determine resource eligibility, even when the entire trust corpus could be paid to the customer, the spouse or both.

Disbursements from a jointly-owned trust must be made to or for the benefit of the customer in at least the same percentage as the customer's ownership interest. For example, if the customer owns 50% of the trust assets, 50% of any disbursements must be made to or for the benefit of the customer. When the customer receives less than his or her ownership percentage, the difference is reviewed as a transfer.

Treatment of Trust Assets:

Excluded assets assigned to a trust remain excluded, except for home property. When home property is assigned to the trust the equity value is a counted resource (MA705K.1).

Types of Non-special Treatment Trusts:

There are four kinds of non-special treatment trusts:

- Revocable;
- Irrevocable;
- Medicaid Qualifying Trusts (MQT); and

- Testamentary and Non-Grantor Trusts.

The specific treatment and policy for each of the four types of trusts are discussed in the following sections.

1) Revocable Trusts

Resources

The person's entire ownership interest in the trust corpus is considered a resource.

Income and Share of Cost

Income received by the trust or payments from the trust to or for the benefit of the customer, whichever is greater, are counted for the income test and when determining the customer's Share of Cost (SOC).

NOTE Trust income does not include dividends and interest earned by the trust corpus and added to the principal.

2) Irrevocable Trusts

Resources

When payment can be made from the trust principal to or for the benefit of the customer, the maximum amount that is available for payment is a counted resource.

Income and Share of Cost

Income received by the trust or payments from the trust to or for the benefit of the customer, whichever is greater, are counted for the income test and when determining the customer's SOC.

NOTE Trust income does not include dividends and interest earned by the trust corpus and added to the principal.

3) Medicaid Qualifying Trusts (MQT)

A MQT is a trust created other than by a will that meets all of the following:

- Created on or before August 10, 1993;
- Created and funded by the customer, the customer's spouse or both; and
- The customer or spouse is listed as beneficiary.

Although called a Medicaid Qualifying Trust (MQT), this type of trust may actually cause a customer to not qualify for ALTCS.

Resources

The maximum amount allowed by the terms of the trust to be paid to the customer is a counted resource.

The maximum amount considered available includes only amounts that can be distributed from the trust income or principal. This applies even if the trustee is not actually distributing these amounts.

Income and Share of Cost

Trust income that is counted for the income test and Share of Cost includes:

- Income assigned to the MQT that would otherwise have been paid to the customer; and

NOTE Since income assigned to the trust is already counted, it is not counted again when disbursed in the same month.

- Payments made from trust principal that is NOT being counted in the resource test.

NOTE Payment from trust principal that IS counted as a resource is a conversion of a resource (MA701.3). See MA705 for policy on how to treat specific resource types.

Petition for Release of Funds

To qualify for ALTCS, the beneficiary of an MQT must petition the court for disbursements of trust funds when either of the following applies:

- The terms of the trust only allow trust funds to be paid to or for the benefit of the beneficiary under a court order; or
- The terms of the trust allow the beneficiary to petition the court for trust funds to be disbursed when the trustee refuses to disburse them.

4) Testamentary and Non-Grantor Trusts

Testamentary and non-grantor trusts are funded by the assets of someone other than the customer or the customer's spouse.

If the customer's or spouse's assets have funded any part of the trust, it is not a non-grantor trust. It is one of the trusts in sections 1) through 3) above.

NOTE For trusts created by a will, if the grantor is still living, the testamentary trust does not yet exist.

Resources

The treatment of the trust principal depends on whether the customer is the trustee or the beneficiary and the terms of the trust.

If a customer is the...	Then...
Trustee	• The trust is NOT a resource when the trustee cannot legally access the trust principal for personal use. • The trust IS a resource when the terms of the trust allow the trustee to use the income and resources for his or her own benefit. The maximum amount that can be accessed by the trustee for personal use is counted as a resource.
Beneficiary	The trust is a resource when the beneficiary can terminate the trust to access the trust assets, or can access the trust principal directly or through an order to the trustee. The maximum amount that can be accessed by the beneficiary is counted as a resource. NOTE If the beneficiary cannot terminate the trust, directly access the funds or order the trustee to make payments, the trust principal is not a resource, even if the trust otherwise allows for payments from the principal .

Income and Share of Cost

Use the table below to determine how to treat income or disbursements for a testamentary or non-grantor trust.

NOTE Any trust income or disbursements that are counted as income to the customer are counted for both the income test and for SOC.

If a customer is the...	And...	Then…

Trustee	The trustee may legally access the trust principal for personal use	• Interest or dividends earned by the trust principal are counted as income in the month earned. • Additions to principal from a third party are counted as income. NOTE Disbursements from the trust principal are not counted as income.
	The trustee may NOT legally access the trust principal for personal use	• Any disbursements made to the trustee are counted as income. • Interest or dividends earned by the trust principal are not counted as income unless the terms of the trust state that they belong to the trustee. • Additions to trust principal made directly to the trust are not counted as income.
Beneficiary	The beneficiary may do ANY of the following: • Terminate the trust; • Order the trustee to make payments from the trust; or • Legally access the trust principal	• Interest or dividends earned by the trust principal are counted as income in the month earned. • Additions to principal from a third party are counted as income. NOTE Disbursements from the trust principal are not counted as income.

	The beneficiary may NOT do ANY of the following: • Terminate the trust; • Order the trustee to make payments from the trust; or • Legally access the trust principal	• Disbursements made directly to the beneficiary are counted as income. NOTE Disbursements that are made on behalf of but not directly to the beneficiary are not counted as income. • Interest or dividends earned by the trust are not counted as income unless the terms of the trust state that the beneficiary has a right to the trust earnings. • Additions to trust principal made directly to the trust are not counted as income.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income or both from a trust.
Disbursement	A payment or distribution from the trust corpus or trust earnings.
Irrevocable	A trust that is irrevocable cannot be changed or ended by the grantor or the grantor's representative after it is made. NOTE A trust that states it is irrevocable but will end by some action taken by the grantor or the grantor's representative is a revocable trust.
Non-grantor trust	A trust funded with the assets of someone other than the beneficiary. For example, a grandparent creates a trust funded with her own money for

	the benefit of her grandchild. Non-grantor trusts are sometimes called "Special Needs Trusts".
Revocable	A trust that may be changed or ended. NOTE A trust that says it can be changed or ended by a court is considered a revocable trust.
Testamentary trust	A trust created by a will upon the person's death.
Trust Corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. NOTE The trust corpus may also be called the trust principal.
Trustee	A person or organization that manages the trust resources and income for the benefit of the beneficiaries.
Trust document	The formal document that created the trust. It contains the powers of the trustees and rights of the beneficiaries. It may be a will, a deed in trust or a formal declaration of trust.

Proof

The proof needed for non-special treatment trusts may depend on whose assets funded the trust and whether the customer or spouse has access to the trust funds.

Proof needed for non-special treatment trusts includes:

If the trust is...	Then the proof needed is...
All Non-Special Treatment Trusts	• All of the pages of the trust document. This includes all amendments, restatements

	and schedules from the date the trust was created to the current month; • Any court records relating to the trust; • Proof of all resources and income transferred into or out of the trust during the application period. Examples include: ◦ Title transfer documents; ◦ Quit-claim deeds; and ◦ Financial account statements; • Proof of the source of all income or resources assigned to the trust; and • Proof that all income or resources assigned to the trust are legally titled to the trust. NOTE Assets that do not have a legal title, such as personal effects, do not require proof.
Irrevocable trust or MQT	• All of the proof needed for all non-special treatment trusts; and • Proof of the maximum amount that may be disbursed from the trust. NOTE The trust document may not state the maximum amount that may be disbursed from the trust. In this case, a statement from the financial institution of entity holding the trust funds is acceptable.
Testamentary Trust	• All of the proof needed for all non-special treatment trusts; and • A copy of the will that created the trust.

In addition to the proof listed above, the table below lists other proof needed in special circumstances:

If the trust is...	Then the proof needed is...
Funded with the customer's or spouse's assets	• Power of Attorney, legal guardianship or conservatorship documents when someone other than the beneficiary, spouse, or parent of a minor beneficiary created the trust; and • Proof of the value of the income or resources used to fund the trust when the trust was established.
A counted resource to the customer (customer has access to the principal)	• Proof of the value of income and resources currently assigned to the trust; and • Proof of all transfers made from the trust to someone other than the customer during the past five years.
No longer funded	Proof that all items assigned to the trust have been transferred out of the trust. Examples include: • Title transfer documents; • Quit-claim deeds; and • Bank statements showing the trust account is closed.
Revoked	A written statement signed and dated by a person with the authority to revoke the trust, such as the trustee or the person who created the trust. A trust will normally be revoked in the same method that created it: • When the trust document was notarized, the written statement revoking the trust must be notarized. • When a court initially approved the trust, the revocation must be approved by the court.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407 AAC R9-28-408

803 Special Treatment Trusts

803 Special Treatment Trusts

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Special Treatment Trust Overview

Revised 08/17/2021

Policy

Special Treatment Trusts (STTs) may allow people who would not otherwise qualify due to excess resources or income to become eligible for ALTCS. The assets in a STT are not counted for the income and resource tests. In return, AHCCCS recovers the cost of these benefits from the trust upon the death of the customer or termination of the trust.

There are three types of STT:

- Trusts for Individuals Under Age 65 with a Disability;
- Income-Only Trusts; and
- Pooled Trusts.

The trust must meet certain conditions to qualify as a STT. If a trust does not meet these conditions, it does not qualify for special treatment. All STTs are reviewed by AHCCCS to ensure that they qualify for special treatment.

The conditions that apply to all three STT types are listed in the table below:

Condition	Description
Date of creation	The trust must be created on or after August 11, 1993. NOTE A trust created before August 11, 1993 must be dissolved and recreated to qualify as a STT.
Customer as beneficiary	The customer must be designated as the beneficiary of the trust.
AHCCCS or “State Medicaid Agency” as remainder beneficiary	• Irrevocable trusts must name AHCCCS or the State Medicaid Agency as the remainder beneficiary upon the death of the customer. • Revocable trusts must name AHCCCS or the State Medicaid Agency as the remainder beneficiary upon the trust being

	revoked or terminated, or upon the death of the customer.
Restrictions on disbursements	The trust must state that disbursements cannot be made for purposes other than those described in ARS §36-2934.01. Additionally, the trust cannot allow the trustee to make disbursements which are prohibited by ARS §36-2934.01. As one example, a trust cannot allow a trustee to make loans to other people. Thus, a trust that generally allows a trustee to make “loans” is too vague and does not comply with ARS §36-2934.01.
Restrictions on trust expenses	The trust must state that it will allow disbursements for reasonable and necessary administrative expenses as approved by AHCCCS, or by the Probate Court with advance notice to AHCCCS. Further, any provision allowing for such reasonable and necessary administrative expenses must state that it will allow for those expenses as approved by AHCCCS, or by the Probate Court with advance notice to AHCCCS.
Share of cost	The trust must state that on a monthly basis, the trustee is to pay any share of cost amount from the trust income. NOTE This only applies when the trust receives income that is counted in the share of cost calculation.
References to moves out of state	To retain Arizona’s beneficiary rights, the trust cannot require all references to Arizona, ALTCS or AHCCCS to be replaced by parallel references to a Medicaid agency in another state.
Direct deposit	The trust must require that all income assigned to the trust by the grantor be directly deposited, when legally allowed, into an account titled to the trust.

Financial account with trust assets	Any financial account created with trust assets must be titled to show that the account is held by the trust. Example: • Bob Smith Income Only Trust- Mary Smith Trustee. • Billy Jones Supplemental Needs Trust.
Reference to federal law	The trust must contain reference to: • Title 42 of the United States Code; 42 USC §1396p(d); or • Section 1917(d)(4) of the Social Security Act.

The conditions and proof that are unique to each type of STT are covered in the following sections:

- MA803B - Trusts for Individuals Under Age 65 with a Disability;
- MA803C - Income-Only Trusts; and
- MA803D - Pooled Trusts.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income or both from a trust.
Disbursement	A payment or distribution from the trust corpus or trust earnings.
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer, but are no longer

	owned by the customer. The trust corpus may also be called the trust principal.

Proof

The proof needed to show the trust document meets all of the conditions for special treatment includes:

- All pages of the trust document, including any schedules, amendments, restatements and signature pages;
- Power of Attorney, legal guardianship or conservatorship documents when someone other than the beneficiary, spouse, or parent of a minor beneficiary created the trust;

NOTE When the customer's spouse signs the trust for the customer as POA, guardian, or conservator, the POA, guardianship, or conservatorship documents are required.

- Any court documents related to the trust;
- For any income assigned to the trust, a copy of the request to the income source for direct deposit to the trust account;
- For financial accounts containing trust assets, all account statements from the date the trust account was opened through the current month; and
- Documents like quit claim deeds, vehicle titles, and bank statements showing that items assigned to the trust have been titled to the trust.

Being listed on the Trust Assets Schedule does not automatically make an item an asset of the trust. It must also be legally titled to the trust.

Proof needed for a trust that has been revoked - If the trust has been revoked, a written statement signed and dated by a person with the authority to revoke the trust. A trust will normally be revoked by the same method that created it:

- When the trust document was notarized, the written statement revoking the trust must be notarized.
- When a court initially approved the trust, the revocation must be approved by the court.

Legal Authority

Program	Legal Authorities

ALTCS	42 USC § 1396p(d) ARS § 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

B Trusts for Individuals Under Age 65 with a Disability

Revised 04/16/2024

Policy

In addition to the conditions listed in MA803A, this type of trust has the following conditions:

Condition	Description
Trustor	The trust must be set up by one of the following: • the customer; • the customer's parent; • the customer's grandparent; • the customer's legal guardian; or • a court.
Trust corpus	The trust corpus contains only the customer's income and resources. A trust that contains income or resources of another person cannot qualify as a STT. Thus, a trust which allows the trustee to accept additions without clearly stating that those additions can only include the customer's income and resources does not comply with this requirement. NOTE The customer's income and resources may be freely added to the trust until the customer turns 65.
Age	The customer can be any age when the trust is created but any funding or additions to the trust after the customer turns 65 years old is reviewed as a transfer that may affect eligibility (MA902I).
Disability	The customer must have a disability at the time that the trust is created. Disability can be determined by:

	• The Disability Determination Services Administration (DDSA) using the same criteria used for the SSI-Cash program; • A Medical Eligibility Specialist using the Preadmission Screening (PAS) to determine a medical need for long term care services; or • A diagnosis of Serious Mental Illness (SMI) determined by the Arizona Department of Health Services. When the customer was not receiving SSI or SSA disability benefits at the time the trust was created, a retroactive disability determination is requested.

Definitions

Term	Definition
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The trust document itself is used for proof of who created the trust and the age of the customer at the time it was created.

In addition to the proof listed in MA803A, other proof needed for this type of trust includes:

Proof of disability

The following items can be used for proof that the customer has a disability and the date the disability began:

- A Pre-Admission Screening (PAS) decision showing that the customer has been determined to be medically in need of long-term care.

- Records from SSA showing the person is receiving SSA or SSI disability payments or has been determined disabled.
- An SMI Determination Summary Report or SMI Eligibility Outcome form that includes a SMI diagnosis of functional inability to live in an independent setting or risk of serious harm to self or others.

Proof of the source of trust assets

Proof that the trust corpus contains only the customer's assets includes documents and written statements showing the customer owned the item before it was titled to the trust. Examples of some documents that may be used include:

- Deed and title transfer documents;
- Records from the County Assessor or County Recorder; and
- Financial account statements.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407 AAC R9-28-408

C Income Only Trusts

Revised 04/26/2022

Policy

An Income-Only Trust (IOT) can allow a customer to qualify for ALTCS when income eligibility is determined using the 300% Federal Benefit Rate (FBR) Gross Income Test. This includes when the customer only qualifies for acute care services due to a transfer penalty period or the customer's living arrangements. See MA521B for detailed policy on the income test used based on living arrangements.

NOTE An IOT cannot help a customer qualify for ALTCS when the Net Income Test is used or to qualify for any other AHCCCS program.

This kind of trust is sometimes known as a stream-of-income, income-cap, or Miller trust.

In addition to the conditions listed in MA803A, this type of trust has the following conditions:

Condition	Description
Trustor	The trust must be created by the: • Customer; • Customer's parent, if the customer is a minor child; • Customer's spouse; or • Legal representative, including a court or administrative body with legal authority to act on behalf of the customer or spouse.
Trust corpus	The trust can only be funded with the customer's income. Resources cannot be added to or used to fund the trust. When resources are added to an IOT, the trust loses its special treatment until the resources are removed. Thus, a trust which allows the trustee to accept additions without clearly stating that those additions can only include the customer's income does not comply with this requirement.

	The IOT account must be set up with all or a part of the customer's current monthly income and have a $0 balance at the time it is set up.
Income assigned to an IOT	An IOT should only be created when *counted* income is more than 300% of the FBR. Income that is not counted should not be assigned to or deposited into the trust. However, if it is deposited into the trust, it is subject to the same requirements as any other income deposited into the trust. NOTE See MA902I for policy on income transferred to an IOT.
Assignment of gross income to the IOT	The full amount of any source of income must be assigned to and deposited into the trust account. The trust document or Schedule A must list the customer's gross income from the assigned source. The trust document or Schedule A may state "gross" income is assigned from the source instead of listing the actual gross payment amount.
Ending tax withholding	Since tax payments are not an allowed trust disbursement until there is an actual tax liability, taxes may not be deducted from income assigned to the trust. The customer must ask the income source to stop tax withholding.
Ending other income deductions	Since union dues, life insurance premiums, or insurance premiums to cover other people are not allowed trust disbursements, these expenses may not be deducted from income assigned to the trust. The customer must ask the income source to stop deductions for these items.
Income may not be higher than the Private Pay Rate (PPR)	For an IOT to qualify for special treatment, the customer's counted income not assigned to the trust plus the income assigned to the trust must be equal to or less than the private pay rate for the geographic area in which the customer lives (see MA905.6).

	NOTE Interest and dividends earned by the trust and added to the principal are not counted.
Undue hardship for income higher than the PPR	When the trust meets all other conditions except the customer's total counted income is higher than the PPR, an exception may be made on a case-by-case basis when the customer claims that the private pay rate is not enough to meet his or her needs.

Definitions

Term	Definition
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The trust document itself is used for proof of who created the trust and that the full amount of the gross income is assigned to the IOT.

In addition to the proof listed in MA803A, other proof needed for an IOT includes:

- A copy of the request to stop deductions for withholding taxes, life insurance premiums, and union dues from the income going into the trust, if applicable;
- The account statements from the date the trust account was opened to show that the account was funded with all or part of the customer's current monthly income and previously had a zero balance;
- For financial accounts containing trust assets, all account statements from the date the trust account was opened through the current month; and
- Proof of total countable income.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

D Pooled Trusts

Revised 04/26/2022

Policy

In addition to the conditions listed in MA803A, this type of trust has the following conditions:

Condition	Description
Trustor	The trust must be set up by the customer, the customer's parent, grandparent, legal guardian, or a court. A Pooled Trust is considered created on the date that the Joinder Agreement is signed by the customer or representative and the non-profit association that manages the trust.
Trust corpus	The trust corpus contains only the customer's income and resources. A trust that contains income or resources of another person cannot qualify as a STT. Thus, a trust which allows the trustee to accept additions without clearly stating that those additions can only include the customer's income and resources does not comply with this requirement. NOTE The customer's income and resources may be freely added to the trust until the customer turns 65.
Age	The customer can be any age when the trust is created NOTE When the trust meets all of the conditions and is created before the customer turns 65, the trust can keep its special treatment status after the customer turns 65. However, any additions to the trust after the customer turns 65 are reviewed as transfers (MA902I).
Disability	The customer must have a disability at the time that the trust is created. Disability can be determined by:

	• The Disability Determination Services Administration (DDSA) using the same criteria used for the SSI-Cash program; • A Medical Eligibility Specialist using the Preadmission Screening (PAS) to determine a medical need for long term care services; or • A diagnosis of Serious Mental Illness (SMI) determined by the Arizona Department of Health Services. • When the customer was not receiving SSI or SSA disability benefits at the time the trust was created, a retroactive disability determination is requested.
Management of the trust	The trust must be managed by a non-profit association. While the income or resources of all trust beneficiaries may be pooled for investment and management purposes, a separate trust account must be kept for each person.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income, or both from a trust.
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The trust document itself is used for proof of who created the trust and the age of the customer at the time the trust was created.

In addition to the proof listed in MA803A, other proof needed for a pooled trust includes:

Proof of disability

The following items can be used for proof that the customer has a disability and the date the disability began:

- A Pre-Admission Screening (PAS) decision showing that the customer has been determined to be medically in need of long-term care.
- Records from SSA showing the person is receiving SSA or SSI disability payments or has been determined disabled.
- An SMI Determination Summary Report or SMI Eligibility Outcome form that includes a SMI diagnosis of functional inability to live in an independent setting or risk of serious harm to self or others.

Proof of the source of trust assets

Proof that the trust corpus contains only the customer's assets includes documents and written statements showing the customer owned the item before it was titled to the trust. Examples of some documents that may be used include:

- Deed and title transfer documents;
- Records from the County Assessor or County Recorder; and
- Financial account statements.

Proof of Pooled Trust Management

- Documents showing that the company or organization managing the Pooled Trust is a non-profit association; and
- Accounting statements showing that a separate trust account is being kept for the customer.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(d) ARS 36-2934.01

	AAC R9-28-407.E AAC R9-28-408.F

E Special Treatment Trusts and ALTCS Eligibility

Revised 04/29/2025

Policy

This section covers the following ALTCS policies for Special Treatment Trusts (STTs):

- Disbursements;
- How income is counted for Special Treatment Trusts;
- Requirements for trustees;
- Penalties for late reporting; and
- Violations of Special Treatment Trust requirements.

1) Disbursements

Disbursements can only be made for the benefit of the customer and for purposes listed in state law at ARS §36-2934.01.

> NOTE For household expenses or any other shared expense, only the customer's proportionate share is an allowed disbursement. The total expense divided by the number of people who share the benefit of the expense equals the customer's share.

The following table lists examples of allowed disbursements:

Disbursement type	Description
Share of cost payment (SOC)	The amount an ALTCS customer must pay toward the cost of long-term care services.
Personal Needs Allowance (PNA)	The amount allowed for the customer's personal needs (see MA1201C.1). A PNA may only be disbursed from an Income Only Trust. The PNA is considered a payment for shelter. It may be paid as a lump sum or for individual items.

Legal and professional expenses related to administering the trust or for the trust beneficiary	• Income taxes owed on income earned by the trust or assigned to the trust. • Investment fees related to administering the trust. • Reasonable professional expenses, for example accounting and attorney fees, related to administering the trust. • Guardianship and conservatorship fees for the trust beneficiary based on the fair market value of the services provided.
Medical expenses	Health insurance premiums, medically necessary medical expenses, and special medical needs of the customer, including: • Expenses to make the home accessible to the customer. • Purchase and maintenance of a specially equipped vehicle, if titled to the trust or a lien is placed on the title by the trust for the purchase price of the vehicle. • Durable medical equipment. • Over the counter supplies and medications including diapers, lotions, and cleansing wipes. • Personal care service when determined medically necessary by the beneficiary's physician. The services must be provided by an NOTE Payments for personal care services provided by a financially responsible relative cannot be higher than the AHCCCS fee for service rate.
Spouse or family maintenance allowance	Payment for the maintenance needs of a spouse or other dependent as described in MA1201C from the trust income.

Burial expenses for the customer	Disbursements for the customer's burial expenses are limited to one of the following: • Purchase of a prepaid burial plan funded by an irrevocable life insurance policy, irrevocable burial account, irrevocable trust account or irrevocable escrow account. NOTE Any amount of the disbursement that exceeds the itemized burial expenses is an uncompensated transfer. • Purchase of life insurance to fund a burial plan for the customer with a face value of not more than $1,500 after allowing deductions for burial plot items. • A burial fund account of not more than $1,500.
Other expenses for the customer's benefit	• Costs for food, clothing, and shelter. • Home property and other real property purchased by and titled to the trust. • Items for entertainment, education, or vocational needs consistent with the customer's ability to use these items. • Travel expenses for a companion, including a financially responsible relative, when a companion is needed to allow the customer to travel for non-medical reasons. • For Pooled and Disabled Under 65 trusts, disbursements to qualified Achieving a Better Life Experience (ABLE) accounts established for the customer's benefit. (When reported at least 45 days in advance and approved by AHCCCS.) • Other expenses personally approved by the Director.

Disbursements that do not meet the requirements in ARS §36-2934.01 are not allowed.

Effective until 2025-04-25

Some examples of disbursements that are not allowed from an STT include:

- Gifts, payments, or loans to or for the benefit of anyone other than the beneficiary, including reimbursements to third parties for the customer's expenses;
- Child support and alimony payments that are not garnished;
- Paying all the shelter costs for a shared household;
- Income taxes when there is no actual tax liability;
- Vacation expenses for family members;
- Payments on past debts, including paying down credit cards;
- Health insurance premiums for other people; and
- Burial funds that do not meet the requirements listed in the table above.

When non-allowed disbursements have been made, the trust may lose its entitlement to special treatment. The disbursements may also need to be reviewed as a transfer with uncompensated value (see Chapter 900 – Transfers).

2) How Income is Counted for Special Treatment Trusts

Trust income and disbursements are counted as described in this section, regardless of the terms of the trust document.

The following table describes how income and disbursements are treated for income eligibility and for Share of Cost (SOC).

NOTE For the ALTCS Income Test, the total countable income outside the trust plus the total countable disbursements from the trust may not exceed the ALTCS income limit.

Income Type	Counted for the income test?	Counted for SOC?
• Counted income received by the customer that is not assigned to the trust; or • Counted income assigned to the trust but not deposited to the trust account in the month received.	Yes	Yes
Amounts from the trust paid directly to the customer for any reason.	Yes	No

Any payments from the trust on behalf of the customer for food or shelter. This includes room and board in a boarding home or an alternative Home and Community Based Services (HCBS) arrangement.	Yes	No
Income assigned to the trust that is manually or direct deposited into the trust account in the month received. **Exception**: Excluded income deposited into the trust is not counted for SOC.	No	Yes
For Pooled and Disabled Under 65 trusts, structured settlement annuity payments irrevocably assigned to the trust. NOTE These payments are considered income to the trust, not the customer.	No	No
Interest or dividends earned by the trust corpus and added to the trust principal.	No	No
Payments from the trust that are not paid directly to the customer or are not payments for the customer's food or shelter.	No	No
Payments from the trust for the customer's PNA NOTE The increased portion of the PNA for garnished child support or spousal support is not counted for income eligibility.	Yes	No

For examples, see STTs and Income Calculations and STTs and SOC Calculations.

3) Requirements for Trustees

The trustee of a STT has specific responsibilities related to providing proof and reporting changes. If the trustee fails or refuses to cooperate with these requirements, the trust can lose its special treatment status.

A trustee must:

- Provide proof needed to determine if the trust qualifies as a STT;

- Provide proof of disbursements and the related expenses;
- Report changes in trust income or disbursements;
- Report changes in trustees, as well as changes to an existing trustee's phone number or address;
- Report if the trust purchases real or personal property; and
- Report when the trust is revoked or terminated.

Other trustee responsibilities depend on whether the trust is still in its initial review to see if it qualifies as a STT, or it has already been approved as a STT.

Initial Special Treatment Trust Review

The trustee must provide the following documents for the trust review:

- The entire trust document;
- Proof of trust assets and disbursements from the date the trust was created to the current month;
- Proof of the source of the initial funding of the trust; and
- The Acknowledgment of Responsibilities as Trustee for a Special Treatment Trust form (DE-522).

The trustee must also provide one of the following forms:

- For trusts for individuals under age 65 with a disability or Pooled Trusts, the Special Treatment Trust Anticipated Disbursements (DE-312) form; or
- The Income Only Trust Anticipated Disbursements (DE-313) form.

The Anticipated Disbursement forms are used to state what costs and expenses will be paid from the trust.

For IOTs, the SOC MUST be paid from the trust. When the SOC is greater than the total income assigned to the trust, the full amount of the income deposited to the trust must be disbursed for the SOC. The SOC disbursement cannot be reduced to allow for other trust expenses.

Reporting Changes

After the STT is approved, the trustee must report any new trust funding or changes to the planned disbursements listed on the DE-312 or DE-313 forms at least 45 days in advance.

See Disbursement Request Examples

When the trustee cannot report changes by this due date because of circumstances beyond his or her control, the trustee must report the change within 30 calendar days from the date of the change or emergency disbursement. However, the notice is still considered late. See section 4 below for penalties that may be applied.

A major change, such as the customer moving from an HCBS living arrangement to a nursing facility, may change the trust disbursements needed, especially with an IOT. When this happens, the trustee must provide trust account records and complete a new DE-312 or DE-313 form listing anticipated disbursements for the next 12 months.

Reporting Requirements at a Renewal

At renewal, the trustee must provide information and update forms as described in the table below:

Type of Trust	**Requirements**
Trusts for a Person Under Age 65 with a Disability OR Pooled Trust	The trustee must report any changes to the trust corpus and provide all of the following documents: • Court ordered annual accounting documents or trust account records showing the actual trust income and disbursements since the last renewal; • A report of expected trust income and disbursements over the next twelve months using the Special Treatment Trust Anticipated Disbursements (DE-312) form; • Titles for any new trust assets; and • Proof for any assets removed from the trust.
Income-Only Trust	The trustee must report the amount of the trust corpus at the time of the renewal and provide both of the following:

	• Trust account records showing the actual trust income and disbursements since the last renewal; and • A completed Income Only Trust Anticipated Disbursements (DE-313) form for the next 12 months.

Annual Accounting Statements Placed with the Court

Trustees of STTs with a large trust corpus (usually Trusts for Individuals Under Age 65 with a Disability) are sometimes required to file quarterly, semi-annual, or annual accounting statements with the court that approved the trust creation.

4) Penalties for Late Reporting

Changes to income or trust disbursements can result in the customer losing eligibility or paying an increased share of cost for one or more months.

The trustee of an STT must report changes in income assigned to the trust or to disbursements from the trust at least 45 calendar days before the change happens. This is to allow enough time, if needed, to process any change in the SOC or eligibility for the month the change will happen.

When the trustee reports these changes late, the change is reviewed to see if the SOC would have been higher, or eligibility would have been affected for past months. If so, the adverse action that would have been applied if the change had been reported on time is applied to the next month possible allowing for advance notice.

When an adverse action is taken to stop ALTCS eligibility or increase the customer's SOC due to late reporting, the customer may appeal the decision. This may result in eligibility or SOC being continued at the previous level during the appeal. If the Agency decision is upheld at the hearing, the adverse action is applied for future months.

5) Violations of Special Treatment Trust Requirements

Violating the terms or conditions of a STT can result in the trust losing its Special Treatment status. Actions that violate the terms of a STT include:

- Depositing resources into an income-only trust;
- Depositing income or resources belonging to someone other than the customer into the trust;
- Breaches of "spendthrift" restrictions such as assigning, pledging, or otherwise obstructing the trust resources for certain personal debts or other obligations;
- Issuing disbursements from the trust that are not for the benefit of the customer;

- Giving false information about trust income or disbursements; and
- Failing to cooperate with trust reporting or proof requirements.

When a violation has occurred and the trust is no longer entitled to special treatment, it is treated as either a revocable or irrevocable non-special treatment trust (see MA802), until the trustee corrects the violation.

NOTE If counting the trust resources and income as available due to losing special treatment would cause an undue hardship, the situation is reviewed by the agency on a case-by-case basis.

Definitions

Term	Definition
Advance notice	A period of at least 10 days before the date the adverse action will be taken.
Adverse action	A change to decrease or stop benefits or to increase the customer's costs.
Disbursement	A payment or distribution from the trust corpus or trust earnings.
Financially responsible relative	Includes the following: • Customer's spouse; or • If the customer is under age 18, the customer's parents.
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.
Medically necessary	Health care services or supplies needed to diagnose or treat an illness, injury, condition,

	disease or its symptoms and that meet accepted standards of medicine.
Home Accessibility	Medical necessary modifications made to the customer's home that allow the customer to live more independently. Examples include, but are not limited to: widening doorways, clear floor space for wheelchairs to move throughout the home, lower countertops, installing an entryway ramp, and adding grab bars in bathrooms.

Proof

Proof of disbursements

- Anticipated Disbursements form (DE-312 or DE-313) with all 12 months completed, signed by the trustee;

See Special Treatment Trust Anticipated Disbursements Form (DE-312) and Income-Only Trust Anticipated Disbursements Form (DE-313) for examples.

- Check registers or other records of payments that were made from the trust. The records should show the payments date, amount paid, and what was received. Include explanations for changes made to the trust assets, such as accounts closed, properties sold, or titles changed;
- Receipts, invoices, or billing statements for any legal or professional services to be disbursed from the trust;
- Proof of health insurance premium amounts that will be paid from the trust;
- Proof of any shelter expenses that will be paid from the trust;
- For burial expenses, a quote or estimate from the burial provider showing the type of pre-need burial plan and costs, unless the request is for a life insurance policy or designated burial account of $1,500 or less; and
- A written explanation of any planned medical expenses, payments to the trust beneficiary, entertainment, vocational, or transportation expense disbursements.

Proof of Trustee agreement to abide by the STT requirements

- Acknowledgement of Responsibilities as Trustee for a Special Treatment Trust form (DE-522) signed by the trustee.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

804 Undue Hardship Claims for Trusts

Revised 02/14/2020

Policy

The trust provisions may be waived when denying eligibility for long term care services creates an undue hardship. Undue hardship exists when applying the trust provisions would deprive the customer of:

- Medical care such that his or her health or life would be endangered; or
- Food, clothing, shelter, or other necessities of life due to the customer's income at or below 100% of the federal poverty level (FPL). See MA615.2 Income Standards for FPL limits.

Undue hardship does not exist when application of the trust provisions only causes inconvenience or restricts the customer's lifestyle but would not put him or her at risk of serious deprivation.

To qualify for an undue hardship, ALL of the following conditions must be met:

- The customer does not have the income or resources to pay for the medical care that he or she needs;
- The customer does not have any other means of obtaining the medical care that he or she needs, including other insurance, benefits or third-party liability; and
- The customer qualifies for ALTCS except for trust policy.

Undue hardship decisions are made on a case-by-case basis.

Definitions

Term	Definition
Other benefits	Benefits that entitle the customer to medical care, such as VA benefits.

Proof

Proof includes:

- A written statement from the customer that he or she is requesting an undue hardship determination, and the reason the customer believes an undue hardship exists;

- Proof of the customer’s medical needs and expenses;
- Proof of income and resources for all months for which the customer is requesting an undue hardship;
- Proof of any medical insurance the customer has; and
- Any other information to support the customer’s claim of undue hardship.

Legal Authority

Program	Legal Authorities
All Programs	42 USC § 1396p(d)(5) ARS 36-2934.01

Chapter 900 Transfers

900 Introduction

This chapter explains how to evaluate transfers of income or resources that could impact a customer's eligibility to get long-term care services.

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement.

901 Transfers Overview

Revised 07/17/2020

Policy

Transfer policy applies to customers who are applying for or receiving long-term care services, including customers who receive SSI Cash or Freedom to Work.

Transferring ownership of an asset for less than current market value may result in a period of time where the customer cannot get long-term care services. This period is called the “transfer penalty period”.

This policy applies to all transfers made during the look-back period.

See Example Establishing the Look-Back Period.

A transfer that happened before the look-back period does not affect the customer’s eligibility unless a penalty period was established by an earlier application and has not expired. In this case, the penalty period applies to the current application.

See Example Previous penalty period in effect at new application.

Any transfers that occurred during the look-back period or after the application was submitted must be reviewed to see if the customer received compensation for the full value of the asset. If the customer did not receive compensation for the full value of the asset, it is considered an “uncompensated transfer”. The uncompensated value is used to determine the length of any penalty period.

ALTCS eligibility is not stopped or denied due to an uncompensated transfer. If all other eligibility requirements are met, the customer will receive the limited ALTCS service package (MA302.2) during the penalty period.

Definitions

Term	Definition
Transfer	Giving legal ownership of an asset in whole or in part, to someone else. Some actions that cause a change in legal ownership include: • Changing the title or deed; • Selling or purchasing a resource;

	• Trading or exchanging one asset for another; • Making a loan; • Giving away a resource or income; • Assigning assets to another person or entity; and • Buying an annuity. After a transfer occurs, the asset no longer belongs to the former owner to the same degree that it did before the transfer. The former owner's total assets have a different value, or have been converted from one type of asset to another.
Assets	A person's income and resources. This includes income and resources the person is entitled to get, even if the person takes action to avoid receiving them.
Assignment of Assets	Designating or setting aside an asset for a specific purpose. An assignment may be revocable or irrevocable. • A revocable assignment of income or resources is not a transfer. Instead, the assets are considered "constructively received". See MA604B and MA703C for additional information about constructively received assets. • An irrevocable assignment of income or resources is a transfer.
Compensation	Money, real or personal property, food, shelter, or services received in exchange for a transferred asset. Compensation does not include either of the following: • Items or services with no cash value. For example, "love and consideration" is not compensation; or • Any part of a payment specifically identified as paying for interest.

Current Market Value (CMV)	Also known as “Fair Market Value”. For a resource, the actual dollar amount of the resource if sold on the open market at the time of the transfer. For income, the actual dollar amount of the income at the time it was transferred. See Determining the Uncompensated Value of a Transferred Stream of Income for additional information.
Equity value	The CMV of an asset less any outstanding loans, mortgages, or other legal encumbrances.
Look-Back Period	The 60-month period before the month the customer applies for ALTCS. The look-back period begins on the first day of the 60th month prior to the month of application.
Uncompensated Value	The difference between the equity value of an asset at the time it is transferred, and the amount of compensation that the customer received in exchange. The uncompensated value of a transfer may never be less than $0.00.

Proof

When a countable income or resource has been transferred, documents need to be provided to prove:

- The date of the transfer. For transfers of real property, the date of transfer is the date the transfer document is signed and notarized, not the date the document is recorded;
- The person who owned the item both before and after the transfer;
- Any legal debts and liens against the transferred item at the time of the transfer;
- The CMV of the transferred item at the time of the transfer; and
- Any compensation received for the transfer.

NOTE For proof of a resource’s CMV see the specific policy for that type of resource in MA705.

Legal Authority

Program	Legal Authorities
ALTCS FTW-ALTCS	42 USC 1396p(c) 42 CFR 435.1005 ARS 36-2934(B) AAC R9-28-401 and 409

902 Transfers that may Affect Eligibility

902 Transfers That May Affect Eligibility

In general, a transfer assets may affect the customer's eligibility for long term care services under the ALTCS program when the transfer:

- Is made without receiving full compensation; and
- Is not described in MA903 - Transfers That Do Not Affect Eligibility.

The customer may still be eligible for acute medical services under ALTCS Acute Care if all other requirements are met.

The transfers described in the following sections may affect the customer's eligibility:

- Actions that would cause income or resources not to be received (MA902A);
- Creating joint ownership giving another person an ownership interest in the asset (MA902B);
- Withdrawal of funds from a financial account by a joint owner (MA902C);
- Adding a joint owner to home property (MA902D);
- Transferring home property (MA902D);
- Transferring real property and retaining a life estate interest (MA902D);
- Transferring the right to receive income (MA902E);
- Purchase of a life estate in another person's home (MA902F);
- Purchasing an Irrevocable Annuity (MA902G);
- Loans, including promissory notes and property agreements (MA902H);
- Transferring assets to certain types of trusts (MA902I); and
- Making disbursements from certain trusts that are not to or for the benefit of the customer (MA902I).

A Actions That Would Cause Income or Resources Not To Be Received

Policy

An action or failure to take action that results in the customer or customer's spouse not receiving income or resources may be a transfer with uncompensated value.

Examples of actions that would cause income or resources not to be received include:

- Waiving or refusing an inheritance;
- Waiving or assigning pension income;
- Refusing to take legal action to get a court ordered payment that is not being paid;
- Refusing to accept or receive an injury settlement; and
- Diverting insurance awards or court settlements into a trust or similar device to be held for the benefit of the person who won the settlement.

Actions or inactions of any of the following persons result in uncompensated transfers:

- The customer;
- The customer's spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the customer or the customer's spouse; and
- Any person, including a court or administrative body, acting at the direction of or upon the request of the customer or the customer's spouse.

EXCEPTION:

If the person cannot afford to take the action required to get the income or resource, or if the cost of getting the income or resource is greater than what the income or resource is worth, there may be no uncompensated value.

Definitions

Term	Definition

Equity value	The asset's current market value (CMV) less any outstanding loans, mortgages, or other legal encumbrances.
Uncompensated value (UV)	The difference between the asset's equity value, and the amount of compensation received as a result of the transfer.

Proof

When there is action or failure to take action that causes income or resources not to be received by the customer or the customer's spouse, the following proof is needed:

- That the customer or customer's spouse was or is entitled to receive the income or resource; and
- The value of the resource or income at the time that it was refused.

If the customer claims that the cost to get the resource or income is greater than the its value, the customer will also need to provide proof of:

- The cost of getting the resource or income; or
- That the person cannot afford to take the action needed to get the resource or income.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c) AAC R9-28-401 and 409

B Creating Joint Ownership

Revised 11/02/2021

Policy

Placing another person's name on an asset may limit the availability of the resource or the customer's right to sell or dispose of the resource. For example, this may happen when adding the other person's name requires that the person agree to the sale or disposal of the resource where no such agreement was needed before.

When the customer places another person's name on real property as a joint owner, the value of the other owner's interest in the property is a transfer.

> NOTE Adding another person's name to the title of a financial account usually does not change the customer's access to the funds. However, the title change must be reviewed to ensure that the customer's access has not been restricted, and the actual use of the funds must be reviewed for possible transfers.

Review how resources are titled to determine whether or not a transfer has occurred. The following table includes common title language and how it may affect the customer's ownership and access to the resource:

When the jointly owned asset is titled...	**Then...**
• The customer "or" another person; • The customer "and/or" another person; or • No designation; just multiple names listed.	The customer's right to sell or otherwise use or dispose of the asset has not been limited and does not result in a transfer with uncompensated value. NOTE However, it is a transfer when the other person sells, or uses up, the jointly titled resource.
Customer "and" another person	There is a transfer. The customer's right to sell or otherwise use or dispose of the asset has been limited because the customer must now get the other owner to agree to the sale, use or disposal of the asset. NOTE The transfer occurs when the other person's name is added to the title.

See Creating Joint Ownership - Examples

Definitions

Term	Definition
Joint Ownership	More than one person has legal right to use, sell or dispose of a resource. See MA704B for more policy on jointly owned resources.

Proof

When a countable income or resource has been transferred, documents need to be provided to prove:

- The date of the transfer. For transfers of real property, the date of transfer is the date the transfer document is signed and notarized, not the date the document is recorded;
- The person who owned the item both before and after the transfer;
- The Current Market Value (CMV) of the transferred item or the actual future cash value of income at the time of the transfer; and
- Any and all legal encumbrances such as debts and liens against the transferred item at the time of the transfer.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(3) AAC R9-28-401 and 409

C Withdrawals from Jointly Owned Accounts

Policy

A withdrawal of money from a financial account titled to the customer by a joint account owner other than the owner's spouse may be a transfer with uncompensated value.

The date of transfer is the date the funds were withdrawn or spent to make payments or purchases that were not for the benefit of the customer.

Exception:

Although funds held in a jointly owned account are considered the property of the customer, the customer has the opportunity to prove that the customer did not deposit some or all of the funds in the account.

A person who wants to rebut ownership of the funds in the account may present evidence to prove that all or part of the funds are the property of another person. See MA705l for more details.

If either the customer or the other owner can prove that the funds withdrawn were deposited into the account by the co-owner and did not belong to the customer, withdrawal of those funds is not considered a transfer.

Definitions

Term	Definition
Rebuttal of Account Ownership	An opportunity to provide proof of the actual ownership of funds in a financial account.

Proof

The customer must also provide all of the following:

- Account records showing deposits and withdrawals for all months in which ownership is being rebutted;
- Proof of the source and ownership of the deposits;

- Account records or a statement from the financial institution showing that the customer's portion of the funds have been removed from the account, and that the customer is no longer listed as an owner or signer.

When the customer is rebutting account ownership, the customer and each other account owner must provide a written statement, under penalty of perjury, of all of the following:

- Who owns the funds in the account;
- Why there is a joint account;
- Who has made deposits to and withdrawals from the account; and
- How withdrawals have been spent.

NOTE If the only other account holder is incompetent or a minor, the customer must provide a statement that meets these requirements from a person who was aware of the circumstances surrounding establishment of the account.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(3) AAC R9-28-401 and 409

D Transfers of Real Property

Policy

1) Transfer of Home Property

Transfer of home property is not treated as a transfer of an excluded resource under MA905. Transferring ownership without full compensation may result in a penalty period.

2) Property Transfer with Retention of a Life Estate Interest

When the customer or spouse transfers property to another individual but retains a life estate interest in the transferred asset, a transfer has occurred. The current market value of the life estate interest (See MA705T) is subtracted from the equity value of the property. The difference is the amount of uncompensated value.

NOTE The value of the customer's life estate interest may be excluded as home property if the property is the customer's principal residence.

Definitions

Term	Definition
Life Estate	A life estate is ownership by a right to the use of the property without title to the property (see MA705T).

Proof

When real property has been transferred, the person must provide proof of:

- The date of the transfer; and ownership before and after the transfer. Some examples of proof include the following:
    - Sales contracts;
    - Deeds;
    - Property titles.

- Documentation to prove the Current Market Value (CMV) of the property. Primary proof of a property's CMV is the assessed value from current tax bills or County Assessor records. If these assessments cannot be used or the customer disagrees with the assessment, current written estimates of the property's CMV must be obtained from two knowledgeable sources.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(A) AAC R9-28-401 and 409

E Transfer of an Income Stream

Policy

When a person gives up the right to a stream of income (for example, a pension), the amount of uncompensated value is the lifetime value of the income that would have been received.

The transfer date is the date that the income stream was assigned to someone else or otherwise given up.

Whether or not the assignment results in a transfer depends on whether the assignment is revocable or irrevocable.

A revocable assignment of income or resources is not a transfer. Instead, the assets are considered "constructively received".

- Constructively received resources (MA703C).
- Constructively received income (MA604B).

Irrevocable Assignment: "Irrevocably assigned" means a resource or income has been placed in another's name and only that person can take the action needed to make the resource or income available to the customer.

- If a customer irrevocably assigns a resource to another party, the assignment is a transfer. When a person irrevocably assigns the right to all future payments from a source, the total long-term value of the transferred income is added together to determine the amount of the transfer.
- When a person irrevocably assigns some income payments, but does not assign the right to all future payments from that source, the assigned payments are considered constructively received income and are counted as the customer's income.

Definitions

Term	Definition
Assignment	To designate or set a resource aside for a specific purpose. It may result in the customer no longer owning all or part of an asset. An assignment might be revocable or irrevocable.

Proof

When a countable stream of income has been transferred, documents need to be provided to prove:

- The date of the transfer;
- The person who owned the item both before and after the transfer;
- The type of assignment; revocable or irrevocable assignment.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(A) AAC R9-28-401 and 409

F Purchase of a Life Estate in Another Person's Home

Policy

The purchase of a life estate in another person's home is a transfer of assets for less than fair market value unless the purchaser resides in the home for 12 consecutive months after the date of the purchase.

NOTE The one year residency requirement does not replace other policy on how life estates are treated. The amount used to purchase the life estate will still need to be evaluated to determine if compensation is received for the purchase of the life estate.

For example, if the customer uses $100,000 to purchase a life estate in another customer's home that provides the person with a life estate value of $60,000, there is an uncompensated value of $40,000.

Definitions

Term	Definition
Life Estate	A life estate is ownership by a right to the use of the property without title to the property (see MA705T).

Proof

When a life estate has been purchased in another person's home, documents need to be provided to prove:

- The date of the purchase;
- The amount paid to purchase the life estate; and
- The equity value of the other person's home.

Proof may include, but is not limited to, the following:

- Deeds;
- Wills; and
- Other legal documents.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(J) AAC R9-28-401 and 409

G Purchase of an Irrevocable Annuity

Policy

In general, an irrevocable annuity bought in the look-back period, or a revocable annuity that becomes irrevocable in the look-back period may be a transfer of assets for less than full value.

Exception:

Full value is considered to be received when the annuity meets the requirements in the table below:

The annuity must...	AND meet all conditions below...
• Name AHCCCS as the primary beneficiary; or • If the owner has a spouse, disabled child or minor child, AHCCCS must be listed as beneficiary in the second position after the spouse, disabled child or minor child.	• Was created using funds in a ROTH IRA, 408 or other employer sponsored plan; OR • Was purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; AND • Provides equal monthly payments with no balloon, deferred or increasing or decreasing monthly payments (small differences due to changes in interest rates are allowed); • The annuitant is the customer or the customer's spouse; • Is a "Period Certain" annuity that that will return the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table (from socialsecurity.gov); and • The number of months that annuity payments will be issued should be less than the number of months of the person's life expectancy (multiply figure from the Period Life Table (from socialsecurity.gov) by 12).

When the annuity does not meet all requirements above, the value of the annuity on the date it became irrevocable is a transfer with uncompensated value.

Effective until 2025-04-25

See Example Annuities Which are a Compensated Transfer

See Example An Annuity that is an Uncompensated Transfer

Definitions

Term	Definition
Annuitant	A person entitled to payments from an annuity
Annuity	A financial product that in return for premium payments issues periodic payments to the person over a period of time once it is annuitized.
Annuitized	An annuity account or fund that has become irrevocable and is issuing payments according to the terms of the annuity contract.
Beneficiary	A person entitled to any remaining pay-out of an annuity upon the death of the annuitant.
Irrevocable annuity	An annuity issuing payments in accordance with the annuity contract, and cannot be cashed in. Also called an “immediate” annuity.
Revocable	An annuity contract that can be surrendered and the funds in the account withdrawn. Also called a “deferred” annuity.

Proof

Proof of contract terms, including length of the contract, payment amounts, annuitant’s name, and beneficiary, may include one or more of the following documents:

- Copies of the annuity contract and account statements from the annuity or insurance company;

- A Request for Verification of Annuity (DE-235) form, completed by the annuity company or life insurance company;
- A copy of the annuity application the customer signed at the time the annuity was purchased; or

NOTE Generally the beneficiary is listed in the annuity application and not in the annuity contract itself.

