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105.01 Verification Matrices

(Eff. 08/01/15)

Verification matrices are designed to provide high level guidance concerning verification. The goal is to help eligibility workers to verify eligibility criteria at the appropriate level to prevent over or under documentation and to aid in consistent determinations.

105.01.01 Non-Financial and Income Verification Matrix

(Rev. 04/17/20)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | **Acceptable Sources**Only **one** data source is needed to verify an element |
|  | **Element** | **Primary Data Sources**(If unable to verify, use a Secondary Source) | **Secondary Data Sources**(Not all data sources are listed) |
| **Non-Financial** | **Citizenship** | * **SVES**
* **Federal Hub**
* **Person Composite Service (PCS)**
* **DMV**
 | * **Passport**
* **Certificate of Naturalization**
* **Birth Certificate**
 |
| **Identity** | * **SVES**
* **Federal Hub**
* **Person Composite Service (PCS)**
* **DMV**
 | * **Passport**
* **Certificate of Naturalization**
* **Driver’s License**
 |
| **Social Security Number (SSN)** | * **SVES**
* **BENDEX**
* **Federal Hub**
* **Person Composite Service (PCS)**
 | * **Social Security Card**
* **Social Security Letter**
* **SS-5**
 |
| **Age/Date of Birth** | * **SVES**
* **BENDEX**
* **Federal Hub**
* **Person Composite Service (PCS)**
 | * **Birth Certificate**
* **Driver’s License**
 |
| **Lawful Presence**(Alien Status, Lawful Permanent Resident) | * **SAVE**
* **Federal Hub**
* **Person Composite Service (PCS)**
* **SVES (40 Work Quarters)**
 | * **USCIS Document**
 |
| **Residency** | **Client Statement** |  |
| **Out-of-State Benefits** | **Client Statement** |  |
| **Marital Status** | **Client Statement** |  |
| **Relationship** | **Client Statement** |  |
| **Household Composition/****Tax Filing Status** | **Client Statement** |  |
| **Income** | **Unearned Income** | * **BENDEX**
* **SDX**
* **UCB**
* **State Retirement System**
 | * **Collateral Call**
* **Award Letter**
* **Check Stub**
* **DHHS Verification Forms**
 |
| **Earned** | * **Wage Match**
* **Person Composite Service (PCS) Wage Verification**
* **VerifyDirect**
* **CHIP**
 | * **Collateral Call**
* **Check Stub**
* **DHHS Form 1245 or other written statement from employer**
 |
| **Self-Employment** | * **Tax Return**
 |  |
| **Contributions** | **Client Statement** |  |
| **Category Specific** | **Pregnancy**(Pregnant Woman) | **Client Statement** |  |
| **School Attendance**(If the only Qualifying Child for a PCR is Age 18) | **Client Statement** |  |
| **Disability**(Non-MAGI with Applicant under age 65) | * **BENDEX**
* **SDX**
 | * **SSA/SSI Award Letter**
* **MAO99**
 |

|  |  |  |
| --- | --- | --- |
| **Electronic Source** | **Client Statement** | **Hard Copy** |

105.01.02 Resource Verification Matrix

(Rev. 02/01/23)

|  |  |  | **Acceptable Sources**Only consider resources for non-MAGI programs |
| --- | --- | --- | --- |
|  | **Resource** | **Verification Sources** | **Instruction** |
| **Bank** | **Checking Account Savings Account Certificate of Deposit** | * **Documented call to Financial Institution**
* **Asset Verification System (AVS)**
* **Bank Statement**
* **Account Information from Bank website**
 | * **Verify:**
	+ **Name of Bank**
	+ **Account Number**
	+ **Account Balance**
* **Obtain balance for month of application**
* **Obtain balance for each Retroactive month**
 |
| **IRA, 401-K, Retirement Account** | * **Documented call to Financial Institution**
* **Asset Verification System (AVS). Does not include brokerage firms**
* **Financial Institution Statement**
 | * **Verify:**
	+ **Name of Institution**
	+ **Account Number**
	+ **Account Balance**
 |
| **DirectExpress**(Direct deposit account for U.S. government benefits) | * **Client Statement**
 | * **Accept client statement of account balance**
 |
| **Property** | **Homestead Property****Non-Homestead Property** | * **County Tax Assessor**
	+ **Use county website if available**
	+ **Send DHHS Form 1255 if the county does not have property records online**
* **Property Tax Notice**
 | * **Verify if the client alleges property:**
	+ **Owner(s)**
	+ **Location/Address**
	+ **Map/block/parcel number**
	+ **Value**
* **Accept client statement if no real property is alleged\***