- Other written statement completed by the annuity company or life insurance company, containing the terms of the contract.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(F) and (G) AAC R9-28-401 and 409

H Loans

Policy

When a person loans money or other resources it is a transfer of that resource. Promissory notes, loan agreements and property agreements must be reviewed to see if the person received full value for the resource, or if the transfer was uncompensated. The date of the transfer is the date the note, loan or agreement was created or when it became non-negotiable, whichever is later.

How loan agreements are treated for transfer policy may depend on the type of loan and whether the person is the lender or the borrower.

See the following policy for more details:

Customer is the lender:

Promissory notes, loan agreements and property agreements that cannot be sold have no value as a resource, and the amount loaned is an uncompensated transfer.

Loans agreements may be in writing or oral. However, since they cannot be sold, oral loan agreements are all uncompensated transfers until the debt is paid back in full.

Customer is the borrower:

Under Arizona law, oral loans are only legally valid for a one year period. Any payments the customer makes after the one-year period is considered a transfer.

See example Oral loan payments made more than a year after the agreement.

Definitions

Term	Definition
Negotiable	Means the promissory note, loan, or property agreement can be sold. Generally an agreement of this type can be sold when it meets all of the following: • It can be assigned or transferred to someone else; • The terms of the agreement can be enforced; and

	• It does not contain terms which make it unmarketable. The value is the amount of the outstanding principal balance.
Non-negotiable	Non-negotiable means that there is a legal barrier to the transfer of ownership. If the note, loan or property agreement is not negotiable, it has no value as a resource.
Marketable	Means something that a reasonable purchaser would accept.
Outstanding principal balance	Means the original amount of the note, loan or property agreement, minus any payments made on the principal.

For more information about loans see MA705R.

Proof

Negotiable/Not negotiable

Proof may include, but it not limited to, any of the following:

- Court order saying that the resource may or may not be sold; or
- Language in the note, loan or agreement document that it cannot be sold, assigned or transferred to someone else.
- Written statement from a knowledgeable source that the note, loan or agreement can or cannot be sold.

NOTE No proof is needed that an oral loan is not negotiable.

Terms of an Oral Loan Agreement

For proof of the terms of an oral loan agreement, the person who made the loan must complete a Request for Verification of Money Loaned (DE-231) form. The person who received the loan must complete a Request for Verification of Money Borrowed (DE-230) form.

Unpaid Principal Balance of the Loan

Proof of the unpaid principal balance of a promissory note, loan or property agreement includes proof of the original principal balance **and** proof of any payments made on the principal.

Proof of the original principal balance includes but is not limited to the following types of documents:

- Bank notes;
- Bills of sale;
- Mortgage contracts;
- Sales agreements;
- Bank statements; or
- Letter from a bank officer.

Proof of payments includes but is not limited to the following types of documents:

- Payment books;
- Bank or other financial account statements; and
- Letter from bank officers that provide the unpaid principal balance or the original balance and all principal payments made.

Legal Authority

Program	**Legal Authorities**
ALTCS	42 USC 1396p(c)(1)(I) AAC R9-28-401 and 409

I Assets Placed in a Trust

Policy

When a counted resource or home property is placed in a trust, a transfer for less than fair market value is usually considered to have taken place. A person placing a resource in a trust generally gives up ownership of the resource to the trust. If the person does not receive fair compensation in return, a transfer penalty may be imposed.

How a transfer to a trust is treated depends on the type of trust. This section provides policy for reviewing trusts to determine whether a transfer with uncompensated value has happened and any transfer penalty period. This section discusses:

- Transfers to Special Treatment Trusts;
- Transfers to Revocable Trusts;
- Transfers to Irrevocable Trusts; and
- Irrevocable Burial Trusts.

1) Transfers to Special Treatment Trusts (STT)

The transfer of income or resources to a STT may affect the customer's ALTCS eligibility. The affect of a transfer depends on the type of Special Treatment Trust:

If the trust is a...	Then...
Trust for Disabled Individual Under Age 65	Transfer policy does not apply to income or resources transferred to the trust while the customer is under age 65. NOTE Any income or resources added to the trust after the customer turns 65 years of age must be reviewed as a transfer.
Income-only Trust	Transfer policy applies to income transferred to an Income-only trust. The amount of uncompensated value is the difference between the amount of monthly income put into the trust and the monthly amount paid out on behalf of the customer.

	See Example Income-only Trust.
Pooled Trust	Transfer policy does not apply to income or resources transferred to the trust while the customer is under age 65. NOTE Any income or resources added to the trust after the customer turns 65 years of age must be reviewed as a transfer.

2) Transfers to Revocable Trusts

A transfer of resources into a revocable trust is not considered an uncompensated transfer because the resources in the trust are still available to the customer.

See Examples Transfers to Revocable Trusts.

3) Transfers to Irrevocable Trusts

When a customer creates an irrevocable trust where any part of the trust assets cannot be paid to or on behalf of the customer, that part is reviewed as a transfer for less than fair market value.

The date of transfer is the latest of the following:

- The date the trust was created;
- The date when payments to could no longer be made from the trust; or
- The date the resource was assigned to the trust.

See Example Irrevocable Trust Transfers.

4) Irrevocable Burial Trust

Since the funds placed into a burial trust are not tied to specific good and services, they must be evaluated as a transfer. Up to $9,000 in a burial trust may be considered a compensated transfer when the burial trust meets both of the following conditions:

- The individual does not already have an irrevocable burial plan; and
- The burial trust contract specifies that any amount not used for burial will revert to the person’s estate, where it would be subject of the Estate Recovery program.

Any amount placed into a burial trust that does not meet both conditions shall be evaluated as a transfer with uncompensated value.

If the burial trust that meets both conditions but the amount in the trust is more than $9,000, the amount over $9,000 is a transfer with uncompensated value.

Definition

Term	Definition
Revocable	The person who establishes the trust reserves the right to revoke it. A revocable trust can be nullified by: • Withdrawal; • Recall; • A restatement of the trust; • Reversal or revocation; or • The transfer of all trust assets out of the trust. A trust, which provides that the trust can be modified or terminated by a court, is considered to be a revocable trust.
Irrevocable	The trust may not be revoked after its creation, by the grantor or a representative. NOTE A trust instrument, which states that the trust is irrevocable but which will terminate by some action taken by the grantor, is considered a revocable trust.

Proof

See MA802 for the proof needed for revocable and irrevocable trusts. See MA803 for the proof needed for Special Treatment Trusts (STT).

When assets have been placed in a trust, documents need to be provided to prove:

- The date of the transfer. Proof includes, but is not limited to, the following:

    - Copy of the trust document;
    - Court documents;
    - Deeds; and
    - Proof of disbursements.
- The equity value of the transferred item or the actual future cash value of income at the time of the transfer.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c) and (d) AAC R9-28-401 and 409

903 Transfers That Do Not Affect Eligibility

903 Transfers That Do Not Affect Eligibility

Revised 08/07/2020

In general, a transfer of assets may not affect the customer's eligibility for long term care services under the ALTCS program when the transfer:

- Was made before the lookback date (MA903A)
- Was made by certain other people (MA903B)
- Does not include the customer's resources (MA903C)
- Was adding another person's name to a financial account (MA903D)
- Was made to pay the customer's legal debt (MA903E)
- Was a transfer of an excluded resource, with some exceptions. (MA903F)
- Was a transfer of a home property to specific people (MA903G)
- Was a transfer of resources for the benefit of specific individuals (MA903H)

A Transfer Before the Look-Back Period

Revised 08/07/2020

Policy

A transfer that happened before the look-back period (MA901) does not affect the customer's eligibility for long term care services.

Exception:

The transfer may have been established within the look-back period of an earlier application. Earlier applications are reviewed to see if there is a penalty period that has not yet ended. If there is a penalty period from an earlier application that has not yet ended, the customer must serve the rest of the penalty period.

Definitions

Term	Definition
Look-Back Period	The 60 month period before the month the customer applies for ALTCS

Proof

The customer's statement that the transfer occurred on a date before the look-back period is accepted unless there is information that makes it questionable.

When needed, proof that a transfer occurred before the look-back period includes:

- Sales contracts;
- Receipts;
- Bank statements;
- Deeds;
- Records from the County Assessor or County Recorder showing the date the transfer occurred; and
- Other documents showing the date of the transfer.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

B Transfers Made by Certain Other People

Revised 03/22/2022

Policy

A transfer does not affect the customer's eligibility for long term care services when made by someone other than:

- The customer;
- The customer's spouse;
- Any other person, with the legal authority to act on behalf of the customer or spouse; or
- A person or agency, including a court or administrative body, that was acting at the request of the customer or spouse.

NOTE A transfer ordered by a court as the result of a judgment against the customer does not affect eligibility for long term care services as the court's authority was not given by the customer and the court is not acting at the customer's request.

Definitions

Term	Definition
Administrative body	A government unit or agency that exercises a legal or regulatory authority.

Proof

When a transfer is made by someone that did not have authority to act for and did not act at the request of the customer or spouse, proof of the following is needed.

Proof of who made the transfer

Proof includes the following documents when signed or authorized by the person who made the transfer:

- Court documents;
- Deeds; and
- Canceled checks and bank transactions.

Proof of the person's relationship to the customer

Relationships include family relationships, Powers of Attorney (POA), guardians or conservators. Proof of relationships includes:

- POA documents;
- Court orders awarding guardianship or conservatorship.

Proof that the transfers were made by someone without legal authority

Proof that a person made the transfer without the legal authority to do so includes:

- Police reports about the transfer;
- Adult Protective Services (APS) reports of financial exploitation; or
- Other documents that show a person's authority to act on behalf of the customer. For example, a limited Medical Power of Attorney that does not give the representative the right to make financial decisions.

Legal Authority

Programs	**Legal Authority**
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

C Transfers That Do Not Include the Customer's Resources

Revised 08/07/2020

Policy

Transfers that did not include resources of the customer or the customer's spouse do not affect the customer's eligibility for long term care services. See Transfers that Do Not Affect Eligibility Examples.

Proof

When a transfer was made that did not include the customer's resources, proof of who owned the resource at the time of the transfer is needed. Proof includes:

- Deeds;
- Purchase agreements;
- County Assessor or County Recorder records; and
- Bank statements.

NOTE A customer may have held legal title to a resource without having equity interest in the resource (MA704C.1). In this case, bank statements and canceled checks showing that someone else's funds were used to purchase the resource may be used as proof that the customer did not have any equity interest.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

D Adding a Person's Name to a Financial Account

Revised 08/07/2020

Policy

Adding another person's name to a customer's financial account as a joint owner is usually not considered a transfer. The funds in the financial account still belong to and can be accessed by the customer (MA705I).

Exception:

If adding the other person's name to the account changes the customer's access to or right to use the money in the account, it is reviewed as a transfer (see MA902B and MA902C).

NOTE The customer is assumed to retain full access to the assets in the account unless there is evidence to the contrary.

Proof

When information or evidence indicates the customer's access to the account has been changed, proof of the customer's access to the account is needed. Examples of proof include bank records or court documents that show any changes to the customer's ability to access funds.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

E Purchases and Payment of Debts

Revised 08/07/2020

Policy

A transfer does not affect the customer's eligibility for long term care services when the resource is used:

- To make a purchase at current market value (CMV) for the customer; or
- To pay the customer's valid debt.

NOTE Repayment of the customer's debt from a Special Treatment Trust is not allowed (MA803E.1).

Proof

Proof that funds were spent for the benefit of the customer includes:

- Receipts for purchases; or
- Bill payment records.

Proof of CMV is only needed when the purchased goods or services appear to be worth less than the customer paid. For proof of a resource's CMV, see the specific policy for that type of resource in MA705.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

F Transfers of Excluded Resources or Income

Revised 08/07/2020

Policy

In general, the transfer of an excluded resource or income does not affect the customer's eligibility for long term care services. However, there are exceptions to the general rule. Transferring the following excluded resources may affect the customer's eligibility, unless the transfer meets the requirements in MA903G or MA903H:

- Home property (MA705K);
- Proceeds from the sale of home property (MA705K); or
- Refunds from HCBS or nursing facilities for services the customer self-paid before being approved for ALTCS (MA705J).

Proof

Proof that a resource is excluded depends on the resource type. See MA705 for examples of proof by resource type.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

G Transfer of Home Property to Specific People

Revised 08/07/2020

Policy

The transfer of home property to any of the people listed below does not affect eligibility for long term care services:

- The customer's spouse;
- The customer's child or stepchild, when the child is under 21 years of age;
- The customer's child or stepchild, of any age, who lived in the customer's home for at least two years immediately before the date the customer became institutionalized, AND provided care to the customer that allowed the customer to live at home rather than in a medical institution;
- The customer's sibling who has an equity interest (MA704C) in the home and who lived in the home with the customer for at least one year immediately before the date the customer became institutionalized; or
- The customer's child or stepchild, of any age, who has been determined to have a qualifying disability, including blindness (see MA504 and MA509).

NOTE For the transfer policy in this section, a qualifying disability does NOT include a determination of severe impairment.

Definitions

Term	Definition
Actuarially sound	For transfer policy, means that the full value of the transfer should be received by the person within his or her expected life span
Institutionalized	For purposes of the transfer of a home, a customer is considered institutionalized when the customer: • Is living in a nursing facility; • Is in a medical treatment facility and Medicaid payments are made based on a level of care provided in a nursing facility; or

	• Is eligible for home or community based services through the Arizona Long Term Care System (ALTCS) program.
Severe impairment	A medical condition that significantly limits a person's physical or mental abilities to do basic work activities. (see MA509)

Proof

Use the following table to determine what kind of proof is needed to prove that the home property was transferred to a specific individual and will not affect eligibility:

When the home property was transferred to...	**Then proof is needed of....**
The customer's spouse	The customer's legal marriage to the spouse. See MA520 for a more detailed list of proof.
The customer's child or step child with a qualifying disability OR To a trust for the sole benefit of the customer's child with a qualifying disability	The child's relationship to the customer. Proof includes birth certificates, court documents and church records. When the child is a step-child, proof is needed of: • The child's relationship to the customer's spouse; AND • The customer's marriage to the child's parent NOTE The death of the child's parent does not terminate the step-parent's relationship
	The child's qualifying disability. Proof includes: • Electronic confirmation from Social Security; • Award letters showing the child receives Social Security Disability benefits or SSI-Cash based on disability;

	• PAS approval; or • SMI determination
	• In addition to the items above, when the transfer was made to a trust, a copy of the trust document, showing that:The trust is for the sole benefit of the customer's child; • The trust clearly sets out the conditions of the transfer and who can benefit from it; AND NOTE Unless it is a Special Treatment Trust, the trust includes a spending plan for the benefit of the child that is actuarially sound.
A son or daughter who lived with and provided care to the customer that allowed the customer to live at home rather than in a medical institution	The person's relationship to the customer. Proof includes birth certificates, court documents and church records.
	The period of time the person lived with the customer, before the customer was institutionalized.
	The type and amount of care provided by the person that allowed the customer to live at home instead of in an institution. NOTE Proof must include the customer's medical condition and need for care during the period of time that the care was provided.
A sibling who lived in the home and has equity interest in the home	The sibling's relationship to the customer. Proof includes birth certificates, court documents and church records.
	The period of time the sibling lived with the customer, before the customer was institutionalized

	When and how the sibling acquired equity interest in the property. Proof of equity interest in the property includes any the following: • Receipts • Cancelled checks; and • Other documents showing the siblings investment in the property.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

H Transfer of Resources to or for the Benefit of Specific Individuals

Revised 08/07/2020

Policy

A transfer of income or a countable resource other than home property does not affect the customer's eligibility for long term care services when the transfer is:

- To the customer's spouse, or to another person for the sole benefit of the customer's spouse;
- To the customer's child or stepchild, of any age, who has been determined to have a qualifying disability, including blindness (see MA504 and MA509);
- To a trust established solely for the benefit of the customer's child or stepchild, regardless of age, who has been determined to have a qualifying disability, including blindness (see MA504 and MA509); or
- To a trust established solely for the benefit of a person with a qualifying disability (MA509), who was under 65 years of age at the time of the trust's creation

NOTE For the transfer policy in this section, a qualifying disability does NOT include a determination of severe impairment.

Definitions

Term	Definition
Determination of severe impairment	A medical condition that significantly limits a person's physical or mental abilities to do basic work activities. (see MA509)

Proof

Use the table below to determine what proof is needed:

If the resource was transferred to...	Then proof is needed for...

Another person for the sole benefit of the customer's spouse	The customer's legal marriage to the spouse. See MA520 for proof needed.
	The transfer was for the sole benefit of the spouse. This proof must be in the form of a written document that legally binds the parties to a specific course of action, like trust documents and quit-claim deeds. The document must meet both of the following: • The document must clearly set out the conditions of the transfer and who can benefit from it; AND • Unless the trust is a Special Treatment Trust, the document must include a spending plan for the benefit of the spouse. The spending plan must provide that the full value of the transfer will be received by the spouse within his or her expected life span. NOTE Without such a document, a transfer cannot be considered as made for the sole benefit of the spouse.
To the customer's child or step child with a qualifying disability OR To a trust for the sole benefit of the customer's child or step child with a qualifying disability	The child's relationship to the customer. Proof includes birth certificates, court documents and church records. When the child is a step-child proof is needed of: • The child's relationship to the customer's spouse; AND • The customer's marriage to the child's parent NOTE The death of the child's parent does not terminate the step-parent's relationship

	The child's qualifying disability. Proof includes: • Electronic confirmation from Social Security; • Award letters showing the child receives Social Security Disability benefits or SSI-Cash based on disability; • PAS approval; or • SMI determination
	In addition to the items above, if the transfer was made to a trust, a copy of the trust document, showing that: • The trust is for the sole benefit of the customer's child; • The trust clearly sets out the conditions of the transfer and who can benefit from it; and NOTE Unless it is a Special Treatment Trust, the trust includes a spending plan for the benefit of the child that is actuarially sound.
A Special Treatment Trust	The person's qualifying disability. Proof includes: • Electronic confirmation from Social Security; • Award letters showing the child receives Social Security Disability benefits or SSI-Cash based on disability; • PAS approval; or • SMI determination
	The date of birth of the person. Proof includes: • Electronic confirmation from Social Security; • Birth records,or

	• Driver's license or other government-issued ID that lists a date of birth.
	A copy of the trust document that meets the Special Treatment Trust requirements (see MA803 – Special Treatment Trusts).

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

904 Compensation Received for Transfers

Revised 10/22/2024

Policy

For transfers that are not exempt under MA903, the value of the compensation received determines whether the transfer affects long term care services. When the compensation received is equal to or more than the resource value, the transfer does not affect long-term care services.

However, if less than full value is received for the transferred resource, the difference is the uncompensated value and may result in a transfer penalty period. During a penalty period, the customer cannot get long-term care services.

Compensation may be received in different ways. Each may have different rules and proof needed to show the amount of compensation received. The compensation may be received:

- In cash;
- As real or personal property;
- As the assumption of a legal debt;
- As personal care services; or
- As items or services before the date of the transfer.

The following sections give more details on the ways that compensation is received and counted, and proof needed.

1) Compensation in Cash

Compensation in cash is the total amount paid to the customer in exchange for a resource. The value of the cash compensation is the gross amount paid to the customer. The value is not reduced by valid expenses attributed to the sale (for example, closing costs or commissions for real estate sales).

2) Real or Personal Property as Compensation

When the compensation is real or personal property, the value of compensation is the equity value of the property in the month the customer received it or when a contract for sale was signed and notarized, if earlier.

3) Compensation in the Form of Assuming a Legal Debt

When a person pays or takes over a legal debt owed by the customer, the value of the compensation is the outstanding principal amount at the time it was taken over. Interest payments are not included.

4) Compensation in the Form of Personal Care Services

The value of personal care services provided to the customer can be considered as compensation only when:

- There is a valid personal care contract. The contract may be written or oral; and
- The contract is executed before the services are provided. A contract is not valid when services were provided before the agreement was made.

If the contract is not valid, the personal care services cannot be allowed as compensation. See definition for valid contract below.

5) Compensation Received Before the Transfer

Items or services received before the transfer may be considered as compensation only when Items or services were provided according to the terms of a valid contract.

A contract may be written or oral and must be in place before the items or services are provided. A contract is not valid when the items or services were provided before the agreement was made.

If the contract is not valid, the items or services received before the transfer cannot be allowed as compensation.

Definitions

Term	Definition
Assumption of a legal debt	The act of taking over payments for and being legally assigned for someone else’s legal debt.
Compensation	Something given or received in exchange for services, property, debt, or loss.

Direct Care Worker	The following relatives of a member are defined as family members in the context of what family members may get paid to provide services to AHCCCS members: • Spouse, • Adult children/Stepchildren, • Son/Daughter-in-law, • Grandchildren, • Siblings/Step Siblings, • Parents/Stepparents/Adoptive Parents, • Grandparents, • Mother/Father-in-law, or • Brother/Sister-in-law.
Equity Value	Means the current market value of a resource less any outstanding loans, mortgages, liens, or legal debts.
Oral Contract	A legally binding agreement made verbally. Oral contracts are only legally binding for one year in Arizona. NOTE To be considered valid, full payment must be received within one year of the date of the oral contract.
Personal Care Services	Also called Attendant Care services. A list of these services is available in section 1240 of the AHCCCS Medical Policy Manual;
Valid Contract	To be considered valid, a contract must meet all of the following: • Was executed by the customer or the customer's legal representative;

	• Must specify the items or types of services to be provided, how often they will be provided, and the amount of time to be spent providing each service; • Payments are or were made according to the terms of the contract; and • Written contracts must be signed and dated by the person providing the items or services, and the customer or the customer's legal representative. Personal care contracts have the following additional requirements: • Payments must be made at least monthly while services are being provided, unless the amount or form of payment is not available at the time services are provided. For example, if the payment for the contract is a house; and • A personal care contract can be an agreement for a spouse to provide services to the other spouse, or for a parent to provide services for a minor child when the Direct Care Worker requirements are met. NOTE A representative cannot sign the agreement and also be the one paid for providing services, unless the document that provides the representative's legal authority to act for the customer specifically states that the representative can self-contract to provide services.

Proof

To determine whether full compensation was received for a transfer proof is needed of the following:

- The date of the transfer;
- The value of the resource on the date it was transferred; and

- Proof of the value of the compensation received.

1) Proof of the transfer date

Proof of the date a transfer was made includes:

- Sales receipts;
- Property deeds;
- Loan agreements;
- Financial account statements showing the transfer;
- Canceled checks;
- Trust documents; and
- Other documents and records showing the date of the change in ownership.

NOTE For real property, the date of transfer is the date the document transferring ownership is signed and notarized, not the date it is recorded.

2) Proof of the resource value on the date transferred

The proof needed to determine the equity value of the resource on the date of transfer depends on the type of resource. See MA705 for examples of proof by resource type.

3) Proof of the value of compensation received

The proof needed to determine the value of compensation received depends on the type of compensation. The following table gives examples of proof by type of compensation:

If the compensation is...	Then proof is needed of...
Cash	The amount received. Documents that can be used for proof include: • Financial account statements showing the deposited amount;

	• Canceled checks made out to the customer or the customer's spouse; and • Other documents that show the customer received the cash compensation.
Resources other than cash	Who previously owned the resource and that ownership was transferred to the customer. Proof includes: • Sales receipts; • Property deeds; • Other documents and records showing the previous owner and the change in ownership.
	The equity value of the resource when it was received by the customer. See MA705 for proof by resource type.
Assumption of legal debt	The debt being legally assigned to the other person. Proof includes: • Legal documents showing the transfer of the debt and the amount of the outstanding principal still owed at the time of the transfer; • Collateral contact to the lender that confirms the debt has been legally assumed by the other person, and the amount of the outstanding principal at the time the debt was assumed.

Personal care services	A valid personal care contract. Proof is needed that all requirements for a valid contract in policy section 4 above are met. Some of the items that may be needed include: • For written contracts, a copy of the contract; • For oral contracts, signed statements of the terms and date of the oral contract are needed from both parties; • Documents or other evidence that the terms of the contract were or are being followed; • Certification or licenses if compensation is claimed for care that requires a higher level of skill; • Supporting legal documents; • Statements from witnesses to the agreement; and • Dated correspondence about the agreement.
Compensation received before the transfer	A valid contract. Proof is needed that all requirements for a valid contract in policy section 5 above are met. Some of the items that may be needed include: • For written contracts, a copy of the contract; • For oral contracts, signed statements of the terms and date of the oral contract are needed from both parties; • Documents or other evidence that the terms of the contract were or are being followed; • Supporting legal documents; • Statements from witnesses to the agreement; and

	• Dated correspondence about the agreement.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c) AAC R9-28-401 and 409

905 Transfer Penalty Period

Revised 04/22/2025

Policy

For transfers that are not exempt under MA903 and the compensation received is less than the equity value of the transferred resource, the difference is the “uncompensated value”. When a transfer results in uncompensated value, a transfer penalty period is calculated. During a transfer penalty period, the customer cannot get long-term care services.

NOTE There is no limit on the length of a transfer penalty period.

See Example - Length of the Transfer Penalty Period.

1) Transfer Penalty Calculation

The penalty period is calculated by dividing the uncompensated value by the Private Pay Rate (PPR) for the geographic area in which the customer lived as of the month the customer was first approved for ALTCS. Because the PPR varies by year and geographic area, the penalty period assessed for the same amount may vary by customer.

When the division does not result in an even number, the fraction of a month is not dropped. The fraction results in a partial penalty month. However, when calculating the partial penalty month, any fraction of a day is dropped.

The Transfer Penalty Period calculation steps are shown in the following table:

Step	Action
1	Divide the uncompensated value of the transfer by the customer’s PPR.
2	Multiply any fraction from Step 1 by 30. NOTE For this calculation, 30 is used as the multiplier no matter how many days there are in the month.
3	When the result from Step 2 ends in a fraction, drop the fraction to get the number of whole days in the partial penalty month.

NOTE When the customer has a partial penalty month, the share of cost for that month prorated based on the number of days in that month the customer is eligible for full ALTCS benefits.

See Examples – Transfer Penalty Period Calculations

2) Transfer Penalty Period Begin Date

As a general rule, a transfer penalty period begins the month the uncompensated transfer occurs, or the first month the customer is approved for ALTCS, whichever is later.

Exceptions:

- When a transfer was made before the application is approved, the penalty period begins the first month the customer qualifies for full ALTCS services.
- When the customer already has a transfer penalty period that has not ended, the new penalty period does not begin until the current penalty period ends.

NOTE Different transfer penalty periods are not applied to the same months and do not overlap.

See Examples - Transfer Penalty Period Begin Date.

3) Multiple Transfers Made in Different Months

All uncompensated transfers made during a month are added up to determine if they total more than $1,500. If the total uncompensated value of transfers in a month is not more than $1,500, they are viewed as not made to qualify for ALTCS, and do not result in a penalty period (MA906). When the uncompensated value is more than $1,500 in a month, a penalty period must be determined.

The following table describes how to determine penalty periods when there are multiple months with total uncompensated transfers of more than $1,500:

If the Transfers are made...	**Then...**
Before ALTCS is approved	All transfers for the look-back period are added together, and one penalty period is assigned. See Example Multiple Transfers Made Before ALTCS Approval.
In consecutive months after approval	The transfers are added together, and one penalty period assigned.

	See Example Multiple Transfers Made in Consecutive Months After ALTCS Approval.
Are made or discovered after approval, but were not made in consecutive months	The earliest month with transfers is determined. The penalty period for the transfers made in that month and any consecutive months is calculated. • If the resulting penalty period extends to or past the next transfer in a non-consecutive month, the later transfer is added to the earlier transfers and one penalty period is calculated. The begin date is the month of the earliest transfer. • If the resulting penalty period ends before the next transfer in a non-consecutive month, the penalty periods are calculated separately. The begin date of the second penalty period is the non-consecutive month in which the later transfer was made. See Example Multiple Transfers Made in Non-Consecutive Months After ALTCS Approval.

4) Division of the Penalty Period Between Spouses

With one exception, when both spouses qualify for ALTCS the penalty period is equally divided between the two spouses as follows:

If...	**Then...**
Both spouses currently qualify for ALTCS	The penalty period is divided and applied equally between the spouses.
The customer is in a transfer penalty period when the spouse applies and qualifies for ALTCS	The remaining penalty period is divided and applied equally between the spouses.

The transfer penalty period was divided between the spouses, but one spouse dies or becomes ineligible for ALTCS before the end of the penalty period.	The ineligible spouse's remaining penalty period is applied to the spouse who remains on ALTCS; extending that spouse's penalty period.

See Example Dividing the Penalty Period Between Spouses

Exception:

Transfers by the community spouse after ALTCS approval. After the initial rules period, the transfer of resources owned solely by the community spouse does not affect the customer's eligibility (see MA707.7).

5) Duration of the Penalty Period

Once the length of a transfer penalty period is established, it does not change unless the full amount of the transferred income or resources are returned to the customer. The penalty period continues to run even when the customer loses ALTCS eligibility during the penalty period.

See Changes in the Penalty Period Examples.

6) Private Pay Rates

The Private Pay Rates vary according to the county in which the customer resides. Private Pay Rates are updated once per year in October but may be updated more frequently.

Customer's County of Residence	10/01/2023 to 12/31/2023	1/1/2024 to 09/30/2024	10/01/2024 to 9/30/2025
Maricopa, Pima, Pinal	$7,826.46	$7,867.16	$8,201.34
All other counties	$7,281.17	$7,319.03	$7,752.73

See Prior Private Pay Rates for rates from 10/1/1988 to present.

Definitions

Term	Definition

Customer's Private Pay Rate	The Private Pay Rate for the geographic area where the customer lived the first time he or she was approved for ALTCS.
Transfer Penalty Period	A period of time that the customer cannot get long term care services.

Proof

When a countable income or resource has been transferred, documents need to be provided to prove:

- The date of the transfer. For transfers of real property, the date of transfer is the date the transfer document is signed and notarized, not the date the document is recorded;
- The person who owned the item both before and after the transfer;
- The Current Market Value (CMV) of the transferred item or the actual future cash value of income at the time of the transfer; and
- Any and all legal encumbrances such as debts and liens against the transferred item at the time of the transfer.

Legal Authority

Program	Legal Authorities
ALTCS FTW-ALTCS	42 USC 1396p(c)(1) and (2) AAC R9-28-401 and 409

906 Rebutting the Transfer Penalty Period

Revised 07/10/2020

Policy

A transfer penalty period may be ended or waived if the customer successfully demonstrates one of the following:

- All of the transferred income or resources have been returned to the customer;
- Full compensation was received for the transferred resource or income;
- The customer intended to sell or trade the resource or income for its current market value (CMV), or for other valuable consideration that would equal the CMV; or
- The income or resources were transferred exclusively for a purpose other than to qualify for ALTCS benefits.

1) Return of Transferred Income or Resource

When convincing proof is received that all of the transferred income or resource has been returned to the customer, the following policies are applied:

- The penalty period is ended the month in which all of the transferred income or resources were returned.
- The returned income or resource is counted as of the month of return.

2) Receipt of Compensation

The value of compensation received by the customer is determined according to the kind of compensation using the policy in MA904.

When convincing proof is received that the customer received full compensation, the following policy is applied:

- The penalty period is ended the month in which full compensation was received.
- The returned income or resource is counted as of the month it was received.

3) Intent to Sell or Trade for Current Market Value

The customer may have intended to get CMV for the income or resource, but was unable to, due to reasons outside of the customer's control. When convincing proof is received that the customer intended to sell or trade the income or resource for CMV, the penalty period is waived.

4) Transfer Not Made to Qualify for ALTCS

Transfers are assumed to be made to qualify for ALTCS. To meet this condition, all of the following must be met:

- The customer must have a specific reason for the transfer that is completely unrelated to qualifying for ALTCS;
- None of the factors in the decision to transfer the item may be related to qualifying for ALTCS; and
- The customer must show that a need for ALTCS services could not have been anticipated at the time the transfer was made.

When convincing proof is received that the transfer was not made to qualify for ALTCS, the penalty period is waived.

The Public Information Brochure on Transfers (DE-818) provides information about transfers and rebuttals.

Definition

Term	Definition
Convincing Evidence	Supporting proof required to establish the customer's claim to the satisfaction of the state.
Full compensation	Compensation that is equal to or more than the market value of the item at the time it was transferred.
Rebuttal	A process to dispute the transfer penalty period.

Proof

When the customer wants to rebut the proposed transfer penalty period, the customer must provide proof that one of the rebuttal conditions was met. The burden of proof that the penalty period should not be applied rests with the customer.

The specific proof needed for each rebuttal reason is described below.

1) Return of Transferred Item

To rebut the penalty period based on the return of the transferred income or resource, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- A list of the income or resources returned; and
- The date that each item was returned to the customer.

NOTE The penalty period will not be reduced or ended when only a part of the transferred items are returned.

Supporting proof

Proof that the income or resources were returned will vary depending on the type of item, but examples include:

- Property deed signed and notarized after the initial transfer showing the customer as owner;
- Bank statement or deposit record showing return of cash to the customer's account; or
- Title document issued after the initial transfer showing the customer as owner.

2) Full Compensation Received

To rebut the penalty period based on full compensation being received, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- The type of compensation received;
- The value of the compensation received; and
- The date that compensation was received.

Supporting proof

Proof that the customer has received full compensation for the transferred item will vary depending on the type of item. Examples include:

- When the compensation was in the form of real property, a deed showing the customer as owner, dated after the initial transfer;
- A bank statement or financial record showing cash compensation deposited to the customer's account;
- Other title documents or legal ownership records dated after the initial transfer showing the customer as the new owner of the item received as compensation; and
- When compensation was received in the form of bills or expenses paid on the customer's behalf, the person making the payments must provide proof that the expenses were paid from his or her own funds.

3) Intent to Dispose of Asset for Current Market Value

To rebut the penalty period based on intent to get CMV for the asset, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- Purpose for transferring the income or resource;
- Attempts made to dispose of resource or income at CMV;
- Reasons for accepting less than the CMV for the resource or income;
- Why the customer believes that adequate compensation was received;
- Customer's relationship, if any, to the person to whom the income or resource was transferred; and
- Customer's means of or plans for self-support after the transfer.

Supporting proof

Proof that the customer intended to get CMV for the transferred item will vary depending on the type of item. Examples include:

- Written offers for purchase;
- Declarations from the realtor contracted to sell the property; or
- Estimates of the value of the resource from professional, knowledgeable sources.

4) Transfer Not Made to Qualify for ALTCS

To rebut the penalty period based on the transfer not made to qualify for ALTCS, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- The specific reason for transferring the asset; and
- Why a need for ALTCS services could not have been anticipated at the time the transfer was made.

NOTE A verbal statement cannot be accepted. The customer must provide a signed, written statement.

Supporting proof

Proof will vary depending on the situation. Examples include:

- Court documents showing the transfer was ordered by a court and none of the following people asked or petitioned the court to order the transfer:
  - The customer;
  - The customer's spouse;
  - A person with legal authority to act on behalf of the customer or the customer's spouse; or
  - A person acting at the direction or request of the customer or the customer's spouse.
- Medical records showing that the customer's current need for ALTCS services is solely due to the diagnosis of a disabling condition or a trauma, like an accident or injury that happened after the transfer;
- Legal and other written documents showing that after the transfer there was an unexpected loss of other income or resources that would have prevented the customer from qualifying for ALTCS;
- At the time of the transfer the customer could not have anticipated qualifying for ALTCS due to other circumstances that would have prevented ALTCS eligibility; or
- Proof that the customer's total counted income and resources would have been below the ALTCS limits standard at all times from the month of transfer through the present month, even if the transferred income or resource had been kept. This reason does not apply to the transfer of excluded resources or home property.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(A) 42 USC 1396p(c)(2) AAC R9-28-401 and 409

907 Undue Hardship Claims for Transfer Penalties

Revised 07/10/2020

Policy

The transfer penalty period may be waived if denial of eligibility for long term care services creates an undue hardship. To request undue hardship, the customer must qualify for ALTCS except for transfer policy.

Undue hardship decisions are made on a case-by-case basis. The application must be approved for the limited service package due to a transfer penalty before undue hardship is requested. A customer must meet the requirements in section one or section two for undue hardship to be considered.

1) Undue hardship may be met

A request for undue hardship will be considered when the transfer penalty would deprive the customer of:

- Medical care to the point that the customer's life or health would be endangered; or
- Food, clothing, shelter or other necessities of life as shown by the fact that the customer's income is less than or equal to 100% of the Federal Poverty Level (FPL). See MA615.2 for the 100% FPL income standard.

2) Undue hardship is met

A request for undue hardship will be granted when a violation of legal authority has occurred. The customer or representative will need to provide proof of all of the following:

- The customer is incapacitated as established by the Court or by a physician;
- The person who had the legal authority to handle the customer's finances has violated the terms of that legal authority; and
- A person acting on the customer's behalf has exhausted all legal remedies to get the asset back, including filing a police report and seeking recovery through civil court.

3) Undue hardship is not met

The request for undue hardship will not be granted when:

- The customer was mentally competent and would have been aware of the consequences of the transfers at the time the transfers occurred; or
- The customer was mentally competent and gave another person the legal authority to make the transfers, and the person did not violate the limits of that authority in making the transfers.

Definitions

Term	Definition
Financial legal authority	For purposes of transfer policy, the legal right to sell, trade, use, or give away a person's income or resources. This authority can be in the form of: • Power of Attorney (POA); • Conservator; or • Legal Guardian.
Incapacitated	Mentally impaired and lacking sufficient understanding or capacity to make or communicate responsible decisions as determined by a court or physician.
Mentally competent	Having the mental capacity and understanding to responsibly participate in making one's own decisions to which they are accountable for.

Proof

Proof of undue hardship, the customer's mental competence, and of financial legal authority includes:

- Court documents, medical records, and written statements from a physician about the customer's mental competence or incapacity;
- Proof of medical and other expenses to support a claim that the customer would be deprived of medically necessary care or food and shelter without long-term care services;
- Medical records;
- Eviction notice from the customer's current facility; or
- Any other documents supporting the customer's claim.

Proof of exhausting all legal remedies to get an asset back includes:

- Court documents;
- Adult Protective Services (APS) reports;
- Police reports; or
- Claims filed with the Attorney General's office.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(2)(D) AAC R9-28-409.H

Chapter 1000 Pre-admission Screening

1000 Introduction

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed;

1001 General Provisions

Revised 01/11/2023

Policy

To qualify for Arizona Long Term Care System (ALTCS) services a person must be medically eligible. This is determined using the pre-admission screening (PAS) assessment.

There are two PAS manuals used in determining medical eligibility. One manual EPD PAS is for applicants or members who are assessed using the elderly or physically disabled (EPD) PAS tool; the other manual DD PAS is for applicants or members who are assessed using one of the developmentally disabled (DD) PAS tools. The tools and related glossaries and definitions of abbreviations are available from the Administration upon request.

The following are examples of the PAS tools used:

- DD and EPD 0-5
- DD and EPD 6-11
- DD 12+
- EPD

Definitions

Term	Definition
Developmentally disabled	Determined by the Department of Economic Security/Division of Developmental Disabilities in accordance with ARS 36-551.
Medically eligible	Immediate risk of institutionalization. The status of an applicant or member under ARS § 36-2934(A)(5) and as specified in ARS § 36-2936 and in the Administration's Section 1115 Waiver with the Centers for Medicare and Medicaid Services (CMS).

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Applicant or member score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 441.302 ARS 36-2934(A)(5) ARS 36-2936 AAC R9-22-101 AAC R9-28-302

1002 Preadmission Screening (PAS) Process

Revised 08/16/2022

Policy

The PAS Assessor shall use the PAS instrument as described below to determine whether the following customers are at immediate risk of institutionalization:

- The Assessor shall use the appropriate PAS instrument described in MA1003 to assess customers with a physical disability who are at least six years old. After assessing a child with a physical disability who is at least six years but less than 12 years, the Assessor shall refer the child for a physician consultant review as described in MA1006.
- The Assessor shall use the age-specific PAS instrument described in MA1005 to assess a customer who has a physical disability and less than six years old. After assessing the child, the Assessor shall refer the child for physician consultant review.
- The Assessor shall use the PAS instrument described in MA1005 to assess customers who are **not** living in a nursing facility (NF). After assessing a child less than six months of age with a developmental disability, the Assessor shall refer the child for physician consultant review.
- The Assessor shall use the PAS instrument described in MA1003 for customers with a developmental disability living in a Nursing Facility (NF).
- The Assessor shall use the PAS instrument described in MA1003 or MA1005, whichever is applicable, to assess a customer classified as ventilator dependent under Section 1902(e)(9) of the Social Security Act.

The PAS assessment is completed by a PAS Assessor who is a registered nurse or social worker:

PAS assessments are completed face-to-face, by telephone, or virtually with a customer, except when the customer is deceased. The Assessor makes reasonable efforts to obtain the customer's available medical records. The Assessor may also obtain information for the PAS assessment from interviews with the:

- Customer;
- Parent;
- Guardian;
- Caregiver; or
- Any person familiar with the customer's functional or medical condition.

Using the information described above, the Assessor completes the PAS assessment using his or her education, experience, professional judgment, and training.

After the PAS assessment is completed, the PAS score is calculated and compared to the established threshold score in MA1003 and MA1005. Except as determined by physician consultant review, the threshold score is the point at which a customer is considered to be at immediate risk of institutionalization.

Upon request from a person acting on behalf of the customer, the Administration shall conduct a PAS assessment to determine whether a deceased customer would have been eligible to receive ALTCS benefits during the time period covered by the application or in any prior quarter month.

A Private Request PAS assessment may be requested for a customer who is not applying for ALTCS to determine if the customer is at risk of institutionalization and requires care equal to that provided in a NF or Intermediate Care facility (ICF). The PAS is completed without charge. Private Request PAS assessments are processed through Eligibility Review (see MA1006). A face-to-face assessment must be conducted for a Private Request PAS.

An eligible PAS, including a Private Request PAS, may be used for up to 180 days when a customer is denied and later reapplies. An ineligible PAS is never used for a new application.

Definition

Term	Definition
Assessor	Social worker as defined in this section or a licensed registered nurse who: • Is employed by the Administration to conduct PAS assessments; • Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours; and • Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.
Social worker	An individual with two years of case management-related experience or a baccalaureate or master's degree in social work, rehabilitation, counseling, education, sociology, psychology, or other closely related field.

Proof

Proof of immediate risk of institutionalization demonstrated through:

- A PAS score equal to or higher than the applicable PAS threshold; or
- Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-2936 AAC R9-28-303

1003 Preadmission Screening Criteria for an Applicant or Member who is Elderly or Physically Disabled (EPD)

Revised 08/27/2024

Policy

The PAS instrument for an applicant or member who is EPD includes the following categories:

- Intake information category. The Assessor solicits intake information category information on an applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
- Functional assessment category. The Assessor solicits functional assessment category information on an applicant's or member's:
    - Need for assistance with activities of daily living in the residential environment or other routine setting, including:
        - Bathing;
        - Dressing;
        - Grooming;
        - Eating;
        - Mobility; and
        - Transferring;
    - Communication and sensory skills, including hearing, expressive communication, and vision; and
    - Continence, including bowel and bladder functioning.
- Emotional and cognitive functioning category. The Assessor solicits emotional and cognitive functioning category information on an applicant's or member's:
    - Orientation to person, place, and time. In soliciting this information, the Assessor shall also take into account the caregiver's judgment; and
    - Behavior, including:
        - Wandering;
        - Self-injurious behavior;
        - Aggression;

        - Resistiveness; or
        - Disruptive behavior.

- Medical assessment category. The Assessor solicits medical assessment category information on a customer's:
    - Medical conditions that have an impact on the customer's functional ability in relation to activities of daily living, continence, and vision;
    - Medical condition that requires medical or nursing service and treatment;
    - Medication, treatment, and allergies;
    - Specific services and treatments that the customer is currently receiving; and
    - Physical measurements, hospitalization history, and ventilator dependency.

The Assessor shall use the PAS instrument to assess a customer who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the Assessor's PAS assessment to calculate three scores: a functional score, a medical score, and a total score.

- Functional score.
    - The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
    - The functional items in the following categories are scored according to the matrix shown below:
        - Activities of daily living;
        - Continence;
        - Sensory;
        - Orientation; and
        - Behavior.
    - The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by a customer is 166.
- Medical score.
    - In the medical assessment matrix, all items in the following categories are scored according to:

        - Medical conditions according to the matrix below, and
        - Medical or nursing services or treatments according to the matrix below.
    - The Administration calculates the medical score based on the customer's:
        - Diagnosis of Alzheimer's, dementia, or organic brain syndrome (OBS);
        - Diagnosis of paralysis; and
        - Current use of oxygen.
    - The maximum medical score attainable by an applicant or member is 31.5.
- Total score.
    - The sum of a customer's functional and medical score equals the total score.
    - The total score is compared to the established threshold score as calculated under this Section. For a customer who is EPD, the threshold score is 60.
    - A customer is determined at immediate risk of institutionalization if the total score is equal to or greater than 60.

The following matrices represent the number of points available and the respective weight for each scored item.

- Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
- Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the customer:
    - Does not have the scored medical condition;
    - Does not need the scored medical or nursing services; or
    - Does not receive the scored medical or nursing services.

• **Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
ACTIVITIES OF DAILY LIVING SECTION			

• Mobility	• 0 – 3	• 5	• 0 – 15
• Transfer	• 0 – 3	• 5	• 0 – 15
• Bathing	• 0 – 3	• 5	• 0 – 15
• Dressing	• 0 – 3	• 5	• 0 – 15
• Grooming	• 0 – 3	• 5	• 0 – 15
• Eating	• 0 – 3	• 5	• 0 – 15
• Toileting	• 0 – 3	• 5	• 0 – 15
CONTINENCE SECTION			
• Bowel	• 0 – 3	• 1	• 0 – 3
• Bladder	• 0 – 3	• 1	• 0 – 3
SENSORY SECTION			
• Vision	• 0 – 3	• 2	• 0 - 6
• ORIENTATION SECTION			
• Place	• 0 – 4	• 0.5	• 0 – 2
• Time	• 0 – 4	• 0.5	• 0 – 2
EMOTIONAL OR COGNITIVE BEHAVIOR SECTION			
• Aggression - Frequency	• 0 – 3	• 1.5	• 0 – 4.5

• Aggression – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Self-Injurious – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Self-Injurious – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Wandering – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Wandering – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Resistiveness – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Resistiveness – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Disruptive – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Disruptive - Intervention	• 0 – 3	• 1.5	• 0 – 4.5

• **Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
MEDICAL CONDITIONS SECTION			
• Paralysis	• 0 – 1	• 6.5	• 0 - 6.5
• Alzheimer's, OBS, or Dementia	• 0 – 1	• 20	• 0 – 20

SERVICES AND TREATMENTS SECTION			
• Oxygen	• 0 – 1	• 5	• 0 – 5

Definitions

Term	Definition
Aggression	Physically attacking another, including: • Throwing an object; • Punching; • Biting; • Pushing; • Pinching; • Pulling hair; • Scratching; or • Physically threatening behavior.
Bathing	The process of washing, rinsing, and drying all parts of the body, including an applicant's or member's ability to transfer to a tub or shower and to obtain bath water and equipment.
Continence	The customer's ability to control the discharge of body waste from bladder and bowel.
Current or currently	Belonging to the present time.
Dressing	The physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the customer's ability to put on artificial limbs,

	braces, and other appliances that are needed daily.
Eating	The process of putting food and fluids by any means into the digestive system.
Emotional and cognitive functioning	An customer's orientation and mental state, as evidenced in aggressive, self-injurious, wandering, disruptive, and resistive behaviors.
Functional assessment	An evaluation of information about a customer's ability to perform activities related to: • Developmental milestones; • Activities of daily living; • Communication; and • Behavior.
Grooming	A customer's process of tending to appearance. Grooming includes: • Combing or brushing hair; • Shaving; and • Oral hygiene (including denture care). Grooming does not include aesthetics such as styling, skin care, nail care, and applying cosmetics.
Intervention	Therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.
Medical assessment	An evaluation of a customer's medical condition and the customer's need for medical services.

Medical or nursing services and treatments, or services and treatments	Specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.
Mobility	The extent of a customer's purposeful movement within a residential environment.
Orientation	A customer's awareness of self in relation to person, place, and time.
Physically disabled	A customer who is determined physically impaired by the Administration through the PAS assessment as allowed under the Administration's Section 1115 Waiver with CMS.
Resistiveness	Inappropriately obstinate and uncooperative behaviors, including: • Passive or active obstinate behaviors; • Refusing to participate in self-care; or • Refusing to take necessary medications. Resistiveness does not include difficulties with auditory processing or reasonable expressions of self-advocacy.
Self-injurious behavior	Repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body. Self-injurious behavior does not include suicide attempts, accidents or risky lifestyle choices.
Sensory	Of or relating to the senses.

Toileting	The process involved in a customer's managing the elimination of urine and feces in an appropriate place.
Transferring	A customer's ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.
Vision	The ability to perceive objects with the eyes.
Wandering	A customer's moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Customer score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the customer has this status.

Legal Authority

Program	Legal Authorities
ALTCS	AAC R9-28-304

1004 Developmental Disability Status

Revised 12/20/2022

Policy

Customers may be determined to be eligible for services by the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). Eligible customers include those who have been diagnosed with an intellectual cognitive disorder, cerebral palsy, seizure disorder, autism, or down syndrome, and who have significant impairment of their functional abilities.

For children less than six years of age, a diagnosis of developmental delay or risk for developmental disability may serve as the qualifying diagnosis for DES/DDD. Arizona Revised Statutes require that DES/DDD be the provider of services to people with a developmental disability.

The PAS process is intended to determine whether a customer's current functional abilities and medical stability, resulting from a developmental disability, indicate a need for services at the nursing facility (NF) or intermediate care facility (ICF) level of care.

> NOTE Customers with developmental disabilities who qualify to receive services from DES/DDD but are not at risk of institutionalization at the NF or ICF level of care, do not qualify for ALTCS.

ALTCS assigns a DD status to each customer depending on eligibility for DES/DDD services. This status is indicated on the PAS Intake Notice. The DD status classifications are:

- Potential DD. The customer appears to have a cognitive disability, cerebral palsy, seizure disorder autism, or down syndrome, but eligibility has not been determined by DES/DDD.
- DD. DES/DDD has identified the customer has a qualifying developmental disability.
- DD in NF. DES/DDD has identified the customer has a qualifying developmental disability and is living in a nursing facility.
- Not DD. The customer is not diagnosed as having a qualifying developmental disability or has a DD diagnosis but does not qualify for DES/DDD services.