**\*Exception: Long Term Care**  |
| **Vehicle** | * **County Tax Assessor**
	+ **Use county website if available**
	+ **Send DHHS Form 1255 if the county does not have property records online**
* **Property Tax Notice**
* **DMV Webtool**
 | * **Accept client statement if no vehicles are alleged**
 |
| * **Liberalized: MPPM 302.16**
* **Accept client statement if one or two vehicles are alleged**
* **Verify if three or more vehicles are alleged**
 |
| * **Strict: MPPM 402.17.01**
* **Accept client statement if one vehicle is alleged**
* **Verify if two or more vehicles are alleged**
 |
| **Life Insurance** | **Life Insurance Policy**(Do not verify term life insurance provided through employment) | * **Documented call or written statement by agent**
* **Documented call to insurance company (automated system or call center)**
* **Copy of policy**
* **DHHS Form 1280**
* **Applicant**
 | * **Accept attestation if no insurance is alleged**
* **Accept attestation if life insurance is alleged with a total face value of all policies for each insured person is less than or equal to $10,000**
* **Items to verify if client alleges life insurance with a total face value of all policies for each insured person is greater than $10,000:**
	+ **Name of Company**
	+ **Policy Number**
	+ **Type – Whole or Term**
	+ **Face Value**
	+ **Cash Value**
	+ **Dividends, if any**
 |

105.01.03 Long Term Care Verification Matrix

(Eff. 09/01/16)

| **Look-Back** |
| --- |
| **Element** | **Policy Reminder** | **Verification/Documentation** |
| **Bank/Financial Accounts**MPPM 302.26.02MPPM 304.09.02C | * Review bank statements for Month of Application and Three Months prior to Application if provided. Do not request from the applicant
* Create Financial Institution (FI) and Geosearch AVS requests. If a transfer is indicated, wait for response
* Look for unusual withdrawals/deposits which exceed income
* Compare Monthly interest earned to Year to Date interest earned
 | * Hard copy from applicant
* Collateral Phone call with financial institution
* Asset Verification System (AVS)
* DHHS Form 1253 or bank specific form (Only if unable to verify with AVS)
 |
| **Property**MPPM 302.14.01MPPM 304.05.03MPPM 304.09.02C | * Complete property check for applicant’s county of residence and where lived within the past five years
* If applicant lived out of state, complete/send property check but do not wait for a response unless the applicant indicates current property or transfer.
 | * Always use On-line property check if available (In-State or Out-of-State)
* Hard copy from applicant
* DHHS Form 1255 ME
 |
| **Probate**MPPM 302.13MPPM 304.09.02C | * Complete a probate search only if the applicant indicates an inheritance within the past 5 years
 | * DHHS Form 1255 ME
* Copy of will, estate accounting form, deed of distribution or other court documents
 |
| **Eligible Out-of-State Applicant** | * If an applicant who is Medicaid eligible in another state for LTC moves in-state, a new look-back must not be completed
 | * Written or verbal statement from the state Medicaid agency
* Written or verbal statement from LTC facility
 |
| **Previous Look-Back completed within past 5 years** | * If an applicant who is Medicaid eligible in another state for LTC moves in-state, a new look-back must not be completed
 | * Written or verbal statement from the state Medicaid agency
* Written or verbal statement from LTC facility that the individual transferred from a Medicaid facility in another state
 |

| **Deductions** |
| --- |
| **Element** | **Policy Reminder** | **Verification/Documentation** |
| **Health Insurance Premium** | * Health insurance premiums which are paid by an institutionalized individual can be deducted from income; AND
* A deduction can only be given for the part of the premium which provides coverage for the institutionalized person
 | * Hard copy of bill or receipt from the insurance company
* Documented phone call with the insurance company or agent
* Deduction on a bank statement (if the insurance coverage is only for the institutionalized person)
 |
| **Home Maintenance Allowance** | * Allowance can be given for up to six full calendar months for necessary household expenses
* Six month count begins the first full calendar month the applicant is in an institutional setting (Hospital or Nursing Facility)
* Allowance is for actual household expenses not to exceed the current SSI limit
* Deduction is applied during recurring income calculation
* Deduction can be requested at any point within the six month period and applied retroactively
 | * Letter from physician certifying the applicant is expected to return home within six months
* Written or verbal statement of household expenses. Must detail the type and amount of expenses
* Only request copies if the reported expense is excessive and is needed to give the full allowance
* Deduct household expenses in the following order until full allowance is used
	+ Mortgage or Rent
	+ Electricity, Water and Sewer
	+ Telephone and internet
	+ Cable and other utilities and expenses
 |
| **Spousal Allocation** | * An allocation can be given to a community spouse by the institutionalized spouse
* The institutionalized spouse must agree to provide the allocation
* The community spouse must cooperate and provide income and resource information to receive the allocation
 | * Question must be answered on DHHS Form 3401 or the DHHS Form 3400-B
* Verification of spousal income/resources
 |
| **Dependent Allocation** | * An allocation can be given to a dependent relative by the institutionalized person
* The institutionalized person must agree to provide the allocation
* The dependent relative must cooperate by providing information to receive the allocation
 | * Written Statement which has the:
	+ Name of the dependent relative;
	+ Relationship of the dependent relative to the institutionalized person;
	+ Nature of the dependency of the dependent relative; and
	+ Name and relationship to the person with whom the dependent relative will be living
 |

| **Other** |
| --- |
| **Element** | **Policy Reminder** | **Verification/Documentation** |
| **Separated Spouse** | If a person who is separated but not divorced applies for an institutional program, the eligibility worker MUST attempt to contact the community spouse and obtain resource information. | * If the community spouse receives SSI, no contact is required
* If the location of the spouse is known, attempt contact:
	+ If spouse does not cooperate, document and treat Institutional Spouse as an individual
		- If a DHHS 1233 is sent, continue processing the application. Process as a change if something is returned

Cooperating:* Document income for spousal allocation
* Document Resources

Non-Cooperating:* Failure to respond to DHHS Form 1233
* Documented phone call
* Written Statement of refusal
 |
| **Income Trust** | * Individuals with income over the income limit can establish an income trust
* Income which is deposited into the trust does not count toward the income limit
* All income received is used to calculate the cost of care
* An Income Trust document must be completed before approving eligibility
* There must be a separately designated account (can be an existing account). No other income or resources can be deposited into the account
* Income is not protected for the month of entry or discharge
 | * Copy of properly executed Income Trust document
* Designated bank account for trust
 |

105.02 Scripts

(Eff. 08/01/15)

Scripts are designed for workers to use when initiating phone calls to applicant’s to provide a framework for gathering information used in the eligibility process. The goal is to help eligibility workers to verify eligibility criteria at the appropriate level to prevent over or under documentation and to aid in consistent determinations.

105.02.01 Disability Process Script

(Eff. 08/01/15)

The following Disability Process Script must be used to make contact with the applicant who may require a disability decision.