Children ages six and over who are customers of DES/DDD must have one of the five DD qualifying diagnoses identified above to be considered DD for their ALTCS application or reassessment.

Definitions

N/A

Proof

The following are proof of immediate risk of institutionalization:

- PAS score equal to or higher than the applicable PAS threshold score; or
- A finding by a physician consultant reviewer that the customer meets this requirement.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-551 AAC R9-28-303

1005 Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

Policy

The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of three PAS instruments specifically designed to assess an applicant or member in the following age groups:

- 12 years of age and older,
- 6 through 11 years of age, and
- 0 through 5 years of age.

The PAS instruments for an applicant or member who is DD include three major categories:

- Intake information category. The Assessor solicits intake information category information on an applicant's or member's demographic background. The components of this category are not included in the calculated PAS score.
- Functional assessment category. The functional assessment category differs by age group as indicated below:
    - For an applicant or member 12 years of age and older, the Assessor solicits the functional assessment category information on an applicant's or member's:
        - Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
        - Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
        - Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.
    - For an applicant or member 6 through 11 years of age, the Assessor solicits the functional assessment category information on an applicant's or member's:
        - Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;

        - Communication, including expressive verbal communication and clarity of communication; and
        - Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.
    - For an applicant or member 6 months through 5 years of age, the Assessor scores items in the developmental milestones section based on the age of the applicant or member.
    - For an applicant or member less than 6 months of age, the Assessor shall not complete a functional assessment. The Assessor shall include a description of the applicant's or member's development in the PAS instrument narrative summary.
- Medical assessment category. The Assessor solicits medical assessment category information on an applicant's or member's:
    - Medical condition;
    - Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
    - Current medication;
    - Medical stability;
    - Sensory functioning;
    - Physical measurements; and
    - Current placement, ventilator dependency, and eligibility for DES Division of Developmental Disabilities program services.

The Assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.

- Functional score.
    - The Administration calculates the functional score from responses to scored items in the functional assessment category. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
    - The functional assessment items in the following categories are scored:
        - For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections also are scored;

        - For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections also are scored; and
        - For an applicant or member 6 months through 5 years of age, all age-specific items are scored.
    - The sum of the weighted scores equals the functional score. The range of weighted scores per item is presented below:

Age Group	Range for Weighted Score per Item	Maximum Functional Score Attainable
12 and older	0 – 11.2	124.1
6 through 11	0 – 24	112.5
6 months through 5	0 – 5.0	106.02

- No minimum functional score is required.
- Medical score.
    - The Administration calculates the medical score from responses to scored items in the medical assessment category. For each response to a scored item, a number of points is assigned.
    - The medical assessment items in the following categories are scored:
        - For an applicant or member 12 years of age and older and 6 years of age through 11 years of age, designated items in the medical conditions section are scored; and
        - For an applicant or member 6 months of age through 5 years of age designated items in the medical conditions, services and treatments, and medical stability sections are scored.
    - For an applicant less than 6 months of age, only the medical assessment section of the PAS is completed. There is no weighted or calculated score assigned. The Assessor shall refer the applicant or member for physician consultant review in accordance with Section 1006.
    - The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

Age Group	Range for Weighted Score per Item	Maximum Functional Score Attainable
12 and older	0 – 20.6	21.4
6 through 11	0 – 2.5	5
6 months through 5	0 – 10	60

- No minimum medical score is required.
- Total score.
    - The sum of an applicant's or member's functional and medical score equals the total score.
    - The total score is compared to the established threshold score as calculated under this Section. For an applicant or member who is DD, the threshold score is 40.
    - An applicant or member is determined at immediate risk of institutionalization if the total score is equal to or greater than 40.

The following matrices represent the number of points available and the respective weight for each scored item.

- Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
- Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
    - Does not have the scored medical condition,
    - Does not need the scored medical or nursing services, or
    - Does not receive the scored medical or nursing services.

• **Age Group 12 and Older Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**

INDEPENDENT LIVING SKILLS SECTION			
• Hand Use, Food Preparation	• 0 – 3	• 3.5	• 0 – 10.5
• Ambulation, Toileting, Eating, Dressing, Personal Hygiene	• 0 – 4	• 2.8	• 0 – 11.2
COMMUNICATIVE SKILLS AND COGNITIVE ABILITIES SECTION			
• Associating Time, Remembering Instructions	• 0 – 3	• 0.5	• 0 – 1.5
BEHAVIOR SECTION			
• Aggression, Threatening, Self-Injurious	• 0 – 4	• 2.8	• 0 – 11.2
• Resistive	• 0 – 3	• 3.5	• 0 – 10.5

• **Age Group 12 and Older Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
MEDICAL CONDITIONS SECTION			
• Cerebral Palsy, Epilepsy	• 0 – 1	• 0.4	• 0 - 0.4
• Moderate, Severe, or Profound	• 0 – 1	• 20.6	• 0 - 20.6

Mental Retardation			

• **Age Group 6 through 11 Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
INDEPENDENT LIVING SKILLS SECTION			
• Climbing Stairs, Wheelchair Mobility, Bladder Control	• 0 – 3	• 1.875	• 0 – 5.625
• Ambulation, Dressing, Bathing, Toileting	• 0 – 4	• 1.5	• 0 – 6
• Crawling or Standing	• 0 - 5	• 1.25	• 0 – 6.25
• Rolling or Sitting	• 0 – 8	• 0.833	• 0 – 6.66
COMMUNICATION SECTION			
• Clarity	• 0 – 4	• 1.5	• 0 – 6
• Expressive Communication	• 0 – 5	• 1.25	• 0 – 6.25
BEHAVIOR SECTION			
• Wandering	• 0 – 4	• 6	• 0 – 24
• Disruptive	• 0 – 3	• 7.5	• 0 – 22.5

• **Age Group 6 through 11 Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
MEDICAL CONDITIONS SECTION			
• Cerebral Palsy, Epilepsy	• 0 – 1	• 2.5	• 0 - 2.5

• **Age Group 6 months through 5 Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
DEVELOPMENTAL MILESTONES SECTION (FACTORS MEASURING AN INDIVIDUAL'S DEGREE OF FUNCTIONAL GROWTH)			
• 6 – 9 Months	• 0 – 1	• 5.0	• 0 – 5.0
• 9 – 11 Months	• 0 – 1	• 4.1	• 0 – 4.1
• 12 – 17 Months	• 0 – 1	• 2.9	• 0 – 2.9
• 18 – 23 Months	• 0 – 1	• 2.125	• 0 – 2.125
• 24 – 29 Months	• 0 – 1	• 1.75	• 0 – 1.75
• 30 – 35 Months	• 0 – 1	• 1.55	• 0 – 1.55
• 36 – 47 Months	• 0 – 1	• 1.34	• 0 – 1.34

• 48 – 59 Months	• 0 – 1	• 1.14	• 0 – 1.14
• 60 Months+	• 0 – 1	• 1.03	• 0 – 1.03

• **Age Group 6 months through 5 Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighted Score per Item (P) x (W)**
MEDICAL ASSESSMENT			
• Cerebral Palsy	• 0 – 1	• 5.0	• 0 – 5.0
• Epilepsy	• 0 – 1	• 5.0	• 0 – 5.0
• Moderate, Severe, or Profound Mental Retardation • (36 months and older only)	• 0 – 1	• 15.0	• 0 – 15.0
• Autism + M-CHAT: Fails at least six M-CHAT based questions • (18 months and older only)	• 0 – 1	• 7.0	• 0 – 7.0
• Autism + Behaviors: Exhibits at least 3 of 4 specific behaviors	• 0 – 1	• 5.0	• 0 – 5.0

• (36 months and older only)			
• Autism + Behaviors: Exhibits at least 6 of 8 specific behaviors • (36 months and older only)	• 0 – 1	• 10.0	• 0 – 10.0
• Drug Regulation + Administration • (6 months to 35 months)	• 0 – 1	• 1.0	• 0 – 1.0
• Drug Regulation + Administration • (36 months and older)	• 0 – 1	• 1.5	• 0 – 1.5
• Non-Bowel/ Bladder Ostomy Care • (6 months to 35 months)	• 0 – 1	• 7.0	• 0 – 7.0
• Non-Bowel/ Bladder Ostomy Care • (36 months and older)	• 0 – 1	• 5.0	• 0 – 5.0
• Tube Feeding • (6 months to 35 months)	• 0 – 1	• 7.0	• 0 – 7.0
• Tube Feeding • (36 months and older)	• 0 – 1	• 5.0	• 0 – 5.0

• Physical Therapy or Occupational Therapy • (6 months to 35 months)	• 0 – 1	• 1.0	• 0 – 1.0
• Physical Therapy or Occupational Therapy • (36 months and older)	• 0 – 1	• 1.5	• 0 – 1.5
• Acute Hospital Admission: One	• 0 – 1	• 1.0	• 0 – 1.0
• Acute Hospital Admission: Two or More	• 0 – 1	• 2.0	• 0 – 2.0
• Direct Care Staff Trained • (6 months to 35 months)	• 0 – 1	• 0.5	• 0 – 0.5
• Direct Care Staff Trained • (36 months and older)	• 0 – 1	• 1.0	• 0 – 1.0
• Special Diet	• 0 – 1	• 2.0	• 0 – 2.0

Definitions

Term	Definition
Aggression	Physically attacking another, including:

	• Throwing objects; • Punching; • Biting; • Pushing; • Pinching; • Pulling hair; or • Scratching.
Ambulation	The ability to walk, including quality of the walking and the degree of independence in walking.
Associating time with an event and an action	An applicant's or member's ability to associate a regular event with a specific time-frame.
Bathing or showering	An applicant's or member's ability to complete the bathing process, including: • Drawing the bath water; • Washing; • Rinsing; • Drying all parts of the body; and • Washing the hair.
Clarity of communication	An ability to speak in recognizable language or use a formal symbolic substitution, such as American Sign Language.
Climbing stairs or a ramp	An applicant's or member's ability to move up and down stairs or a ramp.
Community mobility	An applicant's or member's ability to move about a neighborhood or community independently, by any mode of transportation.

Current or currently	As defined in Section 1003.
Crawling and standing	An applicant's or member's ability to crawl and stand with or without support.
Developmental milestone	A measure of an applicant's or member's functional abilities, including: • Fine and gross motor skills; • Expressive and receptive language; • Social skills; • Self-help skills; and • Emotional or affective development.
Disruptive behavior	Inappropriate behavior by an applicant or member, including: • Urinating or defecating in inappropriate places; • Sexual behavior inappropriate to time, place or person; or • Excessive whining, crying or screaming that interferes with an applicant's or member's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.
Dressing	An applicant's or member's ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces, nor does it reflect an applicant's or member's ability to match colors or choose clothing appropriate for the weather.
Eating or drinking	The process of putting food and fluid by any means into the digestive system.

Expressive verbal communication	An applicant's or member's ability to communicate thoughts with words or sounds.
Food preparation	An applicant's or member's ability to prepare a simple meal, including a sandwich, cereal, or a frozen meal.
Frequency	Number of times a specific behavior occurs within a specified interval.
Functional assessment	As defined in Section 1003.
Hand use	An applicant's or member's ability to use both hands, or one hand if the applicant or member has only one hand or has the use of only one hand.
Intervention	As defined in Section 1003.
M-CHAT™	Modified Checklist for Autism in Toddlers
Medical assessment	As defined in Section 1003.
Personal hygiene	The process of tending to one's appearance. Personal hygiene may include: • Combing or brushing hair; • Washing face and hands; • Shaving; • Performing routine nail care; • Oral hygiene (including denture care); and • Menstrual care. Personal hygiene does not include aesthetics such as styling hair, skin care, and applying cosmetics.

Remembering an instruction and demonstration	An applicant's or member's ability to recall an instruction or demonstration on how to complete a specific task.
Resistiveness or rebelliousness	An applicant's or member's inappropriate, stubborn, or uncooperative behavior. Resistiveness or rebelliousness does not include an applicant's or member's difficulty with processing information or reasonable expression of self-advocacy that includes an applicant's or member's expression of wants and needs.
Rolling and sitting	An applicant's or member's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.
Running or wandering away	An applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.
Self-injurious behavior	An applicant's or member's repeated behavior that causes injury to the applicant or member.
Special diet	A diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.
Toileting	As defined in Section 1003.
Verbal or physical threatening	Any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.
Vision	As defined in Section 1003.
Wheelchair mobility	An applicant's or member's mobility using a wheelchair. Wheelchair mobility does not include the ability to transfer to the wheelchair.

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Applicant or member score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	AAC 9-28-305

1006 Eligibility Review

Revised 08/03/2021

Policy

Eligibility review is an important part of the Pre-Admission Screening (PAS) assessment process. An eligibility review is conducted when the final PAS score may not be an accurate reflection of the customer's need for Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) level of care.

Eligibility reviews are mainly used for PAS assessments that score below the eligibility threshold but are also used in certain situations when the score is above the eligibility threshold.

There are two types of Eligibility Reviews:

- PAS Analyst Review Consultant (PARC) reviews, and
- Physician Review.

1) PAS Analyst Review Consultant (PARC) Review

A PAS Analyst Review Consultant (PARC), reviews PAS assessments that have been reviewed and referred by a Benefits and Eligibility Manager (BEM) in the following situations:

- PAS Reassessments scoring below the eligibility threshold but that appear eligible. If the PARC review does not confirm that the customer remains medically eligible, the PAS is then referred to a physician consultant for review.
- Initial elderly or physically disabled (EPD) PAS assessments for customers whose PAS score meets the eligibility threshold and have a both a medical condition and a psychiatric condition that may be contributing to the customer's need for care. If the PARC review is unable to determine if the customer's psychiatric condition is a contributing factor in meeting the eligibility threshold, the case will be referred to a physician consultant.

2) Physician Review

A physician consultant reviews the PAS assessment and available medical records, and uses professional judgment to determine whether or not a customer has a developmental disability or a non-psychiatric medical condition that by itself, or in combination with other medical conditions, places the customer at immediate risk of institutionalization.

The physician consultant reviews initial PAS assessments referred after review by a Benefits and Eligibility Manager or PARC, as well as all PAS reassessments that are no longer scoring eligible.

After reviewing the PAS for accuracy and completeness, the Benefits and Eligibility Manager will request a physician review in the following circumstances:

- The EPD PAS score is less than the threshold of 60 but is at least 56;
- The DD PAS score is less than threshold of 40 but is at least 38;
- A customer scores below the threshold (60 for EPD and 40 for DD) but the PAS assessor and Benefits and Eligibility Manager have reasonable cause to believe that the customer's functional abilities or medical conditions may place the customer at immediate risk of institutionalization;
- The EPD PAS score is less than the threshold and the customer has a documented diagnosis of autism or autistic-like behavior;
- The EPD PAS score is at or above the threshold, but the customer has a serious mental illness, as defined in ARS § 36-550, that may be contributing to the need for care at a level provided in a nursing facility or intermediate care facility;
- The EPD PAS score is at or above the threshold for a customer on AHCCCS in an acute care program, but the Benefits and Eligibility Manager has reasonable cause to believe that the applicant's condition is improving and needs less than 90 days of institutional care;
- The customer has a physical disability and is less than 12 years of age;
- The customer is under six months of age;
- An ALTCS customer is living in a SNF or ICF and at reassessment, no longer meets the eligibility threshold score for ALTCS or ALTCS Transitional, as defined in MA1010; and
- An ALTCS DD customer is determined to no longer be DD-eligible by the DES Department of Developmental Disabilities and does not meet the EPD scoring threshold.

The physician consultant reviews and considers the following when determining medical eligibility:

- Dependence on others for help with activities of daily living;
- Delay in development;
- Continence;
- Orientation;
- Behavior;
- Medical conditions, including stability and prognosis of the condition;
- Any medical nursing treatment provided to the customer including skilled monitoring, medication, and therapeutic procedures;
- The degree to which the customer must be supervised;

- The skill and training required of the customer's caregiver; and
- Any other significant factors that impact the individual case.

If the physician consultant cannot make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the customer or contact others familiar with the customer's needs, including a primary care physician or other caregiver, to make the determination.

The physician consultant must document the reasons for the determination in the physician review comment section of the PAS assessment.

Definitions

Term	Definition
Physician consultant	A physician who contracts with the Administration to complete eligibility reviews of PAS assessments.
Immediate risk of institutionalization	A need for the level of care typically provided in an institution, like a skilled nursing facility or Intermediate Care Facility.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-550 ARS 36-2936(I) AAC R9-28-303

1007 PAS Reassessments

Revised 01/15/2020

Policy

PAS reassessments must be completed on some ALTCS members to determine continued medical eligibility. The criteria for continued qualification for ALTCS services are the same as for the initial PAS.

EPD Members who were made eligible by physician consultant review on their last assessment and are under age 65 require an annual assessment.

A reassessment may be completed at any time for the following reasons:

- A routine audit of the PAS assessment reveals a question regarding the eligibility determination;
- A review by Administration or an ALTCS physician consultant determines the member may not have a continuing need for long term care services; or
- A Program Contractor, case manager, nursing facility, or other party requests a review that reveals a question regarding continuing eligibility.

NOTE A reassessment may be scheduled at six months when it appears that a customer may not have a continued need for long term care services in the judgment of the physician consultant or PAS Assessor, in consultation with his or her supervisor.

Definitions

Term	Definition
Reassessment	Means the process of redetermining PAS eligibility for ALTCS services.

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Applicant or member score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	AAC R9-28-306

1008 Applicant/Member Issue Referrals

Revised 08/20/2024

Policy

When a PAS Assessor witnesses a situation with an applicant or member that calls for immediate intervention, the Assessor shall do one of the following:

- For life-threatening situations, call 911.
- For other situations, notify Adult Protective Services (APS) or Department of Child Safety (DCS) of the presence of serious physical or medical neglect.

When it appears that a referral to APS or DCS may be appropriate, the Assessor shall discuss the issue with his or her supervisor. In some cases, depending on the severity of the issue, the discussion may occur after the referral has been made. In less urgent situations, the supervisor may contact the AHCCCS Division of Managed Care Operations/Clinical Quality Management (DMCO/CQM) for guidance regarding contacting APS or DCS.

In addition, the Assessor shall notify DMCO/CQM using the online form on the AHCCCS website at https://www.azahcccs.gov/ACMS/default.aspx whenever one of the following is suspected:

- A problem with the quality of the care being provided to the member;
- The member is being abused or neglected;
- The member has unmet medical or dental needs;
- Provider fraud has been committed; or
- The member is residing in an unlicensed or uncertified room and board home and is receiving direct, personal, or supervisory care services on other than a temporary basis pending ALTCS approval.

When completing the online Quality of Care Received form the Assessor shall indicate the severity status level as follows:

- Severity Level 1. Potential quality of care issue with **minimal** adverse effects (issue **may** impact the member if not resolved).
- Severity Level 2. Potential quality of care issue with **moderate** adverse effects (issue **will** impact the member if not resolved).
- Severity Level 3. Potential quality of care issue that **immediately** impacts the member and is life-threatening or dangerous.

Definitions

N/A

Proof

A Customer Issue Referral (CIR) form completed by the Assessor or Benefits and Eligibility Specialist.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 483.430

1009 Preadmission Screening and Resident Review (PASRR)

Revised 08/20/2024

Policy

Under the federally-mandated Preadmission Screening and Resident Review (PASRR) program, all customers entering a Medicaid-certified nursing facility after January 1, 1989 must be screened for intellectual cognitive disability and serious mental illness (ICD/MI), to avoid inappropriate placement.

The PASRR is a two-level screening process. Hospital discharge planners and nursing facility staff complete the PASRR prior to admission to a nursing facility (NF). The Level I screening determines whether the customer has any diagnosis or other presenting evidence that suggests the presence of ICD/MI. If there is an indication of ICD/MI, the case must be referred for a Level II determination.

The Level II screening determines whether the customer is ICD/MI and whether he or she can be appropriately treated in a NF setting. If a Level II determination is indicated in Section E of the PASRR Screening Document, the customer or the customer's representative must sign in Section F. Admission to a NF cannot occur until the Level II is completed and indicates that NF admission is appropriate.

Referrals for Level II evaluations for potential mental illness are sent to the PASRR Coordinator at the Arizona Department of Health Services, Division of Behavioral Health Services. Referrals for Level II evaluations for potential intellectual cognitive disability are sent to the Arizona Department of Economic Security, Division of Developmental Disabilities.

Nursing facilities must do all of the following for PASRR:

- Ensure that the Level I screening and, if applicable, Level II determinations have been completed and are kept in the customer's current medical chart;
- Perform a new Level I screening and, if applicable, a Level II, when a customer enters a NF for convalescent or respite care and is later found to require more than 30 days of NF care; and
- Perform a new Level I screening and, if applicable, a Level II, when a customer's mental health condition changes or new medical records information becomes available that indicates the possible need for a Level II referral.

PAS Assessors shall report any nursing facilities that are not in compliance with this regulation to the PASRR Coordinator in DMCO.

Definitions

Term	Definition
Intellectual cognitive disability	Is defined as a chronic disability that impairs general intellectual functioning or adaptive behavior and requires treatment or services. The impairment must be demonstrated before age 22. The impairment must be likely to continue indefinitely and substantially limit the customer's ability to function in major life activities.
Serious mental illness	Is defined as a condition that impairs emotional or behavioral functioning to the point that it interferes with the person's ability to remain in the community without supportive treatment. The mental impairment is severe and persistent and may limit the customer's ability to: • Function in primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation; or • Seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services. NOTE Although people with a primary diagnosis of intellectual cognitive disability frequently have similar problems or limitations, they are not included in this definition.

Proof

Completed PASRR Level I screening and Level II determination, if applicable, in customer's case file maintained by nursing facility.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396b 42 CFR 483.112 42 CFR 483.130 ARS 36-2903.03 AAC 9-28-404

1010 The ALTCS Transitional Program

Revised 01/15/2020

Policy

The ALTCS Transitional program is a program for customers who have improved medically, functionally or both to the point that they no longer need the level of care that is provided in a nursing facility (NF) or intermediate care facility institutionalization for individuals with intellectual disabilities (ICF-IID). These customers are determined through the PAS reassessment process to still need long-term care services, but at a lower level of care.

1) Who qualifies for ALTCS Transitional?

The ALTCS Transitional program is only available to customers who have been approved for ALTCS. It is not available to customer who fail the initial PAS and are not at risk of institutionalization.

The medical eligibility criteria for ALTCS Transitional are as follows:

- DD customers - Receive a score of 30 or higher during the PAS reassessment, or must have a diagnosis of moderate, severe, or profound cognitive disability.
- EPD customers, under age 12 - Must be found eligible for ALTCS Transitional through physician consultant review.
- EPD customers, ages 12 and older - Receive a score of 40 or higher during the PAS reassessment.

The ALTCS Transitional effective date is the first of the month following the PAS decision date, allowing for advance notice of the change.

2) ALTCS Transitional - Covered Services

The ALTCS Transitional program allows customers who meet the lower level of care, to continue to receive all other medically necessary ALTCS covered services. Customers living in a NF or ICF-IID when determined eligible for the ALTCS Transitional Program may get continued NF or ICF-IID services for up to 90 days while being moved to an HCBS placement by the Program Contractor.

An ALTCS Transitional customer’s condition may worsen to the point that NF services are again medically necessary. The Program Contractor can place the customer in an NF temporarily, provided the stay is not more than 90 continuous days per admission.

NOTE When an ALTCS Transitional customer may need NF care longer than 90 days, the Program Contractor must request a PAS reassessment. When the customer is

determined to be at risk of institutionalization, the customer will be moved back to Full ALTCS effective the first day of the month following the PAS reassessment.

Definitions

Term	Definition
Intermediate Care Facility for Individuals with Intellectual Disabilities.	An institution that: • Is primarily for the diagnosis, treatment, or rehabilitation of people with intellectual disabilities or related conditions; and • Provides ongoing evaluation, planning, 24-hour supervision, coordination, and health or rehabilitative services to help each person function at his or her greatest ability.

Proof

The following information is used as proof of eligibility for ALTCS Transitional:

- Current eligibility approved in the eligibility determination system, HEAplus; AND
- PAS reassessment records showing a PAS score below the threshold for ALTCS but equal to or higher than the threshold score for ALTCS Transitional; or
- Records of a Physician Review determination that the applicant or member meets the criteria for ALTCS Transitional.

Legal Authority

Program	Legal Authorities
ALTCS	AAC 9-28-307

1011 Quality Assurance

Revised 06/14/2022

Policy

The PAS Quality Assurance (QA) Unit consists of nurses and social workers who monitor and evaluate the EPD and DD PAS process. The goal of the unit is to provide feedback on the accuracy and consistency of PAS implementation statewide.

PAS QA staff review completed PAS assessments. The review includes;

- Health-e-Arizona plus (HEAplus) data entry
- Case notes;
- DocuWare; and
- Any other proof in the case file.

Findings from the reviews are collected and used to identify trends that show a need for training, changes to PAS assessment tools, PAS manuals, or the new hire orientation process.

PAS Assessors are responsible for monitoring and improving the quality of the assessments they conduct. Supervisors support quality improvement by:

- Reviewing completed assessments for accuracy and completeness;
- Observing PAS interviews;
- Providing technical assistance;
- Coaching; and
- Identifying training opportunities on an ongoing basis.

Proof

Documentation of quality control activities as maintained by the Quality Assurance Unit and eligibility office supervisors.

Legal Authority

Program	Legal Authorities

ALTCS	ARS 36-2903.01B3(d)

Chapter 1100 Enrollment

1100 Introduction

For each enrollment topic in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply to the topic.

1101 Enrollment Overview

Revised 10/01/2018

Policy

Customers who qualify for AHCCCS Medical Assistance are enrolled with an AHCCCS Complete Care (ACC) plan, an ALTCS Program Contractor or a fee-for-service plan.

Enrollment Rights

The customer may file a grievance for an adverse action related to enrollment or provision of services taken by a health plan, a program contractor or AHCCCS. See MA1710 - Grievances for more information.

Enrollment Rosters

Each contractor receives enrollment files from AHCCCS. Daily and monthly enrollment files are produced. The availability of enrollment files to the contractor is considered legal notification of the contractor's responsibility for providing care to customers.

Daily enrollment files include:

- New members for whom the contractor is responsible;
- Persons for whom the contractor is no longer responsible, including persons who are:
    - Newly disenrolled; or
    - Deceased;
- Changes to customers' demographic data, like name, address or date of birth;
- Rate codes; and
- Share of cost information.

Monthly enrollment files are produced three days prior to the end of the month for each contractor. They identify the total active population for each contractor as of the first of the next month.

Definitions

Term	Definition

AHCCCS Complete Care (ACC) plan	An entity with a prepaid capitated contract with AHCCCS to provide acute care medical services to AHCCCS customers.
Arizona Long Term Care System (ALTCS) Program Contractor	A contracted managed care organization that provides long term care, acute care, behavioral health, and case management services to eligible customers who are determined to need an institutional level of care.
Fee-For-Service (FFS)	Means AHCCCS pays providers directly for covered services provided to the customer, instead of the payment being made through a contracted health plan.

Legal Authorities

This requirement applies to the following programs:

Program	**Legal Authorities**
ALTCS and FTW-ALTCS	AAC R9-28-412 through R9-28-418
All programs except ALTCS and FTW-ALTCS	AAC R9-22-1701 through R9-22-1705

1102 Enrollment with a Health Plan

1102 Enrollment with a Health Plan

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 10/08/2024

Policy

AHCCCS health plans provide physical and behavioral health services to customers. The health plan contracts with primary care physicians, specialists, dentists, hospitals, and other providers to form a network of service providers. Most health plans serve specific Geographic Service Areas (GSAs), which are made up of specific Arizona counties.

This section covers:

- The Arizona counties assigned to each GSA, and
- Health plans that serve specific customer groups

1) Health plans available by county

The following table lists the counties assigned to each GSA:

Geographic Service Areas	Counties
Central	• Gila • Maricopa • Pinal
North	• Apache • Coconino • Mohave • Navajo • Yavapai
South	• Cochise • Graham

	• Greenlee • La Paz • Pima • Santa Cruz • Yuma

When a Zip code crosses two different counties, the Zip code is assigned to a specific GSA. The health plan is responsible for providing services to members residing in the entire ZIP code that is assigned to the GSA.

The split ZIP codes GSA assignments are as follows:

Zip Code	Split Between These Counties	Assigned GSA
85342	Yavapai and Maricopa	Central
85390	Yavapai and Maricopa	Central
85358	Yavapai and Maricopa	Central
85542	Gila and Graham	South
85550	Gila and Graham	South
85645	Pima and Santa Cruz	South
85192	Gila and Pinal	South

To review a list of the health plans available by county see AHCCCS Health Plan Links.

2) Health plans that serve specific customer groups

- Mercy Care Department of Child Safety Comprehensive Health Plan (DCS CHP) provides services to children in Arizona foster care statewide.

- American Indian Health Program (AIHP) is available to American Indians statewide who choose not to enroll in one of the health plans available by county.
- Mercy Care provides services to customers who have a serious mental illness (SMI) living in the counties of Maricopa, Gila, and Pinal (excluding ZIP codes 85542, 85192, and 85550).
- Arizona Complete Health provides services to customers who have an SMI, living in Northern or Southern Arizona. This includes the Southern counties of Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma (including ZIP codes 85542, 85192, and 85550) and the Northern counties of Apache, Coconino, Mohave, Navajo, and Yavapai.

Definitions

Term	Definition
Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP)	A health plan administered by the Arizona Department of Child Safety (DCS) that provide services to children in the custody of the State of Arizona's foster care system.
Integrated Health Plan	A plan that joins physical and behavioral health services to treat all aspects of healthcare needs for members under a chosen health plan.
Managed Care Organization	Contracts with primary care physicians (PCP), specialists, dentists, hospitals and other ancillary providers to form a network of service providers.
Primary Care Physician (PCP)	The health care provider chosen by or assigned to a patient to provide medical care, maintain the patient's medical records and make referrals for medically necessary specialty care.

Legal Authority

Program	Legal Authorities

All programs except ALTCS and Medicare Savings Program (MSP)	42 CFR 438.71 AAC R9-22-1702

B Initial Health Plan Enrollment

Revised 04/26/2022

Policy

Within 10 days of enrollment, the health plan provides the customer with:

- Printed information about the health plan's services and service locations;
- The name, address, and telephone number of the customer's primary care provider (PCP); and
- Information on how the customer may change PCPs

Customers receive an AHCCCS Medical Assistance ID card in the mail that includes the health plan's contact information. Customers must present this ID card whenever medical services are requested or provided (ex., doctor's office, hospital, lab, or pharmacy). Customers who do not receive an ID card should call their health plan.

Most customers who do not currently have AHCCCS coverage have a choice of health plans that serve their Geographic Service Area (GSA).

When a customer does not choose a health plan before the application is approved, AHCCCS automatically assigns a health plan and enrolls the customer. The customer is sent a Freedom of Choice letter informing them of the health plan they were assigned and giving them a 90-day period to choose a different health plan. When the customer does not contact AHCCCS to choose a different health plan, the customer remains enrolled with the auto-assigned health plan.

NOTE American Indians customers living within the bounds of the tribal nation that do not choose a plan will be automatically enrolled in AIHP.

Exceptions:

The following customers do not have a health plan choice:

- Customers diagnosed with a Serious Mental Illness (SMI);
- Children in State of Arizona foster care; and
- Customers who were enrolled with a health plan within 90 days before the new approval, AND that health plan remains available in the customer's GSA.

Customers that need help selecting a health plan may:

- Visit www.azahcccs.gov/choice; or
- Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800) 334-5283 from area codes (520) and (928).

Definitions

Term	Definition
Freedom of Choice	Customers may select the health plan of their choice within 90 days of auto assignment.
Geographic Service Area (GSA)	AHCCCS awards health plan contracts by GSA. AHCCCS Complete Care (ACC) health plans are responsible for providing services to customers residing in the GSA.

Legal Authority

Program	Legal Authorities
All programs except ALTCS and Medicare Savings Program (MSP)	42 CFR 438.71 AAC R9-22-1702

C Effective Date of Health Plan Enrollment

Revised 09/24/2015

Policy

The effective date of initial enrollment in a health plan depends on the program and other circumstances:

Scenario	Effective Date
Customer's eligibility is changing from ALTCS to AHCCCS Medical Services	Enrollment with the health plan begins the day after the last day of ALTCS eligibility.
All other initial enrollment	Enrollment with the health plan begins on the effective date of eligibility for AHCCCS Medical Assistance, but no earlier than the first day of the month of application.

Definitions

Term	Definition
Effective date of enrollment	The date that the AHCCCS Complete Care (ACC) plan becomes responsible for providing AHCCCS covered services.

Legal Authorities

Program	Legal Authorities
All programs except ALTCS and Medicare Savings Program (MSP)	AAC R9-22-1702

Effective until 2025-04-25

D Newborn Enrollment

Revised 09/14/2021

Policy

The newborn's enrollment is determined by both the:

- Mother's enrollment; and
- Newborn's date of birth.

1) Health Plan Assignment for Newborns

When the newborn's mother is eligible and enrolled with an AHCCCS Complete Care (ACC) plan or AIHP, the newborn is enrolled in the same plan as the mother.

The newborn is auto-assigned to a health plan when the mother:

- Is not enrolled with a health plan or American Indian Health Program (AIHP);
- Has a Children's Rehabilitative Services (CRS) designation;
- Is enrolled with Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP); or
- Is enrolled with a program contractor or tribal ALTCS contractor.

Health plans and hospitals notify AHCCCS of the birth of a newborn so that the newborn can be enrolled with a health plan.

2) ID Card

The newborn's AHCCCS ID card is not sent until the first name is received from the eligibility source.

3) Enrollment Choice

A Freedom of Choice letter is sent to the mother notifying her of the right to choose a different health plan for the child within 90 days from the date of the enrollment notice.

When customers need help selecting a health plan they may:

- Visit www.azahcccs.gov/choice; or

Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1 (800)-334-5283 from area codes (520) and (928).

Definitions

Term	Definition
Freedom of Choice	Customers may select the health plan of their choice within 90 days of auto assignment.

Legal Authority

Program	Legal Authorities
Deemed Newborns	42 CFR 438.71 AAC R9-22-1704 AAC R9-31-309

E Guaranteed Enrollment Periods

Revised 04/15/2025

Policy

The guarantee period is calculated at the time the discontinuance is received by PMMIS. Eligibility for the guaranteed enrollment period is based on the reason the customer became ineligible for the AHCCCS program.

NOTE Customers receiving Medicare Savings Program (MSP) or Federal Emergency Services (FES) only, do not have guaranteed enrollment periods.

Guaranteed enrollment periods apply as follows:

If...	The guaranteed enrollment period is...	Unless the customer...
It is the first time the customer has ever been enrolled with an AHCCCS Complete Care (ACC) plan	Six months	• Dies • Moves out of state; • Cannot be located and mail is returned to the agency as undeliverable; • Is incarcerated; • Is adopted; • Was ineligible at the time of initial enrollment; or • Voluntarily withdraws from the program.
The customer is under age 19 when approved or renewed.	12 months	• Dies; • Reaches age 19; • Moves out of state; • Cannot be located and mail is returned to the agency as undeliverable;

		• Becomes eligible for SSI Cash or ALTCS and approved in error [manual process]; • Was approved or renewed in error; or • Voluntarily withdraws from the program.
The customer is under age 19, currently in KidsCare, and cascading into a higher medical eligibility program	12 months. The effective start date and the renewal date will be reset and align the Medicaid Renewal date for all household members. NOTE This does not apply to MSP programs, Medicaid programs where the customer does not meet the age requirement, SSI-MAO and Specialty Categories (DAC, PICKLE), YATI, and TMA	• Dies • Reaches age 19; • Moves out of state; • Was approved or renewed in error; • Voluntarily withdraws from the program; or • Is a DCS customer.

Definitions

Term	Definition
Guaranteed Enrollment Period	A period of enrollment that continues even when the customer no longer qualifies for AHCCCS or KidsCare for certain reasons.

Legal Authority

Program	Legal Authorities

All Programs (except MSP and KidsCare)	42 USC 1396a(e)(12) AAC R9-22-1705
KidsCare	42 USC 1397gg(e)(1) AAC R9-31-307

F Health Plan Enrollment Changes

Revised 03/25/2025

Policy

In general, customers enrolled in a health plan may change their enrollment once a year during their enrollment choice month.

The enrollment choice month is the month in which the customer was first enrolled with an AHCCCS Complete Care (ACC) plan. During the enrollment choice month, a customer can change their health plan by:

- Calling (602) 417-7100 from area codes (480), (602), and (623) or
- Calling 1 (800)-334-5283 from area codes (520) and (928).

Customers who do not want to change their health plan do not have to do anything to remain enrolled with the current health plan.

When a customer does change health plans, the month after the enrollment choice month is the transitional month. During this time AHCCCS notifies both the current health plan and the new health plan of the enrollment change. This allows the health plans time to transfer records and welcome new members.

When more than one person in a household receives AHCCCS Medical Assistance, an enrollment choice month is assigned to the household using the enrollment choice month of the customer that has been on AHCCCS for the longest time. All customers in the household who want to change health plans may do so at that time.

Exceptions:

The annual enrollment process does not apply to any of the following customers:

- Foster care children enrolled with Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP); and
- Customers diagnosed with a Serious Mental Illness.

When customers need help selecting a health plan they may:

- Visit www.azahcccs.gov/choice; or
- Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800) 334-5283 from area codes (520) and (928).

There are situations when the customer's enrollment may be changed outside the annual enrollment period. Listed below are the reasons enrollment may be changed:

Situation/Status	Description
Auto Assignment	When a customer has been auto assigned to a health plan, they may change health plans within 90 days. This is known as Freedom of Choice.
Change to Full Services	When a customer is eligible to move from FES to full services, the customer is sent a letter giving the opportunity to select a health plan and notifying them of the change in services.
Continuity of Care	Health plan changes may be approved on a case-by-case basis to ensure the customer's access to care. Approval requires an agreement from both health plan's Medical Directors. The health plans determine the effective date of the enrollment change. NOTE When the health plans cannot reach an agreement, the AHCCCS Chief Medical Officer makes the decision and the Division of Health Care Management notifies the health plans and the customer.
Family continuity	A customer auto assigned to a different health plan than other currently enrolled family members can change to the health plan in which the other family members are enrolled. NOTE Other family members are not permitted to change to the health plan to which the customer was auto assigned.
Foster Care	When a child is no longer in the custody of Arizona foster care, the customer can choose a health plan.
Grievance	A change in enrollment is allowed when the change is a result of the final outcome of a grievance.

Incorrect Enrollment	If a customer made a pre-enrollment choice but was assigned to the wrong health plan in error, a change may be made.
American Indians	An American Indian customer may change from an available health plan to American Indian Health Program (AIHP) or from AIHP to an available health plan at any time.
Newborn	Newborns are automatically assigned to the mother's health plan. The mother is given 90 days to select another health plan for the newborn. Newborns of Federal Emergency Services (FES) mothers are auto assigned and the mother is given 90 days to select a health plan.
Same Day Plan Change	A member can change their health plan choice within the same day of the original request.
Customer Moves to a New GSA	If the customer moves and his or her current health plan is not available in the new GSA, the customer has 90 days to choose a health plan in the new GSA.

Customers can contact the Agency directly to report an enrollment error or request an enrollment change. The customer may:

- Call (602) 417-7100 or 1-800-962-6690; or
- Send written requests to 801 E. Jefferson St., MD 3400, Phoenix, AZ 85034.

Definitions

Term	Definition
Enrollment Choice Month	The first month after the material is mailed is the enrollment choice month.

Transitional Month	The second month is the transitional month. During this time AHCCCS notifies both the current health plan and the new health plan of the enrollment change. This allows the health plans adequate time to transfer records and welcome new members.

Legal Authority

Program	Legal Authorities
All Programs	AAC R9-22-1702 42 CFR 438.71

1103 Fee-For-Service

Revised 03/25/2025

Policy

Services are provided on a fee-for-service basis in the following situations:

Service Package	When the customer...
AHCCCS Medical Services	• Is eligible to have medical bills paid during the three months prior to application (Prior Quarter) • Is eligible for Federal Emergency Services (FES) through the Federal Emergency Services Program (FSP); • Enrolls with American Indian Health Program (AIHP); • Is eligible for Hospital Presumptive Eligibility (HPE); • Has less than 30 days of prospective eligibility; or • Is eligible only for a retroactive period of eligibility.
ALTCS Services	• The customer is eligible for ALTCS services only during the prior period. Example: The customer dies before ALTCS is approved but is eligible for ALTCS services in the prior period. ALTCS services are paid on a fee-for-service basis. • The customer is enrolled with a tribal contractor, or there is no tribal or EPD program contractor serving the customer's geographical service area.

	• The Assistant Director of the Division of Member Services approves (on a case-by-case basis) fee-for-service payment for long term care services during the prior period for a customer who: ◦ Was enrolled with an AHCCCS Complete Care (ACC) plan when ALTCS was approved; and ◦ The AHCCCS Complete Care (ACC) plan's responsibility for paying for nursing facility services for a 90-day period per contract year ended prior to the date the ALTCS approval was processed.

Definitions

Term	Definition
AHCCCS American Indian Health Program (AIHP)	AIHP is responsible for paying fee-for-service claims submitted for American Indians who have chosen not to enroll in an acute capitated health plan. If the American Indian customer does not choose a plan and lives within the bounds of the tribal nation, the customer will be automatically enrolled in AIHP.
Federal Emergency Services Program (FESP)	Emergency services provided to immigrants who are eligible for Medicaid except for their immigration status.
Hospital Presumptive Eligibility (HPE)	Temporary coverage for people who are likely to qualify for AHCCCS Medical Assistance. See MA417 for details. NOTE Eligibility for HPE is determined by qualified hospitals

Legal Authority

Program	Legal Authorities
All programs	AAC R9-22-1702 AAC R9-28-416 AAC R9-22-1601

1104 Enrollment with a Program Contractor

1104 Enrollment with a Program Contractor

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 04/29/2025

There are three types of organizations that serve as ALTCS program contractors:

- Program contractors for individuals who are age 65 or older (elderly) or have a physical disability (EPD).

NOTE Program contractors for EPD customers are determined by the customer's county of fiscal responsibility (see MA1104B). However, customers that have a Dual Eligible Special Needs Plan (DSNP) with Medicare will be automatically moved to the EPD Program Contractor that is aligned with their Medicare DSNP.

- The Department of Economic Security (DES/DDD); and
- American Indian contractors.

Policy

1) When Does Enrollment Occur?

The effective date of enrollment is determined by the customer's AHCCCS status on the date of approval.

If the customer is...	Then ALTCS enrollment and capitation...
Enrolled with an AHCCCS Complete Care (ACC) plan at the time of approval	Begins on the date ALTCS approval the ALTCS approval is processed. The customer is disenrolled from the AHCCCS Complete Care (ACC) plan the day before. Exception: If the effective date of ALTCS eligibility is before the date the customer was enrolled with a health plan, the prior period begins on the first day of the ALTCS application (or the first eligible month) and ends on the day before the health plan enrollment began. Enrolled with an AHCCCS Complete Care (ACC) plan at Time of Approval Example

Not enrolled with an AHCCCS health plan	Is retroactive to the effective date of eligibility (prior period coverage). Not Enrolled with an AHCCCS Complete Care (ACC) plan Example The customer may also have unpaid medical bills from services received in the three months prior to the month of application (Prior Quarter) on a Fee-For-Service basis if determined to be eligible for ALTCS during the months in which the medical services were received.
Enrolled with a Dual Eligible Special Needs Plan (DSNP)	Customers that are enrolled in an EPD Program Contractor plan need to have their enrollment aligned to their Dual Eligible Special Needs Plan (DSNP) with Medicare. This is known as Exclusively Aligned Enrollment (EAE). The customer will be automatically moved to the EPD Program Contractor that is aligned with their Medicare DSNP.

2) What happens after enrollment?

After enrollment occurs:

- The program contractor gives the customer written information about their organization.
- The customer chooses the doctor he or she prefers as a primary care physician (PCP) from the program contractor's list of participating physicians. If the customer does not choose a PCP, one is assigned. The primary care physician coordinates care and acts as a gatekeeper. If the customer's current doctor is a member of the program contractor's network, the customer does not need to change doctors.
- A case manager assigned by the program contractor contacts the customer and the customer's representative soon after enrollment to establish a service plan that best meets the customer's needs. Input from the customer and the customer's family is encouraged.
- The customer receives an ID card in the mail from the program contractor that includes the name and phone number of the program contractor. The customer presents this ID card whenever medical services are requested or provided (ex., doctor's offices, hospitals, labs and pharmacies).

NOTE DDD members receive their ID cards from DDD. American Indian Health Plan (AIHP) members receive their ID cards from AHCCCS.

Definitions

Term	Definition
Program Contractor	Program contractors are responsible for: • Providing services through a managed care plan (health maintenance organization); • Contracting with providers to form a network of service providers; and • Assigning a case manager who works with the customer's primary care physician (PCP) to develop a service plan. The case manager authorizes all long term care services provided through ALTCS.
County of Fiscal Responsibility	The Arizona county that is responsible for paying the State's funding match for the customer's ALTCS Service Package. NOTE The county of physical presence (where customer physically resides) and the county of fiscal responsibility may be the same or different counties.
Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 CFR 422.107

	ARS 36-2933 AAC R9-28-412 through R9-28-417

B EPD Program and Contractor Enrollment Process

Revised 04/29/2025

Policy

Only customers who are age 65 or older (elderly) or have a physical disability (EPD) whose county of fiscal responsibility (MA1104E) is Maricopa County, Gila County, Pinal County or Pima County may choose their program contractor. Other fiscal counties do not have multiple program contractors. Enrollment in a program contractor is determined according to the following policy:

- All ALTCS customers who have a developmental disability are enrolled with the Division of Developmental Disabilities (MA1104C).
- EPD American Indians that are within the bounds of a tribal nation are enrolled with the tribe or Native American Community Health (NACH) if the tribe is not a program contractor (MA1104D).
- EPD customers whose county of fiscal responsibility is Maricopa County, Gila County, Pinal County or Pima County may choose their program contractor (MA1104E).
- All other EPD customers are enrolled with the program contractor that serves their county of fiscal responsibility.
- An EPD Program contractor is determined based on the customer's county of fiscal responsibility and their Dual Eligible Special Needs Plan (DSNP) with Medicare, if the customer has one.

Program Contractors for EPD Customers Not Enrolled with a Tribal Contractor

When a customer does not choose a program contractor before the application is approved, AHCCCS automatically assigns a program contractor and enrolls the customer. A Freedom of Choice letter is mailed to customers informing them of the program contractor they were enrolled in and giving them a 90-day period to choose a different program contractor if they wish to change. If the customer does not contact AHCCCS to choose a different program contractor, the customer will remain enrolled with the auto-assigned program contractor.

AHCCCS currently contracts with the following program contractors to provide ALTCS services to EPD customers who are not enrolled with a tribal contractor:

ALTCS-EPD Program Contractor	Counties Served

Banner – University Family Care https://www.bannerufc.com/acc 2701 E. Elvira Road Tucson, AZ 85756 Toll free (800) 582-8686	Maricopa, Gila, Pinal, Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma
Mercy Care Plan http://www.mercycareplan.com/ 4350 E. Cotton Center Blvd., Bldg. D Phoenix, AZ 85040 (602) 263-3000 Toll free 1-800-624-3879	Gila, Maricopa, Pinal, and Pima
UnitedHealthcare http://www.uhccommunityplan.com/ 1 E. Washington Street Phoenix, AZ 85004 Toll free 1-800-293-3740	Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai

When customers need assistance selecting a program contractor, they may

- visit www.azahcccs.gov/altcschoice; or
- contact the AHCCCS Benefits and Eligibility Specialist for choice counseling.

Definitions

Term	Definition

Choice Counseling	Providing information and services to help customers make enrollment decisions. It includes answering questions and identifying factors to consider when choosing a program contractor. Choice counseling **does not** include making recommendations for or against enrollment into a specific program contractor.
Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.

Legal Authority

This requirement applies to the following program:

Program	**Legal Authorities**
ALTCS	42 CFR 438.71 42 CFR 422.107 ARS 36-2933 AAC R9-28-413

C DDD Enrollment

Revised 11/26/2019

Policy

The Department of Economic Security (DES), Division of Developmental Disabilities (DDD) is the statewide ALTCS program contractor for persons with developmental disablities.

An ALTCS customer is enrolled with DDD when DES/DDD has determined that the customer is eligible for services from their agency.

Customers have a choice of DDD health plans that provide physical and behavioral health services, Children's Rehabilitative Services (CRS) and limited long term services and supports. All other long-term care services and support coordination are provided by DES/DDD. The DDD Health Plans are:

- United Healthcare Complete Plan; and
- Mercy Care Plan

Exception:

American Indian and Alaska Native customers have other enrollment options, See MA1104D for more information.

Definitions

Term	Definition
Department of Economic Services, Division of Developmental Disability (DES/DDD)	The state agency responsible for: • Providing services to customers who have specific disabilities; and • Screening, referring, and making eligibility determinations for DDD services. NOTE DES/DDD also administers a 100% state-funded program for customers with developmental disabilities who are not eligible for ALTCS.

Legal Authority

Program	Legal Authorities
ALTCS – DES/DDD	ARS 36-2933 AAC R9-28-414

D American Indian Enrollment

Revised 04/29/2025

Policy

American Indian and Alaska Native customers that qualify for ALTCS are enrolled based on the following policies:

If the customer...	Then the customer is enrolled in...
Has a developmentally disability	One of the following DDD health plan choices • United Healthcare Complete Plan; • Mercy Care Plan; or • DDD American Indian Health Plan (DDD/AIHP) NOTE When enrolling with DDD/AIHP, the customer can also choose to have behavioral health services provided by the Tribal Regional Behavioral Health Authority (TRBHA).
Currently resides or resided within the bounds of a tribal nation prior to placement in an off-tribal land nursing facility (on-tribal land status)	The tribe that serves that reservation. The customer does not have to be a member of the contracting tribe. Example: A Hopi customer living within the bounds of the Navajo Tribal Nation is enrolled with the Navajo Nation. NOTE If the tribal nation is not served by one of the seven tribes identified as an American Indian program contractor, the person is enrolled in Native American Community Health (NACH). Exception: Persons who reside within the bounds of a tribal nation, but lack any tribal membership are

	enrolled with an elderly and/or physically disabled (EPD) program contractor.
Lives in a home and community-based services (HCBS) setting that is not within the bounds of a tribal nation	An EPD program contractor based on the customer's county of fiscal responsibility. NOTE When the customer has a Dual Eligible Special Needs Plan (DSNP) with Medicare, the customer will be automatically moved to the EPD Program Contractor that is aligned with their Medicare DSNP.