| Disability Process Script 105.02.01 |
| --- |
| Step | Script | Actions |
| **Call** |  | *Make call using the contact information on the application. If a person answers the call, go to* [***Introduction***](#Intro)***.****If you get voice mail, go to* [***Call Back Message***](#Call_Back_Message)***.****If there is no answer, go to* **Prepare Disability Packet.**MPPM 102.06.02A*.* |
| **Call Back Message** | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone recently contacted our agency and I am following up for more information. I will call back in the next 5 minutes. Thank you. | *After 3-5 minutes, attempt a second call to the applicant/ beneficiary.**If a person answers the call, go to* [**Introduction**](#Intro)**.***If there is no answer Go to* [**Failed Contact**](#Failed_Contact)**.** |
| **Failed Contact** | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. I am calling today because someone recently contacted our agency. Since I am unable to reach anyone at this time, I will follow up with you through the mail. If you have any questions about this call, you may contact the Healthy Connections Member Services Call Center at 1-888-549-0820 and someone will be able to help you. Once again, that number is 1-888-549-0820. Thank you. | *Go to* **Prepare Disability Packet.**MPPM 102.06.02A |
| **Introduction** | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Applicant (or Authorized Representative)? | *If person on the phone says the applicant is not available, go to* [**Not Available**](#Not_Avail)*.* *If able to speak with the applicant, go to* [**Available**](#Avail)*.**If applicant is the person on the phone, go to* [**Available**](#Avail)*.* |
| **Not Available** | Mr./Ms. Last Name recently contacted our agency and we need to speak with him/her to get some more information. Since we cannot speak with Mr./Ms. Last Name right now we will contact him/her by mail. Can we take a few moments to make sure we have the correct contact information for Mr./Ms. Last Name? | *If the person on the phone is willing, confirm the name (ask if it is the person’s legal name and check the spelling), date of birth if the person knows it, and contact information (address and phone number).***END CALL***Go to* ***Prepare Disability Packet.*** MPPM 102.06.02A |
| **Available** | Mr./Ms. Last Name, you recently contacted our agency to apply for benefits and we need to follow up to get some additional information. First I need to confirm I am speaking with the right person. | *If someone other than the applicant answered the call, reintroduce yourself before continuing with the script.**Ask for name and date of birth of the individual and match and confirm with the information on the application. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to* [**Disability Script**](#Dis_Script)***.****If unable to confirm the identity of the applicant, indicate you will have to send the request by mail and go to Go to Prepare Disability Packet. MPPM 102.06.02A* |
| **Disability Script** | On your application for Medicaid, you checked that you may be disabled. We are trying to help make the process go a little more smoothly, so we want to give you some information about applying for Medicaid based on disability so you can make the best decision about what to do next. | Go to [**General Medicaid Information**](#Gen_Med_Info)**.** |
| **General Medicaid Information** | Medicaid is for people who have a financial need, but it is more than just how much money you may or may not have. You must also be part of a coverage group, or category. In addition to being disabled or aged 65 or older, there are four other broad categories. You can be a: * Child under age 19;
* Pregnant women;
* Parent (or other caretakers of children) in families with dependent children; or
* Person diagnosed with and receiving treatment for breast or cervical cancer.

Do you believe you may be part of one of these other groups?  | *If the person indicates he/she may be eligible under one of the other categorical groups, explore possible eligibility in a MAGI group.**If the person does not indicate possible eligibility in a MAGI group, go to* [**Define**](#Define)***.*** |
| **Define** | Because you checked on the application that you have a disabling physical, mental, or emotional health condition that causes limitations in activities, we want to talk about what that means and explain the disability determination process.Medicaid uses the same definition of disability as the Social Security Administration (SSA). This definition is different than that used by other programs. This may be different than you receiving disability from work or the VA or your doctor telling you that you are disabled and need special medical treatment or some kind of accommodation, such as handicap parking. You are only eligible for Social Security if you have a permanent and total disability. You will not receive benefits if your disability is partial or short-term. Because Medicaid has the same rule, you must be totally disabled to be eligible as part of this coverage group.Social Security's disability definition is based on your inability to work. You may be considered disabled under Social Security rules if: * You cannot do work that you did before;
* It is determined that you cannot adjust to other work because of your medical condition(s); and
* Your disability lasts or is expected to last for at least one year.

Disability is more than just having a serious medical problem. Your age, education, work history and how long your problem is expected to last all make a difference. For instance, an individual may not be able to go back to a past job requiring heavy lifting and standing but might be able to work at a different job that requires light lifting and mostly sitting. | ***If example is needed to explain:***A 32 year old office worker with a college degree who is no longer able to walk may not be disabled. On the other hand, a 59-year-old construction worker who did not finish high school who has the same condition may be disabled.***If person indicates condition is terminal:***I’m sorry to hear that. This is something that is taken into consideration in making the decision.Go to [**SSA Screening**](#SSA_Screen)**.** |
| **SSA Screening** | Applying for disability can be a long process. Normally the best first step is to apply for disability with the Social Security Administration (SSA). There are a couple of different programs with SSA based on your work history, marital status, your living arrangement (for instance, are you living with someone or living by yourself) and what you may own.Have you already applied for SSA disability?  | *If the applicant answers yes, go to* [***SSA Status***](#SSA_Stat)***.****If the applicant answers no, go to* [**Disability Process**](#Dis_Proccess)***.****If the applicant wants contact information for SSA:*You can go to the Social Security website to get more information and to apply for benefits at [www.ssa.gov](http://www.ssa.gov).*If the applicant wants a phone number for SSA:*You can get more information by calling SSA at 1-800-772-1213 (TTY 1-800-325-0778) |
| **SSA Status** | Has SSA approved or denied your application? | *If approved, ask for verification then go to* [**Process Application**](#Proc_App)*.**If denied, go to* [**Disability** **Process**](#Dis_Proccess)**.** |
| **Disability Process** | In South Carolina, Medicaid and Social Security use the same agency to make disability decisions. If you are waiting on a decision from Social Security, we will ask you to fill out the disability forms. When Disability Determination Services (DDS) gets the paperwork, they will match it with your Social Security application and work both at the same time. Getting a disability decision can take a long time, but providing all the requested information can prevent unnecessary delays. By applying for Social Security, if you are eligible you may be able get a monthly check.We can send a request for a disability determination if you have not already filed with Social Security. It will still take about the same amount of time that it takes to get a decision for Social Security.  | *Go to* [**Application for Other Benefits**](#App_Other_Bene)***.*** |
| **Application for Other Benefits** | One of the Medicaid eligibility rules is you must apply for any income benefits for which you may be eligible. This does not include programs that are based on need, such as SNAP (Food Stamps), Family Independence (at DSS), Supplemental Security Income (SSI) or some VA programs.What this means is if we get a decision back from DDS and they say you are disabled, we have to check to see if you applied for Social Security Disability benefits. If you have not applied and you do not have a good reason, we will have to deny your application for Medicaid until you can show us that you have applied for Social Security. | *Go to* [**Next Step**](#Next_Step)***.*** |
| **Next Step** | Based on what we have talked about today, do you feel that your disability meets the Social Security requirements? | *If applicant says Yes and wants to pursue disability, go to* [**Continue Process**](#Cont_Proc)***.****If applicant says No and does not want to pursue disability, go to* [**Other Category**](#Other_Cat)***.*** |
| **Continue Process** | If you think you may have a disability that meets Social Security’s requirements, we will send you some forms to fill out. The questions on the form will ask about the following:1. Medical information – a description of the problems you are having, the doctors you have seen, hospital visits, tests
2. Education history – grade completed, school attended
3. Work history – Jobs worked in the past 15 years and the kind of work you did

You will also have space to give any other information you think may help.There will also be a second form that you will need to sign and date that will allow us to obtain medical records needed to make the disability decision. Do not write any other information on the form. You will need to send the whole packet back to us within 15 days so we can continue the process. An envelope is included but you must put the postage on it. | *Discuss any other information that needs to be requested on the DHHS Form 1233 ME.**Go to*[**End Call**](#End_Call) |
| **Other Category** | Based on what we have talked about, If you decide that your disability is not likely to meet Social Security’s requirements, then we can use your application to see if there is anything else that you may be eligible for. Depending on your situation, you may be eligible for another full Medicaid category, a limited benefit Medicaid program, or you may not be eligible at all. | *Discuss any other information that needs to be requested on the DHHS Form 1233 ME.**Go to* [**End Call**](#End_Call) |
| **End Call** | Thank you for your time today. If you think of any questions after this call, you can call the Healthy Connections Member Services Call Center at 1-888-549-0820 and they can help you. |  |