Definitions

Term	Definition
American Indian Program Contractors	Seven American Indian tribes deliver case management services and provide directly or arrange for services to American Indians who are elderly and/or physically disabled and reside on-reservation. These tribes are: • Gila River Indian Community; • Hopi Tribe; • Navajo Nation; • Pascua Yaqui Tribe; • San Carlos Apache Tribe; • Tohono O'Odham Nation; and • White Mountain Apache Tribe.
Native American Community Health (NACH)	NACH provides case management services to elderly and/or physically disabled American Indian ALTCS customers who live on-reservation and do not receive ALTCS case management from a tribe.

Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS – American Indian Customers	42 CFR 422.107 ARS 36-2932 and 2933 AAC R9-28-415

E County of Fiscal Responsibility

Revised 04/29/2025

Policy

The county of fiscal responsibility must be determined for all ALTCS customers. However, this determination only affects customers who are age 65 or older (elderly) or have a physical disability (EPD) and are enrolled with an EPD program contractor. Not all counties have the same program contractors. The fiscal county is determined in order to enroll the customer with the correct program contractor for that fiscal county.

The Benefits and Eligibility Specialist determines the customer's county of fiscal responsibility. The following criteria are used to establish the county of fiscal responsibility:

If the applicant is...	And...	Then the county of fiscal responsibility is...
An adult	• Resides in his or her own home; or • Moved from another state directly into a nursing facility or alternative HCBS setting in Arizona	The county where the applicant currently resides.
	• Resides in a nursing facility; or • Alternative HCBS setting	The county where the applicant last resided in his or her own home.
	• Moved from the Arizona State Hospital to a nursing facility or alternative HCBS; or • Moved from a penal institution to a nursing facility or alternative HCBS	The county where the applicant resided in his or her own home prior to admission to Arizona State Hospital or the public institution.

A child (under age 18)	Parental rights have not been legally severed	The county where the parent(s) live at the time of ALTCS approval.
	Parental rights have been legally severed	The county where the child resides.
	Parents are legally separated	The county where the parent the child resides with.

County of Fiscal Responsibility Examples

How Is Enrollment Affected?

Although the county of fiscal responsibility must be determined for all ALTCS customers, this determination only affects customers who are age 65 and older (elderly) and/or have a physical disability who are not American Indians with on-tribal lands status and not Developmentally disabled.

If the customer is...	**Then the county of fiscal responsibility...**
• An American Indian with on-tribal lands status; or • Developmentally disabled.	Does not affect enrollment.
Elderly and/or physically disabled (including an American Indian who does not have on-tribal lands status)	Affects enrollment with a program contractor.

The customer's fiscal county and the customer's Dual Eligible Special Needs Plan (DSNP) with Medicare, if the customer has one, is used to determine enrollment with a program contractor. Customers that have a DSNP will be automatically moved to the EPD Program Contractor that is aligned with their DSNP.

Definitions

Term	Definition
County of Fiscal Responsibility	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the customer's ALTCS Service Package. The county of physical presence (the county in which the customer physically resides) and the county of fiscal responsibility may be the same county or different counties.
Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 CFR 422.107 ARS 36-2913 AAC R9-28-712

F Fiscal County Changes

Policy

After ALTCS is approved, the county of fiscal responsibility is changed only when:

- An adult customer moves to his or her own home in a different county;
- The adult customer's program contractors for the county of fiscal responsibility and residing county both agree to change the enrollment to the program contractor for the county where the customer resides; or
- The parent(s) of a child customer under age 18 move to another county.

When the county of fiscal responsibility is changed, the county change and any related enrollment change is effective the day the change is made.

Fiscal County Changes Examples

1) When A Fiscal County Change May Occur

After ALTCS approval, the county of fiscal responsibility is changed when one of the following happens:

If the applicant is...	And...	Then the county of fiscal responsibility is...
An adult	The customer moves to his or her own home in a different county	Changed when the customer's move is reported by: • The customer; • The customer's representative; or • An Electronic Member Change Report is sent to the ALTCS local office by the program contractor.
	The customer moves to a nursing facility or alternative	Changed when a DMPS Eligibility System Support (ESS)

	residential setting in another county	representative requests a fiscal county change. NOTE This occurs when Eligibility System Support (ESS) receives a Program Contractor Change Request form (DE-621) confirming that the program contractors for both counties have agreed to an enrollment change.
	The customer moves from a nursing facility or alternative HCBS setting into the Arizona State Hospital from a county other than Maricopa county	
	The customer moves from the Arizona State Hospital or a nursing facility to another nursing facility or alternative HCBS setting from a county other than Maricopa county	
A child (under age 18) Child Examples	The customer's parents move to another county	Changed when the customer's move is reported.
	The customer's parents and the customer live in different counties	Changed to the county in which the customer resides only when an Eligibility System Support (ESS) representative requests a fiscal county change. NOTE This occurs when Eligibility System Support (ESS) receives a Program Contractor Change Request form (DE-621) confirming that the program contractors for both counties have agreed to an enrollment change.

2) Effect on Enrollment

When the county of fiscal responsibility changes, the customer's enrollment with a program contractor also changes if the customer's current program contractor does not serve the new county.

Effect on Enrollment Examples

Definitions

Term	Definition
County of Fiscal Responsibility	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the customer's ALTCS Service Package. The county of physical presence (the county in which the customer physically resides) and the county of fiscal responsibility may be the same county or different counties.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2913 AAC R9-28-712

1105 ALTCS Enrollment in a Choice County

Revised 04/29/2025

Policy

ALTCS customers who are age 65 or older (elderly) or who have a physically disability (EPD) whose county of fiscal responsibility is Maricopa County, Gila County, Pinal County, or Pima County have a choice of program contractors.

Exceptions:

- See MA1104D for American Indian customers with on-tribal lands status.
- Customers who are Developmentally Disabled are enrolled with the Division of Developmental Disabilities
- Customers that are enrolled in an EPD Program Contractor plan need to have their enrollment aligned to their Dual Eligible Special Needs Plan (DSNP) with Medicare, if they have one.
- A customer who is reapplying for ALTCS is reenrolled with the former program contractor when the application is approved within 90 days of disenrollment.

If a customer does not choose a program contractor before the application is approved, AHCCCS automatically assigns a program contractor and enrolls the customer. A Freedom of Choice letter is mailed to customers informing them of the program contractor they were enrolled in and giving them a 90-day period to choose a different program contractor if they wish to change. If the customer does not contact AHCCCS to choose a different program contractor, the customer will remain enrolled with the auto-assigned program contractor.

1) Who May Make an Enrollment Choice

The following policy is used to determine who has the authority to make an enrollment choice:

If...	Then...
The customer has a legal representative	Only the legal representative may choose a program contractor for the customer.

The customer does not have a legal representative	The customer, an authorized representative, a family member, a friend, a neighbor, or any other interested party who does not have a conflict of interest may make the enrollment choice
More than one person indicates a choice	All parties are contacted to attempt to determine a mutually acceptable choice. If everyone still disagrees, use the following hierarchy to determine which person is given priority in choosing: • Legal representative • Applicant • Spouse • Parent • Authorized representative

If the customer or representative has not selected a program contractor despite reasonable efforts, and has not requested additional time, the Benefits and Eligibility Specialist will see if a choice can be made for the customer. If the customer's primary healthcare provider(s) contract with only one of the available program contractors, the worker will choose that program contractor for the customer. Otherwise, the customer will be automatically assigned to a program contractor.

2) Conflicts of Interest

A person with a conflict of interest is not allowed to make an enrollment choice for the applicant.

If the customer is unable to make the enrollment choice and there is no one without a conflict of interest who can make the choice, AHCCCS chooses the program contractor.

A social worker employed by a nursing facility, or a case manager employed by a program contractor (even if acting as an authorized representative) has a conflict of interest because the selection may have a financial impact on the person's employer.

3) ALTCS Office Responsibilities

The ALTCS office is responsible for:

- Providing enrollment choice information;

- Helping the customer make an informed choice; and
- Documenting enrollment choice, unless a choice cannot be made, and the customer is auto-assigned to a program contractor.

4) Notice of Enrollment Choice

The customer will receive an AHCCCS ID card with confirmation of enrollment. The name and telephone number of the program contractor are printed on the customer's ID card.

The ID card is mailed to the customer after enrollment is processed. The customer should receive the card a few days after the application is approved.

Definitions

Term	Definition
Choice County	A county that has more than one program contractor available to ALTCS customers who are age 65 or older (elderly) or have a physical disability (EPD). Currently, Maricopa, Gila, Pinal, and Pima are choice counties.
Conflict of Interest	When a person is employed by or somehow related to a business or entity with a financial interest in the customer's enrollment or placement.
Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 CFR 422.107

	ARS 36-2932 and 2933 AAC R9-28-413

1106 ALTCS Enrollment Changes

1106 ALTCS Enrollment Changes

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Policies About ALTCS Enrollment Changes

Revised 04/29/2025

Policy

The following general policies apply to changes in the customer's enrollment after initial approval:

- The customer must be enrolled with a program contractor that serves the customer's county of fiscal responsibility.
- A fiscal county change may also result in an enrollment change when the customer's current program contractor does not serve the customer's new county of fiscal responsibility.
- Because some program contractors serve multiple counties, a fiscal county change does not always result in an enrollment change. If the former and new counties of fiscal responsibility are both served by the same program contractor, enrollment remains unchanged when the county of fiscal responsibility changes.
- An agreement between two program contractors to transfer responsibility for the customer's care will result in a fiscal county change, unless the change is between program contractors within Maricopa County or Pima County.
- Customers that have Exclusively Aligned Enrollment (EAE) with a Dual Eligible Special Needs Plan (DSNP) must first change their DSNP plan with Medicare before the EPD program contractor choice can be changed.

Some changes require approval (or agreement) by the customer's Program Contractor(s). See the following sections for situations when approval or agreement is required or not:

- Changes that do not require program contractor agreement (MA1106.B); and
- Changes requiring program contractor agreement (MA1106.C).

NOTE The enrollment change policy in this section applies only to customers who are elderly and/or physically disabled (EPD) and not to customers who receive services through the DES Division of Developmental Disabilities.

Placements by a Program Contractor

When a program contractor places a customer in a nursing facility or alternative residential setting in a different county, the county of fiscal responsibility and enrollment do not automatically change. This may be done to allow a customer to receive specialized treatment or because of lack of beds in the contractor's county.

Definitions

Term	Definition
Program Contractor	Program contractors are responsible for: • Providing services through a managed care plan (health maintenance organization); • Contracting with providers to form a network of service providers; and • Assigning a case manager who works with the customer's primary care physician (PCP) to develop a service plan. The case manager authorizes all long term care services provided through ALTCS.
Elderly and/or Physically Disabled (EPD)	Elderly and physically disabled refers to customers who are not developmentally disabled but: • Are age 65 or older; or • Have been determined disabled by SSA for SSI MAO, or medically eligible for ALTCS based on physical disabilities.
Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.
Exclusively Aligned Enrollment (EAE)	Customers that are enrolled in an EPD Program Contractor plan need to have their enrollment aligned to their Dual Eligible Special Needs Plan (DSNP) with Medicare.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS – EPD Program	42 CFR 422.107 ARS 36-2932 and 2933 AAC R9-28-413

B Changes That Do Not Require Program Contractor Agreement

Revised 04/29/2025

Policy

The ALTCS local office may initiate some enrollment and fiscal county changes when information is received from the:

- Customer;
- Customer's representative; or
- Current program contractor.

The ALTCS local office may change the customer's enrollment when:

- A customer who is enrolled with DES/DDD loses developmentally disabled status;
- A tribal contractor requests an enrollment change; or
- The fiscal county changes.

NOTE Customers enrolled in a Dual Eligible Special Needs Plan (DSNP) with Medicare must have their EPD Program Contractor aligned with their Medicare DSNP. To change the EPD program contractor aligned with the DSNP, customers must first change their DSNP with Medicare.

1) Loss of DD Status

Enrollment must be changed when a customer who is enrolled with DES/DDD loses developmentally disabled (DD) status:

- If the customer is an American Indian, the enrollment is changed based on the policy in MA1104.D.
- All other eligible customers are enrolled with an EPD program contractor based on the customer's county of fiscal responsibility.

2) Tribal Contractor Requests Enrollment Change

When an American Indian customer living within the bounds of the tribal nation, either in a medical institution or HCBS facility, moves to an HCBS facility outside the bounds of the tribal nation, the

tribal contractor must determine if the customer should be enrolled with the program contractor in the new location.

To request an enrollment change, the tribal contractor must call or write the Division of Managed Care Operations (DMCO). If the DMCO agrees with the recommendation, the tribal contractor sends an Electronic Member Change Report to the ALTCS local office instructing the Benefits and Eligibility Specialist to change the program contractor to the county where the customer now resides. Agreement by the new program contractor is not required.

3) Fiscal County Changes

If the fiscal county changes to a county that is not served by the current program contractor, enrollment is changed to a program contractor serving the county in which the customer’s home is located.

C Changes Requiring Program Contractor Agreement

Revised 08/20/2024

Policy

When agreement of the program contractors is required, both the enrollment change and the effective date must be approved by both the current and requested ALTCS program contractors. Officials representing both program contractors must complete and sign portions of the Program Contractor Change Request (Exhibit 1620-8 in the AHCCCS Medical Policy Manual).

If the requested program contractor does not agree to the change, the current program contractor can ask the Division of Managed Care Operations (DMCO) to review the case situation. If the Division of Managed Care Operations (DMCO) determines a change in enrollment would be in the best interest of the customer, DMCO may authorize the enrollment change. If the DMCO determines that a change in enrollment would not be in the best interest of the customer or does not support the choice of the customer, the Division of Managed Care Operations (DMCO) may deny the enrollment change. The customer may file an appeal with AHCCCS.

Approval of both program contractors is required when:

Who initiated the enrollment change...	Reason for change...
Customer or customer's representative	• Customer has moved to a medical facility or alternative HCBS living arrangement in a county not served by the current program contractor. • Parent(s) and child customer live in different counties.
Program Contractor	• Program contractor is responsible for a customer residing outside of their service area and wishes to enroll customer with program contractor who serves the area. • Customer residing in an institution wishes to move to another institution outside of the area served by the customer's program contractor. • Customer initiates move to medical facility or alternative residential facility in another county and requests an enrollment change through the current program contractor.

Effective until 2025-04-25

1107 ALTCS Enrollment Change Within a Choice County

1107 ALTCS Enrollment Change Within a Choice County

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 09/21/2017

Each year effective on the customer's anniversary date, an ALTCS customer whose fiscal county is Maricopa County, Gila County, Pinal County, or Pima County has the opportunity to change enrollment to one of the other program contractors that serves their fiscal county.

Policy

1) Enrollment Changes Prior to the Anniversary Date

Generally, once enrollment occurs a customer cannot change enrollment until their anniversary date. However, an ALTCS customer whose county of fiscal responsibility is Maricopa County, Gila County, Pinal County, or Pima County may ask to change to a different program contractor serving that county. In certain circumstances, the customer's request may be approved to allow an enrollment change prior to the anniversary date.

The ALTCS local offices have the authority to approve the change request when any of the following conditions exist:

- Erroneous information or agency error;
- Lack of initial enrollment choice;
- Lack of annual enrollment choice;
- Family continuity of care;
- Continuity of institutional or residential setting; and
- Failure to correctly apply the 90-day re-enrollment policy.

An enrollment change may also be made based on medical continuity of care, but requires the involvement of both the current and receiving program contractors.

If an enrollment change is requested for another reason, the customer is referred to his or her current program contractor.

2) Who May Request an Enrollment Change?

The customer or the customer's representative may contact the ALTCS local office and request an enrollment change.

The current program contractor sends an Electronic Member Change Report to the ALTCS local office when the customer or representative requests an enrollment change through their current program contractor and claims one of the situations in MA1107C.

3) Effective Date

An enrollment change is effective the first day of the month following the month in which the change is made.

NOTE When the county of fiscal responsibility is changed, the county change and any related enrollment change is effective the day the change is made.

4) Denial of Enrollment Change Requests

The customer will receive a denial letter informing them of their hearing rights. The customer may file a grievance with AHCCCS if an enrollment change request is denied.

5) Evaluating the Request

Definitions

Term	Definition
Anniversary Date	The date that coverage first goes into effect becomes its anniversary date each year.
90 Day Re-enrollment Rule	If the customer was enrolled with an AHCCCS program contractor within the 90 days prior to the current approval date, the customer is automatically re-enrolled with the same program contractor.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2932 and 2933 AAC R9-28-413

B Annual Enrollment Choice

Revised 04/29/2025

Policy

Annual enrollment choice is a two-month process. An Annual Enrollment Notice is mailed to the customer or representative approximately two months prior to the customer's anniversary date.

The first month is the customer's choice month. During this month the customer has the option to change to a different program contractor. The customer is instructed to call the Communications Center or return the form to the Communications Center in Central Office by the end of the month to change to a different program contractor. The customer does not need to do anything to remain with the same program contractor. At the end of the month the program contractors are notified of the upcoming enrollment changes.

The second month is the program contractors' transition month. This period allows program contractors to arrange for the transition in case management and providers. The program contractors must be allowed a minimum of one full calendar month to arrange for the transition in case management and providers so there is no interruption in the customer's medical care and services.

1) Requests Received During the Transition Month

AHCCCS accepts an annual enrollment change request through the last day of the transition month. However, the enrollment change will be delayed by one month to provide the required transition period.

2)Requests Received Outside the Annual Enrollment Period

After the annual enrollment period ends, the Communications Center refers all enrollment change requests received on or after the customer's anniversary date to the ALTCS local office for resolution.

> NOTE Customers that are enrolled in an EPD Program Contractor plan need to have their enrollment aligned to their Dual Eligible Special Needs Plan (DSNP) with Medicare. When a customer wants to change their Program Contractor that is aligned with their DSNP, they first need to change their DSNP with Medicare.

Definitions

Term	Definition
Choice Month	The first month of annual enrollment choice is the customer's choice month. During this month the customer has the option to change to a different program contractor.
Transition Month	The second month of annual enrollment choice is the program contractors' transition month. This period allows program contractors to arrange for the transition in case management and providers.
Anniversary Month	The month that coverage first goes into effect becomes its anniversary month each year.
Dual Eligible Special Needs Plan (DSNP)	A type of Medicare Advantage (Part C) plan designed for persons who are eligible for both Medicare and Medicaid.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	42 CFR 422.107 ARS 36-2933 AAC R9-28-413

C Enrollment Changes Authorized by ALTCS Offices

Revised 09/21/2017

Policy

ALTCS local offices have authority to approve a request to change enrollment to another program contractor when:

- Incorrect information was provided to the customer or representative or the agency made an error when the customer was enrolled.
- Customer enrolled or was automatically enrolled with a program contractor that does not contract with that customer's medical providers or facility;
- Lack of initial enrollment choice for a customer living in either Maricopa or Pima Counties;
- Lack of annual enrollment choice because the customer did not receive notice of annual enrollment;
- Customer requests to be enrolled with the same program contractor as other family members;
- Continuity of institutional or residential setting when the customer's program contractor terminates their contract with the long term care medical institution or HCBS community facility; and
- Failure by AHCCCS staff to correctly apply the 90-Day re-enrollment policy.

1) Receipt of Enrollment Change Requests

An ALTCS office may receive an enrollment change request from:

- The customer or the customer's representative; or
- The current program contractor. The current program contractor contacts the ALTCS local office when the customer or representative requests an enrollment change through the current program contractor and claims one of the situations described in this Subsection.

2) Incorrect Information or Agency Error

This situation exists when the customer or representative made an enrollment choice based on incorrect information regarding facility, residential setting, primary care physician or other provider contracting with the chosen program contractor based on information provided at the program contractors website, marketing materials or agency error.

Incorrect information includes omissions or failure to divulge network limitations and restrictions in the program contractor's marketing material or database submissions.

3) Customer Enrolled with Program Contractor that Does Not Contract with the Customer's Provider

This situation exists when the customer enrolled or was automatically enrolled with a program contractor that does not contract with that customer's medical providers or facility but another program contractor does.

4) Lack of Initial Enrollment Choice

Lack of initial enrollment choice exists when an ALTCS applicant whose fiscal county was Maricopa County, Gila County, Pinal County, or Pima County was entitled to enrollment choice and was, for any reason, not given a choice of program contractors during the application process.

5) Lack of Annual Enrollment Choice

Lack of enrollment choice means the customer was entitled to participate in an Annual Enrollment Choice, but

- Was not sent an Annual Enrollment Choice notice; or
- Was sent an Annual Enrollment Choice notice but the notice was not received; or
- Was sent an Annual Enrollment Choice notice but was unable to participate in the annual enrollment choice due to circumstances beyond the customer's control (i.e., the customer or representative was hospitalized, the anniversary date fell within a 90-day disenroll/enroll period).

6) Family Continuity of Care

A family continuity of care issue exists when the customer, either through auto-assignment or the choice process is not enrolled with the same program contractor as other family members. Family members, especially married couples, may request, for continuity of care, to be enrolled with the same program contractor.

7) Continuity of Institutional or Residential Setting

An enrollment change may be approved when the customer's program contractor terminates their contract with the institutional or alternative residential setting in which the customer lives, and the customer or the customer's representative requests to change to a program contractor who does contract with the customer's institutional or alternative residential setting. The customer must be enrolled and living in the facility at the time of the contract termination.

If the provider (nursing facility or alternative residential setting) terminates the contract, instruction from the Program Support Administration is required before the Benefits and Eligibility Specialist makes any enrollment change.

8) Failure to Correctly Apply the 90-Day Re-Enrollment Policy

This situation exists when the customer:

- Lost ALTCS eligibility and was disenrolled;
- Was subsequently reapproved for ALTCS within 90-days of the disenrollment date; and
- Was enrolled with a different program contractor.

To correct this situation, the customer is re-enrolled with the program contractor he or she was enrolled with prior to the disenrollment.

9) Evaluating the Request

Definitions

Term	Definition
Family Continuity of Care	The customer requests to be enrolled with the same program contractor as other family members.
90 Day Re-enrollment Rule	If the customer was enrolled with an AHCCCS Complete Care (ACC) plan within the 90 days prior to the current approval date, the customer is automatically re-enrolled with the same health plan.
Annual Enrollment Choice	Annual enrollment choice is a two-month process that allows a customer to select a new AHCCCS Complete Care (ACC) plan: • Choice month; and • Transition month.
Choice Month	The first month of annual enrollment choice is the customer's choice month. During this month the customer has the option to change to a different program contractor.

Transition Month	The second month of annual enrollment choice is the program contractors' transition month. This period allows program contractors to arrange for the transition in case management and providers.
Anniversary Month	The month that coverage first goes into effect becomes its anniversary month each year.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2933 AAC R9-28-413

D Medical Continuity of Care

Policy

Special program contractor changes may be approved on a case-by-case basis to ensure the customer's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.

Approval requires consent of the Medical Directors of both program contractors or approval by the AHCCCS Chief Medical Officer.

The program contractors determine the effective date of the enrollment change.

Definitions

Term	Definition
Medical Continuity of Care	Special program contractor changes to ensure the customer's access to care. This is made on a case-by-case basis.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2932 and 2933 AAC R9-28-413

1108 Disenrollment

Revised 04/29/2025

Policy

Disenrollment due to loss of eligibility is effective with the end of the month prior to the effective date of discontinuance with the following exceptions:

- Death;
- Voluntary discontinuance;
- Discontinuance due to a hearing decision; and
- Incarceration.

1) Death

Disenrollment due to death is effective on the date of death.

2) Voluntary Discontinuance

Disenrollment based on a request for voluntary discontinuance by the customer or the customer's representative is effective on the last day of the month prior to the effective date of discontinuance.

Exception: If the customer or representative requests an immediate voluntary discontinuance, disenrollment is effective the day after the date the discontinuance is received by PMMIS.

3) Discontinuance Due to a Hearing

When benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld, disenrollment is effective the date the discontinuance (based on the hearing decision) is received by PMMIS.

4) Incarceration

When a customer is detained and incarcerated, the customer should not be disenrolled when all other eligibility requirements are met, enrollment is changed to a no pay status.

Definitions

Term	Definition

Voluntary Withdrawal	Disenrollment based on a request for voluntary discontinuance by the customer or the customer's representative.
Eligibility Hearing	The eligibility hearing is an administrative process. It is designed to ensure a fair and impartial review of an adverse action that is appealed.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
All Programs	AAC R9-22-1705(C) AAC R9-28-418 (ALTCS)

1109 Childrens Rehabilitative Services

1109 Children's Rehabilitative Services

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A Overview

Revised 10/01/2018

Policy

Children's Rehabilitative Services (CRS) is a designation that provides medical treatment, rehabilitation, and related support services for customers with special health care needs.

To get a CRS designation, the customer must meet the following requirements:

- Be under the age of 21 at the time of initial determination of the CRS designation
- Have a CRS-qualifying condition requiring active treatment; and
- Receiving full acute AHCCCS Medical Assistance or ALTCS/DDD services.

Definitions

Term	Definition
Active Treatment	There is a current need for medical, surgical, or therapeutic treatment of the CRS qualifying condition, or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition will be needed within 18 months of the date of the most recent CRS service.
CRS-qualifying condition	One of the physical conditions listed in the Arizona Administrative Code at R9-22-1303. These include conditions affecting the following: • Cardiovascular system; • Endocrine system; • Genitourinary system; • Ear, nose, or throat; • Musculoskeletal system;

	• Gastrointestinal system; • Nervous system; • Ophthalmology; • Respiratory system; • Dermatologic system; • Metabolic system; and • Hemoglobinopathies.

Legal Authority

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 9 AAC 22, Article 13

B CRS Application and Designation

Revised 11/26/2019

Policy

1) Children's Rehabilitative Services (CRS) Application and Designation

A CRS application must be filled out and submitted with medical records from the specialist who is treating the CRS condition. The medical records need to include information about the person's medical condition and the need for treatment within 18 months.

Anyone can complete a CRS application for the customer, including a family member, doctor, or health plan representative. The completed application along with the medical records can be mailed, faxed or dropped off in person to the CRS Unit.

A copy of the CRS application with instructions and contact information for the CRS Unit are available on the AHCCCS website at: https://azahcccs.gov/PlansProviders/CurrentProviders/CRSreferrals.html

2) Processing Timeframes

The CRS designation decision must be completed within 60 days of the date that a complete CRS application is submitted to the CRS Unit. The customer and the AHCCCS Complete Care (ACC) plan are sent a letter with the CRS decision. The CRS designation starts the date the decision is made.

An AHCCCS provider or health plan may ask for a rush on the CRS decision when the customer has an urgent need for treatment. The CRS Unit reviews these requests and works with the health plan to coordinate the process as needed.

3) Responsibility for covering CRS Services

Customers with a CRS designation get CRS services through their AHCCCS Complete Care plan. DDD customers get their CRS services through their DDD Health Plan.

If the customer opts out of their CRS designation, the customer will get the same services through their AHCCCS Complete Care (ACC) plan.

Definitions

Term	Definition
Department of Economic Security Division of Developmental Disability (DES/DDD)	The ALTCS program contractor for all developmentally disabled persons statewide. DDD is responsible for: • Providing a variety of services to persons who have specific disabilities; • Screening and referring developmentally disabled participants to AHCCCS for an ALTCS eligibility determination. NOTE DDD also administers a 100% state-funded program for persons with a developmental disability who are not eligible for ALTCS.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 9 AAC 22, Article 13

C CRS Designation Changes

Revised 11/26/2019

Policy

1) Removal of Designation

CRS designation ends when the customer:

- Is disenrolled from AHCCCS;
- Transitions to ALTCS/EPD and is enrolled with a program contractor;
- Asks to remove the CRS designation; or
- No longer meets the medical eligibility requirements for the CRS program.

NOTE If a medical condition is removed from the list of CRS qualifying conditions in R9-22-1303, it does not impact a customer's CRS designation for customers who are already in active treatment for that condition.

2) Re-designation

CRS customers under age 21 that lose AHCCCS eligibility but regain it within 12 months will get a CRS designation without a new application.

Customers may also get a CRS designation without a new application when they have opted out of CRS, but change their minds within 12 months.

The AHCCCS CRS Unit may use the information already in the system to determine if the customer is eligible for CRS , or may need updated documentation.

Legal Authority

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 9 AAC 22, Article 13

D CRS Designation Reviews

Revised 10/01/2018

Policy

Continued designation for CRS is reviewed when the customer is no longer in active treatment for a CRS qualifying condition. The health plan notifies AHCCCS that the CRS customer is no longer in active treatment.

The AHCCCS CRS Unit reviews the customer's continued need for services. If needed, additional medical documentation is requested from the health plan.

If the customer no longer needs treatment for a CRS qualifying condition, a letter is sent to the customer that the CRS designation is ending and the customer's right to appeal the decision. The health plan is also notified of the decision.

If it is determined that the customer is still eligible for a CRS designation, the health plan is notified of the decision.

Definitions

Term	Definition
CRS qualifying condition	One of the physical conditions listed in the Arizona Administrative Code at R9-22-1303. These include conditions affecting the following: • Cardiovascular system; • Endocrine system; • Genitourinary system; • Ear, nose, or throat; • Musculoskeletal system; • Gastrointestinal system; • Nervous system; • Vision;

	• Respiratory system; • Dermatologic system; • Metabolic system; and • Hemoglobinopathies.

Legal Authority

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 AAC R9-22, Article 13

Chapter 1200 Customer Costs

1200 Introduction

In this chapter you will find:

- The policies for premiums, co-payments, the Transplant Program share of cost and the ALTCS share of cost;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply.

1201 ALTCS Share of Cost (SOC)

1201 ALTCS Share of Cost (SOC)

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A Overview

Revised 03/28/2023

Policy

The Share of Cost (SOC) is a monthly amount a customer must pay toward the cost of long term care services. Customers who qualify for ALTCS or FTW – ALTCS may have a SOC. However, the maximum SOC is limited to the monthly capitation rate for the customer.

Customers who get ALTCS Acute Care only, and FTW – ALTCS customers who live in an HCBS setting do not have a SOC.

The SOC amount is based on the customer's:

- Counted income;
- Living arrangement; and
- Allowed SOC deductions.

The SOC is recalculated each time there is a change in the customer's income or amount of the SOC deductions.

The ALTCS program contractor is usually responsible for collecting the SOC from the customer. However, there are exceptions as described in the table below:

If the customer...	**Then...**
Is eligible, but not enrolled during a month	The program contractor is not responsible for collecting the customer's SOC for that month.
Changes program contractors during the month	Each program contractor is entitled to a portion of the monthly SOC based on the number of days the customer is enrolled with that program contractor. The program contractor with whom the customer is first enrolled during the month is responsible for collecting the SOC, figuring each program contractor's share, and transferring the prorated SOC amount to the receiving program contractor.

Definitions

Term	Definition
ALTCS Acute Care only	The customer qualifies for the ALTCS program but cannot receive long-term services.
Capitation rate	A fixed rate paid to the health plan or program contractor for the delivery of services to each customer enrolled with that health plan or program contractor, regardless of the amount of medical services the customer receives.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) 42 CFR 435.725 and 435.726 ARS 36-2932(L) AAC R9-28-408, 410, 411
FTW-ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) ARS 36-2950 AAC R9-28-1321

B Income Used to Calculate the SOC

Revised 12/27/2022

Policy

The income used for the Share of Cost (SOC) calculation is generally the same as the income used for income eligibility, but some income types are counted differently when calculating SOC.

The following table describes how to count these incomes for SOC:

If the customer...	Then…
• Receives SSI Cash; • Lives in a certified Long Term Care (LTC) medical facility; and • Has more than 50% of their cost-of-care paid for by ALTCS	When the customer has no additional income, the counted SSI Cash amount is $30.00. When the customer's additional income is equal to or more than $50.00, the counted SSI Cash amount is $0.00. When the customer's additional income is less than $50.00, the counted SSI Cash amount is the difference between $50.00 and the additional income. Countable SSI Cash cannot exceed $30.00.
• Is a veteran or the surviving spouse of a veteran; • Has no spouse or dependents; and • Is a resident of an Arizona State Veteran Home	Count all Veteran's Assistance (VA) benefit amounts including: • Aid and Attendance (A&A); and • Unusual Medical Expenses (UME). See MA606RRR for more information about VA benefits.
Has income assigned to a Special Treatment Trust	See MA803E.2 for instructions.
Is eligible for FTW - ALTCS	Gross earned and unearned income is counted.
Was determined eligible using Community Spouse policy	Only the customer's income is counted.

Definitions

Term	Definition
Gross income	Income amount before any deductions like taxes or insurance.

Legal Authority

Program	Legal Authorities
ALTCS FTW - ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) 42 CFR 435.725 and 726 ARS 36-2932(L) and 36-2934.01 AAC R9-28-408, 410, 411 AAC R9-28-1321 (FTW – ALTCS)

C Share of Cost (SOC) Deductions

Revised 02/04/2025

Policy

Certain deductions are subtracted from the customer's total counted income when determining the Share of Cost (SOC). The table below lists the deductions that apply.

When ALTCS eligibility was determined using…	Then the customer may qualify for…
Community spouse or non-community spouse rules (All customers)	• Personal Needs Allowance (PNA); • Medicare and other Third-Party Liability (TPL) health insurance premiums; and • Non-covered medical expenses.
Community spouse policy	• Community Spouse Monthly Income Allowance (CSMIA). The income of the institutionalized spouse must actually be given to the community spouse to allow this deduction; and • A family allowance, for each dependent family member. Proof of the family's income must be provided to allow this deduction.
Non-community spouse policy	• Any one of the following maintenance needs allowances: ◦ Spousal Needs Allowance; ◦ Family Needs Allowance; or ◦ Home Maintenance Needs Allowance; and • A special deduction for some residents of the Arizona State Veteran Home.

1) Personal Needs Allowance (PNA)

The amount of the Personal Needs Allowance (PNA) is determined on a month-by-month basis. The PNA amount depends on the customer's living arrangement during the calendar month. For more information about living arrangements, see MA521.

The amount of the PNA is calculated as follows:

If the customer...	Then the PNA for that month is...
Lives in a long-term care medical facility for the entire calendar month	• 15% of the Federal Benefit Rate (FBR) for ALTCS customers; or • 15% of the FBR plus 50% of the customer's gross earned income for the month for FTW – ALTCS customers
During any part of the calendar month, lives in: • His or her own home; • An HCBS setting; or • A jail, prison, or other detention facility	300% of the FBR.
Has garnished court-ordered child support or spousal support	Increased by the amount of the garnished court-ordered child support or spousal support including administrative fees. See Example PNA for Garnishment

The Table below lists the FBR Standards used to determine the PNA:

	Effective 01/01/2023 to 12/31/2023	Effective 01/01/2024 to 12/31/2024	Effective 01/01/2025 to 12/31/2025
15% of the FBR	$137.10	$141.45	$145.05
300% of the FBR	$2,742.00	$2,829.00	$2,901.00

2) Spousal Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, a customer with a spouse but no dependent children living at home gets a deduction for the maintenance needs of the spouse. The customer may be living either in a medical facility or in the community.

The spousal allowance is calculated by subtracting the spouse's counted income from the amount of the individual FBR.

3) Family Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, a customer with dependent children living at home gets a deduction for the maintenance needs of the family. The customer may be living either in a medical facility or in the community.

The customer's family includes any of the following living in the home:

- The customer's spouse; and
- The customer's dependent children, including stepchildren.

The Family Allowance is determined by subtracting the combined counted income of the spouse and children from the AFDC A-1 Need Standard shown in the table below for the number of family members (not counting the customer).

Number of people	Need Standard
1	$567
2	$765
3	$964
4	$1,162
5	$1,360
6	$1,559

7	$1,757
8	$1,955
9	$2,153
10	$2,351
11	$2,549
12	$2,747
13	$2,945

NOTE For families larger than 13, add $198 to the Need Standard for each additional person.

See Family Allowance (Non-CS) SOC Examples

4) Home Maintenance Needs Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, the customer may qualify for a Home Maintenance Needs Allowance for up to six months when the customer:

- Lives in a medical institution for the entire calendar month;
- Does not have a spouse or child living at home;
- Is responsible for paying shelter expenses to maintain his or her home; and
- Is likely to return to the home within six months of the date the customer entered the medical institution.

The Home Maintenance Needs Allowance is based on a federal standard and changes infrequently:

Effective 01/01/1989 to 06/30/1993	**Effective 07/01/1993 to Present**

$138.00	$210.00

The Home Maintenance Needs Allowance is deducted beginning the first month following the month the customer entered the medical institution.

In the case of institutionalized couples, only one Home Maintenance Needs Allowance is allowed. If both spouses are expected to return home within the six-month period, the Home Maintenance Needs Allowance is deducted from the SOC of the spouse for whom it would be most beneficial.

The home maintenance allowance can be applied to separate periods of institutionalization for the same customer. However, a temporary absence from an institution is not a basis for beginning a new six-month period for the deduction. The customer must be discharged from the institution before another six-month period is allowed.

See Home Maintenance Needs Allowance SOC Examples

5) Community Spouse Monthly Income Allowance (CSMIA)

When eligibility is determined using community spouse policy, a customer may qualify for a Community Spouse Monthly Income Allowance (CSMIA) deduction when the customer actually gives the monthly CSMIA amount to the community spouse.

If a court has ordered the customer to pay monthly financial support for the community spouse, the CSMIA is the higher of:

- The amount of the monthly support ordered by the court; or
- The calculated CSMIA.

NOTE An Administrative Law Judge may increase the amount of the MMMNA when the customer or spouse appeals the amount and there is proof that the community spouse has a greater need due to circumstances resulting in significant financial hardship.

Steps used to calculate the CSMIA

The following steps are used to calculate the CSMIA. Detailed information about the amounts used in the steps is included below the table:

Step	Action
1	Add the Utility Allowance to the Community Spouse’s verified shelter costs.

2	Take the total from Step 1 and subtract 30% of the Monthly Spousal Need Standard. Any remaining amount is the Excess Shelter Allowance.
3	Add the Excess Shelter Allowance and the Monthly Spousal Need Standard. The result is the Minimum Monthly Maintenance Needs Allowance (MMMNA).
4	Compare the MMMNA from Step 3 to the Maximum Monthly Maintenance Needs Standard.
5	Take the lower of the amounts from Step 4 and subtract the counted monthly income of the community spouse. The result is the CSMIA.

Standards used to calculate the CSMIA

The following standards are used in calculating the Community Spouse Monthly Income Allowance (CSMIA) for a community spouse. These are federal standards that change annually:

	Effective 07/01/2021 to 06/30/2022	**Effective 07/01/2022 to 06/30/2023**	**Effective 07/01/2023 to 06/30/2024**	**Effective 07/01/2024 to 06/30/2025**
Monthly Spousal Need Standard	$2,178.00	$2,289.00	$2,465.00	$2,555.00
30% of the Monthly Spousal Need Standard	$654.00	$687.00	$740.00	$767.00

	Effective 01/01/2022 to 12/31/2022	**Effective 01/01/2023 to 12/31/2023**	**Effective 01/01/2024 to 12/31/2024**	**Effective 01/01/2025 to 12/31/2025**

Maximum Monthly Spousal Need Standard	$3,435.00	$3,715.50	$3,853.50	$3,948.00

Standard Utility Allowance (SUA)

Effective 10/01/2021	Effective 10/01/2022	Effective 10/01/2023	Effective 10/01/2024
$288.00	$325.00	$318.00	$314.00

Utility Allowance

When calculating the CSMIA, the customer qualifies for a Utility Allowance when:

- The customer or community spouse pays for heating or cooling the home where the community spouse resides; and
- The costs are billed separately from their rent or mortgage on a regular basis.

The household does not need to be billed by a utility company to get this allowance. If the utility bill is in another person's name but the customer or spouse pays the bill, the customer gets the Utility Allowance.

The customer can get the Utility Allowance even when the household has heating or cooling costs for only part of the year. This includes those who have heating but not cooling costs, or cooling costs but not heating costs.

A Utility Allowance is allowed when household receives Low Income Home Energy Assistance (LIHEA) payments directly or through a vendor.

When the household qualifies for a Utility Allowance, the amount allowed is either:

- The Standard Utility Allowance (SUA); or
- A portion of the SUA.

When the household shares utility expenses with another household, or does not have a separate utility meter:

- The SUA is divided equally by the number of households which share the expense, if each pays an equal share; or
- The SUA is prorated among the households based on the portion paid by each.

When the household pays a required condominium or cooperative maintenance charge that includes a utility expense, that utility expense amount is subtracted from the SUA to get the Utility Allowance.

The following expenses do not qualify the household for the Utility Allowance:

- Costs of operating fans for cooling, portable space heaters, electric blankets, and heat lamps;
- Costs for cooking stoves, unless the stove is the primary heating source;
- The costs of cutting wood for heating;
- Costs for water for evaporative coolers; and
- Costs only for excess heating or cooling expenses. For example, when a customer’s utilities are included in the rent up to a certain usage level or dollar amount, the excess amount does not qualify.

When both spouses live in the community, each spouse gets the full Utility Allowance calculated.

Excess Shelter Allowance

A customer may get an Excess Shelter Allowance only for verified shelter expenses.

Shelter expenses that are paid annually, semi-annually, or quarterly, such as taxes, and homeowner's insurance, are divided by the number of months they cover to determine a monthly amount.

When both spouses are receiving or intending to receive HCBS, share the same residence, and are eligible for ALTCS benefits, each is entitled to half of the verified shelter expenses for the Excess Shelter Allowance.

See Community Spouse SOC Examples

6) Community Spouse Family Allowance

When eligibility is determined using community spouse policy, a customer may qualify for a Community Spouse Family Allowance when the customer has a dependent family member living at home with the community spouse.

A family member must meet all of the following to be considered a dependent:

- Income low enough to be claimed as a tax dependent;
- At least 50% of the cost of the family member's support was paid by the customer and the community spouse; and
- Citizenship or residency requirements.

When both spouses are eligible for ALTCS benefits and living in the community, each spouse gets one-half of the Family Allowance.

Income low enough to be claimed as a tax dependent

The family member must not receive enough income during the year to have to file a tax return. For current information about who must file a tax return, go to the IRS webpage listed below and select Publication (Publ.) 501.

http://apps.irs.gov/app/picklist/list/formsPublications.html

Exception:

A child whose income is high enough to have to pay taxes can still be considered a dependent when he or she meets any of the following criteria:

- Was under 19 years of age at the end of the calendar year; or
- Was under 24 years of age at the end of the calendar year and was enrolled as a full-time student at a school during any 5 months of the calendar year.

NOTE The school must have a regular teaching staff, course of study, and enrolled body of students in attendance. On-the-job training courses or correspondence schools do not qualify.

A married family member who is required to file a tax return and files a joint return cannot be a dependent. When the married family member is not required to file and only filed to get a refund, the person can be a dependent.

Support Requirement

To be considered a dependent, the institutionalized or community spouse must have paid over half of the family member's support in the calendar year, including such items as:

- Basic needs like food, clothing and housing;
- Medical and dental care;
- Recreation; and
- Education.

In general, when both parents together paid more than half of the child's support, the child is considered the dependent of the custodial parent if the parents are divorced or separated.

The child is only the dependent of a non-custodial parent when:

- The custodial parent signs IRS Form 8332, or similar written statement, agreeing not to claim the child as a dependent, or
- A divorce decree or other court order states that the non-custodial parent can take an income tax exemption for the child, and the non-custodial parent provided at least $600 for the child's support in the calendar year.

Citizenship or Residency Requirements

To be considered a dependent, the family member must meet one of the following:

- A citizen or national of the U.S.;
- A noncitizen who is a resident of the U.S., Canada, or Mexico; or
- A noncitizen child adopted by and living the entire calendar year with a U.S. citizen parent in a foreign country.

Calculation

The Family Allowance is calculated for each dependent as follows:

Step	Action
1	Start with the Monthly Spousal Need Standard and subtract the dependent's counted monthly income.
2	Divide the remainder from Step 1 by three. The result is the Community Spouse Family Needs Allowance for that family member.

See Community Spouse SOC Examples

7) Health Insurance Premiums

A SOC deduction is allowed for health insurance premiums the customer pays for his or her own coverage. A deduction is not allowed for premiums paid by anyone else or for any part of the premium that covers anyone else. When the premium covers people in addition to the customer, only the customer's share of the premium is allowed as a SOC deduction. Health insurance includes any of the following:

- Medicare;
- Group health insurance;
- Dental insurance;
- Hearing aid insurance;
- Vision care insurance;
- Foot (care services) insurance; and
- Prescription drug plans.

Exception:

Premiums for insurance policies that pay a flat rate benefit or a set amount to the person regardless of the actual charges or expenses are not allowed as SOC deductions.

Prorating Health Insurance Premiums

When the premium is billed less often than monthly (for example, quarterly or annually), the customer can choose to have the health insurance premium payment either:

- Deducted from the SOC for the month in which the payment is due; or
- Divided by the number of months it is meant to cover to get a monthly SOC deduction.

See Example Prorating Health Insurance Premiums

Pension Supplements for Health Insurance Premiums

When the customer's pension benefit includes an amount to pay for all or part of the cost of health insurance premiums, a SOC deduction is only allowed for the amount of the health insurance premium that exceeds the amount reimbursed. When the customer also pays health insurance premiums for a spouse, the customer's share of the insurance premium is compared to the total reimbursement received. A SOC deduction is allowed only for the amount of the customer's share of the insurance premium that exceeds the total reimbursement.

See Example Pension Supplement for Health Insurance Premiums

Extra Help for Medicare Part D Coverage

When a customer's Medicare Part D premium is all or partly paid by the Extra Help program, a SOC deduction is only allowed for the amount of the Medicare Part D premium the customer actually pays.

See Example Extra Help for Medicare Part D Coverage

8) Non-Covered Medical Expenses

A SOC deduction is allowed for medical expenses that are not covered by the program contractor or any other health insurance.

NOTE When the customer is not eligible for the ALTCS full benefit package due to a transfer penalty period, non-covered medical expenses during that period will not be allowed as a SOC deduction.

To qualify for the SOC deduction, the expense must:

- Be medically necessary;
- Be ordered by a licensed healthcare professional (i.e., doctor, dentist, or other provider);
- Not be covered by a third-party (including percentages of unpaid expenses);
- Be the customer's responsibility to pay;
- Be either:
  - A type of care not normally covered by AHCCCS benefits, or
  - A type of care normally covered by AHCCCS, but that AHCCCS cannot pay because the customer was not eligible during the time of service; and
- Has been provided within a specific time period, as described in the table below.

When the customer has non-covered medical expenses and the…	Then…
Application is pending	The deduction for unpaid expenses applies to services received up to 3 months prior to the month the application is submitted.

	See Example Expenses Incurred While an Application is Pending
ALTCS eligibility is ongoing	• Proof of current payments must be received by the last day of the month after the payment is made. • There is no time limit on reporting unpaid non-covered medical expenses.

Paid Expenses

The amount of the deduction is the actual amount paid for the non-covered medical expense.

When the actual amount paid is more than the SOC for that month, the SOC is zero. Any remaining amount is not deducted in a future month.

See Example Current Payments for Services

Unpaid Expenses

The unpaid balance is the total charge for the medical expense minus the amount covered by a third-party payor minus any payments made.

When an unpaid balance is more than the SOC for the month, the remaining unpaid balance is deducted in the next month. The deduction continues until the full balance is applied.

NOTE A non-covered medical expense paid by a friend, relative, or other party is treated as the customer's unpaid expense when the customer has an agreement to repay that person.

See Example Unpaid Expenses

The allowable amount of the deduction is determined as follows:

When the non-covered medical expense is...	**The amount of the deduction is...**
A type of service that is covered under the AHCCCS Medical Benefits Package	Limited to the amount Medicaid would normally pay.
A type of medical expense that is not covered under the AHCCCS Medical Benefits Package.	The fair market value for the medical expense.

A long-term care service not covered due to a transfer penalty period.	Zero.
The customer's responsibility such as: • Co-payments; • Co-insurance; and • Deductibles	The amount the customer is responsible to pay.

See Example Calculating the SOC Deduction for Non-Covered Medical Expenses

9) Special Deduction for Some Residents of an Arizona State Veteran Home

A customer who is a resident of an Arizona State Veteran Home gets a special SOC deduction when:

- The customer is a veteran or the surviving spouse of a veteran; and
- The customer has no spouse or dependent children.

Up to $90.00 of the VA pension benefits, including increases for aid and attendance and unusual medical expenses, is allowed as a deduction from the SOC.

The deduction may not exceed the total VA payment. When the customer receives less than $90.00 in VA benefits, the deduction is equal to the VA payment.

Definitions

Term	Definition
Arizona State Veteran Homes (ASVHs)	Medicare certified skilled nursing facilities owned and operated by the State of Arizona. ASVHs serve the long-term care and rehabilitative needs of the veterans of Arizona.

Heating and cooling costs	Heating costs include expenses of electricity, gas, wood, and other heating fuels. Cooling costs include costs for room air conditioners, central air conditioning or evaporative coolers.
Child	Natural, adopted or stepchild of the customer or the community spouse.
Medically necessary	A covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.
Non-covered medical services	Non-covered medical services are medically necessary medical or remedial services that are not covered by the ALTCS program contractor.
Shelter expenses	Shelter costs include rent, mortgage, real property taxes, homeowner's association fees, and homeowner's insurance.
Third-party liability (TPL)	Responsibility of a person, entity, or program to pay for any of a person's medical costs. Third-party liability includes: • Health and dental insurance; • Payments from insurance; • Payments from lawsuits; • Other medical settlements, claims, or benefits; and • Medical support for a child from an absent parent.

Proof

The proof needed varies depending on the SOC deduction as described below:

1) Proof for the Home Maintenance Needs Allowance

Proof of Shelter Expenses

The customer must provide proof that he or she has shelter expenses that need to be paid to maintain the home. Items that may be used as proof include:

- Mortgage statements;
- Tax statements or bills;
- Utility bills;
- Homeowner's insurance or association fee bills; and
- Telephone call to any of the above companies confirming the customer's responsibility for and the amount of the expense.

Likely to Return Home

Proof is limited to a written statement from a physician that states the customer is likely to return to the home within six months from the date the customer entered the institution. The physician's statement must be provided before the date the customer is expected to return home and must show the potential discharge date.

2) Proof for the CSMIA

Excess Shelter Allowance

Items that may be used as proof include:

- Mortgage statements;
- Tax statements or bills;
- Utility bills;
- Homeowner's insurance or association fee bills; and
- Telephone call to any of the above companies confirming the customer's responsibility for and the amount of the expense.

3) Proof of Health Insurance Premiums

Proof of the amount of the premium and who is responsible to pay the premium must be provided before the premium amount can be deducted from the SOC. When proof of a future premium amount is received, the premium amount is deducted from the future SOC.

NOTE If someone other than the customer is paying the premium, it is not necessary to prove the amount of the premium since it is not an allowable deduction from the SOC.

4) Proof of Non-Covered Medical Expenses

To allow a SOC deduction for a non-covered medical expense, the following must be verified:

- The expense is medically necessary;
- The services were provided by a licensed health care professional;
- The expense is not covered by the customer's insurance or a third-party liability;
- The expense will not be covered by the AHCCCS Medical Benefits package;
- The customer is responsible for payment; and
- The amount and date the expense was incurred or paid.

Proof that Services Were Medically Necessary

Proof that the service was medically necessary includes:

- A written statement by a licensed health care professional; or
- Billing statements for preventive services

5) Proof of Garnished Court-Ordered Child Support or Spousal Support

To allow an increase in the Personal Needs Allowance (PNA) for garnished court-ordered child support or spousal support, the following proof must be provided:

- Court documents; and
- Proof the income is garnished. Proof includes:
    - Letter from payor;
    - Pay stubs; or
    - Collateral contact with the source of the payment.

Legal Authority

Program	Legal Authority

ALTCS	42 USC 1396a(q) 42 USC 1396r-5(d) 42 CFR 435.725 and 726 ARS 36-2932(L) AAC R9-28-408 and 410

D ALTCS Cost Effectiveness Study Share of Cost (CES SOC)

Revised 03/30/2018

Policy

Program contractors cannot by law pay more for a person's HCBS than they would pay for that same person in a nursing facility, except for a very short amount of time.

The Cost Effectiveness Study Share of Cost (CES SOC) gives the program contractor a figure to use in determining if providing HCBS to a customer is cost effective.

The program contractor may advise the person to consider other alternatives or options if the cost of the HCBS needed is more than the program contractor would be allowed to pay if the customer were in a nursing facility.

1202 Co Payments

1202 Co-Payments

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A Mandatory and Optional Co-Payment Groups

Revised 03/03/2014

Policy

Customers who receive AHCCCS Medical Assistance under the following programs are responsible for either optional or mandatory co-payments, unless they meet any one of the exemption criteria in MA1205:

Optional	Mandatory
• SSI Cash • SSI MAO • Caretaker relative • Child • FTW • YATI	• Transitional Medical Assistance (TMA)

1) Exemptions

A customer who meets any of the following is exempt from co-payments:

- Under age 19;
- Children eligible to receive services from the Children's Rehabilitative Services (CRS) program;
- Diagnosed as Seriously Mentally Ill (SMI) by the Arizona Department of Health Services (ADHS);
- Receiving acute care benefits and temporarily living in a nursing home or residential facility, but only when the customer's medical condition would otherwise require hospitalization. This exemption is limited to 90 days in a contract year;
- Receiving hospice care;
- Enrolled with American Indian Health Program (AIHP);

- Eligible for AHCCCS Medical Assistance on a fee-for-service (FFS) basis; or
- Pregnant.

2) Exempt Coverage Groups

Customers who qualify for AHCCCS Medical Assistance under any of the following coverage groups are exempt from co-payment requirements:

- ALTCS, including Freedom to Work-ALTCS;
- Medicare Savings Programs (QMB, SLMB or QI-1);
- KidsCare.
- Adult Group (temporarily)
- Breast & Cervical Cancer Treatment Program

3) Co-Payment Amounts for the Optional Group

Co-payments apply only to specific services and to people who are not exempt.

Co-payments for the optional group described in MA1205 are as follows:

Service	Amount
Prescriptions	$2.30
Doctor or other Provider outpatient office visits for evaluation and management of care (Well Person) or non-emergency surgical procedures	$3.40
Physical, Occupational or Speech Therapies	$2.30

NOTE Providers are required to provide these services even if the member is unable to afford the co-payment.

4) Co-Payment Amounts for TMA Customers

Co-payments for TMA customers who are not exempt (MA1205 and MA1205) are as follows:

Service	Amount
Prescriptions	$2.30
Doctor or other Provider outpatient office visits for evaluation and management of care (Well Person)	$4.00
Physical, Occupational or Speech Therapies	$3.00
Non-emergency surgical procedures in an outpatient setting.	$3.00

NOTE These co-payments are mandatory and the pharmacist or medical service provider can deny a TMA customer services if the customer does not make the co-pays.

A family receiving TMA will not be required to make the co-pays if the total amount of the co-pays the family made is more than 5% of the family's gross income (before taxes and deductions) during a calendar quarter.

AHCCCS will inform customers when family co-pays exceed 5%. However, if a customer thinks that he or she has paid co-pays that equal 5% of the customer's family total quarterly income and AHCCCS has not told the customer that this has happened, the customer should send copies of receipts or other proof of how much the customer has paid to AHCCCS, 801 East Jefferson, Mail Drop 3600, Phoenix, Arizona 85034.

Definitions

Term	Definition
Co-Payment	A co-payment is the amount that the customer pays to a medical provider when a medical service is received. Customers who are eligible in some AHCCCS coverage groups have

	optional co-payments, while others have mandatory co-payments.
Optional co-payments	When a customer has optional co-payments, the provider must provide the service even when the customer does not pay the co-payment.
Mandatory co-payments	When a customer has mandatory co-payments, the provider may refuse to provide the service when the customer does not pay the co-payment.

Legal Authority

Program	Legal Authorities
All Programs	42 USC 1302 42 CFR 435.Part 447 ARS 36-2903.01(D)(4) AAC R9-22-711

1203 AHCCCS Freedom to Work (FTW) Premiums

1203 AHCCCS Freedom to Work (FTW) Premiums

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A General Information About FTW Premiums

Revised 07/12/2022

Policy

A FTW premium is calculated for all customers who qualify for:

- AHCCCS Medical Services under an AHCCCS FTW coverage group; or
- FTW-ALTCS services and do not have a Share of Cost (SOC).

The FTW premium amount is based on the customer's net countable monthly earned income:

From	To	Premium
$0.00	$500.00	$0
$500.01	$750.00	$10
$750.01	$1,000.00	$15
$1,000.01	$1,250.00	$20
$1,250.01	$1,500.00	$25
$1,500.01	$1,750.00	$30
$1,750.01	The FTW income limit (250% FPL)	$35

Exception:

American Indian and Alaska Native customers, as well as the children and grandchildren of tribal members, are not charged a premium when they prove their tribal enrollment (or that of their parent/grandparent).

1) Proof of Tribal Enrollment

American Indians and Alaska Natives who qualify for FTW must provide proof of tribal enrollment to be exempt from monthly premium charges. Proof of enrollment or tribal membership includes:

- Certificate of Degree of Indian Blood;
- Tribal ID;
- Tribal Census Record; and
- Other document provided by the tribe stating that the person is an enrolled member of the tribe.

Children and grandchildren of tribal members must submit documentation that proves they are descendants of a tribal member. Proof includes:

- An official letter on tribal letterhead from the tribe stating that the applicant is a child or grandchild of a tribal member; or
- A document verifying the tribal member's enrollment in the tribe and a document verifying that the applicant is a child or grandchild of the tribal member.

When a person claiming to be a American Indian, Alaska Native, or the child/grandchild of a tribal member does not provide proof of tribal enrollment, the premium exemption does not apply and a premium may be charged.

NOTE Do not deny eligibility because there is no proof of tribal enrollment.

When a person is approved with a premium and later provides proof of tribal enrollment, the person is exempt from paying the premium beginning the month after the proof is provided.

2) When Do Premiums Begin?

Premiums begin with the month following the month in which the approval is dispositioned.

Premium Examples

3) Informing Customers of the Premium Amount

An approval notice or change notice is used to:

- Show the customer how countable earned income was calculated;
- Inform the customer of the premium amount;
- Inform the customer of his or her right to appeal the amount of the premium; and

- Advise the customer to report changes in income or work expenses that could cause a change in the premium amount.

Definitions

Term	Definition
Freedom to Work (FTW) Program	The FTW program is for people with disabilities who are working. There are two FTW coverage groups: • The Basic Coverage Group; and • The Medically Improved Group.
Freedom to Work (FTW) Premium	An AHCCCS FTW premium is calculated for all customers who qualify for: • AHCCCS Medical Services under an AHCCCS FTW coverage group; or • AHCCCS FTW – ALTCS HCBS services.

Legal Authority

Program	Legal Authorities
AHCCCS FTW FTW-ALTCS HCBS	42 USC 1396a(a)(10)(A)(ii)(XV) and 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 and ARS 36-2950 AAC R9-22-1909

B Premium Billing and Payment

Revised 11/06/2020

Policy

The AHCCCS Division of Business and Finance (DBF) sends a bill for the premium to the customer on the first day of each month. If the first day of the month is a weekend or holiday, the bills are mailed on the first workday of the month.

The billing statement notifies the customer of:

- The current amount due; and
- Past due amounts.

1) When Are Premium Payments Due?

Premiums are prospective. This means:

- The premium is due on the 15th of the month following the month the person is approved for AHCCCS FTW.
- The premium for each following month is due by the 15th of that month.

If a payment is not received by the 15th of the month, it is considered late.

2) How Can Payments be Made?

The customer or anyone else may pay the premium by:

- Cashier's check or personal check;
- Money order; or
- Credit or debit card.

Payments can be made online using AHCCCS' Online Premium Payment service or can be mailed to the following address:

STATE OF ARIZONA AHCCCS

File 749228

Los Angeles, CA 90074-9228

Important! When mailing a payment, it may take five to seven days to be processed and credited.

Payments may be made in advance. For example, the customer may pay quarterly, bi-annually or annually.

3) Premium Payment During an Appeal Process

When an AHCCCS FTW customer with a premium wants to have AHCCCS Medical Assistance continued during the appeal process, the customer must:

- Request a hearing prior to the effective date of discontinuance; and
- Pay the premium for the first month of the appeal period in advance.

Premium Payment During an Appeal Process Example

4) Appeal of the Premium Amount

If the customer appeals the amount of the premium for an FTW approval, the customer must pay the assessed premium throughout the hearing process.

If a customer appeals an increase in the AHCCCS FTW premium and the appeal request is received prior to the effective date of the premium increase, the premium amount is decreased to the lower amount until a hearing decision is made.

5) When Are Changes in the Premium Amount Effective?

A decrease in a customer's premium is effective the month after proof of the income or Impairment Related Work Expenses (IRWE) change is provided.

An increase in a customer's premium is effective the first month after a 10-day advance notice is sent to the customer. When there are less than 10 days before the first day of the next month, the premium is increased the first day of the month after that.

Definitions

Term	Definition

Impairment Related Work Expenses (IRWE)	The cost of services and items that a person needs in order to work because of a physical or mental impairment.

Legal Authority

Program	Legal Authorities
AHCCCS FTW FTW-ALTCS HCBS	42 USC 1396a(a)(10)(A)(ii)(XV) and 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 and ARS 36-2950 AAC R9-22-1909

C Non-Payment of Premiums

Revised 08/03/2018

Policy

When payments fall more than one month behind, AHCCCS FTW eligibility is stopped the first day of the following month.

Unpaid AHCCCS FTW premiums do not affect the customer's eligibility for any other AHCCCS Medical Assistance programs.

When the customer pays the entire outstanding balance before the date the AHCCCS FTW ends, eligibility is continued.

When the customer does not pay the entire outstanding balance before the date the AHCCCS FTW ends, the customer cannot qualify for AHCCCS FTW again until the full amount is paid, even when the premium amount under a later application is zero.

Legal Authority

Program	Legal Authorities
AHCCCS FTW FTW-ALTCS	42 USC 1396a(a)(10)(A)(ii)(XV) and 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 and ARS 36-2950 AAC R9-22-1909

1204 KidsCare Premiums

1204 KidsCare Premiums

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information About KidsCare Premiums

Revised 01/30/2025

Policy

Children enrolled in KidsCare are charged a monthly premium based on the Income Group's total income and the number of children enrolled in KidsCare.

NOTE American Indians and Alaska Natives, as well as the children and grandchildren of tribal members, are not charged a premium when they prove their tribal enrollment (or that of their parent/grandparent).

1) Proof of Tribal Enrollment

American Indians and Alaska Natives who qualify for KidsCare must provide proof of tribal enrollment to be exempt from monthly premium charges. Proof of enrollment or tribal membership includes:

Certificate of Degree of Indian Blood;

- Tribal ID;
- Tribal Census Record; and
- Other document provided by the tribe stating that the person is an enrolled member of the tribe.

Children and grandchildren of tribal members must submit documentation that proves they are descendants of a tribal member. Proof includes:

- An official letter on tribal letterhead from the tribe stating that the applicant is a child or grandchild of a tribal member; or
- A document verifying the tribal member's enrollment in the tribe, and a document verifying that the applicant is a child or grandchild of the tribal member.

When a person claiming to be an American Indian, Alaska Native, or the child/grandchild of a tribal member does not provide proof of tribal enrollment, the premium exemption does not apply, and a premium may be charged.

NOTE Eligibility is not denied because there is no proof of tribal enrollment.

When a person is approved with a premium and later provides proof of tribal enrollment, the person is exempt from paying the premium beginning the month after the proof is provided.

2) KidsCare Premiums

Listed below are the monthly premium amounts for children:

Household Size	Income Less Than or Equal to 150% FPL	Income Greater Than 150% But Less Than or Equal to 175%	Income Greater Than 175% But Less Than or Equal to 225%
1	$0.00 - $1,957.00	$1,957.01- $2,283.00	$2,283.01- $2,935.00
2	$0.00 - $2,644.00	$2,644.01- $3,085.00	$3,085.01- $3,966.00
3	$0.00 - $3,332.00	$3,332.01- $3,887.00	$3,887.01- $4,997.00
4	$0.00 - $4,019.00	$4,019.01- $4,689.00	$4,689.01- $6,029.00
5	$0.00 - $4,707.00	$4,707.01- $5,491.00	$5,491.01- $7,060.00
6	$0.00 - $5,394.00	$5,394.01- $6,293.00	$6,293.01- $8,091.00
7	$0.00 - $6,082.00	$6,082.01- $7,095.00	$7,095.01- $9,122.00
8	$0.00 - $6,769.00	$6,769.01- $7,897.00	$7,897.01- $10,154.00
9	$0.00 - $7,457.00	$7,457.01- $8,699.00	$8,699.01- $11,185.00
10	$0.00 - $8,144.00	$8,144.01- $9,502.00	$9,602.01- $12,216.00
Each Additional Customer*	Add $688.00	Add $803.00	Add $1,032.00
Premium Amount for Children	One Child $10.00/More Than One Child $15.00	One Child $40.00/ More Than One Child $60.00	One Child $50.00/ More Than One Child $70.00

*“Each additional” is an approximate amount only.

3) Premium for Cases with Multiple Income Groups

A case may consist of multiple income groups. The monthly premium amount for a child is based on the income group with the highest income level and the number of eligible children in income groups. This means that instead of having a separate premium for each income group, the case will only be charged one premium that covers everyone in that case.

See Example - Premium for Cases with Multiple Income Groups

Definitions

Term	Definition
KidsCare	KidsCare is for uninsured children under age 19 who are not eligible for Medicaid.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4)\ and 36-2982 AAC R9-31-303

B Premium Billing and Payment

Revised 08/20/2024

Policy

The AHCCCS Division of Business and Finance (DBF) receives premium information and mails a bill for the premium to the customer on the 1st day of each month. When the 1st day of the month is a weekend or holiday, the bills are mailed on the first working day.

The monthly billing statement notifies the customer of:

- The children enrolled in KidsCare;
- The date covered;
- The total amount due; and
- Premium due date.

1) When Are Premium Payments Due?

Premiums are due by the 15th of the month for the current month's eligibility.

When the balance is not paid before the first of the following month, the next premium billing statement includes the:

- Current month's premium(s);
- Past due amount; and

Information about the premium hardship waiver (MA1204D) if there is a past due amount for the child's premium.

2) How Can Payments be Made?

The customer or anyone else may pay the premium by:

- Cashier's check;
- Personal check;
- Money order; or
- Credit or debit card.

NOTE The AHCCCS website (azahcccs.gov) allows customers to pay their premiums on-line using either a debit card, credit card, or a bank account.

Premiums may be made in advance. For example, the customer may pay quarterly, bi-annually or annually.

3) Premium Changes

A change in income, number of members in the household, or the number of children who are KidsCare eligible may affect the premium amount.

When there is a decrease in premium and the change is verified by the 25th day of the month, the change is effective the month following the month the change is verified. When there is a decrease in premium and the change is verified on or after the 26th day of the month, the change is effective the second month following the month the change is verified. However, when the premium amount increases, a letter must be issued to inform the household of the increase at least 10 days before the first day of the following month. When the letter is issued less than 10 days before the first of the following month, the increase does not take effect until the first day of the month after that.

Definitions

Term	Definition
Division of Business and Finance (DBF)	DBF is responsible for the billing, collection, and tracking of premium payments

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E, 457.570, and 457.805 ARS 36-2903.01(D)(4) and 36-2982 AAC R9-31-303

	AAC R9-31-1417

D Premium Hardship Waiver for KidsCare

Revised 11/06/2020

Policy

A person may request to waive a child's premium for the prior or current month due to a hardship in the month. When the premium is waived for the current month, the premium for the prior month is also waived even when there are no expenses in that month.

The main contact must have paid or be required to pay the expense during the month the premium is waived. When the premium is waived and the customer does not pay the expense, the premium cannot be waived again using the same expense. When a person has ongoing expenses, the premium may be waived for future months as well. When the premium is waived for future months, it must be reevaluated at renewal.

A hardship exists when a member of the budget group died or the budget group has one or more of the following expenses which exceed 10% of the countable gross income of the budget group:

- Medically necessary expenses for any member of the budget group that insurance did not pay for. Medically necessary means a covered service provided by a physician or other licensed practitioner to prevent disease, disability, or other adverse health conditions or their progression or prolong life;
- Health insurance premiums for any member of the budget group;
- Unexpected expenses for repairs to the home. Repairs include items such as fixing a leaky roof, replacing a non-working air conditioner, repairing plumbing, etc. Repairs do not include remodeling or redecorating; or
- Expenses for repairs to a budget group member's transportation so the individual can get to work. This does not include routine maintenance such as tune-ups, oil changes, etc.

1) Proof

The Main Contact's statement on the written request as proof of income and death of a budget group member is accepted.

The Main Contact must provide proof of the expense(s). Proof of the expense(s) includes a copy of the bill or receipt that shows the type, date, and amount of the expense. An estimate is not considered proof.

2) Re-Evaluate Waiver at Renewal

When the premium is currently waived on an ongoing basis, the hardship waiver will be reviewed again at time of renewal even when benefits are being discontinued. When the children remain eligible for the hardship waiver and appeal the discontinuance, the premium is waived during the appeal process.

Definitions

Term	Definition
Hardship Waiver	A request to waive the KidsCare premium for customers with a financial hardship.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4) and 36-2982 AAC R9-31-303

E Premiums During 12-Month Guarantee and Appeals Process

Revised 08/06/2024

Policy

A child who is eligible solely due to the 12-month guarantee period is counted in the premium calculation.

1) 12-Month Guarantee Premium Amount

When a child is eligible due to the guarantee period, the premium amount is recalculated based on the number of children who remain either KidsCare eligible or who are eligible under the guarantee period. One premium amount is calculated for all children in the case. When the income budgeted exceeds the limit, the maximum premium amount is used.

2) 12-Month Guarantee Letter

A KidsCare Guarantee Letter is sent indicating that benefits are continuing under the guarantee period and the revised premium amount.

3) Premiums During Appeal

When a customer wants to have KidsCare continued during the appeal process, the customer must:

- Request a hearing prior to the effective date of discontinuance;
- Pay the full monthly premium amount prior to the date of the discontinuance; and
- Continue to pay the full monthly premium amount each month during the hearing process.

When the payment is not received by the end of the month, coverage is stopped for the remainder of the fair hearing period.

4) Appeal Due to Premium Increase

When a customer appeals an increase in the KidsCare premium and the hearing request is received prior to the effective date of the premium increase, restore the premium amount to the lower amount until a hearing decision is made. The customer must pay the premium throughout the hearing process.

Definitions

Term	Definition
Guaranteed Enrollment Period	Available to customers of certain AHCCCS Medical Assistance programs who are enrolled with a health plan for the first time and become ineligible prior to enrollment.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4) and 36-2982 AAC R9-31-303

1205 Transplant Extended Eligibility Program - Share of Cost

Revised 01/30/2025

Policy

Customers that qualify for the Transplant Extended Eligibility Program must pay a “share of cost” to the medical facility performing the transplant.

The following determine the share of cost amount:

- The number of family members in the customer’s household;
- The customer’s family income for a three-month period; and
- The customer’s family medical expenses for a three-month period.

1) Family members

When they live with the customer, the following family members’ income and expenses are used in the Transplant Share of Cost determination:

- Customer;
- Customer’s spouse;
- The customer’s or spouse’s children under age 19; and
- When the customer is under age 19 and unmarried, the customer’s parents.

2) Family Income

The family‘s countable income is determined for a three-month period. The Three-Month Income Period is:

- The month the customer was determined ineligible.
- The month following the month of the customer was determined ineligible.
- The second month following the month the customer was determined ineligible.

3) Medical Expenses

The family's allowable medical expenses over a three-month period are deducted from countable income in the Transplant Share of Cost determination. The Three-Month Expense Period consists of:

- The month prior to the month the customer was determined ineligible.
- The month the customer was determined ineligible.
- The month after the month the customer was determined ineligible.

Expenses incurred during the Three-Month Expense Period by family members who have died or moved out of the home can be used in determining the Transplant Share of Cost when both of the following are met:

- The family member who died or moved out was living in the home when the medical expenses were incurred; AND
- A family member who still lives in the home is financially responsible for paying the medical expenses.

4) 40% of FPL Amounts

The TSOC is based on income in excess of 40% of the FPL for the customer's family size. The following table provides the 40% FPL monthly amounts:

Family Size	**40%**
1	$522.00
2	$705.00
3	$889.00
4	$1,072.00
5	$1,225.00

6	$1,439.00
7	$1,622.00
8	$1,805.00
Each Additional*	$184.00

*”Each Additional” is an approximate amount only.

5) Transplant Share of Cost (TSOC) Calculation

Follow the steps below to calculate the TSOC.

Step	Action
1	Total the countable family income for the Three-Month Income Period.
2	Find the 40% of the FPL amount for the number of family members and multiply by three to get the Three-Month Income Standard.
3	Subtract the Three-Month Income Standard from the total income from Step 1.
4	Subtract the allowable expenses incurred in the Three-Month Expense Period from the remaining income from Step 3.
5	Divide the remaining amount from Step 4 by the budget group size to get the customer’s Transplant Share of Cost amount.

Definitions

Term	Definition

Transplant Share of Cost	The amount a Transplant Extended Eligibility Program customer must pay toward the cost of the transplant procedure.
Countable income	For the Transplant Extended Eligibility Program, is gross income from any source that is not excluded by law from being counted in the determining eligibility for AHCCCS Medical Assistance.
Allowable Medical Expenses	To be allowed as a deduction from income, medical expenses must be the financial responsibility of the family and must be incurred in the United States. Examples of allowable medical expenses include: • Assistive devices and durable medical equipment, and maintenance and repair costs; • Audiology and optometry services, including eyeglasses and hearing aids; • Chiropractic services; • Dental services; • Family planning services; • Homeopathic and naturopathic services provided by a licensed practitioner; • Inpatient and outpatient services; • Laboratory and X-ray services; • Long-term care services • Health insurance premiums, co-payments, and deductibles; • Occupational and physical therapy services; • Doctor’s visits; • Prescription drugs and medical supplies; and

	• The cost of purchasing and maintaining service animals. Examples of medical expenses that are NOT allowable include: • Custodial or room and board services; • Expenses covered by insurance or paid by someone other than a family member listed in section 1; • Expenses that have been written off by the provider; • Over-the-counter medication, vitamins, and food supplements, unless prescribed by a physician; and • Non-emergency transportation costs.

Legal Authority

Program	Legal Authorities
Transplant Extended Eligibility Program	ARS 36-2907.10 and 36-2907.11

Chapter 1300 Applications

1300 Introduction

This chapter contains information for processing AHCCCS Medical Assistance applications.

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- The timeframe for the requirement; and
- A list of the federal and state laws that apply to the requirement by program.

1301 General Information for All Applicants

1301 General Information for All Applicants

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A Application Forms, Assistance, Cooperation and Voter Registration

Revised 10/24/2023

Policy

To qualify for AHCCCS Medical Assistance (MA), the customer or someone acting responsibly for the customer must submit a signed application. The application must be on a form accepted by AHCCCS.

See MA533 for other requirements for a valid application.

1) Application Forms

The Agency accepts the following application forms:

- Health-e-Arizona Plus (HEAplus) Online Application;
- The Department of Economic Security (DES)/Family Assistance Administration (FAA) – Arizona Health Care Cost Containment System (AHCCCS) Joint Application for Benefits;
- Application for Help with Health Coverage Costs;
- Application for AHCCCS Health Insurance and Medicare Savings Programs;
- The Centers for Medicare and Medicaid Services (CMS) Paper Application;
- Breast and Cervical Cancer Treatment Program (BCCTP) Referral Form (BC-100).

2) Who May Sign the Application?

Any of the following people may sign the application for a customer:

- The customer;
- The customer's legal or authorized representative;
- An adult who is in the customer's MAGI Budget Group or Premium Tax Credit Budget Group (MA602D)
- When the customer is a minor child or is incapacitated, someone acting responsibly for the customer.

The application may be signed in writing, by electronic signature, or by a recorded voice signature.

NOTE When the person signs with a mark, a third party must witness the signature and sign the application attesting to witnessing the signature.

3) Authorized Representatives

The customer may choose a person or an organization as their Authorized Representative. The representative must agree to comply with federal and state conflict of interest and confidentiality requirements.

When an organization is authorized to act on the customer's behalf, each person that interacts with AHCCCS for that organization must sign an Authorized Representative (DE-112) form. The form may be signed in writing, by electronic signature, or by a recorded voice signature when applicable.

NOTE When a new authorized representative is from the same organization an updated DE-112 only needs the new representative's signature. To choose an authorized representative, the customer and representative must provide:

- An Authorized Representative Form (DE-112);
- The Authorized Representative section of the Application for Benefits (FAA-0001A);
- The Authorized Representative section of the Application for AHCCCS Medical Assistance and Medicare Savings Programs (DE-103); or
- A legal document giving the representative the authority to represent the customer. Acceptable documents include:
    - A Financial or General Power of Attorney;
    - Letters of Acceptance of legal guardianship or conservatorship (a petition is not acceptable); or
    - Court orders.
- United HealthCare Authorization of Assistance form

NOTE An Authorized Representative form is also needed for the person to agree to confidentiality of information provided when:

- a legal document gives the person authority to the represent the customer; or
- a representing organization selects a different person to act on the customer's behalf.

The customer may authorize the representative to do any or all of the following:

- Complete, sign and submit applications, renewal forms, and other documents for the customer;
- Receive copies of the notices and other communications about the customer's MA; or

- Act on behalf of the customer in all other matters related to MA.

The Authorized Representative Form expires when:

- The customer reapplies after a discontinuance, and the new application date is more than 90 days after the prior application date;
- The customer designates a new Authorized Representative;
- The customer or Authorized Representative revokes the authorization; or
- The customer is no longer receiving MA.

NOTE The Authorized Representative Form expires 90 days after MA coverage ends.

4) Customer Assistance

When needed, Benefits and Eligibility Specialists and other staff will help the customer with the application process.

Customers may also have someone of their choice help them with the application process. This includes:

- Going with the customer to the local office;
- Helping the customer fill out the application; and
- Representing the customer.

5) Customer Cooperation

Customers and their representatives must cooperate in the application process. This includes:

- Providing information and any proof needed;

NOTE Proof is only requested from the customer when it is not available from previous records and electronic sources, or the proof found conflicts with the customer's statement.

- Reporting changes; and
- Taking any action needed to qualify for the MA program.

6) Opportunity to Register to Vote

The National Voter Registration Act (NVRA) of 1993 and Arizona Revised Statutes (ARS) require that public assistance offices provide customers with an opportunity to register to vote at the time of application.

Definitions

Term	Definition
Authorized Representative	A person or an organization appointed by the customer to act on their behalf for the application process, renewing eligibility or other communications.
Electronic Signature	An electronic or digital method of identification executed or adopted by a person with the intent to be bound by or to authenticate a record and has the same force and effect as a written signature. The signature must be unique to the person using it and linked to a record in a manner so that if the record is changed the electronic signature is invalidated.
Legal representative	A person authorized by law to represent the customer. This includes: • A person appointed by a Court of Law to represent an individual; • The natural or adoptive custodial parent of a minor child; or • An agency appointed by a Court of Law as guardian of the customer; for example, a tribal social services (foster care) agency.
Organization	An organized body of people with a particular purpose, especially a business, society, or association.

Timeframes

Application processing periods vary by program and are initiated by application date. See MA1301.B for program-specific timeframes.

Legal Authority

Program	Legal Authorities
All Programs	52 USC 20506 42 CFR 435.907 42 CFR 435.908 42 CFR 435.923 42 CFR 457.340 (KidsCare)

B Application Processing

Revised 10/08/2024

Policy

The customer, or someone acting on the customer's behalf, may start the application in a variety of ways as described in the following table:

When the application is made for...	Then the application may be started by...
Arizona Long Term Care System	The customer or representative by: • Mail; • Phone; • Email; • Fax; • Visiting a local ALTCS or AHCCCS office; or • Home visit.
Breast and Cervical Cancer Treatment Program	One of the Arizona National Breast and Cervical Cancer Early Detection Programs (AZ-NBCCEDP) programs by: • Mail; • Email; or • Fax.
Any other AHCCCS Medical Assistance program	The customer or representative by: • Online through Health-e-Arizona Plus (HEAplus); • Phone;

	• Email; • Fax; • Visiting a local AHCCCS or DES-FAA office; or • Visiting a participating assistor office.

See the following links to find a local office:

- DES-FAA: https://des.az.gov/find-your-local-office
- ALTCS: https://azahcccs.gov/Members/ALTCSlocations.html
- AHCCCS: https://www.azahcccs.gov/shared/AHCCCScontacts.html

1) Application Date

The application date is determined as follows:

When the application is for...	And the signed application is received...	Then the application date is...
Any program	By Health-e-Arizona Plus (HEAplus)	The date the application is submitted in HEAplus.
	By mail	The date the application is received by any of the following: • AHCCCS local office; • ALTCS local office; • DES-FAA local office; or • Outreach site designated to accept AHCCCS Medical Assistance applications.

	By phone	The date the application is received over the phone.
	By email	The date the application is received by any of the offices listed above, even when received afterhours, on a weekend, or a holiday.
	By fax	The date the application is received by any of the offices listed above, even when received afterhours, on a weekend, or a holiday.
	By visiting a local office	The date the person delivers the application to a local office.
	By a Community Assistor	• The date the application is signed and dated; or • The date the application is received when the application is not dated.
	From a hospital for a hospitalized customer	• The date the application is signed and dated; or • The date on the admittance or cover sheet when the application is not dated.
BCCTP	From an Arizona National Breast and Cervical Cancer Early Detection Program (AZ-NBCCEDP)	The date the diagnostic procedure was performed that confirmed a diagnosis of breast cancer, cervical cancer, or a pre-cancerous cervical lesion. NOTE This date will be earlier than the date the application is received.

ALTCS	During a home visit	Date of the home visit.

NOTE An application may be accepted without a signature. However, the application must be signed by an authorized person before it can be approved.

2) Missing Customer Information

When an application is received with missing information, the eligibility worker will attempt to get the information electronically. If the information is not available electronically, a request for information will be sent to the customer.

3) Processing Period

The processing period begins the day of the application date and ends on the date that the decision has been made and the customer is notified.

Expedited processing requests should only be made if:

- The application is already submitted, and
- All pending verifications are available in HEAplus, and
- The applicant meets one of the below criteria:
    - Requires an immediate hospital admission due to a medical condition; or
    - Requires immediate admission to a behavioral health treatment center

NOTE If the person is currently in a hospital, then the hospital question should be answered "Yes"; which will trigger routing to the appropriate unit for processing.

4) Decision Letters

Each person that applies for MA must receive a letter explaining the decision on their application. The decision letter is available electronically as soon as the decision is processed.

Letters must be sent to the following persons:

- The customer;
- The customer’s legal representative; and

- The customer's authorized representative when the customer and representative do not live together.

5) Requests for Information

A letter is sent to the customer when more information is needed to make a decision. Customers are given at least 15 days from the date of the letter to provide the requested information.

6) Processing Period Extensions

The application processing period may be extended beyond the processing time frame and the Benefits and Eligibility Specialist and customer must continue to take all actions needed to get the information when any of the following conditions are met:

- A Policy Clarification Request (PCR) is needed that will affect the eligibility decision;
- A Disability Determinations Services Administration (DDSA) decision is pending; or
- The customer requests a one-time five-day extension beyond the processing time, to get documentation or proof needed for the eligibility decision.

Definitions

Term	Definition
Calendar Day	Any day in the month. This includes weekends and holidays.
Working Day	Any day Monday through Friday, excluding federal and state holidays.

Timeframes

When the customer is applying for:	Then the processing period is...

SSI-MAO or FTW based on disability	90 calendar days from the application date
KidsCare	30 calendar days from the application date
BCCTP	7 calendar days from the date a complete application is received by AHCCCS.
All other programs	45 calendar days from the application date Exceptions: • 20 calendar days from the application date when the customer is pregnant • 7 calendar days from the application date ONLY when the customer is hospitalized AND no proof or other information is needed for the determination

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.907 42 CFR 435.912 42 CFR 457.340 (KidsCare) AAC R9-22-1413(A) AAC R9-22-2006(A)

C Voluntary Withdrawal of Applications

Revised 09/13/2022

Policy

A person or the person's representative may ask for an application to be withdrawn.

NOTE When a legal representative turned in the application, only the legal representative (or their authorized representative) can ask to withdraw the application.

An application may be withdrawn in writing or verbally.

1) Written Request to Withdraw

A written, signed request for withdrawal may be accepted in one of the following formats:

- Voluntary Withdrawal of Application or Benefits (DE-130) form;
- Voluntary withdrawal option in Health-e-Arizona Plus (HEAplus); or
- A signed, written request to withdraw the application.

2) Verbal Requests to Withdraw

When a verbal request to voluntarily withdraw is made, the application is denied based on the verbal request. A denial letter is sent to notify the person that the application has been denied.

When a person or the person's representative contacts the office to take back the voluntary withdrawal request within 35 days of the denial letter, the case is reopened. When more than 35 days have passed, a new application is required.

Definitions

Term	Definition
Legal representative	A person authorized by law to represent the customer. This includes:

	• A person appointed by a Court of Law to represent an individual; • The natural or adoptive custodial parent of a minor child; or • An agency appointed by a Court of Law as guardian of the customer, such as a tribal social services (foster care) agency.
Authorized Representative	A person, or an organization, appointed by the customer to act on their behalf for the application process, renewing eligibility, or other communications.

Timeframes

A person may voluntarily withdraw an application at any time prior to the date an eligibility decision is made.

Legal Authority

Program	Legal Authorities
All Programs	CFR 42 431.213 AAC R9-22-313, R9-28-401

D Financial Quality Assurance

Revised 06/14/2022

Policy

The Financial Quality Assurance (QA) Unit has experienced Benefits and Eligibility Specialists (BESs) who monitor and evaluate the financial eligibility process. The goal of the unit is to provide feedback on the accuracy and consistency of financial eligibility statewide.

Financial QA staff review completed applications. The review includes:

- Health-e-Arizona plus (HEAplus) data entry;
- Case notes;
- Data returned by the HUBS;
- DocuWare; and
- Any other proof in the case file

Findings from the reviews are collected and used to identify trends that show a need for training, manual revisions, or changes to the new hire orientation process. Benefits and Eligibility Specialists are responsible for monitoring and improving the quality of the work they complete. Supervisors support quality improvement by:

- Reviewing completed applications for accuracy and completeness;
- Observing financial interviews;
- Providing technical assistance;
- Coaching; and
- Identifying training opportunities on an ongoing basis.

Proof

Proof consists of documentation of quality control activities that are maintained by the Quality Assurance Unit and eligibility office supervisors.

Legal Authority

Program	Legal Authorities
All Programs	CFR 42 431.213 AAC R9-22-313, R9-28-401

1302 Special Procedures for Certain Applicants

1302 Special Procedures for Certain Applicants

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Children in Tribal Foster Care

Revised 02/20/2019

Policy

AHCCCS Medical Assistance eligibility for children in Tribal foster care is determined by the Department of Economic Security, Family Assistance Administration (FAA) or by AHCCCS, depending on the AHCCCS program. These cases are not referred to the Department of Child Safety (DCS).

When an application is received for a child in Tribal foster care:

- The Tribe is considered the legal guardian and the Tribal Social Services worker can apply for the child without an Authorized Representative form.
- Arizona residency is already established for the child unless the child is placed outside of Arizona.
- Income and other information for members of the foster family is not needed to determine eligibility for the child.

NOTE The only time income information may be needed is when a sibling is in the same foster care placement.

Definitions

Term	Definition
Tribal Foster Care	A foster care program run and maintained by an Arizona Tribe.

Legal Authority

Program	Legal Authorities
All programs	42 CFR 435.907 and 908 42 CFR 435.923

	42 CFR 457.340 (KidsCare)

B Deceased Customers

Revised 11/16/2018

Policy

The fact that a person died before the application was filed or an eligibility decision was made does not stop the person from qualifying for a period before the date of death.

Legal Authority

Program	Legal Authorities
All programs except QMB and KidsCare	42 CFR 435.914 R9-22-1407 R9-22-1501(D) R9-28-401.01

C Customer Who Are Homeless, Incapacitated or Have an Impairment

Revised 08/31/2021

Policy

Customers identified in this section may not be able to gather proof needed for the eligibility process and may need extra help.

The state worker will make reasonable efforts to obtain proof on behalf of the customer when the customer is unable to cooperate with the application process because the customer:

- Is Homeless,
- Has a physical or mental impairment, or
- Is Incapacitated.

When a customer is incapacitated, a Physician's Statement of Incapacity (DE-217) may be needed to help get information to approve eligibility. For example, it may be needed to authorize release of financial or medical information to the Agency.

Customers may be referred to a Public Fiduciary when there is no one with the authority to manage the customer's affairs or willing to help in the application process.

See Public Fiduciary Referral Examples

Definitions

Term	Definition
Homeless	A person who does not have a fixed residence. For example: • A public or private place not meant for human habitation; • A supervised shelter designed to provide temporary shelter to homeless persons. • A half-way house or similar place that provides temporary residence.

	• A room provided rent free in another person's home for 90 days or less. • A place not designed, or ordinarily used, for sleeping. This includes places like a car, bus station, hallway, park, or sidewalk.
Incapacitated	A person who is physically and/or mentally unable to apply for Medical Assistance for him or herself and is unable to authorize someone in writing to act as a representative. • Incapacity is not an issue if the person is represented by: • Court appointed legal guardian or conservator; • Someone previously appointed by customer as a durable general power of attorney (POA) and the POA is still valid; • Someone previously appointed by the person as an Authorized Representative and the Authorized Representative form is still valid; • For customer's under age 18, a natural or adoptive parent; • Spouse, unless divorced or legally separated; or • An adult who is in the customer's MAGI Budget Group (MA602D).

Legal Authority

Program	Legal Authorities
All programs except QMB and KidsCare	42 CFR 435.914 R9-22-1407 R9-22-1501(D)

	R9-28-401.01

D Customers in Jail, Prison or Other Detention Facilities

Revised 12/17/2024

Policy

A person in a detention facility like jail, prison or juvenile detention may apply for MA before being released. The application can be approved but benefits generally cannot start until the person is no longer an inmate.

Exception:

- KidsCare can only be approved if within 30 days prior to release from incarceration.
- Eligible juveniles may receive certain AHCCCS services in the 30-day period prior to release.

Definitions

Term	Definition
Inmate	A person who is: • An inmate in a prison within the Arizona Department of Corrections; • An inmate of a county, city, or tribal jail; • An inmate of a prison or jail, prior to arraignment, conviction, or sentencing; • Incarcerated but can leave prison on work release or work furlough, and must return at specific intervals; • Released from prison or jail due to a medical emergency, with no court probation order, who would otherwise be incarcerated except for the medical emergency; • Ordered by the court to reside in the Arizona State Hospital;

	• A child in a juvenile detention center prior to disposition (judgment), due to criminal activity; • A child in a juvenile detention center prior to disposition, due to care, protection, or in the best interest of the child (ex., Child Protective Services), if there is no specific plan for the child that makes the stay at the detention center temporary; or a • A child placed in a secure treatment facility if the facility is part of the criminal justice system. NOTE For more details about when a person may be considered an inmate, see MA525.
Eligible Juveniles	A person who become incarcerated while enrolled in AHCCCS or are determined eligible for AHCCCS while incarcerated and is: • Under 21 years of age or • Former foster youth up to the age of 26

Legal Authority

Program	Legal Authorities
All programs except KidsCare	42 CFR 435.1009; 42 CFR 435.1010
KidsCare	42 CFR 457.310

E Customers in the Address Confidentiality Program

Revised 11/16/2018

Policy

The Address Confidentiality Program (ACP) provides survivors and victims of domestic violence, sexual offenses, and/or stalking with a means to prevent abusers from locating them through public records. The ACP was signed into law April 19, 2011 and is administered by the Secretary of State's Office.

The ACP provides two critical services:

1. A legal substitute address, which may be used as a residential, school, or work address. This address has no reflection of their actual address. When presented with a current and valid authorization card, accept the substitute address as the lawful address of record.

2. A mail forwarding service. The ACP receives first class mail for ACP participants and forwards the mail to the participant's actual confidential mailing address. The ACP also accepts registered, certified, and legal mail on behalf of the participants. ACP does not forward magazines, junk mail, or packages.

NOTE Participation in The Address Confidentiality Program is not confidential, only the participant's actual address is confidential.

Definitions

Term	Definition
Actual address	Participant's residential, work, or school address, including the county and voting precinct number.

Legal Authority

Program	Legal Authorities
All programs	ARS 41-162

F Customers Requesting Letters in an Alternative Format

Policy

Customers, representatives, and legal guardians who receive letters from AHCCCS may ask to receive letters in an alternative format, such as large print. See MA1603 for additional information regarding alternative format requests.

Programs and Legal Authorities

Program	Legal Authorities
All programs	42 CFR 435.905(b) 42 CFR 435.917

G Customers Sent by the Social Security Administration

Policy

Applications sent to AHCCCS electronically by the Social Security Administration (SSA) may not have the customer's contact information or all the information needed to determine eligibility. These applications meet the conditions in MA533 and are considered signed when they are sent to AHCCCS.

When an application is sent electronically by SSA but does not have the customer's citizenship status, the customer's attestation is not needed. AHCCCS will request proof when the customer's citizen or qualified noncitizen status cannot be verified electronically.

Programs and Legal Authorities

Program	Legal Authorities
All programs	42 CFR 435.907 42 CFR 435.406 and 407 42 CFR 435.949 and 956(a)(1)(i) 42 CFR 457.320(b)(6) 42 USC 1396b 8 USC 1611, 1612, 1613, and 1641 ARS 36-2903.03 AAC R9-22-305.4,5,6 AAC R9-28-401.01(B)1 AAC R9-29-204.3 AAC R9-31-302(A)

1303 ALTCS Application Process

Revised 12/10/2024

Policy

ALTCS applications are different from other AHCCCS Medical Assistance applications in the following ways:

- A financial interview with the customer or customer's representative is required;
- A Pre-Admission Screening (PAS) assessment is required;
- A Share of Cost (SOC) is estimated and determined; and
- Customers may still qualify for other AHCCCS Medicaid Assistance categories, when they fail to meet requirements that only apply to ALTCS.

General information about the application process can be found in MA1301 and MA1302. This section provides information specific to the ALTCS application process.

1) ALTCS Interview

A financial interview is required for all ALTCS applications. The interview may be in person or by telephone.

The interview may be with the customer or with a person acting on behalf of the customer such as a representative (MA1301A.3).

2) PAS Assessment

To qualify for ALTCS a customer must be determined to need the level of care provided in a hospital, skilled nursing facility or intermediate care facility. This determination is made through the PAS process.

Chapter 1000 contains a complete description of the PAS process.

3) Estimating the Share of Cost

Most nursing facilities require full payment of all facility expenses prior to ALTCS approval. However, some nursing facilities will allow a patient who has applied for ALTCS to pay the estimated share of cost during the application process.

A Share of Cost Estimate is completed for customers who:

- Live in a nursing facility; or
- Expect placement in a nursing facility during the ALTCS application process.

The most accurate information available is used during the application process to calculate the customer's estimated SOC. This estimate may change once proof of income and deductions is received. The SOC amount can change from month to month based on changes in income, deductions and living arrangements;

The fact that an estimated SOC has been provided is no guarantee that the ALTCS application will be approved. Approval is subject to the customer meeting all financial and medical eligibility requirements. If the application is approved, the approval notice will show the actual SOC amount(s);

The nursing facility may require payment in full pending approval of the ALTCS application. However, if the nursing facility agrees to accept estimated SOC payments pending ALTCS approval, the customer should begin paying the estimated SOC amount to the nursing facility while the ALTCS application is being processed;

If the customer paid the estimated SOC and the actual SOC is lower, the nursing facility will refund the difference for each approved month (MA705J).

4) Customers Not Eligible for ALTCS

A customer may qualify for other AHCCCS MA categories when the customer does not qualify for ALTCS for one of the following reasons:

- Failed the PAS;
- Missed Appointment;
- Failed to verify resources;
- Has excess resources; or
- Required Medical records are not provided.

Definitions

Term	Definition
Financial Interview	An interview to collect financial information for ALTCS eligibility. Either the customer or the customer's representative may attend the interview.
Pre-Admission Screening (PAS)	The screening tool and method used to determine whether a customer is medically eligible for the ALTCS program.
Share of Cost Estimate	An estimate of the amount that the customer will be responsible to pay for his or her care under the ALTCS program if approved.

Programs and Legal Authorities

Program	Legal Authorities
ALTCS	42 CFR 435.725 42 CFR 435.907 ARS 36-2933 ARS 36-2934 ARS R9-28-303 AAC R9-28-401.01

1304 SSI-MAO Application Process

1304 SSI-MAO Application Process

Revised 11/29/2018

Overview

This section describes application requirements that are specific to the Supplemental Security Income - Medical Assistance Only (SSI-MAO) program.

- Screening for one of the three specialty groups within SSI-MAO; and
- Disability determinations.

General information about the application process can be found in MA1301 and MA1302.

A SSI-MAO Specialty Groups

Revised 03/22/2022

Policy

There are three SSI-MAO specialty groups:

- Disabled Adult Child (DAC);
- Disabled Widow Widower (DWW); or
- Pickle.

Everyone in these groups previously received SSI Cash benefits from the Social Security Administration.

All persons who apply for SSI-MAO must be screened to see if they qualify for one of the specialty groups.

Persons in the SSI MAO specialty groups must meet all of the SSI MAO requirements as well as the special conditions in MA413. The income limit for all of the SSI-MAO Specialty Groups is 100% of the Federal Benefit Rate (FBR), but special income disregards may apply. If the customer's income is over 100% of the FBR, see the following manual sections for information about income disregards:

- Disabled Adult Child (see MA611C);
- Disabled Widow Widower (see MA611D);
- Pickle (see MA611B)

Definitions

Term	Definition
Federal Benefit Rate (FBR)	The maximum dollar amount paid to an aged, blind, or disabled person under the Supplemental Security Income (SSI) program. It is also known as the Federal Payment Standard or the SSI Standard Benefit Amount.

Legal Authority

Program	Legal Authorities
Disabled Adult Child (DAC)	42 USC 1383c R9-22-1505
Disabled Widow/Widower (DWW)	42 USC 1383c 42 CFR 435.137, 42 CFR 435.138 R9-22-1505
Pickle	42 CFR 435.135 R9-22-1505

B Disability Determination

Revised 03/22/2022

Policy

A referral to the Disability Determination Services Administration (DDSA) is required when the customer:

- Is under age 65;
- Is applying for Medical Assistance and is not eligible for any other category; and
- Does not have proof of disability (MA509) or blindness (MA504).

1) Customers with Serious Mental Illness (SMI)

Depending on the functional criteria reported on the following forms, the customer may be considered disabled or presumed disabled:

- A SMI Determination Report Summary; or
- SMI Eligibility Outcome supplemental form completed and signed by a physician or psychiatrist; and
- Medical evidence supporting the SMI diagnosis.

If the customer is...	Then...
Considered disabled (SMI A)	Medical Assistance benefits may be approved if the customer is otherwise eligible. However, a DDSA referral is required for a random sample of these customers to confirm the disability.
Presumed disabled (SMI B)	Medical Assistance benefits may be approved if the customer is otherwise eligible. However, a DDSA referral is required to confirm disability.

2) Presumptive Eligibility for SSI-Cash

Under certain circumstances, Social Security will approve SSI-Cash for a six-month presumptive eligibility period while determining whether a person meets the criteria of disability. When a person has been approved for presumptive SSI disability benefits, a DDSA referral is not required because the customer is considered to have met the definition of disabled during the presumptive eligibility period.

Definitions

Term	Definition
Serious Mental Illness (SMI)	A diagnosable mental, behavioralm or emotional disorder that results in functional impairment which substantially interferes with or limits one or more major life activities.

Legal Authority

Program	Legal Authorities
SSI-MAO	42 CFR 435.540; 42 CFR 435.541 AAC R9-22-1501

1305 Medicare Savings Program (MSP) Application Process

Revised 11/29/2018

Policy

This section describes application requirements that are specific to the Medicare Savings Program (MSP) program.

- Dual Eligibility
- Receiving SSI-Cash
- Conditional QMB
- Medicare buy-in

General information about the application process can be found in MA1301 and MA1302.

1) Dual Eligibility

People who qualify for QMB or SLMB may also qualify for AHCCCS Medical Assistance. This is known as “dual eligibility”, because the person is eligible for both programs at the same time.

No dual eligibility is possible for people who qualify for QI-1 because the program requires that the customer cannot be eligible for any other Medicaid program.

2) SSI-Cash Recipients

SSI Cash recipients are automatically eligible for QMB benefits if receiving free Medicare Part A. These customers do not need to apply for QMB.