105.02.02 Long Term Care Call Initiation Script

(Eff. 08/01/15)

| Long Term Care Call Initiation Script 105.02.02 |
| --- |
| Step | Script | Actions |
| **Call Preparation**  |  | Review the application and make notes of any information that may be missing, needs clarification or requires verification/documentation.Check all online verification sources which may be available including completion of online property checks.  |
| **Call**  |  | Make call using the contact information on the application. If a person answers the call, go to [**Introduction**](#Intro).If you get voice mail, go to [**Call Back Message**](#Call_Back_Message)**.**If there is no answer, prepare a DHHS Form 1233 and request required information.  |
| **Call Back Message**  | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone recently contacted our agency and I am following up for more information. I will call back in the next 5 minutes. Thank you. | After 3-5 minutes, attempt a second call to the applicant/beneficiary. If a person answers the call, go to [**Introduction**](#Intro)**.**If you reach voice mail on your second attempt, go to [**Failed Contact**](#Failed_Contact). |
| **Failed Contact** | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. I am calling today because someone recently contacted our agency. Since I am unable to reach anyone at this time, I will follow up with you through the mail. If you have any questions about this call, you may contact the Healthy Connections Member Services Call Center at 1-888-549-0820 and someone will be able to help you. Once again, that number is 1-888-549-0820. Thank you. | Prepare a DHHS Form 1233 and request required information. Document attempted contact.  |
| **Introduction**  | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Applicant (or Authorized Representative)? | If person on the phone says the applicant/authorized representative is not available, go to [**Not Available**](#Not_Avail). If able to speak with the applicant/authorized representative, go to [**Available**](#Avail).If applicant/authorized representative is the person on the phone, go to [**Available**](#Avail).  |
| **Not Available**  | *→* Mr./Ms. Last Name recently contacted our agency and we need to speak with him/her to get some more information. Is there another number we can use to speak with him/her or is there another time we can call back? | Obtain the alternate contact number and/or call back time.**END CALL** |
| **Available**  | *→* Mr./Ms. Last Name, you recently contacted our agency to apply for benefits and we need to follow up to get some additional information. I just need to first confirm that I am speaking with the correct person. | If someone other than the applicant answered the call, reintroduce yourself before continuing with the script.Ask for name and date of birth of the individual and match and confirm with the information on the application. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to [**Interview Script**](#Interview_Script)**.** |
| **Interview Script**  | *→* We received your application for Long Term Care Services and we want to go over it with you to make sure we have a good idea of the situation and to let you know about any else you may need to send in. Once we finish this call we will mail you a list of everything we are asking you to return as a reminder. | Go to [**Application Script**](#App_Script)  |

105.02.01A Update Disability Packet Script

(Eff. 03/01/16)

The following Disability Process Script must be used to make contact with the applicant when an application requiring a disability decision has not been processed timely and the DHHS Form 921, Release for Information, is expired or about to expire. Refer to MPPM 102.06.02A.