SSI Cash recipients who are required to pay a premium for Medicare Part A must apply for QMB.

3) Conditional QMB

Most customers who are eligible for Medicare Part A receive free Part A coverage. However, some customers are required to pay a monthly premium.

Customers who are unable or unwilling to pay the Part A premium must apply for Medicare Part A on the condition that their Part A enrollment will only be effective if QMB is later approved. After filing a conditional Part A application with SSA, these customers must apply for QMB.

4) Buy-In Process

When a customer is approved for MSP, the request for Medicare Part A and Part B buy-in is sent to the Centers for Medicare and Medicaid Services (CMS). Requests are sent in once a month. CMS processes the request for buy-in and either accepts or rejects the request. It may take two or three months for payment of the Medicare premiums to begin through the buy-in process.

5) No Medicare Part B but Eligible for SLMB or QI-1

When a customer has Medicare Part A and meets all other requirements, the customer can qualify for SLMB or QI-1 even if they do not have Medicare Part B. The customer can choose to enroll in Medicare Part B and the Part B premium will be paid for through the SLMB or QI-1 eligibility. Customers do not have to enroll in Medicare Part B through this option, and some may not want to enroll. When a customer obtains Medicare part B and later loses eligibility for SLMB or QI-1, they will be responsible to pay the Medicare part B premium. It may take a few months for the buy-in records to update, and the Part B premiums for all months between losing MSP and Social Security records being updated may be deducted at one time from the customer's Social Security benefit.

Definitions

Term	Definition
Medicare Savings Program (MSP)	Provides help with Medicare expenses for customers who are entitled to Medicare Part A.
Dual Eligibility	A customer is eligible for a Medicare Savings Program as well as another AHCCCS program.

Timeframes

See MA1301.B for the processing timeframes.

1306 Freedom to Work (FTW) Application Process

Policy

This section describes application requirements that are specific to the FTW program.

- Meets the FTW disability requirements (see MA509);
- FTW and MSP dual eligibility;
- Does not qualify for AHCCCS Medical Assistance under another program.

A customer who qualifies for AHCCCS FTW coverage may receive either ALTCS services or AHCCCS Medical Assistance:

General information about the application process can be found in MA1301 and MA1302. This section provides information specific to the MSP application process.

1) FTW Disability Determination

If the customer was not previously determined disabled by the Disability Determination Services Administration (DDSA), the AHCCCS FTW Unit requests a special AHCCCS FTW disability determination. DDSA disregards the customer's employment activity that is part of the usual disability determination.

2) FTW and Medicare Savings Program (MSP)

There is no automatic Medicare buy-in for persons who are approved for FTW. However, FTW customers may also qualify for QMB or SLMB.

3) Screening for Other Medicaid Eligibility

- Immediately after the FTW eligibility is approved;
- When the customer becomes ineligible for FTW (e.g., due to age, change in disability, employment, income, or premium non-payment; and
- Annually, during each renewal process.

Timeframes

See MA 1301(B) for processing timeframes.

Effective until 2025-04-25

Legal Authority

Program	Legal Authorities
AHCCCS FTW	42 USC § 1320b-19 ARS § 36-2950

1307 Breast and Cervical Cancer Treatment Program (BCCTP) Application Process

Policy

This section describes application requirements that are specific to the BCCTP program.

- Application referral by an AZ-NBCCEDP provider
- Does not qualify for AHCCCS Medical Assistance under another program that covers full services.

General information about the application process can be found in MA1301 and MA1302.

1) Application referral by an AZ-NBCCEDP provider

The three programs of the AZ-NBCCEDP are:

- Well Woman Healthcheck Program (WWHP);
- The Hopi Women's Health Program; and
- The Navajo Nation Breast and Cervical Cancer Prevention Program.

The AZ-NBCCEDP staff:

- Help women complete an MA application;
- Explain the BCCTP to applicants;
- Provide results of the screening and diagnosis to AHCCCS;
- Refer women who need treatment and appear to be eligible for BCCTP to AHCCCS;
- Provide supporting documentation of eligibility to AHCCCS; and

  NOTE This includes supporting documentation of citizenship status (naturalized citizen or legal noncitizen) and health insurance coverage.

2) Screening for Other MA Eligibility

A woman must be ineligible for all other Medicaid (Title XIX) coverage groups to qualify for the BCCTP coverage group (MA522)

If the woman is eligible for AHCCCS Medical Assistance under any other Medicaid coverage group, she must be approved for the other coverage group.

Review for other MA eligibility when:

- Completing the initial application;
- The customer reports a change in income or household members;
- The customer becomes ineligible for BCCTP (for example, due to the end of cancer treatment, age, health insurance coverage); and
- During the annual renewal.

Definition

Term	Definition
Arizona National Breast and Cervical Cancer Early Detection Program (AZ-NBCCEDP)	Programs funded by the Centers for Disease Control (CDC) to provide breast and cervical cancer screening and diagnosis under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
Well Woman Healthcheck Program (WWHP)	Administered by ADHS, the WWHP contracts with health departments, community health centers, or non-profit health agencies in each of Arizona's counties to provide state-wide services

Timeframes

When the AZ-NBCCEDP considers an application for BCCTP to be complete, they send it to AHCCCS within 24 hours.

See MA1301B for the overall processing timeframe.

Legal Authority

Program	Legal Authorities
BCCTP	42 USC 1396a(a)(10)(A)(ii)(XVIII) ARS § 36-2901.05 R9-22-2003

1308 KidsCare Application Process

Revised 01/15/2020

Policy

This section describes application requirements that are specific to the KidsCare program.

- No creditable coverage in the last three months
- Past unpaid premiums

General information about the application process can be found in MA1301 and MA1302.

1) No creditable coverage in the last three months

At application, if the customer has insurance coverage or has had coverage in the last three months the coverage must be reviewed to see if it is creditable. If coverage has ended, the end-date must be verified.

2) Past unpaid premiums

When a customer's KidsCare benefits end because premiums were not paid, the customer cannot get KidsCare for two months or the premiums are paid in full, whichever comes first.

Definitions

Term	Definition
Creditable Coverage	Health insurance coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). NOTE Eligibility for services through Indian Health Service (IHS) or a tribal organization is not considered creditable coverage for KidsCare. Examples of creditable coverage include: • Medicare;

	• Group health plans including Qualified Health Plans; • Health insurance coverage through a hospital or medical service policy, certificate or plan contract; or • Armed forces insurance (i.e., Tricare).
Non-Creditable Coverage	The following types of policies are considered non-creditable coverage: • Coverage only for accidents (including accidental death and dismemberment); • Liability insurance, including general liability and automobile liability insurance; • Free medical clinics at a work site; • Benefits with limited scope such as dental benefits, vision benefits or long term care benefits; • Coverage for a specific disease or illness (including cancer policies); • Insurance that pays a set amount a day when the person is hospitalized or unable to work.

Timeframes

See MA1301B for the overall processing timeframe.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397jj(b)(1)(C) 42 CFR 457.310(b)(2)(ii); 42 CFR 457.805

	ARS 36-2983(G)(2)

1309 Approval of Applications

1309 Approval of Applications

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information on Approval of Applications

Revised 10/29/2015

Policy

In general, eligibility for AHCCCS Medical Assistance is determined on a month-by-month basis. A customer may be eligible or ineligible for any specific month. See MA1311 for more information.

Definitions

Term	Definition
Approval	An approval is a determination that a person is eligible for Medical Assistance benefits.
Decision Letter	A decision letter notifies a customer of approval or denial of AHCCCS Medical Assistance program eligibility.
Eligibility Begin Date	Effective date a person is eligible for AHCCCS Medical Services.

B Approval Letters

Revised 03/29/2022

Policy

Every person that applies for AHCCCS Medical Assistance must receive a letter explaining the decision on their application. See MA1604 for information regarding written letters.

Generally, approval letters are automatically sent out by:

- Hospital staff from subscriber organizations for HPE; and
- Health-e-Arizona Plus (HEAplus) for all other programs.

Definitions

Term	Definition
Approval Letter	A decision letter that notifies a customer of approval of AHCCCS Medical Assistance program eligibility.
Subscriber Organizations	An organization that has signed a HEAplus subscription agreement that sets forth the terms under which the organization may have access to HEAplus.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare and HPE	42 CFR 435.917
KidsCare	42 CFR 457.340

Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

C General Information on Eligibility Begin Dates

Revised 10/29/2015

Policy

Rules that affect all programs:

- For a person that moves to Arizona from out-of-state, MA eligibility cannot start any earlier than the date of the move to Arizona.
- For a person that has been in jail, prison or another detention facility, MA eligibility cannot start any earlier than the date the person no longer meets the definition of an inmate (see MA525 – Definitions).
- For a newborn child, MA eligibility cannot start any earlier than the newborn's date of birth.

Otherwise, the date eligibility starts varies by program. See the table below:

Program	Eligibility Begin Date
Medicare Savings Program (MSP) – QMB	QMB eligibility begins with the month following the month that QMB eligibility is determined. QMB Begin Date Example
Breast and Cervical Cancer Treatment Program (BCCTP)	BCCTP eligibility begins on the later of: • First day of the application month (the application month for BCCTP is the month of the BCCTP diagnosis); or • First day of the first month in which the customer meets all the BCCTP eligibility requirements. BCCTP Begin Date Examples
KidsCare	• If eligibility is determined by the 25th day of the month, eligibility begins with the first day of the following month.

	• If eligibility is determined after the 25th day of the month eligibility begins the first day of the second month following the determination. KidsCare Begin Date Examples
Hospital Presumptive Eligibility (HPE)	HPE eligibility begins no earlier than the date the HPE application is approved.
All other programs	First day of a month, if the customer is eligible at any time during that month.

Legal Authority

Program	Legal Authorities
All programs (except BCCTP, QMB, KidsCare and HPE)	42 CFR 435.914
Breast and Cervical Cancer Treatment Program (BCCTP)	R9-22-2007
Medicare Savings Program – QMB	42 USC 1396a(e)(8)
KidsCare	42 CFR 457.340(f)
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

1310 Denial of Applications

1310 Denial of Applications

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information on Denial of Applications

Revised 04/22/2025

Policy

An application is denied when any of the conditions below apply:

- The customer does not meet one or more of the conditions of eligibility for an AHCCCS Medical Assistance (MA) program;
- There is insufficient information to make an eligibility determination after all reasonable attempts have been made to obtain the information;
- The ALTCS application can be denied if medical records required are not provided to determine medical eligibility for ALTCS;
- Mail is returned by the post office; the person cannot be located, and residency cannot be determined (MA1502Q);
- The customer has been given a reasonable opportunity period of 90 days to provide the information necessary to determine eligibility and has missed the due date without asking for an extension; or
- Scheduled financial or medical interviews have been missed with no request to reschedule.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 435.914
KidsCare	42 CFR 457.340(e)

B Denial Letters

Revised 03/29/2022

Policy

Each person that applies for AHCCCS Medical Assistance must receive a letter explaining the decision on their application. See MA1604 for information regarding written letters.

Generally, denial letters are automatically sent out by:

- Hospital staff from subscriber organizations for HPE; and
- Health-e-Arizona Plus (HEAplus) for all other programs.

Definitions

Term	Definition
Denial	A determination that a person is not eligible for Medical Assistance benefits.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare and HPE	42 CFR 435.917
KidsCare	42 CFR 457.340(e)
Hospital Presumptive Eligibility	AAC R9-22-1601

1311 Processing Applications for Multiple Months

Revised 06/14/2018

Policy

When determining eligibility for an application, more than one month may need a determination. Determine each month up through the current calendar month separately, using the actual household situation and monthly income or monthly equivalent for each month.

A customer's situation may change from month to month. Since eligibility is determined on a monthly basis, a customer may qualify for one month but not another.

When a customer does not qualify for MA in a past month, but qualifies in the current month, a new application is not needed.

Each month the customer qualifies for MA is approved. Any months the customer does not qualify for MA are denied.

Definitions

Term	Definition
Denial	A denial is a determination that a person is not eligible for Medical Assistance benefits.
Monthly equivalent	The MA programs that use MAGI income rules may prorate some income over more than one month: • Income received less often than monthly (see MA604D) • Regular seasonal or contract income that is not received during the entire year (see MA604F)

Legal Authority

Program	Legal Authorities

All programs except KidsCare and QMB	42 USC 1396a(a)(34) 42 CFR 435.915

1312 Applications for Hospitalized Inmates

Revised 10/01/2024

Policy

A person in jail, prison or other detention facility who is admitted to a hospital as an inpatient is not considered an inmate during the inpatient hospital stay. AHCCCS has agreements with several Arizona counties and the Arizona Department of Corrections (ADOC) to determine eligibility for inmates who are admitted for an inpatient stay.

1) Eligibility Requirements

The inmate must meet the conditions of eligibility for Medicaid to receive medical coverage for their inpatient hospitalization.

The inmate must be an Arizona resident at the time of incarceration and not placed by another state's department of corrections. Being an inmate in an Arizona detention facility does not make the person an Arizona resident

2) Eligibility Period

If the person qualifies, the eligibility may cover an entire month or more, but AHCCCS can only pay for covered services received during the inpatient stay.

3) Processing Inmate Referrals

The DES/FAA Research and Analysis Unit processes all inmate applications received from ADOC.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare and MSP	42 CFR 435.1009 and 1010

1313 Prior Quarter Coverage

Revised 12/19/2023

Policy

This section describes application requirements that are specific to Prior Quarter Coverage.

1) AHCCCS Medical Assistance (MA)

To qualify for Prior Quarter Coverage of MA, the person must:

- Be pregnant, in the 60-day postpartum period, or under age 19;
- Have a medical expense in a Prior Quarter month. The medical expense can be paid or unpaid; and
- Meet all eligibility requirements in the month the medical service occurred.

2) SLMB and QI-1

To qualify for Prior Quarter Coverage of SLMB or QI-1, the person must:

- Be pregnant, in the 60-day postpartum period, or under age 19;
- Have received Medicare Part B in a Prior Quarter month; and
- Meet all eligibility requirements in the month in which Medicare Part B was received.

NOTE Prior quarter coverage for QI-1 cannot begin any earlier than January of the current calendar year.

3) Effective Date of Prior Quarter Coverage:

The prior quarter period depends on when the Prior Quarter Coverage is requested. See the following table for details:

If the request for Prior Quarter Coverage…	Then…
Is submitted at the same time as the application for Medical Assistance (MA).	The Prior Quarter Coverage is the three months before the application month.
Is NOT submitted at the same time as an application for MA	The prior quarter period is the three months before the application month.

AND The MA application is still pending.	
Is NOT submitted at the same time as an application for MA and MSP AND The MA application has already been completed.	The prior quarter period is the three months before the month the customer's request is submitted.

Information about enrollment in AHCCCS fee-for-service for the Prior Quarter Coverage months can be found in MA1103.

Definitions

Term	Definition
Pregnant	A woman expecting the birth of one or more children.
60-day Postpartum Period	A 60-day period starting the day the pregnancy ends. This period applies to a customer who was not enrolled in AHCCCS while pregnant. A customer who is applying for AHCCCS and was pregnant or in their 60-day postpartum period in any of the 3 months before their application month, may be eligible for Prior Quarter Coverage.
Postpartum period	A 12-month period starting the day the pregnancy ends. This period ends on the last day of the 12th month. Customer must be enrolled in AHCCCS while pregnant to be in the 12-month postpartum period as it applies to this group. See Pregnancy and Postpartum for examples.

Timeframes

The standard MA application timeframes apply to Prior Quarter Coverage. Prior Quarter eligibility is determined on a month-by-month basis.

See MA1311 for policy about processing multiple months.

Legal Authority

Program	Legal Authorities
ALTCS BCCTP SSI-MAO Freedom to Work Child Adult SLMB QI-1 Caretaker Relative Pregnant Women	42 CFR 435.915 R9-22-101 & 303

1314 Hospital Presumptive Eligibility (HPE) Application Process

Revised 04/01/2025

Policy

This section describes application requirements that are specific to the **HPE** program.

General information about the application process can be found in MA1301 and MA1302.

1) HPE applications:

A HPE application is a shorter streamlined version of a full AHCCCS Medical Assistance application containing questions only about the following:

- Contact Information;
- Authorized Representative; (if applicable)
- Personal Information; (for all members of the household)
- Citizenship/Residency;
- Pregnancy Information;
- Foster Care Information;
- Employment Information;
- Other Income Information;
- Medicare Information;
- Parent or Caretaker Relative Information
- Application signature.

Unlike other programs, the customer does not need to provide proof of any these factors to qualify for HPE. However, the customer can only qualify for HPE once every 24 months;

NOTE HPE applications may ONLY be completed by hospital employees or vendors contracted with a hospital that have signed an agreement with AHCCCS to process HPE applications.

2) Who can be approved for HPE?

Only a person who is not currently receiving Medicaid, has not had HPE eligibility in the past 24 months, and qualifies for one of the following categories may be approved for HPE:

- Pregnant Woman (MA410)
- Child (MA406)
- Caretaker Relative (MA405)
- Adult (MA401)
- Young Adult Transitional Insurance (MA416)
- Breast and Cervical Cancer Treatment Program (MA404)

3) What is the HPE Period?

The HPE period is a temporary approval period that begins on the date the HPE is approved and continues until the earlier of the following:

- The last day of the month after the month the HPE is approved, if a full Medicaid application is not submitted by this date.
- The date a decision is made on a full Medicaid application when the application is submitted by the last day of the HPE period.

HPE Period examples can be found at MAE1314.

In order for the customer to have eligibility continued beyond the HPE period the customer must complete and submit a full Medicaid application before the end of the HPE period and be found eligible for Medicaid.

4) Who decides HPE eligibility and notifies the customer?

Only qualified hospital staff from Subscriber Organizations determine HPE. This is done by using a shorter streamlined version of the full application in HEAplus and issuing a HPE decision notice.

AHCCCS and DES staff do not make decisions for the HPE program or send decision letters to customers.

Definitions

Term	Definition

Hospital Presumptive Eligibility (HPE)	Temporary coverage for people who are likely to qualify for AHCCCS Medical Assistance. See MA417 for details. NOTE Eligibility for HPE is determined by qualified hospitals
Qualified hospital	A hospital that has agreed to follow the state's HPE policies and procedures.

Legal Authority

Program	Legal Authorities
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

Chapter 1400 Renewals

1400 Introduction

This chapter contains information for processing AHCCCS Medical Assistance renewals.

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- The timeframe for the requirement, if applicable; and
- A list of the federal and state laws that apply to the requirement by program.

1401 General Information about Renewals

1401 General Information about Renewals

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Renewal Processes

Revised 07/12/2022

Policy

1) Renewal Processes — No Response Required

When renewing AHCCCS eligibility, information from the prior application and Federal and State electronic data sources are reviewed to see if there is enough information to determine if the customer still qualifies. When there is enough information available to determine that the customer still qualifies for AHCCCS Medical Assistance, even in another category, eligibility is renewed. A renewal approval letter is sent.

The letter shows the information that was used to renew eligibility. It tells the customer to check the information and report anything that has changed or is not correct. If the information used is current and accurate, the customer does not need to take any further action.

2) Renewal Processes — Response Required

In some cases, eligibility cannot be determined using available information, or the information indicates that the customer no longer qualifies. When this happens, the customer must provide information needed to complete the renewal process.

A renewal letter is sent to the customer. The letter contains the following:

- A pre-populated renewal form with the most current information available from the last application and any electronic data sources; and
- A Request for Information describing any proof needed.

The customer must take the following actions:

- Review the pre-populated renewal form;
- Identify any incorrect information on the form and enter the corrected information on the form;
- Provide proof for any information that was corrected;
- Provide any proof listed in the Request for Information that was sent with the form; and
- Sign the form and submit the signed renewal form with any proof needed.

The customer has 30 days to complete the renewal and provide any information requested. The renewal may be completed by mail, by fax, by phone, or in person. Except for ALTCS customers, renewals can also be completed online in the Health-e-Arizona Plus system.

The following options are available to complete the renewal by phone:

- A voice signature can be provided.
- The customer can confirm the information listed on the prepopulated renewal form is correct.
- The customer may need to provide proof for changes and unverified eligibility factors separately from the call when eligibility staff are unable to get the proof through electronic sources or prior applications.

Customers who do not provide the requested information by the due date will have their eligibility stopped.

When eligibility is stopped for failure to complete the renewal, the customer does not have to submit a new application when:

- The customer submits the completed renewal form before the date the MA eligibility ends, or
- The customer submits the completed renewal form within 90 days of the discontinuance date.

3) Customer Assistance

When needed, Benefits and Eligibility Specialists and other staff will help the customer with the renewal process. Customers may also have someone of their choice help them with the renewal process. This includes:

- Going with the customer to the local office;
- Helping the customer fill out the application; and
- Representing the customer.

4) Customer Cooperation

Customers and their representatives must cooperate in the renewal process. This includes:

- Providing information;
- Reporting changes; and
- Taking any action needed to qualify for the MA program.

5) Opportunity to Register to Vote

The National Voter Registration Act (NVRA) of 1993 and Arizona Revised Statutes (ARS) require that public assistance offices provide applicants and customers with an opportunity to register to vote at the time of renewal. To meet this requirement, Voter Registration forms are sent to customers with renewal letters.

Definitions

Term	Definition
Health-e-Arizona Plus (HEAplus)	Arizona's online application and determination system for AHCCCS Medical Assistance eligibility.
Renewal	A review of financial and non-financial eligibility factors.
Representative	A person appointed by the applicant to act on his or her behalf in the application process

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.908 and 916 42 CFR 457.340 (KidsCare)

B Decision Letters

Policy

All customers must receive a letter explaining the decision on their renewal. See MA1604 for information regarding written letters.

Definitions

Term	Definition
Decision Letter	A letter that notifies a customer of the action taken for their AHCCCS Medical Assistance program eligibility including: • Approval; • Denial; • Discontinuance; • Change in share of cost, premium amount or co-payments; • Change in eligible medical services; and • Enrollment with a health plan or program contractor.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.916 42 CFR 435.919

Effective until 2025-04-25

C Timeframes

Revised 01/07/2025

Policy

AHCCCS Medical Assistance (MA) eligibility must be reviewed and renewed periodically. This section describes how often renewals must be completed.

1) Programs That Must Be Renewed Once Every 12 Months

A renewal of eligibility must be completed once every 12 months for customers enrolled in one of the following MA coverage groups:

- Adult;
- Caretaker Relative;
- Pregnant Woman;
- Child;
- Young Adult Transitional Insurance (YATI);
- KidsCare;
- Deemed Newborns;
- ALTCS;
- SSI-MAO;
- Specified Low-Income Medicare Beneficiary (SLMB);
- AHCCCS Freedom to Work (FTW); and
- Breast and Cervical Cancer Treatment Program (BCCTP).

2) Programs That Must Be Renewed At Least Once Every 12 Months

Qualified Medicare Beneficiaries (QMB) must be completed at least once every 12 months.

3) Programs with Automatic Eligibility

Some customers do not have to complete an AHCCCS renewal because they automatically receive MA by qualifying for one of the following programs:

- SSI-Cash;
- Title IV-E Foster Care; and
- Title IV-E Adoption Assistance.

4) Programs with special Extension Periods

Transitional Medical Assistance (TMA) and Continued Coverage (CC)

The TMA and CC programs are time-limited extensions of coverage for families when a Caretaker Relative's earnings or spousal support puts them over the income limit. These programs must be reviewed for continued eligibility as follows:

- For TMA, at six months and 12 months
- For CC, at four months from the CC start date.

Qualified Individual-1 (QI-1)

Customers are approved for QI-1 until the end of the calendar year. The Federal government funds the QI-1 program on a year-to-year basis. Renewals for QI-1 are completed annually at the end of the calendar year.

Definitions

Term	Definition
Renewal	A review of financial and non-financial eligibility factors.

Programs and Legal Authorities

Program	Legal Authorities

All Programs	42 CFR 435.916

1402 Proof Needed at Renewal

Revised 12/17/2024

Policy

Some requirements are not verified again at renewal as they do not generally change. Any eligibility requirement that could have changed may need to be reviewed and current proof provided. See the table below for more details:

Requirement	Instructions	Programs
Age (MA501)	Does not need to be verified again at renewal. NOTE If the customer is in a program that has an age limit, age must be reviewed to see if the customer still meets the age requirement for the program.	Adult BCCTP Child Deemed Newborns FTW KidsCare SSI-MAO YATI
Blindness (MA504)	Does not need to be verified again at renewal, unless Social Security has determined that the person is no longer blind.	SSI-MAO
Disability (MA509)	Does not need to be verified again at renewal, unless Social Security has determined that the person is no longer disabled.	ALTCS SSI-MAO FTW
U.S. Citizenship (MA507)	Does not need to be verified again at renewal.	All programs

Residency (MA531)	Does not need to be verified again at renewal unless it is questionable.	All programs
Valid Social Security Number (MA532)	Does not need to be verified again at renewal unless the customer: • Provided proof of application for an SSN, but has not yet provided the SSN; or • Is exempt from providing a valid SSN.	All programs
Non-Citizen Status (MA524)	Does not need to be verified again at renewal unless there has been a change in the customer's immigration status. NOTE For qualified non-citizen who only gets emergency services due to the 5-year bar, the status date must be reviewed to see if the bar period has ended.	All programs
Not in an IMD (MA514)	Only verify if it is reported that the child is residing in an IMD.	KidsCare
Medicare Entitlement (MA523)	Does not need to be verified again at renewal unless there is a discrepancy with hub data source information.	MSP Adult SSI-MAO (DWW)
No Creditable Coverage (MA515)	Does not need to be verified again at renewal unless the customer reports a new source of insurance coverage.	BCCTP KidsCare

Ineligible for other MA programs (MA522)	Must be verified at each renewal.	FTW BCCTP KidsCare
Good Cause for not cooperating with DCSS (MA503)	The requirement to cooperate with DCSS in establishing the identity of a child's parents and in obtaining medical support is suspended under a temporary waiver from 09/01/2023 through 06/30/2025. If the customer claims good cause for not cooperating, it must be verified at each renewal.	All programs except KidsCare
Insurance Coverage for Dependent Children (MA518)	Must be verified at each renewal. NOTE Verification should be available from the hub data sources. If the child is receiving MA, this requirement is verified.	Adult
Not eligible for State employee health benefits (MA517)	Does not need to be verified again at renewal unless the customer reports employment with a State Agency.	KidsCare
Income (Chapter 600)	Must be verified at each renewal.	All programs except BCCTP and YATI
Resources (Chapter 700)	All countable resources that can be expected to change and could affect eligibility must be verified at each renewal. Resources are not expected to change when the customer:	ALTCS

	• Has no resources and no income in the most recent approved application and no income is found by the hubs. • Receives SSI Cash or IVE payments and is verified. • Is under age 18 and has less than $1000.00 in resources. • Has less than $1000.00 in resources and only income is Social Security in the most recent approved application, and no other income is found by the hubs. • Is in a Nursing facility and their only resource is a Patient Trust Account. When AVS returns an account value that does not put the customer over the resource limit, it is reasonably compatible and verified. Otherwise, request proof.	
Trusts (Chapter 800)	How trusts are reviewed at renewal depends on whether the trust is a: • Non-Special Treatment Trust; or • Special Treatment Trust.	ALTCS
Cancer Treatment Status (MA505)	Must be verified at each renewal.	BCCTP
Employed (MA510)	Must be verified at each renewal.	FTW

Caretaker Relative of a Dependent Child (MA506)	Does not need to be verified again at renewal unless questionable.	Caretaker Relative Transitional Medical Assistance (TMA) Continued Coverage (CC)
Pregnancy (MA527)	Must be verified at each renewal. However, the woman's statement that she is pregnant is accepted unless there is strong reason to question it.	Pregnant Woman
Living Arrangement (MA521)	Does not need to be verified again at renewal unless questionable.	ALTCS
Student Status	Only verify if the only child living with the caretaker relative is 18 years old (MA506).	Caretaker Relative
	Must be verified at each renewal.	ALTCS SSI-MAO MSP FTW

Definitions

Term	Definition
Renewal	A periodic review of financial and non-financial eligibility factors.

Legal Authority

Program	Legal Authorities

All Programs	42 CFR 435.916 42 CFR 435.940 to 435.956

1403 Persons Losing SSI Cash Eligibility

Revised 12/31/2019

Policy

A customer who receives SSI Cash in Arizona is also eligible for AHCCCS Medical Assistance (MA). If the customer loses SSI Cash, the customer loses automatic eligibility for MA, but may be eligible for another MA program. A two month period is allowed to determine ongoing eligibility. The renewal must be completed or eligibility stopped before the end of the two month period.

Before stopping the customer's MA, a renewal is completed to see if the customer meets the eligibility requirements for any other MA program. The renewal is first done automatically as described in MA1401.A.1.

> NOTE ALTCS eligibility does not stop due to the customer losing SSI Cash. When SSI Cash stops, the customer is no longer categorically eligible for ALTCS, and eligibility must be reviewed to see if the customer still qualifies.

If more information is needed to determine eligibility, the customer is sent a Request for Information letter. Eligibility is stopped if the information is not received by the due date. If the information is returned and the customer is not eligible for another program, his or her MA is stopped, and a discontinuation letter is sent.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
All programs	42 CFR 435.930

Chapter 1500 Changes

1500 Introduction

This chapter explains policy for changes that occur after the initial approval of AHCCCS Medical Assistance eligibility.

NOTE Enrollment change policy is in Chapter 1100.

In this chapter you will find:

- The policy for changes;
- Any definitions needed to explain the policy;
- Any proof needed;
- Timeframes, where applicable; and
- A list of the federal and state laws that apply to the requirement by program.

1501 General Information about Changes

1501 General Information about Changes

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A How a Change May Affect a Customer

Policy

Changes in the customer's circumstances could affect the customer's:

- Ability to get letters from AHCCCS, DES, health plan or program contractor;
- Eligibility for AHCCCS Medical Assistance (MA) programs;
- Share of cost, premium amount or co-payments;
- AHCCCS Medical Assistance service package; or
- Enrollment with health plan or program contractor.

Definitions

Term	Definition
Change in circumstance	Something that happens to a person, which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.

Proof

The type of proof needed depends on the type of change. See MA1502 for types of changes and proof needed.

Timeframes

There are different timeframes for each type of change. See MA1502 for types of changes and timeframe requirements.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.916(c) - (f)

B Change Reporting

Revised 04/27/2021

Policy

Customers or their representatives are required to report any changes that may affect their MA eligibility, premium amount or share of cost. The types of changes that must be reported are described in MA1502. However, anyone who knows about a change in the customer's circumstances may report the change. Changes are most commonly reported by:

- Customer;
- Customer's representative;
- Customer's spouse;
- Customer's relatives, friends or neighbors;
- AHCCCS Complete Care (ACC) plan or program contractors;
- Medical facilities and providers;
- Attorneys; and
- Trustees.

NOTE Information reported by someone other than the customer or the customer's spouse or representative must be confirmed before any action can be taken. The customer or customer's representative must confirm the change report is correct, or other proof must be received, even if the change would not normally need proof. For example, a neighbor reports that the customer moved out of state. This must be confirmed before taking any action as the neighbor may not have accurate information.

1) How Can Changes be Reported?

Changes can be reported:

- Online through Health-e-Arizona Plus (HEAplus);
- By phone;
- By fax;
- In writing; or
- In person.

2) How is the Customer Informed?

The customer is informed about their responsibility to report changes in a variety of ways, including:

- On each approval letter or change letter;
- On the AHCCCS Medical Assistance program application;
- For ALTCS only, verbally during an interview and in writing with the Rights and Responsibilities of Customers (DE-113); or
- Verbally during assistance with an in-person application.

Definitions

Term	Definition
Change in Circumstance	Something that happens to a person which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.
Report	A person notifies the Agency of a change in circumstance.

Proof

The type of proof needed depends on the type of change. See MA1502 for types of changes and proof needed.

Timeframes

In general, changes must be reported as soon as the future event becomes known. However, there are different timeframes for some changes. See MA1502 for types of changes and timeframe requirements.

NOTE Special reporting requirements apply to trustees of Special Treatment Trusts. Trustee reporting requirements are described in MA803.A.

Legal Authority

Program	Legal Authorities
All programs, except KidsCare	42 CFR 435.919(b)(2)
ALTCS	AAC R9-28-411(A)
SSI MAO	AAC R9-22-1501(H)
MSP	AAC R9-29-224
FTW	AAC R9-22-1905 and R9-28-1305
BCCTP	AAC R9-22-2005(D)
KidsCare	42 CFR 457.343 AAC R9-31-308

C Change Letters

Revised 03/29/2022

Policy

A written notice is required if a change in circumstance causes:

- A customer to lose eligibility;
- A decrease in services;
- An increase in the customer's share of cost; or
- An increase in the customer's premium amount.

See MA1604 for information regarding written letters.

Definitions

Term	Definition
Change in Circumstance	Something that happens to a person which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 431.210, 211 and 213 42 CFR 435.917 42 CFR 435.919
KidsCare	42 CFR 457.343

Effective until 2025-04-25

1502 Types of Changes

1502 Types of Changes

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A Address Change

Revised 08/17/2021

Policy

A change in the address of a customer, a customer's spouse, a parent of a minor customer, or a customer's representative must be reported.

1) Customer's Address Changes

A change in the customer's address may affect a variety of factors depending on the program for which the customer is currently eligible. These factors must be reviewed and verified using the proper policy before the address change can be processed.

When the address change is to...	Then the change may affect the customer's...
Outside Arizona	• Eligibility, when the customer is no longer an Arizona resident. • AHCCCS Medical Assistance (MA) services when the person is temporarily out of the state. See MA531 for details on Arizona residency.
A different county	• Eligibility, when there is a change in household members that affects the customer's budget group. See MA1502N for more information. • Enrollment with an AHCCCS Complete Care (ACC) plan or program contractor. Different health plans and program contractors serve different counties. See MA1104 for more information about program contractors.
A jail, prison or other detention facility	Eligibility or enrollment. See MA1502V for specific policy on when a customer is incarcerated.

A long-term care living arrangement	Eligibility, enrollment or share of cost. See MA1502P for specific policy on when a customer's living arrangement changes.

2) Spouse's Address Changes

A change in a spouse's address may affect the customer depending on the program for which the customer is currently eligible. The change must be reviewed and verified according to the proper policy before the address change can be processed.

If...	And the customer is eligible for...	Then the change may affect the customer's...
The customer's spouse moves into or out of the home.	All programs	Eligibility or customer costs. See MA1502N for specific policy on changes to household members.
The spouse moved to a nursing facility	ALTCS	Community spouse policy, which can no longer apply. The change could affect eligibility and share of cost (SOC).

NOTE A change in the spouse's mailing address without a change in the physical address has no effect on the customer.

3) Parent's Address Changes

A change in a parent's address may affect a customer child's eligibility or enrollment depending on the program for which the customer is currently eligible. The impact must be reviewed and verified according to the proper policy before the address change is processed.

NOTE A change in the parent's physical address may affect a customer child's enrollment even when the customer does not move.

When the address change is to...	And the customer is eligible for...	Then the change may affect the customer's...

Another state (permanently)	All programs	Eligibility, when the child is no longer an Arizona resident (MA531).
Another county	ALTCS Elderly and Physically Disabled (EPD)	Enrollment, as enrollment is based on the parent's county of fiscal responsibility (MA1104E).
	DES Division of Developmental Disabilities (DDD) services	No effect on the customer's enrollment.

NOTE A change in the parent's mailing address without a change in the physical address has no effect on the customer child.

4) Other Household Member Address Changes

An address change for other household members may affect the customer's eligibility, share of cost or premium amount:

When the representative is...	Then...
An adult child under age 22 or a tax dependent	Eligibility or customer costs. See MA1502N for specific policy on changes to household members.

5) Representative's Address Changes

When the customer's representative is NOT one of the family or household members listed in sections 2 through 4 above, an address change for the representative does not affect the customer's eligibility, share of cost or premium amount.

6) Offering Customers the Opportunity to Register to Vote

The National Voter Registration Act (NRVA) of 1993 (42 USC § 1973gg) and Arizona Revised Statute 16-140 require that public assistance offices provide customers with an opportunity to register to vote when a person reports a change of address.

Definitions

Term	Definition
Tax dependent	A person who qualifies to be claimed as the customer's dependent for tax purposes.

Proof

The proof required to process an address change depends on who provides the information:

When address change information is provided by the...	Then...
• Customer; • Customer's spouse; or • Customer's representative, including a customer child's parent	The person's statement is accepted.
Anyone else	The customer or customer's representative must be contacted to confirm the reported change.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 435.403 42 CFR 435.916
KidsCare	42 CFR 457.320(d) 42 CFR 457.343

B Age

Revised 05/30/2018

Policy

A change in age can affect a customer's eligibility or premium amount depending on the age and the AHCCCS Medical Assistance (MA) program. See the following table for important age changes:

Turns…	Program	Change
Age 1	Deemed Newborn	Deemed Newborn coverage stops after the month the child turns age 1. Eligibility is reviewed to see if the child qualifies for any other MA program.
	Child	The Child program covers children under age 19, but there are different income limits based on the child's age. At age 1, eligibility is reviewed to see if the child still qualifies using the Child program's income limit for children age 1 through 5 (MA615.11), or for any other MA program.
Age 6	Child	The Child program covers children under age 19, but there are different income limits based on the child's age. At age 6, eligibility is reviewed to see if the child still qualifies using the Child program's income limit for children age 6 through 18 (MA615.12), or for any other MA program.
Age 19	Child KidsCare	Coverage under the Child program and KidsCare program stops after the month the customer turns age

		19. Eligibility is reviewed to see if the customer qualifies for any other MA program.
Age 22	ALTCS SSI-MAO MSP FTW	The Student Earned Income exclusion stops the month after the student turns age 22. The exclusion is removed and eligibility is reviewed to determine the effect. Stopping the Student Earned Income exclusion increases the customer's counted income when: • The customer is the student, and more earnings are counted; • The customer's child is the student, gets a lower Child Allocation; or • The customer's parent is the student, and more income is deemed to the customer from the parent. The increased income may cause a higher premium or Share of Cost, or the customer may no longer qualify for the current MA program. When the customer is no longer eligible for the current MA program, eligibility is reviewed to see if the customer can qualify for any other MA program.
Age 26	YATI	Coverage under the Young Adult Transitional Insurance (YATI) program stops the month after the customer turns age 26. Eligibility is reviewed to see if the customer qualifies for any other MA program.

Age 65	Adult Disabled Widow/ Widower (DWW) FTW BCCTP	Coverage under these programs stops the month after the customer turns age 65. Eligibility is reviewed to see if the customer qualifies for any other MA program.

Definitions

Term	Definition
Student Earned Income exclusion	A deduction from the earned income of qualifying students under age 22. See MA609B.2 for more information.

Timeframes

Age changes are known in advance. Action is taken to process the change for the month after the person's birth month.

Legal Authority

Program	Legal Authorities
Adult	42 CFR 435.119
Child	42 CFR 435.118
Breast & Cervical Cancer Treatment Program (BCCTP)	ARS 36-2901.05(A)(4) AAC R9-22-2003(a)(2)

Freedom to Work (FTW)	ARS 36-2901(6)(g) AAC R9-22-1901 AAC R9-28-1316(2)
Disabled Widow Widower (DWW)	42 USC 1383c(b) AAC R9-22-1505(A)(4)
YATI	42 USC 1396a(a)(10)(A)(i)(IX)
KidsCare	ARS 36-2981(6) AAC R9-31-303(1)

C ALTCS Customer Refusing Services

Revised 05/30/2018

Policy

A customer who refuses home and community based services (HCBS) may be eligible for ALTCS acute care when the customer's income is less than or equal to 100% of the Federal Benefit Rate (FBR). This change to acute care only does not require a 10- calendar day advance notice because long term care services may be reinstated at the customer's request.

When a customer's income exceeds 100% of the FBR, the customer is ineligible for both long term care and acute care services. The change requires a 10-calendar day advance notice to discontinue eligibility because income exceeds the limit.

All program contractors must identify ALTCS customers who refuse services because customers who are living in the community must be receiving or intend to receive HCBS services. The program contractor must notify the ALTCS office that the customer has refused HCBS services.

Definitions

Term	Definition
Refusing Services	Customers enrolled with an ALTCS program contractor, but are refusing HCBS services; sometimes referred to as ALTCS non-users. Refusing HCBS services includes refusing to move from a non-contracted HCBS facility to a contracted facility.

Proof

The ALTCS program contractor may notify the Agency that the customer is refusing ALTCS HCBS long term care services. They must tell the Agency in writing or electronically.

Programs Affected

This applies to the following programs:

- ALTCS

- FTW - ALTCS

Timeframes

The program contractor reports the change after all attempts to work with the customer have failed.

Legal Authority

Program	Legal Authorities
ALTCS FTW - ALTCS	AAC R9-28-406(B)

D Cancer Treatment Ends

Revised 06/01/2021

Policy

When a Breast and Cervical Cancer Treatment Program (BCCTP) customer's treatment end date is reported, the BCCTP eligibility end date is determined using the following table:

When the treatment was for...	Then BCCTP eligibility ends...
A pre-cancerous cervical lesion	4 months after the cancer treatment ends.
Cervical cancer	12 months after the cancer treatment ends.
Breast cancer	12 months after the last provider visit for a treatment other than hormonal therapy; or at the end of hormonal therapy for breast cancer, whichever is later. Because hormonal therapy is usually prescribed for up to 5 years, there is no extended BCCTP eligibility following hormonal therapy.
Metastasized cancer	As determined on a case-by-case basis by the AHCCCS Chief Medical Officer.

When a woman is no longer eligible for BCCTP, her eligibility is reviewed to see if she qualifies for any other AHCCCS Medical Assistance (MA) program.

Definitions

Term	Definition
Treatment End Date	• Date of the last provider visit for a specific therapy for cervical cancer or a pre-cancerous cervical lesion; or

	• Date of the last provider visit for a specific therapy for breast cancer or the end of hormonal therapy, whichever is later.

Proof

A Treatment Status Update (BC-241) with a treatment end date as determined by the AHCCCS Complete Care (ACC) plan doctor. The BC-241 is sent at least every six months until the treatment end date is confirmed.

Programs Affected

This policy applies to the Breast and Cervical Cancer Treatment Program (BCCTP).

Timeframes

AHCCCS uses the treatment end date to determine when BCCTP eligibility ends. Action must be taken early enough to allow time to:

- Determine eligibility for other MA programs, and
- When not eligible for any other MA programs, send a letter in advance telling the customer her eligibility is ending. See MA1501C for requirements.

See Examples - BCCTP timeframes when treatment ends

Legal Authority

Program	Legal Authorities
Breast and Cervical Cancer Treatment Program (BCCTP)	ARS 36-2901.05(A)(2) AAC R9-2003(A)(1)

E Citizen or Noncitizen Status Change

Revised 05/30/2018

Policy

A change in U.S. citizen or noncitizen status may occur when:

- A customer becomes a U.S. citizen through the naturalization process;
- AHCCCS receives evidence that a customer who previously claimed to be a U.S. citizen is actually a noncitizen;
- The 5-year waiting period for a Lawful Permanent Resident, parolee or battered alien to get full AHCCCS benefits ends; or
- A customer's noncitizen status changes.

A change in status may allow a customer to get full AHCCCS Medical Assistance services, or it may cause the customer to lose eligibility for full services.

When a customer's U.S. citizenship or noncitizen status changes, eligibility is reviewed and redetermined.

Definitions

Term	Definition
U.S. Citizen	A person may be a U.S. citizen based on where they were born, having a U.S. citizen parent, by marriage or by naturalization as described in MA507.
Noncitizen	A noncitizen is a person who is not a U.S. citizen or national. See MA524 for details.

Proof

The proof required depends on the change reported:

When the change reported is...	Then proof includes...
Customer has become a naturalized citizen	• A copy of the customer's naturalization certificate • Electronic record of U.S. citizenship from the federal hub.
Change in customer's noncitizen status	USCIS document showing the noncitizen status and SAVE verification.
End of the 5-year waiting period for a Lawful Permanent Resident, Parolee or Battered Noncitizen	The entry date in a qualified status is listed on the proof of qualified status provided at application. No further proof is needed. NOTE Full AHCCCS coverage starts on the first of the month in which the 5-year waiting period ends.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities

All Programs	42 CFR 435.406 ARS 36-2903.03 42 CFR 435.916
ALTCS	AAC R9-28-411(A)(1)(l)
SSI-MAO	AAC R9-22-1501(H)(2)(b) and 1502(C)
Medicare Savings Program (MSP)	AAC R9-29-210
Freedom to Work (FTW)	AAC R9-22-1911 AAC R9-28-1311
Breast and Cervical Cancer Treatment Program (BCCTP)	AAC 9-22-2005(D)(2)
KidsCare	42 CFR 457.343 ARS 36-2983(E) AAC R9-31-303(2)

F CSMIA Amount Made Available to the Community Spouse

Revised 05/30/2018

Policy

The Community Spouse Monthly Income Allowance (CSMIA) is only allowed as a Share of Cost (SOC) deduction for the customer when it is available to the community spouse.

When the full CSMIA is not made available to the community spouse, the CSMIA amount must be adjusted and the customer's SOC recalculated.

When the community spouse also receives AHCCCS Medical Assistance (MA), the amount of the CSMIA made available may affect the amount of his or her counted income depending on the MA program. See MA1502O, for more information about income changes.

Definitions

Term	Definition
Community Spouse Monthly Income Allowance (CSMIA)	A calculated amount to help the community spouse pay his or her living expenses. See MA1201C.5 for details.
Share of Cost (SOC)	The amount a customer is required to pay toward the cost of long term care services.

Proof

Proof that the CSMIA is not available to the community spouse includes:

- Customer's written or verbal statement that he or she will not make the CSMIA available to the community spouse;
- Financial records showing that the CSMIA is not paid to or available to the spouse.

NOTE When the customer's income is deposited to an account that is titled solely or jointly to the community spouse, assume that the community spouse has access to the CSMIA.

Programs Affected

This applies to the following programs:

- ALTCS
- Freedom to Work – ALTCS

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 435.916
Freedom to Work – ALTCS	AAC R9-28-410(C) and R9-28-411(A)(1)(r)

G Death

Revised 03/28/2023

Policy

1) Death of a Customer

When a customer dies his or her eligibility is stopped. When there are other people in the budget group receiving AHCCCS Medical Assistance (MA), the eligibility of these customers must be reviewed as a change in household size (MA1502N).

An ALTCS customer may receive a Share of Cost (SOC) adjustment for the month he or she died. To determine if a SOC adjustment is needed, the prorated capitation rate is compared to the SOC for the month. The SOC for the month the customer died is the prorated capitation rate or the customer's monthly SOC, whichever is lower.

NOTE ALTCS customers who receive Fee-For-Service coverage (MA1103) do not receive a Share of Cost adjustment.

See Prorating Share of Cost When a Customer Dies Examples

2) Death of a Spouse

The death of a customer's spouse results in a change in the customer's marital status and may affect the customer's:

- Income eligibility;
- ALTCS SOC;
- ALTCS resource eligibility; or
- ALTCS transfer penalty, if any.

When the customer is eligible for ALTCS, use of community spouse policy stops the month after the month the customer's spouse died.

The customer's counted income may be less when the deceased spouse was part of the customer's budget group and had income. However, the customer may get more income or resources due to the spouse's death as described below:

- The customer may get increased Social Security (SSA) benefits, all or a portion of the spouse's pension, or Veteran's Administration (VA) benefits.
- The customer may be the beneficiary of death benefits or entitled to assets from the deceased person.

3) Death of a Parent or Other Household Member

The death of a parent or other household member may affect the customer's:

- Income eligibility;
- ALTCS SOC; or
- Resource eligibility (for ALTCS).

The customer's counted income may be less when the deceased person was part of the customer's budget group and had income. However, the customer's income could increase due to qualifying for a survivor's benefit or inheriting income or resources due to the death.

Definitions

Term	Definition
Capitation	A fixed rate paid to the health plan or program contractor for the delivery of services to each customer enrolled with that health plan or program contractor, regardless of the amount of medical services the customer receives.
Death Benefits	Death benefits include, but are not limited to, the following: • Lump sum death benefits from SSA or USOPM; • Railroad Retirement burial benefits; • VA burial benefits; • Life insurance proceeds; • Inheritances in cash or in-kind; or • Cash or in-kind gifts given by relatives, friends, or a community group to assist with expenses related to the death.
Inheritance	Inheritance is cash, a right, or a non-cash item given to a person because of someone's death.

Life Insurance Proceeds	Life insurance proceeds include: • Payments from a life insurance company to the beneficiary of a policy upon the death of the insured; • Payments to the owner of the policy when the policy is surrendered; or • Accelerated life insurance payments.

Proof

The following forms of verification are accepted as proof of date of death:

- Collateral contact with knowledgeable sources such as relatives, case managers, hospital or nursing facility where the customer died, or the funeral home that handled the burial arrangements;
- Social Security record showing date of death;
- Obituary in a newspaper; or
- Death records from Vital Records including:
    - Electronic reporting from the agency; or
    - An official death certificate.

NOTE When records are available from Vital Records they are used over all other forms of proof. Any discrepancies must be reported to Vital Records by a family member. Only a family member can request a change to the death record.

Timeframes

The change must be reported within 10 calendar days of the date of death.

Legal Authority

Program	Legal Authorities

All Programs	42.CFR 431.213(a) 42 CFR 435.916(c)
ALTCS	AAC R9-28-411(A)(1)(g)
SSI-MAO	AAC R9-22-1501(H)(1)(d)
Medicare Savings Program (MSP)	AAC R9-29-213(6)
Freedom to Work (FTW)	AAC R9-22-1905
Breast and Cervical Cancer Treatment Program (BCCTP)	AAC R9-22-2008
KidsCare	42 CFR 457.343 R9-31-310(B)(1)

H DDD Status Change

Revised 06/18/2021

Policy

A change in the customer's eligibility status with the Department of Economic Security's (DES) Division of Developmental Disabilities (DDD) affects the:

- Preadmission Screening (PAS) tool that is used to determine ALTCS medical eligibility;
- Program contractor with whom the customer is enrolled; and
- Types of long term care services available to the customer.

See DD Status Changes for instructions on processing a change in DD status.

Definitions

Term	Definition
Division of Developmental Disabilities (DDD)	The division within DES responsible for providing services to eligible Arizona residents with developmental disabilities, as defined in ARS Title 36, Chapter 5.1.
Preadmission Screening (PAS)	The method of determining whether the customer is medically eligible for the ALTCS program.

Proof

DDD provides information and proof about changes in the customer's DDD status.

Programs Affected

This applies to the following programs:

- ALTCS

- FTW – ALTCS

Legal Authority

Program	Legal Authorities
ALTCS FTW-ALTCS	42 CFR 435.540 42 CFR 435.541 AAC R9-28-402(A)(2) and (3) AAC R9-28-305 and 306

I DDSA Redetermination of Disability or Blindness

Revised 05/30/2018

Policy

SSI-MAO and Freedom to Work (FTW) customers must provide updated information about their disabling conditions in certain circumstances.

The Disability Determination Service Administration (DDSA) usually determines a person to have a disability or blindness for a limited period of time. When this is the case, the person's disability or blindness must be reviewed and determined again at the end of the limited period.

The DDSA decision on the most recent Disability Determination and Transmittal (DE-120) lists the date when next determination is due. This date is also known as the medical diary end date.

Before the medical diary end date, DDSA redetermination forms are sent to SSI-MAO and FTW customers that are under age 65 and do not receive SSI-Cash or Social Security Disability payments. The customer must complete and return these forms to see if they still qualify for SSI-MAO or FTW.

> NOTE AHCCCS does not send DDSA redetermination forms when the customer is receiving Social Security Disability or SSI-Cash payments because this is already done as part of the redetermination process for the payments.

See DDSA Redetermination of Disability or Blindness Referrals for instructions.

Definitions

Term	Definition
Disability Determinations Services Administration (DDSA)	The division of the Arizona Department of Economic Security (DES) Arizona authorized to make disability determinations for the Social Security Administration and for the AHCCCS Administration.
Disability Determination	The disability determination for SSI-MAO is the same as is used for the Social Security Administration.

Proof

The Disability Determination and Transmittal (DE-120) from DDSA with the results of the redetermination.

Programs Affected

This applies to the following programs:

- SSI MAO; and
- FTW.

Timeframes

Processing begins 90 calendar days before the end of the diary date.

Legal Authority

Program	Legal Authorities
SSI-MAO	42 CFR 435.540 42 CFR 435.541 42 CFR 435.916 AAC R9-22-1501(B)
Freedom to Work (FTW)	42 CFR 435.540 42 CFR 435.541 42 CFR 435.916 AAC R9-22-1922(B) AAC R9-28-1324(B)

J Demographic Information

Revised 08/15/2023

Policy

The customer may request a correction of the following demographic information:

- Name;
- Date of birth;
- Social Security number;
- Date of marriage;
- Address; or
- Sex (including gender change)

These changes do not usually cause a change to a customer's eligibility or costs but must be reviewed for possible impact.

Proof

The type of proof depends on the type of change:

When the change is a...	Then the proof required includes...
Name change or correction	• Social Security (SSA) records. • Marriage certificate; • Divorce decree; or • Other court records.
When a customer has a Mononymous name	• Birth Certificate; • Legal documents showing the name change when the customer previously had two names; • Social Security (SSA) Records; and

	• All other needed information to verify pending eligibility factors.
Date of birth correction	See Proof in MA501.
Social Security Number correction	See Proof in MA532.
Date of marriage correction	See Proof in MA1502R
Address change	See Proof in MA1502A
Sex correction, including gender change	Accept the customer's statement. NOTE Warn customers who are eligible for Medicaid and Medicare that this type of change may prevent AHCCCS from paying the Medicare Part B premium when SSA records do not match.

Programs Affected

This applies to all programs.

Legal Authority

Program	Legal Authorities
All Programs (except KidsCare)	42 CFR 435.916
KidsCare	42 CFR 457.343

K Employment with a State Agency

Revised 05/30/2018

Policy

A child does not qualify for KidsCare when the child can get state employee health insurance. See MA517 for details. KidsCare coverage is ended and eligibility is reviewed to determine if the child can qualify for any other MA program.

Definitions

Term	Definition
State employees who do not qualify for State Employee health insurance.	• Employees who work less than 20 hours per week; • Seasonal, temporary, emergency, and clerical pool employees; • Patients or inmates employed in state institutions; • Employees in positions created for rehabilitation only; and • Employees of a state college or university who are hired to work for less than six months, or are not part of a state retirement plan.

Proof

When the person lists coverage through state employee health insurance on the application or verbally, accept the statement as proof.

When the person is a state employee but does not list coverage on the application, proof of coverage includes:

- Pay stubs showing any deduction for health coverage. Dental and vision plans are deductions for health coverage.

- Work Number records showing the person has medical, dental or vision insurance.
- Phone call to the personnel office at the agency, department or university where the person works to confirm whether the employee qualifies for state employee health coverage.

Programs Affected

This applies to the following program:

- KidsCare.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
KidsCare	42 CFR 457.310(c)(1) ARS 36-2983(G)(3)

L Expenses

Revised 07/12/2019

Policy

The customer may report changes to the following types of expenses:

- Share of cost (SOC) related expenses;
- Work-related expenses; or
- Adjusted gross income deductions.

When the customer reports a change in...	Then the change may affect...
SOC-related expenses	The customer's SOC when the customer receives: • ALTCS; or • FTW-ALTCS and lives in a long term care medical facility.
Work-related expenses: • Blind Work Expenses; or • Impairment Related Work Expenses	The customer's income eligibility or premium amount when the customer receives: • SSI-MAO; • MSP; or • FTW.
Adjustments to Gross Income: • Educator expenses; • Certain business expenses of reservists, performing artists and fee-basis government officials; • Health savings account deduction;	The customer's KidsCare premium amount or income eligibility when the customer qualifies for any of the following MA programs: • Adult; • Caretaker Relative; • Pregnant Woman;

• Moving expenses for members of the Armed Forces who move as a result of military orders; • Deductible part of self-employment tax; • Self-employed SEP, SIMPLE and qualified plans; • Self-employed health insurance deductions; • Penalty on early withdrawal of savings; • Alimony paid; when the spousal support agreement was created before 12/31/2018 and has not been modified since that date to add the provisions of the Tax Cuts and Jobs Act of 2017; • IRA deduction; • Student loan interest deduction.	• Child; or • KidsCare.

Definitions

Term	Definition
Blind Work Expenses (BWE)	The reasonable cost of services and items that a person with a DDSA determination of blindness needs in order to work and are necessarily incurred by that person because of the visual impairment. (See MA609B.7)
Impairment Related Work Expenses (IRWE)	The reasonable cost of services and items that a person with a disability needs in order to work and are necessarily incurred by that person because of a physical or mental impairment. (See MA609B.5)
Share of Cost Related Expenses	Certain expenses subtracted from the customer's total counted income to figure the share of cost (SOC) amount. See MA1201C for additional information. These expenses include: • Medicare premium amounts;

	• Third Party Liability insurance (TPL) premiums; • Non-covered medical expenses; or • Shelter expenses
Adjustments to Gross Income	Expenses and income deferrals allowed to determine Adjusted Gross Income (AGI) for tax purposes are also allowed when determining income eligibility using MAGI rules. See MA609C for additional information. See also IRS Publication 17 for full list of the requirements for each adjustment at http://www.irs.gov/publications/p17/index.html).

Proof

Changes to expenses are verified as follows:

When the expense is...	Then the policy used is located at...
Medicare and TPL premium amounts	MA1201C.7
Non-covered medical expenses	MA1201C.8
Shelter expenses	MA1201C.4
Blind Work Expenses	MA609B.7
Impairment Related Work Expenses	MA609B.5
Adjustments to Gross Income	MA609C

Programs Affected

This applies to the following programs:

Effective until 2025-04-25

- ALTCS;
- SSI MAO;
- Medicare Savings Program (MSP);
- Freedom to Work (FTW);
- Adult;
- Caretaker Relative;
- Pregnant Woman;
- Child; and
- KidsCare.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) 42 CFR 435.725 and 726 AAC R9-28-411
SSI MAO Medicare Savings Program (MSP) Freedom to Work (FTW)	20 CFR 416.1112(c) 42 CFR 435.916
Adult Caretaker Relative	42 CFR 435.603 42 CFR 435.916

Pregnant Woman Child	AAC R9-22-306(B)(3)(c)
KidsCare	42 CFR 457.315

M Failure to Cooperate with Division of Child Support Services (DCSS)

Revised 08/13/2024

Policy

The requirement to cooperate with DCSS in establishing the identity of a child's parents and in obtaining medical support is suspended under a temporary waiver from 09/01/2023 through 06/30/2025.

To qualify for or to keep getting AHCCCS Medical Assistance (MA), a person must cooperate with the Division of Child Support Services (DCSS) unless the person has good cause or is exempt. Cooperation includes:

- Providing information needed to determine the paternity of a child in the home who is receiving MA, and
- Taking any actions needed to get medical support from an absent parent, unless the person has good cause not to cooperate.

NOTE There are some situations when a person does not have to cooperate with DCSS.

- A woman while she is pregnant.
- Parents whose children are on KidsCare.

NOTE Parents must cooperate for any other children they have on Medicaid.

Customers who do not comply with this requirement have their MA stopped. The requirement only applies to the customer parent or caretaker relative. The children in the home do not lose their MA when a parent or relative fails to cooperate with DCSS.

Customers who have lost MA for failure to cooperate can qualify again if they meet any of the following:

- Cooperate with DCSS,
- Establish good cause for not cooperating, or
- Become pregnant and are exempt from cooperating.

Definitions

Term	Definition

Division of Child Support Services (DCSS)	The Division of the Department of Economic Security responsible for getting medical support orders in place and enforcing those orders.
Good cause not to cooperate with DCSS	Good cause includes: • Cooperation in determining paternity or getting a support order is reasonably expected to result in physical or emotional harm to the child or the person with whom the child is living; • Legal proceedings for the child's adoption are pending before a court; • The parent is working with a public or licensed private agency to give the child up for adoption, and discussions have not gone on for more than three months; or • The child was conceived as a result of incest or rape.

Proof

Good cause for not cooperating with DCSS

Proof of good cause includes:

- Birth certificate that shows the child was conceived through incest;
- Medical or law enforcement records that show the mother was raped;
- Court or other legal documents showing that adoption proceedings are pending before a court;
- Written statement from the adoption agency that they have been working with the customer on giving up the child for adoption and for how long;
- Court, medical, criminal, child protective services, psychological, social services or law enforcement records showing that the absent parent might physically or emotionally harm the child or caretaker relative; or
- Sworn statements from friends, neighbors, clergy or other people who know the about the situation and can support the good cause claim.

When none of the above is available, the person is asked to provide any information that would support further investigation.

Good cause must be reviewed at renewal and any time there is a change that shows good cause no longer exists.

Cooperation with DCSS

Proof that a person has cooperated with DCSS and can qualify again for MA includes:

- Verification of Cooperation with the Division of Child Support Services form (FAA-1221A), completed by DCSS;
- Other written notice of compliance from DCSS; or
- Phone call to the DCSS to confirm compliance.

Programs Affected

This applies to all programs except KidsCare.

Legal Authority

Program	Legal Authorities
All Programs (except KidsCare)	42 CFR 433.147 42 CFR 435.610
ALTCS	AAC R9-28-401.01(B)(11)
SSI-MAO	AAC R9-22-1501
Medicare Savings Program (MSP)	AAC R9-29-208
Freedom to Work (FTW)	AAC R9-22-1909

N Household and Budget Group Member Changes

Policy

Who is included in the budget group may change due to:

- Birth;
- Death;
- Marriage;
- Separation;
- Divorce;
- People moving into or out of the household; or
- Taxpayer or tax dependent status.

A change in the budget group may affect the customer's eligibility or the customer cost.

See Processing Budget Group Changes for instructions.

Definitions

Term	Definition
Budget Group	Persons included when determining income eligibility.
Tax Dependent	A person claimed as a dependent on someone else's tax return. This can include a person who chooses to or must file a tax return of their own.
Taxpayer	A person who: • Expects to file a tax return for the current year, and • Will not be claimed as a tax dependent by someone else.

	NOTE Spouses who file a joint return and are not claimed as tax dependents by someone else are both considered tax payers.

Proof

The customer’s verbal or written statement about the change is accepted unless questionable.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5 for Community Spouse 20 CFR 416.415, 432, 435, 1163, 1165 and 1202 42 CFR 435.916 AAC R9-28-410
SSI MAO Medicare Savings Program (MSP)	20 CFR 416.415, 432, 435. 1132, 1163 and 1165 42 CFR 435.916 AAC R9-22-1501(H)
Adult	42 CFR 435 603 42 CFR 435.916

Children Caretaker Relative Pregnant Women	AAC R9-22-1420(B)
KidsCare	42 CFR 457.301 and 315 42 CFR 457.343

O Income Changes

Revised 08/03/2021

Policy

Customers must report all changes in income for themselves and anyone else included in their budget group. See MA602 for the people included in the budget group for each AHCCCS Medical Assistance (MA) program. Changes in income may also be found through electronic data matches. A change in income includes any of the following:

- How often the income is received;
- The amount of income received; and
- The source of the income.

Impact of Change in Income

Increases or decreases in income may affect the customer in different ways depending on the program under which the customer is receiving benefits:

When the customer receives...	And the income change is for the...	Then the income change may affect the customer's…
ALTCS	• Customer; • Customer's spouse • Customer or spouse's dependent children	• Income eligibility; or • Share of Cost (SOC).
Freedom to Work (FTW) – ALTCS	• Customer; • Customer's spouse • Customer or spouse's dependent children	• Income eligibility; • SOC; or • Monthly premium.

SSI-MAO Medicare Savings Program (MSP)	• Customer; • Customer's spouse; • Customer or spouse's dependent children; or • Customer's parent (when customer is a minor)	• Income eligibility; or • MA program.
Freedom to Work (FTW)	• Customer; • Customer's spouse; • Customer or spouse's dependent children; or • Customer's parent (when customer is a minor)	• Income eligibility; • MA program; or • Monthly premium.
Adult; Caretaker Relative Child	Anyone in the customer's MAGI budget group (See MA602D)	Income eligibility.
Pregnant Woman	Anyone in the customer's MAGI budget group (See MA602D)	MA program. NOTE Increases in income that happen after the customer is approved as a Pregnant Woman do not affect eligibility.
KidsCare	Anyone in the customer's MAGI budget group (See MA602D)	• Income eligibility; • MA program; or • Monthly premium.
Transitional Medical Assistance/Continuous Coverage (TMA/CC)	Anyone in the customer's MAGI budget group (See MA602D)	MA program. NOTE When income increases after a TMA period or CC is approved, no action is taken until the next renewal.

Young Adult Transitional Insurance (YATI)	Anyone in the customer's MAGI budget group (See MA602D)	MA program. NOTE There is no income limit for YATI.

NOTE A change in income only affects Breast and Cervical Cancer Treatment Program (BCCTP) or YATI when the customer's income decreases enough that he or she qualifies for another MA program.

Definitions

Term	Definition
Income	Income is either earned or unearned. There are many types of income within each category of income. Different policies apply to each type of income as described in MA606.

Proof

Changes to income are verified by following the policy related to the specific income type in MA606.

Programs Affected

This applies to all programs except for BCCTP and YATI.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs, except KidsCare	42 CFR 435.916
ALTCS	AAC R9-28-411
SSI-MAO	AAC R9-22-1501(H) AAC R9-22-1503, 1504 and 1505
Medicare Savings Program (MSP)	AAC R9-29-213
Freedom to Work (FTW)	AAC R9-22-1905
KidsCare	42 CFR 457.315 and 343 R9-31-304 and 308

P Long Term Care Living Arrangement

Revised 09/03/2024

Policy

Changes in a customer's long term care living arrangement, including admission to or discharge from a nursing facility or public institution must be reported.

For a customer who receives services under ALTCS or Freedom to Work (FTW) – ALTCS programs, living arrangement changes may affect the customer's services, Share of Cost (SOC), or premium. See MA521 for detailed policy on living arrangements.

For a Veteran customer, a change in living arrangement may affect:

- Eligibility for VA potential benefits for the customer or applying spouse or dependent; or
- The maximum potential VA income benefit.

See Living Arrangement Changes Examples.

Use the following manual sections for policy related to other living arrangement changes:

When the customer...	Then the following policy is followed...
Moves out of state permanently	MA1502A
Is temporarily out of state	MA1502A
Enters a detention facility	MA1502V

Proof

When the customer reports a new living arrangement the following information is needed:

- Date the customer entered the new living arrangement;
- Type of facility, when customer is residing in a medical or home and community-based setting (HCBS) facility; and
- Date the customer left the previous living arrangement.

When the customer reports that they have moved from a HCBS facility to another HCBS facility, the following can be used as proof:

- Client statement (verbal, written, electronic) from the customer, their spouse, Authorized Representative, Legal Representative or Program Contractor Case Manager/FFS Tribal Case Manager
- A verbal, written or electronic Member Change Report (MCR) from the Program Contractor Case Manager or FFS Tribal Case Manager

NOTE Client statements and a member change report can only be accepted for living arrangement changes that do not impact member's eligibility, enrollment, or Share of Cost.

Programs Affected

This applies to the following programs:

- ALTCS
- FTW-ALTCS

Timeframes

When the customer moves from a setting in which only limited ALTCS services can be provided to a setting where full long term care services can be provided, the customer is eligible for full long term care services beginning on the date that they moved to a setting where long term care services can be provided, rather than the first of the month.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 435.916 42 CFR 435.1005 AAC R9-28-406 AAC R9-28-411(A)(1)(b)
FTW- ALTCS	42 CFR 435.916

	ARS §36-2950 AAC R9-28-406 and R9-28-1315

Q Loss of Contact Due to Returned Mail

Revised 09/19/2023

Policy

When mail sent to a customer has been returned as undeliverable with a forwarding address, attempts to contact the customer to confirm the new address provided by USPS must be made. When no forwarding address is provided, the customer has not reported a change of address and cannot be located; AHCCCS Medical Assistance (MA) benefits are stopped for the following month.

When the customer contacts the Benefits and Eligibility Specialist before the date the MA benefits stop, the customer's benefits are reinstated with no loss of coverage. Reinstate eligibility without requiring a new application for MAGI-based customers whose coverage is terminated for failure to return their renewal forms or necessary information if the individual's renewal form or information is returned within 90 days after coverage is terminated.

Definitions

Term	Definition
Loss of Contact	When a person cannot be located. Mail sent to that person is returned as undeliverable.
Returned Mail	Mail that is returned by the post office as undeliverable with no forwarding address.

Proof

Mail that is returned as undeliverable with no forwarding address.

Programs Affected

This applies to all programs.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 431.213(d) 42 CFR 435.403 42 CFR 435.916
KidsCare	42 CFR 457.343

R Marital Status

Revised 07/10/2020

Policy

When a customer marries or divorces, it may affect the customer's eligibility or the amount the customer must pay for a Share of Cost (SOC), premium or copayments.

When the customer divorces, the change in status is effective the month following the month the divorce is final.

When a customer marries, the change in status is effective the month the marriage took place.

For policy on a change in marital status due to the death of a spouse, see MA1502G.

For policy on physical separation of spouses, see MA1502Z.

The following table describes how changes in marital status may affect different programs:

When the program is...	Then...
ALTCS	The change may affect whether or not: • Community Spouse policy applies; • The spouse's income is included in the income determination; • The spouse's resources are included in the resource determination; and • The spouse's income and expenses are included in the SOC determination.
Freedom to Work (FTW)-ALTCS	The change may affect whether or not Community Spouse policy applies when determining the customer's SOC.
FTW Breast and Cervical Cancer Treatment Program (BCCTP)	The customer may qualify for another Medicaid program because of the different income budgeting for married couples.
SSI-MAO Medicare Savings Program (MSP)	The change may affect whether or not: • The spouse's income is included in the income determination; and

	• The couple income standard may be used instead of the individual standard.
Adult Caretaker Relative Pregnant Woman; Child; or KidsCare	The change may affect who is included in the customer's income group. See MA602D.

See Processing Changes in Marital Status for instructions.

Definitions

Term	Definition
Change in marital status	A customer marries or divorces, or is widowed.

Proof

For all programs except ALTCS and Freedom to Work (FTW), a person's statement of marriage is accepted as proof unless there is evidence to the contrary. A customer's marital status is not needed for FTW eligibility. For ALTCS, see the chart below. The proof needed is based on the marital relationship claimed.

Type	Proof
Legal Marriage	• An official marriage license; • Court or church records; • Marital Status and Family Profile Document issued by the Navajo Nation; • Tribal Family Census Card issued by the Bureau of Indian Affairs; • Marriage license issued by the Navajo Office of Vital Records; or

	• Phone contacts with an official Agency or Court. NOTE Social Security (SSA) or SSI benefit records cannot be used for proof of legal marriage.
Common Law Marriage established outside Arizona	A completed Customer Statement – Common Law Marriage (DE-119) form.
Divorced	Accept the person's statement unless it is questionable. For example, when a customer previously claimed to be married but later claims to be divorced or widowed, ask for proof of the divorce or death.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5 for Community Spouse 42 CFR 435.916 AAC R9-28-411(A)(1)(h)
SSI-MAO	20 CFR 416.432, 435, 1132, and 1163 42 CFR 435.602 42 CFR 435.916 AC R9-22-1501(H)(1)(e)

	AAC R9-22-1503, 1504 and 1505
Medicare Savings Program (MSP)	20 CFR 416.432, 435, 1132, and 1163 42 CFR 435.602 42 CFR 435.916 AAC R9-29-213
Freedom to Work (FTW)	42 CFR 435.916 AAC R9-22-1901
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 AAC R9-22-2008
Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.603 42 CFR 435.916
KidsCare	42 CFR 457.343

S Medical Improvement

Revised 02/03/2020

Policy

A change in medical or functional condition must be reported. An improvement in the customer's medical condition may affect the outcome of a Preadmission Screening (PAS) reassessment for ALTCS.

For a medical improvement that affects the Disability Determinations Services Administration (DDSA) disability determination for SSI-MAO or Freedom to Work (FTW) see MA1502I.

When the PAS reassessment determines the customer ...	Then...
Is medically ineligible	The customer's ALTCS eligibility is discontinued and the customer is screened for other Medicaid eligibility.
Has improved medically or functionally and is no longer at risk of institutionalization at a nursing facility (NF) or intermediate care facility (ICF), but requires a lower level of long term care	The customer is transferred to the ALTCS Transitional program.

Definitions

Term	Definition
Preadmission Screening (PAS)	PAS is ALTCS' method of determining whether a customer is medically eligible for the ALTCS program. The PAS process also is used to determine disability for customers under age 65 who have not been determined to have a disability or blindness by DDSA.

Proof

ALTCS Medical Eligibility staff enter the PAS reassessment results in HEAplus.

Programs Affected

This applies to the ALTCS and FTW-ALTCS programs.

Timeframes

Changes must be reported as soon as the event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS FTW - ALTCS	42 USC 1396(a)(10)(A)(ii)(V) and (XVI) 42 CFR 435.916 AAC R9-28-306 and 307

T Medical Insurance Coverage and Premiums

Revised 06/04/2021

Policy

Medicaid is the payer of last resort. The customer must provide current information about any medical insurance coverage or premium amounts. This information allows the appropriate carrier to be billed.

In some cases, changes in medical coverage or premium amounts may affect a customer's eligibility or Share of Cost (SOC):

When the program is...	Then...
ALTCS ALTCS - Freedom to Work	Changes in the customer's medical insurance premium amounts may affect the customer's SOC for ALTCS services (MA1201C).
Adult	When a parent or other relative is living with a child and is the child's main caretaker, the child must have minimum essential coverage for the person to qualify for the Adult group (MA518).
Breast and Cervical Cancer Treatment Program (BCCTP)	A customer is no longer eligible for BCCTP when she has creditable health insurance coverage, unless she qualifies for an exception (MA515).
KidsCare	A customer is no longer eligible for KidsCare when he or she has creditable health insurance coverage (MA515).

See Processing Changes in Medical Insurance Coverage or Premiums for details.

Definitions

Term	Definition

Creditable Coverage	Health insurance coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). Examples of creditable coverage include: • Medicare; • Group health plans including Qualified Health Plans; • Health insurance coverage through a hospital or medical service policy, certificate or plan contract; or • Armed forces insurance (i.e., TriCare).
Non-Creditable Coverage	The following types of policies are considered non-creditable coverage: • Coverage only for accidents (including accidental death and dismemberment); • Liability insurance, including general liability and automobile liability insurance; • Free medical clinics at a work site; • Benefits with limited scope such as dental benefits, vision benefits or long term care benefits; • Coverage for a specific disease or illness (including cancer policies); • Insurance that pays a set amount a day when the person is hospitalized or unable to work.
Minimum Essential Coverage	Means any of the following kinds of health insurance coverage: • Full AHCCCS Medical Assistance benefits; • Medicare Part A; • TriCare for Life; • Veterans health program;

	• Government health plan for Peace Corps volunteers; • Group and Individual health plans, including Qualified Health Plans purchased on the Federally Facilitated Marketplace; • Employer-sponsored coverage; or • Other health benefits coverage, such as a State health benefits risk pool. Minimum Essential Coverage does NOT include: • Coverage only for accident or disability income insurance; • Liability insurance, including general liability insurance and automobile liability insurance; • Workers' compensation or similar insurance; • Automobile medical payment insurance; • Coverage for on-site medical clinics; • Dental- or vision-only benefits; • Coverage only for long-term care services; • Coverage only for a specified disease or illness; or • Hospital indemnity or other fixed indemnity insurance.

Proof

Proof of new insurance coverage includes:

- Insurance contract;
- Copy of both sides of the insurance card;
- Telephone contact to the insurer to confirm the details of the coverage.

Proof that insurance coverage has ended includes:

- Letter or written statement from the insurer confirming the coverage end date;
- Telephone contact to the insurer confirming the coverage end date;
- Telephone contact to the previous employer to confirm the coverage end date for employer-sponsored insurance.

Proof of a change in premium amount includes:

- Letter or written statement from the insurer with the new premium amount and effective date;
- Telephone call to the insurer confirming the new premium amount and effective date;
- When the customer is no longer paying the premium or someone else is paying the premium, the customer's statement is accepted. No further proof is needed.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Use the following table to determine the effective date for the change.

If the change results in...	**Then the effective date of the change is...**
A decrease in the ALTCS Share of Cost	The later of the first day of the month in which the change: • Took place; or • Was reported to AHCCCS.
• An increase in the ALTCS Share of Cost; or • Loss of eligibility	The first day of the month after the change that allows for adverse action rules.

Legal Authority

Program	Legal Authorities
ALTCS FTW-ALTCS	42 CFR 435.725(c)(4)(i) 42 CFR 435.726(c)(4)(i) 42 CFR 435.916 AAC R9-28-410(C) AAC R9-28-411(A)(1)
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 ARS 36-2901.05 AAC R9-22-2003(A)(5) AAC R9-22-2005(D)(1)
Adult	42 CFR 435.916 42 CFR 435.119(c)
KidsCare	42 CFR 457.310(b)(2)(ii) ARS 36-2983(G)(2) AAC R9-31-303

U Medicare Eligibility Begins

Revised 05/30/2018

Policy

When a person becomes eligible for or starts receiving Medicare it may affect the following:

- Eligibility;
- Services;
- ALTCS Share of Cost (SOC)

Most people begin receiving Medicare coverage at age 65. People who are under age 65 may qualify for Medicare when they meet one of the following:

- Receive Social Security Disability and have Amyotrophic lateral sclerosis (ALS), which is also known as Lou Gehrig's disease;
- Are diagnosed with End Stage Renal Disease (ESRD) and receive maintenance dialysis or a kidney transplant (eligible for Medicare Part A); or
- Received Social Security Disability benefits for 24 months.

To qualify for certain AHCCCS Medical Assistance (MA) groups, a person cannot have Medicare. See the following table for details:

When the MA program is…	Then…
Adult	The customer is no longer eligible for the Adult group when he or she qualifies for Medicare (MA523).
Breast and Cervical Cancer Treatent Program (BCCTP)	The customer is no longer eligible for BCCTP when she has creditable health insurance coverage, which includes Medicare (MA515).
KidsCare	The customer is no longer eligible for KidsCare when he or she has creditable health insurance coverage, which includes Medicare (MA515).

When Medicare begins the following changes may occur:

- Medicare Part A and Part B premiums may be paid by the State because of the customer's MA category or through a Medicare Savings Program (QMB, SLMB or QI-1);
- The customer will no longer be able to receive most prescription medications through AHCCCS, and will need to enroll in a Medicare Part D drug plan;
- Eligibility for MA in the Adult, BCCTP or KidsCare program stops.

Definitions

Term	Definition
Medicare	Medicare is a health insurance program administered by the Social Security Administration (SSA). For additional information about Medicare go to http://medicare.gov/.

Proof

Social Security records are used to see if the customer is entitled to or receiving Medicare Part A and Medicare Part B.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
Medicare Savings Program (MSP)	42 USC 1396d(p) 42 CFR 435.916 AAC R9-29-218
Adult	42 CFR 435.119(a)(3) 42 CFR 435.916
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 ARS 36-2901.05(A)(5) AAC R9-22-2003(A)(5)
KidsCare	42 CFR 457-310 AAC R9-31-303

V Incarcerated

Revised 12/17/2024

Policy

A change in the status of an inmate can affect a customer's eligibility.

1) Customer is reported as incarcerated

In general, AHCCCS cannot pay for any services while a person is incarcerated. When a change is reported that a customer is incarcerated, eligibility will continue, and enrollment will be suspended.

2) Customer is released from incarceration

In general, benefits will resume on the day the customer released.

Exception:

Eligible juveniles may receive certain AHCCCS services in the 30-day period prior to release, see MA1302D for more information.

Definitions

Term	Definition
Inmate of a Penal Institution	A person who is: • An inmate in a federal or state prison; • An inmate of a county, city, or tribal jail; • An inmate of a prison or jail, prior to arraignment, conviction, or sentencing; • Incarcerated but can leave prison on work release or work furlough, and must return at specific intervals; • A child in a juvenile detention center due to criminal activity or held as a material witness; • A person involuntarily placed in a secure treatment facility that is part of the criminal justice system.

Not an Inmate of a Public Institution	A person who is: • After arrest, but before booking, escorted by police to a hospital for medical treatment and held under guard; • Voluntarily living in a public institution; • Released on probation, parole, or a release order with the condition of home arrest, work release, community service, or medical treatment; or • Admitted as an inpatient to a medical institution; • A child held in a juvenile detention center for the care, protection, or in the best interest of the child, if there is a specific plan for that person that makes the stay at the detention center temporary; • A child on intensive probation with the condition of home arrest, treatment in a psychiatric hospital, or a residential treatment center, or outpatient treatment; • A child in a juvenile detention center after disposition when there is a plan to release the child to the community, and the release is only pending arrangements suitable to the child's needs.
Public Institution	An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does NOT include: • Medical institutions; • Intermediate care facilities; • Publicly operated community residence that serves no more than 16 residents; or • State-licensed child care institutions for foster children that house no more than 25 children.

Voluntarily living in a public institution	Means living in a public institution by choice, not as an extension of incarceration. The person is free to leave the institution if he or she chooses.
Eligible Juveniles	A person who become incarcerated while enrolled in Medicaid or are determined eligible for Medicaid while incarcerated and is: • Under 21 years of age or • Former foster youth up to the age of 26

Proof

Proof of incarceration includes:

- The customer's statement;
- Electronic records of incarceration from the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR) or a county jail;

NOTE When the customer's statement conflicts with other information or proof, the detention facility is contacted to confirm the person's status.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Programs and Legal Authorities

Program	Legal Authorities
All Programs (except KidsCare)	42 CFR 435.1009 and 1010

	42 CFR 435.916 AAC R9-22-310 AAC R9-28-406 AAC R9-22-1915 AAC R9-22-2003
KidsCare	42 CFR 457.310 (c)(2)(i) 42 CFR 457.343 ARS 36-2983(G)(4) AAC R9-31-303(9)

W Pregnancy and Postpartum

Revised 12/19/2023

Policy

When a woman becomes pregnant, or is no longer pregnant, the change can affect eligibility and copayments.

When a woman reports that she is pregnant, she may qualify for the Pregnant Woman program. If she qualifies, Pregnant Woman coverage continues through her postpartum period even if her income later increases. Pregnant women do not have to pay copayments.

During the postpartum period, eligibility is reviewed to see if the woman qualifies for any other AHCCCS Medical Assistance (MA) program.

Definition

Term	Definition
Pregnant	Pregnant means that a woman is expecting the birth of one or more children.
60-day Postpartum Period	A 60-day period starting the day the pregnancy ends. This period applies to a customer who was not enrolled in AHCCCS while pregnant. A customer who is applying for AHCCCS and was pregnant or in their 60-day postpartum period in any of the 3 months before their application month, may be eligible for Prior Quarter Coverage.
12-month Postpartum Period	A 12-month period starting the day the pregnancy ends. This period ends on the last day of the 12th month. Customer must be enrolled in AHCCCS while pregnant to be in the 12-month postpartum period as it applies to this group. See Pregnancy and Postpartum for examples.

Proof

The woman's statement that she is pregnant is accepted unless there is strong reason to question the statement.

Programs Affected

This policy applies only to the Pregnant Woman program.

Timeframes

Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
Pregnant Woman	42 CFR 435.116 42 CFR 435.916

X Resource Changes

Revised 03/01/2022

Policy

The customer must report and verify receipt or transfer of all real and personal property.

A change in resources may impact eligibility as follows:

- Uncompensated transfers may result in a period of ineligibility for long term care services, but the customer may continue to qualify for ALTCS Acute Care.
- When the customer's resources exceed the resource standard for the entire calendar month, the customer is ineligible for that month.

NOTE When an ALTCS customer's resources have increased significantly and the customer is under age 65, see MA803 for information about Special Treatment Trusts.

Definitions

Term	Definition
Resource	Resources are items of real or personal property, including cash, which may be used to meet the customer's needs for food or shelter.

Proof

Resource changes are verified as follows:

When the reported change is...	Then...
Transfer of resources	The transfer is verified using policy in MA900.
Increase or decrease in the value of one or more resources	The counted value of a resource is verified using the policy for the specific resource type listed in MA705. Exception:

	When the change results in the customer's resources being over the resource limit, accept the customer's statement as proof.

Programs Affected

This policy applies only to the ALTCS program.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5(c)for Community Spouse 20 CFR 416.1205 42 CFR 435.916 AAC R9-28-407, R9-28-410 and R9-28-411

Y School Attendance Change

Revised 05/30/2018

Policy

A change in school attendance may affect eligibility and countable income for some AHCCCS Medical Assistance (MA) groups. See the table below for how this change affects different programs:

When the MA group is...	And…	Then...
Caretaker Relative	The only child in the home is age 18 and was a student, but is no longer in school	The customer no longer qualifies for the Caretaker Relative group. See MA506 for more policy.
SSI-MAO Medicare Savings Program (MSP) Freedom to Work (FTW) ALTCS-Acute	The customer is the student and is under age 22	A change in student status may affect whether the customer qualifies for the Student Earned Income Exclusion. See MA609B.2 for more policy.
	The customer's child is the student and is age 18 to 21	A change in student status may affect the customer's child allocation amount. See MA609B.8 for more policy.
ALTCS FTW-ALTCS	The customer's child is age 19 to 23	A change in student status may affect whether or not they can be included as dependents when calculating the Community Spouse Family Allowance. See MA1201C.6 for more policy.

Proof

Proof is required as follows:

When the reported change is…	Then…

School attendance has decreased or ended	The customer's statement is accepted.
School attendance began or increased to a level that would allow the customer to qualify for: • Student Earned Income Exclusion; • An additional child allocation; or • MA as a Caretaker Relative.	Proof includes • Written statement from the school; • Telephone contact with the school; • Completed "Verification of School Attendance" form; or • Other documents that provide student status information.

Programs Affected

This policy applies to the following programs:

- ALTCS;
- SSI MAO;
- Medicare Savings Program (MSP);
- Freedom to Work (FTW); and
- Caretaker Relative.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS SSI MAO	42 USC 1382a(b)(1) 20 CFR 416.1112(c)(3) 42 CFR 435.916

Freedom to Work (FTW) Medicare Savings Program (MSP)	AAC R9-28-408(B) and R9-28-411(A) - ALTCS AAC R9-22-1503(A) - SSI-MAO AAC R9-11-1901(5) – FTW AAC R9-29-212 - MSP
Caretaker Relative	42 U.S.C 1396u-1 42 CFR 435.110 42 CFR 435.916

Z Separation

Revised 05/30/2018

Policy

Separation refers to a change in relationship. There are two forms of separation:

- Physical separation; and
- Legal separation.

The effect of separation depends on:

When the spouses are...	And the customer receives...	Then...
Physically separated and no longer living together	SSI MAO Medicare Savings Program (MSP)	Individual budgeting applies beginning the first full month the spouses do not live together.
	ALTCS (Non-Community Spouse)	The separation does not affect the customer's income budgeting but could affect Share of Cost (SOC). Family or spousal maintenance is redetermined.
	ALTCS (Community Spouse) Freedom to Work (FTW) - ALTCS	Community Spouse policy continues to apply unless the spouse moves to a medical facility and is no longer living in the community.
	Breast and Cervical Cancer Treatment Program (BCCTP)	The customer may now qualify for another MA program. When the customer qualifies for another AHCCCS Medical Assistance (MA) program, that eligibility is approved and BCCTP coverage is ended.
	Adult Caretaker Relative	Changes to who lives in the home may impact who is

	Pregnant Woman Child KidsCare	included in the budget group. See MA602D
Legally separated	Any program	Legal separation alone does not affect income or resource budgeting.

Definitions

Term	Definition
Physical Separation	Physical separation means the spouses are not living in the same residence.
Legal Separation	Legal separation involves a court order. The court order may: • Allocate parental rights; • Order the payment of child support or spousal support; and • Provide for the division of marital property and the distribution of assets. Legal separation often is a step toward divorce, but also is used by people who choose not to end their marriage. This may be done for religious reasons or in order to protect assets.

Proof

The customer or representative's statement of the separation and location of the spouse is accepted, unless it is questionable or the customer's ALTCS eligibility is determined using Community Spouse policy.

When the customer's ALTCS eligibility was determined using Community Spouse rules, the living arrangement of the Community Spouse must be verified to determine whether or not to continue using Community Spouse rules. See MA521.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5 for Community Spouse 42 CFR 435.916 AAC R9-28-401, R9-28-410 and R9-28-411(A)(1)(h)
SSI-MAO	20 CFR 416.1132 and 1163 42 CFR 435.602 42 CFR 435.916 AAC R9-22-1501(H)(1)(e) AAC R9-22-1503
Medicare Savings Program (MSP)	20 CFR 416.1132 and 1163 42 CFR 435.602 42 CFR 435.916 AAC R9-29-213
Freedom to Work (FTW)	42 CFR 435.916 AAC R9-22-1901
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 AAC R9-22-2008

MAGI	42 CFR 435.603 42 CFR 435.916 AAC R9-22-1420(B)

AA SSI Cash Eligibility Ends

Revised 12/31/2019

Policy

The Social Security Administration determines eligibility for Supplemental Security Income (SSI) Cash. Customers who are approved for SSI-Cash are automatically eligible for AHCCCS Medical Assistance (MA) and do not have to apply for it separately.

Except for customer's receiving ALTCS, the customer's eligibility for other MA programs is ended once they start receiving SSI-Cash because they get MA automatically.

When a customer loses SSI-Cash eligibility, the customer must be evaluated for eligibility in another MA program (see MA1403).

The following table describes how the loss of SSI Cash affects eligibility:

If the Customer was receiving....	Then...
Medical Assistance automatically due to SSI Cash eligibility	The customer is given a two-month extension of coverage while determining eligibility for any other MA category.
SSI-Cash and ALTCS	The customer is no longer categorically eligible once the SSI-Cash ends. ALTCS eligibility must be redetermined to see if the customer still qualifies for ALTCS.

Definition

Term	Definition
SSI-Cash	Payments from the Social Security Administration (SSA) under Title XVI of the Social Security Act to low-income people who are at least age 65, or have been determined by SSA to have a disability or blindness.

	NOTE Some people do not receive a cash payment because their work income is too high, but are still considered to be receiving SSI-Cash.

Proof

Proof that a person is receiving any of these payments includes:

- AHCCCS records that show the person is currently receiving MA related to SSI-Cash;
- Copies of check stubs for an SSI-Cash payment;
- Social Security award letter;
- Contact by telephone with the agency providing the payment, or
- An electronic record from SSA.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 USC 1383c(a) 42 CFR 435.120 42 CFR 435.916
KidsCare	42 CFR 457.310(b)(2)(ii)

	AAC R9-31-303

BB Voluntary Requests to Stop Medical Assistance

Revised 05/30/2018

Policy

A customer or representative may ask for benefits to be stopped for any AHCCCS Medical Assistance (MA) program at any time. The customer or representative can send this request by:

- Mail;
- Fax;
- Verbal request by telephone; or
- Electronically through HEAplus.

When a customer or main contact asks to stop MA, document the following:

- The date of the request;
- Names of all the customers covered by the request;
- The specific date the customer wants the MA to stop; and
- The reason the customer is asking to stop MA.

1) Written Request to Withdraw

A written, signed request for withdrawal may be accepted in one of the following formats:

- Voluntary Withdrawal of Application or Benefits form (DE-130);
- Withdrawal or Stop Benefits/Appeals Request form (FAA-0574A);
- Voluntary withdrawal option in Health-e-Arizona Plus (HEAplus); or
- A signed, written request to discontinue benefits.

2) Verbal Requests to Withdraw

When a verbal request to voluntarily withdraw is made, the application is discontinued based on the verbal request. A discontinuance letter is sent to notify the person that the benefits have been withdrawn.

Eligibility will be reinstated when the customer contacts AHCCCS/DES to withdraw the request to stop benefits (or to report the request was in error) before the end of the month the action was taken.

Definition

Term	Definition
Voluntary Request to Stop MA	When a customer or representative asks that MA benefits be stopped.

Proof

Proof includes:

- Signed statement asking for benefits to be stopped;
- Documented telephone request; or
- Electronic record in HEAplus.

Programs Affected

This applies to all programs.

Timeframes

When the customer or representative asks that MA benefits be stopped immediately, benefits stop effective the date the action is taken.

Otherwise, benefits stop effective the first day of the following month.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 431.213 42 CFR 435.914 42 CFR 435.916 AAC R9-22-308; R9-22-313; R9-28-401

1503 Discontinuance

Revised 10/12/2021

Policy

When a customer is no longer eligible for a Medical Assistance (MA) program, benefits must be stopped.

Eligibility is stopped when:

- The customer or representative does not provide proof needed to determine eligibility, does not cooperate in resolving discrepancies, or provides inconsistent or unclear information;
- The customer no longer meets a requirement for the current MA program;
- The customer dies (MA1502G);
- The customer asks for MA benefits to be stopped (MA1502BB); or
- Agency mail is returned by the post office as undeliverable, and the customer cannot be located to determine residency (MA1502Q).

Information may be provided before the date that MA benefits stop that could change the decision to stop benefits. In this case, the customer's eligibility is re-evaluated. See the following table for examples:

MA is stopping because…	**And before the MA benefit end date…**
Proof was not provided	The proof requested is received.
The customer did not meet an MA requirement	A change is reported showing that the customer meets the requirement.
The customer asked that MA benefits be stopped	The customer contacts the Benefits and Eligibility Specialist and asks for MA benefits to continue.
Returned mail was received from the Post Office	The customer contacts the Benefits and Eligibility Specialist and provides current address information.

Definition

Term	Definition
Discontinuance	A customer's MA benefits are stopped.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 435.916(c), (d) and (f)
KidsCare	42 CFR 457.343

Chapter 1600 Customer Rights

1600 Introduction

In this Chapter you will find information about customer rights. For each section in this chapter, you will find:

- The policy for the topic;
- Any definitions needed to explain the policy;
- A list of the federal and state laws that apply to the policy by program.

1601 Language Interpretation and Translation

Revised 11/29/2018

Policy

When a customer does not speak or understand English, the customer may provide his or her own interpreter or have AHCCCS provide an interpreter. A customer is not required to accept use of an interpreter provided by the agency.

AHCCCS offers:

- Oral language or sign language interpretation services.
- Translation of written material, as needed.

Even if the customer initially provides his or her own interpreter, the customer may later choose to have the agency provide an interpreter.

Most action notices and agency forms are readily available in English and Spanish. A customer may request a notice or form in a different language by calling 1-855-432-7587.

Legal Authority

Programs	Legal Authorities
All programs	42 CFR 438.10

1602_Confidentiality

1602 Confidentiality

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Safeguarding Confidential Information

Revised 06/14/2022

Policy

Confidential information must be protected and can only be released as allowed by Federal and State laws, regulations, and administrative policy. The following policies apply to AHCCCS customers as well as people who are not applying for benefits, but their information is gathered by AHCCCS for any reason.

There are two main legal authorities for AHCCCS Medical Assistance confidentiality policy:

- Title XIX of the Social Security Act restricts the release of confidential information about Medicaid customers for purposes of administering the Medicaid program.
- The Health Insurance Portability and Accountability Act (HIPAA) sets privacy and security standards that apply to health care facilities, providers and insurers, including AHCCCS.

NOTE Both Title XIX and HIPAA may apply to a situation. When this happens, the stricter of the two is applied.

The following information is considered confidential:

- Names, addresses, ZIP Codes, phone numbers, dates of birth, and Social Security numbers;
- Social and economic circumstances;
- Agency evaluations of personal information;
- Protected health information (PHI), including diagnosis and history of disease or disability and Pre-Admission Screening (PAS);
- Information received from electronic data matches, including reports from Federal and State systems;
- Information received from other sources, such as the Arizona Department of Economic Security, Social Security Administration, or private-sector employers;
- Information received when identifying legally liable third-party sources;
- Information related to alcohol or drug abuse, communicable disease, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), mental health, developmental disability, or genetic testing; and
- Confidential information may be released only as allowed by federal and state law. See MA1602C for detailed policy.

Non-confidential information does not need to be safeguarded. When information cannot be used to identify a specific person, it is not confidential.

Definitions

Term	Definition
Communicable Disease	A contagious, epidemic or infectious disease that must be reported to the local board of health or health department.
Developmental Disability	A severe, chronic condition caused by cognitive disability, cerebral palsy, epilepsy, or autism that is manifested before the age of eighteen.
Pre-Admission Screening (PAS)	A screening tool used to assess a customer's medical need for long-term care services and is at immediate risk of institutionalization in a nursing facility.
Protected Health Information (PHI)	Health and demographic information about a person created or received by a health plan, health care provider, employer, or health care clearinghouse. Any information that relates to a person's health, health care services received, or payment for health care. This includes PAS information.

Legal Authority

Programs	Legal Authority
All Programs	42 U.S.C. 1396a(a)(7) 42 CFR 431.300 through 307 45 CFR, Part 160 and Part 164 AAC R9-22-512

Effective until 2025-04-25

B Obtaining Confidential Information

Revised 09/13/2022

Policy

The customer or the customer's legal representative may authorize someone else to act on behalf of the customer for the eligibility determination process. However, that person may not be able to authorize release of the customer's confidential information. In this situation, the customer or legal representative can give permission to release information to AHCCCS by completing and signing any of the forms listed below:

Form	Description
Release of Information Authorization (DE-200) form	Allows AHCCCS to ask for a broad range of information in order to determine eligibility.
Permission to Release Information (DE-201) form	Used to request specific eligibility information from a third party.
Authorization for the Disclosure of Protected Health Information (DE-202) form	Used to obtain a customer's medical information.
Authorization for the Disclosure of Psychotherapy Notes to the AHCCCS Administration (DE-222) form	Used when a customer's medical records contain psychotherapy notes that could affect the Pre-Admission Screening determination.

Definitions

Term	Definition
Legal Representative	A legal representative is: • A person appointed by a court of law to represent someone else; or • The custodial parent of a minor child.

Authorized Representative	A person, or an organization, authorized by the customer, legal representative, or responsible relative of the customer to act on the customer's behalf in the AHCCCS eligibility process.

Legal Authority

Programs	**Legal Authority**
All Programs	42 CFR 431.300 through 307 45 CFR, Part 160 and Part 164 (subparts A and E) AAC R9-22-512

C Release of Confidential Information

Revised 10/04/2022

Policy

The policy in this section focuses on the release of confidential information and covers three main areas:

- Releasing confidential information for official purposes;
- Authorization to release confidential information; and
- Additional protections for certain medical information.

1) Releasing confidential information for official purposes

Certain medical records have specific protection under Federal or State law and may only be released under specific conditions as described in section 3. Other confidential information may be released to any of the following without specific written authorization, but only when the information will be used for official purposes:

- Other areas of the AHCCCS Administration;
- Arizona Department of Economic Security (DES);
- Arizona Department of Health Services (DHS);
- The State of Arizona Attorney General's Office;
- Federal agencies, such as the U.S. Department of Health and Human Services and the Social Security Administration, related to the administration of AHCCCS programs;
- AHCCCS program contractors and subcontractors, including case managers;
- Health care professionals;
- Law enforcement officials, when related to the administration of AHCCCS programs; and
- Health Management Systems (HMS), the agency's contractor for third-party recoveries, including special treatment trusts and estate recovery.

Requests for information from the media, public interest groups, advocate groups, and requests from the legal community in the form of subpoenas and bankruptcy documents are handled by the

Office of the General Counsel. These documents are time sensitive and are treated differently from customer requests.

2) Authorization to release confidential information

In general, the following people may review and request copies of information in the customer's case file without written permission:

- The customer, when a competent adult or emancipated minor;
- The customer's legal guardian; and
- The custodial parent or legal guardian of a minor customer.

Unless the release of information is for official purposes, all others require written authorization to receive information from the customer's case. When written authorization is needed, one of the people listed above may authorize AHCCCS to release information. The written authorization must be signed, separate from any other document, and must specify all of the following:

- The information that AHCCCS is authorized to release from the case file;
- To whom the release can be made; and
- The period of time the authorization is valid. If no time is stated, the authorization is valid for one year from the date it is signed.

The following guidelines are used to determine who needs written authorization for each type of information:

Information Type	No written authorization needed for…	Written authorization needed for…
Non-Medical Records	• An adult customer, when competent • An emancipated minor child, when competent • The customer's legal guardian • The custodial parent of a minor child customer	• A minor child (from a custodial parent or guardian) • The customer's spouse • The non-custodial parent of a minor child customer • A stepparent

	• The customer's authorized representative • A person with appropriate power of attorney (financial for non-medical information) • The Well Woman HealthCheck program (WWHP) through the Arizona Department of Health when the customer has signed a BCCTP Patient Contact and Consent form (BC-102).	• A customer that has been determined incompetent • The customer's attorney • The customer's conservator • Any other third party • A foster parent (only needed when the foster parent does not have legal guardianship)
PAS Information	Same as non-medical information, except that the customer's authorized representative must have written authorization.	Same as non-medical information above
Medical Records	Same as PAS information, except that the information may only be released when a request for a hearing based on medical eligibility or disability has been filed.	Same as PAS Information, except that the information may only be released when a request for a hearing based on medical eligibility or disability has been filed.