| Update Disability Packet Script |
| --- |
| Step | Script | Actions |
| Call |  | *Make call using the contact information on the application. If a person answers the call, go to* [***Introduction***](#Intro)***.****If you get voice mail, go to* [***Call Back Message***](#Call_Back_Message)***.****If there is no answer, go to* [**Prepare Update Disability Packet**](#Prep_Update)**.** |
| Call Back Message | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone contacted our agency and I am following up for more information. I will call back in the next 5 minutes. Thank you. | *After 3-5 minutes, attempt a second call to the applicant/ beneficiary.**If a person answers the call, go to* [**Introduction**](#Intro)**.***If there is no answer Go to* [**Failed Contact**](#Failed_Contact)**.** |
| Failed Contact | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. I am calling today because someone contacted our agency. Since I am unable to reach anyone at this time, I will follow up with you through the mail. If you have any questions about this call, you may contact the Healthy Connections Member Services Call Center at 1-888-549-0820 and someone will be able to help you. Once again, that number is 1-888-549-0820. Thank you. | *Go to* [**Prepare Update Disability Packet**](#Prep_Update) |
| Introduction | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Applicant (or Authorized Representative)? | *If person on the phone says the applicant is not available, go to* [**Not Available**](#Not_Avail)*.* *If able to speak with the applicant, go to* [**Available**](#Avail)*.**If applicant is the person on the phone, go to* [**Available**](#Avail)*.* |
| Not Available | Mr./Ms. Last Name contacted our agency and we need to speak with him/her to get some more information. Since we cannot speak with Mr./Ms. Last Name right now we will contact him/her by mail. Can we take a few moments to make sure we have the correct contact information for Mr./Ms. Last Name? | *If the person on the phone is willing, confirm the name (ask if it is the person’s legal name and check the spelling), date of birth if the person knows it, and contact information (address and phone number).***END CALL***Go to* [**Prepare Update Disability Packet**](#Prep_Update)***.*** |
| Available | Mr./Ms. Last Name, you contacted our agency to apply for benefits and we need to follow up to get some additional information. First I need to confirm I am speaking with the right person. | *If someone other than the applicant answered the call, reintroduce yourself before continuing with the script.**Ask for name and date of birth of the individual and match and confirm with the information on the application. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to* [**Update Disability Packet Script**](#Dis_Script)***.****If unable to confirm the identity of the applicant, indicate you will have to send the request by mail and go to Go to* [**Prepare Update Disability Packet**](#Prep_Update)**.** |
| Update Disability Packet Script | On your application for Medicaid, you checked that you may be disabled. You filled out a disability packet with your original application but due to a delay, the Information Release Form is more than 10 months old and needs to be updated. I would like to send you a packet so that we can get updated information. | *Go to* [**Update Cover Letter**](#Gen_Med_Info)***.*** |
| Update Cover Letter | The packet will contain several things. The first is a letter that will repeat many of the same things we will talk about today. It will explain that we need to update the information we have on file and give you the instructions on what needs to be done. | *Go to* [**DHHS Form 921**](#Form_921)***.*** |
| DHHS Form 921 | I am sending you a DHHS Form 921, Authorization to Disclose Health Information (Request for Medical Records). This form gives your doctors and other medical providers permission to give Vocational Rehabilitation the needed information to make a decision about your disability. It is important that you send this form back. | *Go to* [**Review Disability Report**](#Rev_Dis_Rep)***.*** |
| Review Disability Report | I am also including a copy of the original Disability Report that you sent in with your application. We want to give you a chance to look over what you told us so you can make any changes, such as a new doctor or medical problem. | *Go to* [**Report Changes**](#Rep_Chan)***.*** |
| Report Changes | If there are any changes you want to tell us about, you can add it on the blank copy of the Disability Report included in this packet. You do not have to fill out the entire form again. You only have to fill out that part where there is a change. For instance, if you have a new doctor you want to add, you can add his or her information on page 2. You would not have to fill out anything else. If you do not have any new information, you do not have to fill out anything on this form. | *Go to* [**Return Envelope**](#Ret_Env)***.*** |
| Return Envelope | We are including an addressed envelope for you to use to return everything to us. Please remember to put a stamp on the envelope or we will not get to us. We ask that you send everything to us within 15 days. Please call the number shown on the letter for the Healthy Connections Member Services Call Center if you will not be able to return everything within 15 days. | *Go to* [**End Call**](#End_Call)***.*** |
| End Call | Thank you for your time today. If you think of any questions after this call, you can call the Healthy Connections Member Services Call Center at 1-888-549-0820 and they can help you. |  |