Generally, there is no charge to the customer or the customer's representative for copying material from the case file. However, there may be a charge for costs when copying a large volume of documents.

An AHCCCS employee must be present any time a case file is viewed by an authorized person, to answer any questions and ensure that the case file is not altered.

3) Additional protections for certain medical information

Certain types of medical information may only be released under specific circumstances, as follows:

Type of Information	Policy

Alcohol or drug abuse information	Cannot be released without specific written consent from the person named in the information.
Communicable disease information	Cannot be released without specific written consent from the person named in the information.
Developmental disability (DD) information, including all records created in the course of providing services to DD customers	Cannot be released without written permission from the parent or guardian of a minor with a developmental disability, or the guardian of an adult with developmental disability. NOTE When no guardian has been appointed, a developmentally disabled adult may authorize the release of his or her own information.
Genetic testing information	Cannot be released without specific written consent from the person named in the information.
Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) information	Cannot be released without specific written consent from the person named in the information.
Mental health information	Cannot be released unless a mental health professional has interviewed the person undergoing treatment. The mental health professional must provide a written statement that releasing the information is in the patient's best interest.

Definitions

Term	Definition
Authorized Representative	A person who may act on the customer's behalf in the AHCCCS eligibility process. This person must be authorized by the customer, the customer's legal representative, or a responsible relative of the customer.

Case File	The record of a customer's applications for AHCCCS Medical Assistance and changes reported, and the resulting eligibility decisions. The case file includes all of the following related to the customer's AHCCCS eligibility: • Proof and information provided for an eligibility decision; • Proof from electronic data sources recorded in the eligibility system; • Information from other electronic data sources when used to determine eligibility; • Supporting documents and information stored in a document imaging system; • Notes created by eligibility staff to support decisions made and actions taken. Some electronic sources may generate information for the customer that is not used to determine eligibility. When the information is not used to determine eligibility and is stored in the customer's record, it is not considered part of the case file.
Competent	Means capable of handling one's own affairs. A person is considered competent unless a court has declared that the person is incompetent.
Conservator	A person appointed by a court to manage another person's finances. A conservator is required by law to act in the best financial interest of the person whose finances he or she manages.
Custodial Parent	The parent or parents to whom the court has awarded legal custody of a minor child.
Emancipated Minor	A minor who meets at least one of these conditions: • Has married or divorced; • Has enlisted in military service; or • Has been declared emancipated by court order.

Foster Parent	Any person licensed by the Department of Economic Security (DES) or an Arizona tribe to provide out-of-home care for a foster child
Incompetent	Means legally declared incapable of pursuing one's own interests and for whom a legal guardian has been appointed.
Legal Guardian	A person who has been appointed by a court to act as a representative for an incompetent person, as well as to manage their property and rights. NOTE This does not include a conservator.
Non-Medical Information	All confidential information in the customer's case file other than medical records.
Official Purposes	Means directly related to administering an AHCCCS program, including the following actions: • Determining eligibility; • Determining the amount of medical assistance; • Providing services; • Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the AHCCCS program; • Evaluating and analyzing AHCCCS operations; and • Recovering AHCCCS costs.
Power of Attorney	A written authorization to act on behalf of another person. The authority given can be as broad or as narrow as the person chooses.

Legal Authority

Programs	**Legal Authority**

All programs	42 CFR 431.300 through 307 45 CFR, Part 160, and Part 164 (subparts A and E) AAC R9-22-512

1603 Non-Discrimination

Revised 02/20/2019

Policy

An AHCCCS customer must be treated fairly and equally regardless of race, color, religion, national origin, sex, age, political beliefs, or disability.

AHCCCS does not discriminate on the basis of disability in admission to, access to, or operation of its programs, activities, services, or in its employment practices. AHCCCS complies with the Americans with Disabilities Act of 1990.

If the customer is visually or hearing impaired and needs an accommodation or a different format to complete an application, the customer may submit a request by speaking to the Benefits and Eligibility Specialist assigned to their case, or by calling 1-855-432-7587.

Legal Authority

Programs	Legal Authorities
All Programs	42 USC 12112 42 CFR 438.12 AAC R9-22-1403

1604 Written Letters

Revised 03/29/2022

Policy

The customer must get a written letter on an agency form when any of the following actions occur:

- An application for AHCCCS Health Insurance is approved or denied;
- Eligibility is discontinued or changed; or
- The amount the customer must pay (premiums or share of cost) is changed.

Letters must be sent to the following persons:

- The customer, unless the customer:
  - Is a dependent child living with a parent, in which case a letter only goes to the parent; or
  - Has a legal representative, in which case a letter only goes to the legal representative;
- The customer's legal representative;
- The customer's authorized representative, responsible relative, or responsible party unless the customer and representative reside together.

1) Approval Letters

An approval letter must contain the following information:

- Type of benefit approved;
- Date eligibility begins;
- Amount the customer must pay in share of cost or premiums, if applicable; and
- Date by which a fair hearing must be requested.

NOTE Hospital Presumptive Eligibility (HPE) approval letters do not include a deadline for filing a fair hearing since people applying only for HPE do not get fair hearing rights.

2) Renewal Letters

A renewal letter must include the following information:

- The type of benefit approved for renewal;
- The amount the customer must pay, if applicable;
- When customer costs or services are changing, the date the change is effective; and
- The date by which an appeal must be requested.

3) Denial Letters

A denial letter must include the following information:

Type of benefit denied;

Effective date of the denial;

Reason for the denial. When the denial is because the person's income or resources are over the limits, the notice must show how the income or resources were calculated;

- Legal references that support the denial;
- Date by which a fair hearing must be requested; and
- If the application was referred to the Federally Facilitated Marketplace for a decision on other insurance affordability programs, an explanation of the referral.

NOTE Denial letters for Hospital Presumptive Eligibility (HPE) are not required to include the above denial letter information.

4) Discontinuance Letters

A discontinuance letter must include the following information:

- The type of benefit(s) discontinued;
- The effective date of the discontinuance;
- The reasons benefits are being stopped;
- How income or resources were calculated when benefits are stopped because income or resources are over the limit;
- The legal references that support the discontinuance;
- The date by which an appeal must be requested; and
- When the application was referred to the Federally Facilitated Marketplace for a decision on other insurance affordability programs, an explanation of the referral.

5) Change Letters

A change letter must include the following information:

- The type or level of benefit that is changing or ending, if applicable;
- The change in the amount of the customer's share of cost or premium, if applicable;
- The effective date of the change;
- The reasons for the change. When the change is caused by the person's income or resources, the notice must also show how the income or resources were calculated;
- The legal references that support the change;
- The date by which a fair hearing must be requested; and
- If the customer was referred to the Federally Facilitated Marketplace for a decision on other insurance affordability programs, an explanation of the referral.

Definitions

Term	Definition
Approval	A determination that a person is eligible for Medical Assistance benefits.
Change	Something that happens to a person which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.
Decision Letter	A letter that notifies a customer of the action taken for their AHCCCS Medical Assistance program eligibility including: • Approval; • Denial; • Discontinuance; • Change in share of cost, premium amount, or co-payments;

	• Change in eligible medical services; and • Enrollment with a health plan or program contractor.
Denial	A determination that a person is not eligible for Medical Assistance benefits.
Discontinuance	A determination that a person is no longer eligible for Medical Assistance benefits.
Renewal	A review of financial and non-financial eligibility factors.

Timeframes

A change that does not decrease or stop benefits or increase the customer's costs does not require advance notice.

In most cases, a change to decrease or stop benefits or to increase the customer's costs is effective on the first day of a future month. There must be at least 10 days before the first day of the future month to allow for the change letter to be sent in advance.

Exceptions:

A 10-day period before the effective date of the change is not required in the following situations:

When...	**Then the effective date of the change is...**
The customer dies and the death is verified	The date of death.
Mail sent to the customer has been returned to AHCCCS, and the Benefits and Eligibility Specialist has no way of contacting the customer	The first day of the following month.
The customer is confirmed as having been approved for medical services in another state	
The customer is incarcerated in a jail or penal institution	The date the customer is incarcerated.

Legal Authority

Programs	Legal Authorities
All programs except KidsCare and HPE	42 CFR 431.210, 431.211, 431.213 42 CFR 435.912, 435.916, 435.917, 435.919 AAC R9-22-312
KidsCare	42 CFR 457.340, 457.343
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

1605 AHCCCS Rules and Regulations

Policy

Descriptions of the federal and state authorities governing the operation of the AHCCCS programs are provided in MA105 of this manual. Internet links to many of the authorities listed are also provided. Copies of these authorities may also be found in public libraries and law libraries.

Upon request, AHCCCS will provide copies of sections of the authorities that are cited on AHCCCS letters and sections this eligibility policy manual to the customer or the customer's representative.

Chapter 1700 Eligibility Hearings

1700 Introduction

For each topic in this chapter, you will find:

- The policy for each requirement;
- Any definitions needed to explain the policy;
- Agency responsibilities, if applicable;
- Customer rights or responsibilities, if applicable;
- The timeframes, if applicable; and
- A list of the federal and state laws that apply.

1701 Eligibility Appeals

Revised 07/10/2020

Policy

A customer has the right to ask for an appeal when an adverse action is taken on the customer's Medical Assistance (MA) application or benefits. This request must be made within 35 calendar days of the date the letter is sent (see MA1702). The customer may also ask for an appeal when a decision is not made about the customer's MA application within the required timeframe (see MA1301B – Timeframes).

A customer has the right to ask for an expedited appeal. A request for an expedited appeal will be approved only when the request is supported by a statement from a medical provider who is recommending a procedure or treatment for the individual. The medical provider statement must say that:

The customer has a procedure or treatment scheduled, or the individual is unable to schedule a procedure or treatment due to the lack of coverage;

The customer does not currently have health insurance that will cover most of the cost of a treatment; and

The customer's life, physical or mental health, or ability to reach, keep, or regain full functionality will be put at serious risk if the customer has to delay a procedure or treatment for 90 days or less from the date of the appeal request.

Expedited appeals must be resolved as soon as possible and no later than seven working days after receipt.

Exceptions:

Customers are not entitled to an appeal when the adverse action is due to a change in Federal or State law. Actions that do not affect the customer's services, benefits or costs are not entitled to an appeal. The customer may file a grievance for such actions (see MA1710).

There are two state agencies in Arizona that determine eligibility for AHCCCS MA programs: AHCCCS and the Department of Economic Security (DES). Generally the agency that makes the eligibility decision processes any appeal request on that decision. However, both agencies work together to coordinate the appeal process when a person asks for an appeal and decisions were made by both agencies. Representatives from both agencies may need to attend the hearing depending on the program decision being appealed.

See the following table for more details on which agency determines each MA program:

If the program is…	Then eligibility is determined by…

• SSI-MAO • Medicare Savings Program	Mainly AHCCCS, but could be either agency
• Adult • Caretaker Relative (including Transitional Medical Assistance and Continuous Coverage) • Pregnant Woman • Child • KidsCare • Young Adult Transitional Insurance	Mainly DES, but could be either agency
• ALTCS • Freedom to Work • Breast and Cervical Cancer Treatment Program	AHCCCS only

NOTE People who are eligible for SSI-Cash, Title IV-E Foster Care or Adoption Subsidy are automatically eligible for MA. A separate MA determination is not done except when the customer is applying for ALTCS.

Definitions

Term	Definition
Adverse Action	In general, an adverse action is any action to: • Deny, suspend or stop MA; • Increase the customer's share of cost or premium amount; or • Reduce services or benefits.

	NOTE This includes actions to approve emergency services only instead of full MA coverage, and changes from full MA coverage to emergency services only.
Appeal	A fair and impartial review of an adverse action or delayed determination.
Department of Economic Security (DES)	The Arizona State agency that determines eligibility for Nutrition Assistance, Cash Assistance, and certain Medical Assistance programs on AHCCCS' behalf.
Fair Hearing Coordinator	Agency staff member that coordinates the hearing process and represents the agency at the fair hearing.
Office of Administrative Hearing (OAH)	The OAH handles coordinating the hearings on behalf of AHCCCS Administration.
Office of Appeals (OOA)	The OOA handles coordinating the hearings on behalf of the Department of Economic Security (DES).

Agency Responsibilities

The agencies' general responsibilities include:

- Taking requests for appeals;
- Contacting the customer if a request for an appeal is made by someone other than a customer or representative;
- Sending any necessary authorization and notification forms to the customer;
- Determining whether a hearing may be granted;
- Coordinating the pre-hearing discussion (see MA1703);
- Scheduling the hearing and notifying the customer; and
- Preparing a hearing packet.

The Office of Administrative Hearings (OAH) or Office of Appeals (OOA) is responsible for the following:

- Setting the hearing date and notifying the customer and the agency Fair Hearing Coordinator;
- Appointing an Administrative Law Judge (ALJ) to conduct the hearing; and
- Providing an interpreter and reasonable accommodations, upon request.

The ALJ is responsible for the following:

- Presiding over the eligibility hearing;
- Basing a decision solely on evidence presented at the hearing; and
- Issuing a written decision.

Customer Rights and Responsibilities

The customer has the right to:

- Review and get a copy of any part of the case file needed to present the case that is not protected by law from being released;
- Review all documents the State agency will use at the hearing;
- Bring legal counsel, a relative, friend, other spokesperson or witness to the hearing;

NOTE Except for legal counsel, anyone representing the customer or serving as a spokesperson or witness for the customer cannot be a paid representative or anyone else being paid to attend the hearing.

- Present all related facts and circumstances;
- Present an argument without unnecessary interference;
- Question or contradict any testimony or evidence. This includes an opportunity to confront or cross-examine witnesses;
- Ask the agency to furnish an interpreter; and
- Ask the agency to make an accommodation for special needs.

Legal Authority

This requirement applies to the following programs:

Programs	Legal Authorities

All programs	42 USC 1396a(3) 42 CFR 431, Subpart E ARS-41-Article 10 9 AAC 34, Article 1

1702 Eligibility Appeal Requests

Revised 09/21/2017

Policy

Any person may ask for an appeal. However, when someone other than the customer or the customer's representative asks for an appeal, AHCCCS must contact the customer to confirm the request.

When a person who is not authorized to represent an incapacitated customer but is acting responsibly on the customer's behalf, the person requesting the appeal must sign and return an Authorized Representative form (DE-112). A Physician Statement of Incapacity form (DE-217) must also be in the customer's case file.

The request for an appeal may be submitted:

- By mail;
- In-person;
- By telephone;
- By fax;
- By e-mail; or
- Through Health-e-Arizona Plus (HEAplus).

NOTE At this time, ALTCS customers are not able to request an appeal through HEAplus.

Each decision letter includes a pre-printed "Appeal Request Form"; or "I Am Asking For A Hearing" section. The customer is not required to use the form or letter to request an appeal.

A written appeal request must contain the following information:

- The customer's name;
- The action or decision the customer is appealing; and
- The reason for the appeal request.

Definitions

Term	Definition

Appeal Request	A request for a hearing regarding an adverse action or delay in the application process.
Decision Letter	A written notice that explains the action that has been taken on a customer's case.
Good Cause	A valid reason for not submitting the appeal request within the 35-day timeframe. Good cause includes: • Illness; • Failure to receive the decision letter; or • Any other reasonable explanation (as determined by the agency).

Timeframes

Appeal requests must be received by the 35th calendar day after the date on the decision letter. When the 35th calendar day is on a weekend or state holiday, the due date is extended to the end of the next business day. Appeal requests received after the 35th calendar day will be denied.

All appeal requests are date-stamped when they are received. The table below lists the date the request is considered received based on how it is sent to the agency:

When the request for hearing is...	**Then the date of request is...**
Sent by mail	The date the letter is received.
Faxed	The date the fax transmission was received.
Sent by email	The date the email was received.
Completed through HEAplus	The date the appeal request is submitted.
Made in person or by telephone	The date the request is made.

Agency Responsibilities

The agency determines if the appeal request was filed within the 35 calendar day timeframe and notifies the customer when the request is denied because it was received late.

Customer Rights and Responsibilities

When the agency denies the customer's appeal request because it was received late, the customer may ask for a good cause hearing.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.220 and 221 9 AAC 34, Article 1

1703 Pre-Hearing Discussion

Revised 11/29/2018

Policy

The pre-hearing discussion is an opportunity for the customer to meet informally with the agency to review and possibly resolve the concerns with the agency's action before the hearing. The pre-hearing discussion may be completed by telephone or in person. The pre-hearing discussion is not mandatory for the customer and cannot delay the formal hearing process. If the pre-hearing discussion does not resolve the issue, the hearing process is continued.

If the pre-hearing discussion results in an informal resolution, the customer is offered the opportunity to voluntarily withdraw the appeal request. See MA1705 for more information on voluntary withdrawals of appeal requests.

NOTE The customer may ask for a review before filing a formal request for appeal.

Definitions

Term	Definition
Pre-Hearing Discussion	An informal meeting between the customer and the agency to see if the issue can be explained or resolved before the hearing.

Agency Responsibilities

The agency contacts the customer and offers to schedule a pre-hearing discussion. During the pre-hearing discussion, the agency:

- Explains why the action was taken;
- Reviews the information used to make the decision with the customer;
- Gives the customer an opportunity to explain why the action should not have been taken, submit more information and clarify any factors involved;
- Explains the appeal and hearing process;
- Explains the customer's potential financial responsibilities.

Customer Rights and Responsibilities

The customer can choose not to have a pre-hearing discussion.

Timeframes

The agency generally schedules and holds the pre-hearing discussion within one to two weeks of receiving the appeal request. However, if the appeal request is made by telephone or in person, the agency may be able to conduct the pre-hearing discussion at the time the appeal request is made.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	N/A

1704 Continue Eligibility or Restore Prior Level of Service or Cost

Revised 09/21/2017

Policy

When the appeal request is received before the effective date of the adverse action, or the adverse action was taken without allowing for advance notice, the customer is entitled to have the action reversed until the hearing decision is made.

Between the time an appeal request is filed and the hearing decision is made, the customer may be entitled to:

- Continued benefits;
- Pay the prior share of cost (SOC) or premium amount; or
- Receive the prior level of covered services.

See When to Adjust Benefits and SOC and Premium Amounts for more information.

Definitions

Term	Definition
Share of Cost	The amount an ALTCS customer is required to pay toward the cost of long term care services. The share of cost is determined on a month-by-month basis (see MA1201).
Premium	Customers enrolled in Freedom to Work or KidsCare are charged a monthly premium. The premium amount is based on income and household size.
Level of Covered Services	The amount and kinds of services covered by the medical assistance program or service package. Examples of a decrease in covered services include:

	• Losing coverage for long-term care services under ALTCS; • Losing full services coverage and only qualifying for Medicare Savings Program (MSP); • Losing full services coverage and only qualifying for emergency services; and • Qualified Medicare Beneficiary (QMB) being reduced to Specified Low-income Medicare Beneficiary (SLMB) or Qualified Individual – 1 (QI-1).

Agency Responsibilities

When the appeal request meets the requirements listed in the Policy section above, the agency restores eligibility, prior SOC and premium amounts, or the prior level of covered services unless the customer specifically asks the agency not to do so.

Customer Rights and Responsibilities

Customers who had an existing premium or SOC amount and asked for an appeal because the premium or SOC increased must continue to pay the prior amount during the hearing process.

The customer may choose not to have eligibility, level of services, SOC or premium restored during the appeal process.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.230 42 CFR 431.231 AAC R9-34-114

1705 Voluntary Withdrawal of Appeal Request

Revised 09/21/2017

Policy

The customer or representative may choose to withdraw the appeal request at any time during the appeal process.

The request may be made:

- In writing, including on a Voluntary Withdrawal (DE-171) form;
- Verbally, if the hearing is not yet scheduled, or

NOTE If benefits were continued or the share of cost or premium has been restored back to the prior amount and the customer has voluntarily asked for a withdrawal of the hearing request, the continued benefits are stopped and the share of cost and premium readjusted.

Definitions

Term	Definition
Voluntary Withdrawal	The customer decides to not pursue the appeal.

Agency Responsibilities

The agency must process the voluntary request to withdrawal at any time during the appeal process.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.223 AAC R9-34-112

Effective until 2025-04-25

1706 Changes Received During the Appeal Process

Revised 07/10/2020

Policy

During the appeal process, a new change may occur before the hearing decision is made that affects the customer's eligibility, level of services, premium, or share of cost amount.

The table below explains how changes are processed when they are received during the appeal process.

If...	Then...
• The customer is approved for continued benefits during the appeal process; AND • The reported change will result in an adverse action.	The change is not processed until the hearing process ends.
• The customer is approved for continued benefits during the appeal process; AND • The change results in a non-adverse action	The change is processed and the customer is sent a new decision letter.
The customer does not have continued benefits.	The change is processed and the customer is sent a new decision letter no matter what the eligibility result is.

Definitions

Term	Definition
Adverse Action	In general, an adverse action is any action to: • Deny, suspend or stop MA;

	• Increase the customer's share of cost or premium amount; or • Reduce services or benefits. NOTE This includes actions to approve emergency services only instead of full MA coverage and changes from full MA coverage to emergency services.
Notice of Action	A notice that explains the action that has been taken on a customer's case.

Agency Responsibilities

Advance notice is given whenever an adverse action is taken before the decision on the original issue.

Customer Rights and Responsibilities

The customer may ask for a fair hearing on the new adverse action and has 35 days from the new notice to file the request.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.231 AAC R9-34-114

1707 The Eligibility Hearing

1707 The Eligibility Hearing

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Scheduling and Notice of Hearing

Revised 12/14/2018

Policy

When an appeal request is filed on time for an action that can be appealed, a hearing is scheduled and a notice sent to the customer that filed the appeal.

The notice includes the:

- Hearing date;
- Issue to be addressed;
- Legal authorities; and
- Hearing rights.

The customer or the agency may ask for a continuance. The request must be made in writing to the Office of Administrative Hearings (OAH) or the Office of Appeals (OOA). The other may accept or reject the request for a continuance, but when a party rejects a request for continuance the ALJ makes the final decision.

The ALJ may grant a continuance request when:

- There is good cause for the postponement; or
- The reason for the request is beyond the control of either party.

Definitions

Term	Definition
Office of Administrative Hearings (OAH)	The office that conducts eligibility hearings on behalf of the AHCCCS Administration.
Office of Appeals (OOA)	The office that conducts eligibility hearings on behalf of the Department of Economic Security Family Assistance Administration (DES/FAA).

Request for a continuance	A request that the appeal be rescheduled until a later date.

Agency Responsibilities

The responsibilities of the agency processing the hearing and the appeals office include

- Scheduling the hearing and notifying the customer;

  NOTE The notice of hearing is sent 20 to 30 days before the scheduled hearing date to give the customer time to prepare for the hearing unless the customer has been approved for an expedited appeal.

- Providing an interpreter and reasonable accommodations, upon request; and
- Preparing a hearing packet.

Customer Rights

The customer has the right to:

- Review and get a copy of any part of the case file needed to present the case that is not protected by law from being released;
- Review all documents the State agency will use at the hearing;
- Bring legal counsel, a relative, friend, other spokesperson or witness to the hearing;

NOTE Except for legal counsel, anyone representing the customer or serving as a spokesperson or witness for the customer cannot be a paid representative or anyone else being paid to attend the hearing.

- Present all related facts and circumstances;
- Present an argument without unnecessary interference;
- Question or contradict any testimony or evidence. This includes an opportunity to confront or cross-examine witnesses;
- Ask the agency to furnish an interpreter; and
- Ask the agency to make an accommodation for special needs.

Timeframes

The timeframe for scheduling and holding the hearing must allow for a hearing decision to be made within 90 days from the date of the hearing request unless:

The customer requests and is granted an expedited appeal; or

A continuance is requested and granted.

When an expedited appeal request is granted, the hearing must be scheduled and held so that an appeal decision can be made within 7 days from the date of the expedited appeal request.

When a continuance is granted, a decision must be made within 120 days from the date of the appeal request.

The following table shows the usual timeframes for scheduling and holding the hearing by agency.

If the agency is...	Then the hearing is scheduled to be held...
AHCCCS	• Within 30 days from the date the request is filed, if related to the ALTCS CSRD or CSMIA. • Within 60 days from the date the request is filed for all other requests.
DES	Between 20 and 45 calendar days from the date the request is filed. NOTE The customer may ask that the hearing be held within less than 20 days.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.210 AAC R9-34-109

B Hearing Attendance and Proceedings

Revised 12/14/2018

Policy

1) Hearing Attendees

The following persons must attend the hearing:

- Administrative Law Judge (ALJ);
- Customer that requested the hearing;
- Agency representative; and

These other persons may attend:

- Any witnesses invited to the hearing by the customer;
- An attorney representing the customer;
- An attorney representing the agency;
- An interpreter provided by the agency;
- Eligibility office staff;
- Agency representative from another agency responsible for the decision (i.e., DDSA).

2) Penalty for Not Attending the Hearing

If an agency representative fails to attend the hearing, the ALJ may move forward with the hearing and issue a decision based on the complainant's testimony.

If the customer or customer's representative fails to attend the hearing without good cause or without receiving a postponement, the ALJ may:

- Proceed with the hearing;
- Reschedule the hearing;
- Issue a recommendation based on the evidence in the hearing record; or
- Deny the appeal.

3) Proceedings

The following chart summarizes the roles of the people involved in the hearing:

If the person is the...	Then the person...
Administrative Law Judge (ALJ)	• Introduces the people attending the hearing; • Explains that the hearing is recorded when available; • Makes a brief opening statement about the hearing procedures or shows a DVD; • Swears everyone in; • May ask for brief opening statements; and • Makes closing statement.
Agency Representative	• Makes a brief opening statement • Gives legal references to support the action(s) taken; • Cross examines agency witnesses; • Cross examines the customer and their witnesses; • Objects to testimony when needed; • Answers questions from the ALJ; and • Makes a closing statement.
Agency Witness(es)	• Answers questions posed by the Agency representative; • Explains how the SOC or premium amount was figured or why eligibility was denied or stopped, the requirements, and why those requirements were not met; and

	• Answers questions posed by the ALJ, the complainant, or the complainant's representative.
Customer	• Testifies and calls witnesses to testify; and • Asks questions of the ALJ, Agency representative or the Agency witnesses; and • Makes a final statement.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.240 AAC R9-34-104 and 105

C Hearing Decision

Revised 12/14/2018

Policy

How the hearing decision is made and issued varies slightly depending on the agency processing the hearing.

AHCCCS:

The ALJ makes a written, recommended decision. The AHCCCS Director reviews the ALJ's recommendation and may amend it. The AHCCCS Director issues the final written decision to the customer.

DES

For DES-administered programs, the ALJ makes a written decision. The Office of Appeals issues the ALJ's written decision to the customer.

Definitions

Term	Definition
Director's Decision	The Director's Decision notifies the complainant of the: • Hearing decision; and • Right to petition for a rehearing.

Timeframes

AHCCCS

The ALJ makes a written recommended decision within 20 days from the day of the hearing. The AHCCCS Director reviews the ALJ's recommendation.

The written decision is issued within 30 days from the date of the ALJ's recommended decision and within 90 days after the date the appeal request was filed, or 120 days if a continuance was requested or granted.

If the appeal request is expedited, the written decision is issued within 7 days after the date the appeal request was filed.

DES

A final decision is issued within 90 days from the appeal request date.

If the appeal request is expedited, the written decision is issued within 7 days after the date the appeal request was filed.

Customer Rights

The customer is notified of the:

- Decision; and
- Right to appeal the decision (see MA1708).

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.244 and 245 AAC R9-34-111

1708 Appeal or Petition for Rehearing of Hearing Decision

Policy

If the agency or the customer disagrees with the fair hearing decision, they can appeal the decision. The process varies depending on the agency:

1) Appeals of an AHCCCS Hearing Decision

When the customer or the agency Fair Hearing Coordinator disagrees with the Director's Decision, he or she may ask for a rehearing from the AHCCCS Director. The customer also has the option to appeal the decision with the Superior Court.

NOTE The customer may petition for a rehearing before filing an appeal with the Superior Court, but does not have to do so.

A rehearing or review may be requested for any of the following reasons:

- An irregularity in the hearing or appeal proceedings and the party was deprived of a fair hearing;
- Misconduct on the part of an involved party, the eligibility office or the agency;
- Newly discovered material evidence that could not have been discovered and produced at the hearing;
- The decision was prejudiced;
- The decision was not justified by the evidence or is contrary to the law; or
- One of the parties had good cause for not appearing at the hearing.

The rehearing process involves a review of the hearing file and other written documents submitted by the customer or the agency. Either party may object to the petition, and on rare occasions, more testimony may be requested. After reviewing the information, the Director issues a Final Decision.

2) Appeals of a DES Hearing Decision

When the customer disagrees with the fair hearing decision, he or she may ask for a review of the decision from the Office of Appeals (OOA) Appeals Board.

NOTE The Appeals Board may accept or decline a rehearing or review of a case.

The Appeals Board conducts the review and notifies the customer and the FAA Policy Support Team (PST) of the review results.

If the OOA Appeals Board decision is unfavorable to the appellant, he or she may submit a request for review to the Appeals Board again.

If the Family Assistance Administration (FAA) disagrees with the OOA Appeals Board decision, FAA must submit a request to the Attorney General's Office. When the Attorney General's Office is in agreement with FAA, the Attorney General's Office submits the request for review to the OOA Appeals Board.

Definitions

Term	Definition
Office of Administrative Hearings (OAH)	The office that conducts fair hearings on behalf of the AHCCCS Administration.
Office of Appeals (OOA)	The office that conducts fair hearings on behalf of the Department of Economic Security (DES).
Superior Court	The Superior Court hears appeals of administration decisions.

Timeframes

In general a request for rehearing or an appeal of the hearing decision must be filed in writing within 35 days of the date of the hearing decision letter.

Exceptions:

- When appealing a DES Fair Hearing decision, the request must be filed in writing to the OOA within 15 calendar days of the mailing date of the decision.
- When the agency is appealing an OOA Appeals Board decision, the request must be sent to the Attorney General's Office within 10 calendar days from the date of the OOA Appeals Board decision.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

All Programs	42 CFR 431.232 and 233 42 CFR 431.244 and 245 ARS 41-1092.08 ARS 41-1092.09 AAC R9-34-113

1709 Disability Reconsideration Requests

Revised 12/14/2018

Policy

A customer may request an appeal when:

- A disability determination was made by the Disability Determinations Services Administration (DDSA);
- The DDSA determined that the customer does not have a disability that meets Social Security criteria; and
- The customer is not eligible for another AHCCCS coverage group.

NOTE When the Social Security Administration denies or stops a customer's SSI-Cash or Social Security disability for not meeting disability criteria, the customer must file the appeal with the Social Security Administration

Definitions

Term	Definition
Disability Determinations Services Administration (DDSA)	The DDSA is a division of the Arizona Department of Economic Security (DES). The DDSA is the only agency in Arizona authorized to make disability determinations for the Social Security Administration and for the AHCCCS Administration.
Disability Reconsideration Request	A request for a hearing to reassess DDSA's determination that a customer is no longer disabled.

Agency Responsibilities

Eligibility Office Responsibility

The eligibility office notifies the Office of Eligibility Appeals (OEA) when:

- An appeal request is received on this issue; and

- The reconsideration paper work has been received and sent to DDSA.

Office of Eligibility Appeals (OEA) Responsibility

OEA monitors the hearing date and if necessary, asks to postpone the hearing until a decision has been received from DDSA about the customer's status.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
SSI-MAO FTW	42 CFR 431.220 AAC R9-34-106

1710 Grievances

Revised 07/12/2022

Policy

A customer also has the right to file a grievance if unsatisfied with a matter other than an adverse action. Adverse actions are actions that can be appealed (see MA1701).

A grievance may be filed by:

- A customer;
- A representative; or
- A provider acting on behalf of the customer.

A grievance may be filed either verbally or in writing with the Agency.

Definitions

Term	Definition
Grievance	An expression of dissatisfaction about any matter other than an adverse action. This includes the quality of care received, the services provided or personal treatment (for example, rudeness or conduct of a provider, health plan or agency staff).
Office of Administrative Hearing (OAH)	The OAH handles coordinating the hearings on behalf of AHCCCS Administration.
Office of the General Counsel (OGC)	Helps OAH with the coordination of the appeals process on behalf of AHCCCS program customers.

Timeframes

Grievances must be filed with the Office of the General Counsel (OGC) within 60 days of the date the action happened, or notice was sent:

- The filing date for a verbal grievance is the date of the verbal communication.
- The filing date of a written grievance is the date it is received by the agency.

The agency issues a decision within 30 days of the filing date unless the customer agrees to an extension.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	AAC R9-34-202, 208, 209 and 210 AAC R9-34-301, 302, 308, 309 and 310

Chapter 1800 Fraud and Abuse

1800 Introduction

This chapter contains information about handling complaints of fraud and abuse, as well as steps to take when fraud or abuse is suspected.

For each section in this chapter, you will find:

- The policy for handling complaints of potential fraud and abuse;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply to the policy by program.

1801 Fraud and Abuse

Revised 04/22/2025

Policy

The AHCCCS Administration is responsible for ensuring that program resources are not misused or wasted, and that customers receive appropriate care and services. This responsibility is carried out in several ways.

- Educating the customer or representative of his or her responsibility to report changes and the penalties for perjury and fraud;
- Resolving inconsistent or questionable information received during the eligibility process;
- Identifying, investigating and resolving fraud and abuse cases; and
- Referring concerns to the appropriate area or agency when there is suspected abuse of a customer; and

1) Customer Education

Customers and representatives must be given information about their responsibility to report changes that could affect eligibility, premiums or Share of Cost and the penalties for fraud and perjury. This information is provided on application forms and eligibility letters, and is also explained during eligibility interviews.

For detailed information about reporting changes see Chapter 1500.

The penalties for fraud and perjury may include civil penalties, repayment of benefits received, and criminal prosecution.

2) Resolving Inconsistencies

To prevent fraud and abuse, Benefits and Eligibility Specialists are responsible for resolving inconsistencies when questionable information is received during the eligibility determination process. Information provided by the customer or representative may be questionable when it is inconsistent with:

- Other statements made during the current application;
- Information previously listed on another application; or
- Information received from other sources.

The customer's individual circumstances are considered in determining if information is questionable.

More information or proof may be needed from the customer to resolve the inconsistency. When the customer does not provide the information or proof needed eligibility may be denied or stopped.

3) Identifying and Addressing Potential Fraud

Indications of possible fraud include, but are not limited to, the following:

- Altered documents;
- Contradictory statements made by the same individual;
- Conflicting statements about the same issue made by different people;
- Information about the customer's actual income or resources is not provided or is misrepresented;
- Statements do not agree with information from other proof, documents or applications; and
- Complaints of fraud or abuse received from a third party.

Cases with potential fraud indicators are referred to the AHCCCS or DES Office of Inspector General (OIG) for investigation.

Upon receiving a report of potential fraud, the AHCCCS or DES OIG staff review evidence received with the report, investigate, and determine whether the evidence indicates fraud.

When evidence of fraud is found, OIG may refer the case the Attorney General for prosecution.

4) Abuse of a Customer

When there is suspected abuse, neglect or quality of care issues, eligibility staff may need to refer the issue to Adult Protective Services (APS) or the Department of Child Safety (DCS) for follow-up.

A referral to one of these areas may be needed when any of the following are suspected:

- A problem with the quality of care being provided to the customer;
- The customer is being abused, neglected or exploited;
- Provider fraud;

- The customer has unmet healthcare needs;
- A customer living in an unlicensed or uncertified room and board home is receiving direct, personal care services on other than a temporary basis pending ALTCS approval;
- There appears to be a problem with the ALTCS case manager regarding the customer.

Definitions

Term	Definition
Abuse of a Customer	Any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.
Exploitation	Illegal or improper use of a vulnerable adult or his resources for another's profit or advantage
Fraud	Any act of knowing deception or misrepresentation. Fraud includes: • Intentionally providing incorrect information or misrepresenting facts with the purpose of obtaining benefits to which the customer would not otherwise be entitled. • Lying, misrepresenting, or omitting certain information with the intent to obtain a service, payment, or other gain (e.g. AHCCCS Medical Assistance) to which the individual would not otherwise be entitled. • Using another person's AHCCCS ID card to obtain medical services. • Intentionally not reporting changes in income, household composition, living arrangements or other factors that affect AHCCCS eligibility.

Legal Authority

Program	Legal Authorities
All programs	42 CFR, Part 455 ARS 36-2905.04

Chapter 1900 Estate Recovery

1900 Introduction

Congress passed the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93) on August 10, 1993. It became effective as Federal law under 42 U.S.C. 1396(p) on October 1, 1993. The passage of this Federal law mandated the states to implement an Estate Recovery Program to recover the costs of certain benefit programs. Arizona implemented its Estate Recovery Program effective January 1, 1994. Under this program, AHCCCS is required to file a claim against an ALTCS customer’s estate to recover its costs for providing Medicaid benefits. This chapter explains the Estate Recovery Program requirements.

For each section in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement by program.

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1901 Estate Recovery Claims

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A Estate Recovery Program Overview

Revised 12/06/2022

Policy

1) To Whom Does Estate Recovery Apply?

Estate recovery applies to any person who meets all of the following:

- Received ALTCS nursing home or HCBS benefits;
- Was 55 years or older when benefits were received;
- Received benefits on or after January 1, 1994, and
- Is deceased.

2) Payments for Which AHCCCS Seeks Recovery

The amount of the AHCCCS claim is the total of all ALTCS payments made by AHCCCS for a customer aged 55 or older. Costs for ALTCS benefits provided before the customer turns 55 are not included. AHCCCS recovers for the following types of payments:

- Capitation payments.
- Medicare coinsurance and deductibles for services provided on or before December 31, 2009. No recovery is made for services provided on or after, January 1, 2010.
- Medicare Part A and Part B premiums paid for months on or before December 31, 2009. No recovery is made for premiums paid for January 2010 or later.
- Reinsurance.
- Fee-for-Service Payments.

3) Assets Subject to Estate Recovery

The AHCCCS estate claim is filed at the time of the customer’s death against all property subject to either Small Estate Affidavit or probate. A home that was solely owned by an ALTCS customer, owned jointly without right of survivorship, or owned jointly with right of survivorship (and the joint owner is deceased) is subject to an AHCCCS claim.

4) Long Term Care Partnership Program Claim Exclusion

If a person has a qualifying long-term care partnership insurance policy and was given a resource exclusion (see MA703F), the AHCCCS estate claim is reduced by the amount of resources deducted as a result of the qualified long term care partnership policy.

5) The AHCCCS Recovery Agent

Health Management Systems, (HMS) is a private firm that handles recoveries on behalf of the AHCCCS, including:

- Claims against a customer's estate;
- TEFRA liens;
- Estate Recovery from Special Treatment Trusts (MA803); and
- Achieving a Better Life Experience (ABLE) accounts (MA705I)

NOTE Recovery from ABLE accounts is only for services provided by AHCCCS from the time the ABLE account was established.

Definitions

Term	Definition
Claim	A claim is a legal demand against the estate of an ALTCS customer to recover payment for AHCCCS expenditures issued on the customer's behalf.
Capitation	A payment arrangement for health care service providers. It pays a group of providers in advance for the delivery of health care services. They are paid a set amount for each enrolled person on a monthly basis.
Coinsurance	The percentage of the costs a patient is responsible for toward his health care bill. It is a percentage, not a set amount.

Deductibles	The set amount of expenses that must be paid out of pocket by the insured before an insurer pays any expenses.
Fee-for-Service Payments	AHCCCS directly pays ALTCS customers' medical bills in limited situations described in MA1103. These payments are called 'fee-for-service' payments.
Reinsurance	Additional insurance that is purchased by an insurance company from one or more other insurance companies.
Small Estate Affidavit	An informal procedure for settling estates with less than $50,000 of assets. It is less structured than ordinary probate, and the services of an attorney may not be required. Claims are settled with creditors without probate procedures.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396(p) ARS 36-2935 AAC R9-22-1006 AAC R9-28-901 and R9-28-912

B Estate Recovery Process

Revised 04/30/2018

Policy

There are three main pieces to the Estate Recovery process:

- Informing Customers About Estate Recovery
- Estate Recovery Claims Process
- Notice to Creditor Letters

1) Informing Customers about Estate Recovery

All customers and representatives are given information about the estate recovery program during the initial application interview.

The Estate Recovery Program Brochure (DE-810) is given to all ALTCS customers following the initial application screening process. This brochure explains how the AHCCCS Estate Recovery Program works.

The customer acknowledges the receipt of the Estate Recovery Program brochure and receiving information on the estate recovery program by signing the application.

2) Estate Recovery Claims Process

When notice is received that a customer who is subject to estate recovery has died, HMS proceeds with estate recovery actions as follows:

Step	Action
1	HMS files a “Demand for Notice” with the probate division of the Arizona Superior Court. The “Demand for Notice” requires that AHCCCS be notified of all legal activity concerning the estate.
2	HMS sends the customer’s representative the following documents: • A “Notice of Intent to File a Claim Against the Estate” • An “Estate Questionnaire”

	• A copy of the “Demand for Notice” NOTE If the estate has already entered probate, HMS bypasses the Demand for Notice and Notice of Intent process. A claim is immediately placed against the estate.
3	HMS reviews the information returned by the representative. If an exemption applies, HMS goes over this with the representative.
4	When the estate contains property that may be subject to a Small Estate Affidavit or probate, and no response is received to the Estate Questionnaire or the estate does not qualify for an exemption, HMS files a “Superior Court Claim Against the Estate”.
5	HMS informs the representative in writing where to send payment, how to file a grievance or request a hearing and how to contact HMS.

3) Notice to Creditor Letters

When probate is filed in court, the executor of the will is legally required to notify creditors to submit claims against the estate by a specific date. If AHCCCS is a creditor because it provided ALTCS benefits to the deceased customer, the executor is required to send AHCCCS a letter advising the Agency to submit its claim. This letter is called a “notice to creditor” letter.

Definitions

Term	Definition
Demand for Notice	A notice that gets filed with the probate division of the Arizona Superior Court. This notice requires that the person or entity filing the notice be notified of all legal activity concerning the estate.
Notice of Intent	Notification sent to the customer’s representative indicating that AHCCCS plans to file a claim against the estate.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-2935 AAC R9-28-911 through R9-28-913

C Estate Claim Exemptions

Revised 04/30/2024

Policy

Some property and resources in the customer's estate may be exempt from estate recovery. There are two groups of estate claim exemptions:

- Estate Claim Exemption for Resources of American Indians and Alaska Natives
- Estate Claim Statutory Exemptions

1) Estate Claim Exemption for Resources of American Indians and Alaska Natives

The following resources belonging to American Indians (AI) and Alaska Natives (AN) are not subject to estate recovery:

- Tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission and the U.S. Claims Court;
- Property, including real property and improvements, located within or near the bounds of a tribal nation or located within the most recent boundaries of a prior federal tribal lands as designated by the Bureau of Indian Affairs of the U.S. Department of the Interior;
- Rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources, or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights.
- Ownership interests in, or usage rights to, items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

2) Estate Claim Statutory Exemptions

In certain circumstances, an AHCCCS estate claim may be deferred. These situations are referred to as Estate Claim Statutory Exemptions. Exemptions may exist when the deceased ALTCS customer is survived by any of the following:

- A spouse;
- A child under age 21; or
- A child of any age who meets SSA or SSI disability criteria and is blind or disabled.

Legal Authorities

Program	Legal Authorities
ALTCS	42 US 1396(p) AAC R9-28-911 through R9-28-913

D Deferment and Reductions of Claims

Revised 07/12/2022

Policy

There are certain situations when AHCCCS may defer estate recovery or reduce its claim and recover a lower amount. The estate recovery process also allows an opportunity for the estate's representative to file grievance and request for a hearing on estate recovery decisions.

These policies are covered in the following three sections:

- Undue Hardship Deferment
- Partial Recovery or Reduction
- Grievance Procedure

1) Undue Hardship Deferment

AHCCCS may defer its claim when an heir or devisee to the estate meets all of the AHCCCS' Undue Hardship described in the following table:

If	And	Then
The estate contains real property, and the heir owns a business located on the property	• The business has been in operation at the property for at least 12 months before the customer's death; • The business provides more than 50% of the heir's livelihood; and • Recovery would result in the heir's loss of livelihood	AHCCCS defers its recovery claim
The estate contains residential property, and the heir currently lives in the residence	• The heir lived in the residence at the time of the ALTCS customer's death;	AHCCCS defers its recovery claim

	• The property was the heir's primary residence for the 12 months immediately before the customer's death; and • The heir does not own another residence	
The estate contains personal property only	• The heir's annual gross income, counting the members of the heir's immediate family as appropriate, is less than the Federal Poverty Level (FPL); and • The heir does not own a home, land, or other real property	AHCCCS defers its recovery claim
The estate contains both real and personal property	• The heir qualifies for an undue hardship	AHCCCS does not grant an undue hardship deferment, but adjusts its claim to the value of the personal property

2) Partial Recovery or Reduction

When there is no Estate Claim Exemption and undue hardship policy is not met, AHCCCS considers a partial recovery or a reduction of its claim against the estate claim.

When HMS notifies an estate of a claim, it also provides information indicating what factors are considered when deciding whether a partial recovery can be approved. These include:

- A financial or medical hardship;
- Whether the heir's household income is less than Federal Poverty Level (FPL);
- The value and type of resources held by the estate (real and personal);
- The amount of the claim;
- The claims of other creditor's and whether any property in the estate has been foreclosed on; and
- Any other factors that may relate to a fair determination.

When an heir wishes to apply for an Undue Hardship deferment of estate claim or reduction of an AHCCCS estate claim, the heir must submit a written statement and provide all supporting documents to HMS no later than 30 days from the date on the “Notification of the AHCCCS Claim Against the Estate.” AHCCCS makes a decision within 60 days of receiving the completed application for a deferment or reduction.

3) Grievance Procedure

Information about how to file an estate recovery grievance and request a fair hearing is included in notices sent to the estate’s personal representative. A grievance must be received by the Office of the General Counsel (OGC) no later than 60 days from the date shown on the “Notification of the AHCCCS Claim Against the Estate” or the “Decision Notice Regarding the AHCCCS Estate Claim.” Grievances must be submitted in writing to:

AHCCCS Administration

Office of the General Counsel

Mail Drop 6200

P.O. Box 25520

Phoenix, Arizona 85002

Definitions

Term	Definition
Heir	A person who is legally entitled to inherit some or all of the estate of another person who has died.
Devisee	A person who inherits or receives a gift of real property by a will.
Real property	Any property that is attached directly to land, as well as the land itself.

Residential real property	Any property used as a residence that is attached directly to land, as well as the land itself.
Personal property	Any resource other than real estate or real property.

Legal Authorities

Program	Legal Authorities
ALTCS	42 US 1396(p) AAC R9-28-911 through R9-28-913

1902 TEFRA Liens

Revised 04/30/2024

Policy

AHCCCS may file a lien against the customer's real property, including the customer's home, after the customer becomes permanently institutionalized at a nursing home, mental health hospital, or other long term care medical facility.

The purpose of the lien is to recover the cost of benefits provided upon the customer's death or upon a sale or transfer of an interest in the property.

The policy in this section covers the following topics:

- Customers subject to a TEFRA Lien
- Exemptions to filing a TEFRA lien
- Notice and filing of a TEFRA lien
- Changes after a TEFRA Lien has been filed
- Sale or transfer of property that has a TEFRA lien
- Non-enforcement of TEFRA liens

1) Customers Subject to a TEFRA Lien

ALTCS customers who are permanently institutionalized will have a lien filed against their home or other real property unless an exemption exists.

NOTE If a customer is discharged from a facility and returns to his or her own home on a permanent basis, the lien will be removed.

2) Exemptions to Filing a Lien

A lien will not be filed against the following real property belonging to members of federally recognized American Indian tribes:

- Tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission and the U.S. Claims Court;

- Property, including real property and improvements, located within or near the bounds of a tribal nation or located within the most recent boundaries of a prior federal tribal lands as designated by the Bureau of Indian Affairs of the U.S. Department of the Interior;

A lien will not be filed if one of the following individuals is lawfully living in the customer's home:

- The customer's spouse;
- The customer's child who is under age 21;
- The customer's child who is blind or permanently and totally disabled; or
- The customer's sibling who has an equity interest in the home and who was living in the member's home for at least one year immediately before the date the customer was permanently institutionalized.

3) Notice and Filing of a TEFRA Lien

Following notification that a customer has lived in an institution for 90 days or more, Health Management Systems (HMS) sends a Notice of Intent to File a Lien and a Questionnaire to the customer or the customer's authorized representative.

If there is no response or HMS determines that the proper criteria have been met, HMS files a TEFRA Lien against the customer's home on behalf of AHCCCS.

Should a customer wish to contest the lien, he or she may file a request for a fair hearing within 30 days of receiving the Notice of Intent.

4) Changes after a TEFRA Lien has been Filed

No further action is taken by AHCCCS after the lien has been filed until either:

- The customer dies;
- The property ownership is sold or transferred; or
- The customer returns home and the lien is removed.

5) Sale or Transfer of Property that has a TEFRA Lien

When property with a TEFRA lien is sold, the customer must repay AHCCCS for payments made by AHCCCS on the customer's behalf. The repayment amount is equal to the amount that

AHCCCS has paid. AHCCCS cannot collect more than the amount that it has paid at the time the property is sold.

6) Non-Enforcement of Liens

A lien will not be enforced against any real property when the customer is survived by his or her:

- Spouse,
- Child under the age of 21, or
- Child who is blind or permanently and totally disabled.
- Sibling who lives in the deceased customer's home and who was living there for a least one year immediately before the date the customer was institutionalized, or
- Child who lives in the deceased customer's home and who was living there for at least two years immediately before the date the customer was institutionalized.

Definitions

Term	Definition
TEFRA Lien	A lien under 42 USC 1396p of the Tax Equity and Fiscal Responsibility Act of 1982.
Permanently Institutionalized	Permanently institutionalized means the customer has lived in a long-term care nursing facility for at least 90 consecutive days and continues to live there and cannot reasonably be expected to be discharged and return to his or her own home.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1396p AAC R9-28-801 through R9-28-807

Effective until 2025-04-25