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| **Prepare Update Disability Packet*** Cover Letter
* Copy of original DHHS Form 3218 ME
* DHHS Form 3218 ME
* DHHS Form 921
 | * Complete the DHHS Form 3218-J ME, Update Disability Packet cover letter
* Print a copy of the applicant’s original completed Disability Report
* On a new Disability Report, type the applicant’s Name, Date of Birth, Social Security Number, Address, Phone Number and other Identification and Contact information
* Fill in the “For DHHS Use Only” box by typing the complete Household Number and Application Date and indicate whether it is a request for an Initial or Retro Only decision and the beginning Retro month
* On the DHHS Form 921, fill in the “To Be Completed By SCDHHS” box by typing the Name, Social Security Number, Date of Birth and complete Household or Application ID number
* Update the DHHS Form 1233 ME to add the Disability Packet
* Mail the DHHS Form 1233 ME and Update Disability Packet to the applicant and give 15 days to return the required information
 |

105.02.03 Long Term Care Application Script

(Eff. 08/01/15)

| **Application Script 105.02.03**Worker ID:       Applicant:       Call Date:       HH/Application Number:        |
| --- |
| **Element**ScriptAdjust as appropriate if speaking with an Authorized Representative **Confirmation/Correction** | **Action** |
| **Applicant Name***→* You entered your name as Full Name. Is this the way that your name is on your Social Security Card? |  |
| [ ]  CorrectChange:       |
| **Date of Birth***→* What is your date of birth? |  |
| [ ]  CorrectChange:       |
| **Social Security Number***→* You show your Social Security Number as Social Security Number? Is this correct? |  |
| [ ]  CorrectChange:       |
| **Home Address***→* You show your home address as Home Address. Is this correct? Do you also receive your mail at this address? |  |
| [ ]  CorrectChange:       |
| **Mailing Address***→* You entered your mailing address as Mailing Address. Is this correct? |  |
| [ ]  CorrectChange:       |
| **Household Members***→* You listed the following people on your application as living with you:Names. Is this correct?*→* Is there anyone else we should add such as a spouse living somewhere else?Record Name, Relationship, Date of Birth and other information as needed |  |
| [ ]  CorrectChange/Addition:      |
| **Legal Documents**→ Does anyone have a Conservatorship, Guardianship or Power of Attorney for you? | [ ]  Copy in File [ ]  1233 – Copy Requested |
| [ ]  None[ ]  Conservatorship [ ]  Guardianship[ ]  Power of AttorneyName:       |
| **Requested Service Type***→* On your application you indicated you are interested in Service Type. Is this correct? | [ ]  Level of Care Request (NH/HCBS)[ ]  Slot Request (OSS) |
| [ ]  Nursing Home[ ]  In Home Care (HCBS)[ ]  OSS |
| **Current Location***→* Are you currently at home, in a hospital, or at some other facility such as a nursing facility or residential care facility? |  |
| [ ]  Home (Own home or with a relative or friend)[ ]  Nursing Home[ ]  Hospital[ ]  CRCFFacility Name:      Date Entered:       If applicant is currently in a nursing facility:→ Did you live at home at any time during the month you entered the nursing facility?  [ ]  Yes [ ]  No |
| **Categorical** | If Disability is not established, go to **Disability Script** |
| [ ]  Aged (Age 65 or older)[ ]  Blind or Disabled[ ]  Disability not established |
| **Retroactive***→* Have you received any medical services in the three months prior to the application? | [ ]  1233 – Retro info requested      |
| [ ]  Retro requested on application[ ]  Retro requested on call[ ]  Retro not requested |
| **Other Benefits***→* Have you or your spouse ever served in the military?*→* Have you or your spouse ever worked somewhere which has a retirement benefit? | [ ]  1233 – Refer to apply for other benefits      |
| [ ]  No other potential income[ ]  Currently receive[ ]  Other potential income      |
| **Income** – ApplicantComplete before call. Make any notes or corrections as necessary: |  |
| *→* You listed the following income on your application: | [ ]  1233 – Income Verification Requested      |
| Source Amount[ ]  SSA/Railroad      [ ]  Veterans Benefits      [ ]  Retirement/Pension      [ ]  Other:

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|       |       |

 |
| *→* Is there any other income that may not have been listed? | [ ]  1233 – Income Verification Requested     Total Reported Income:0.00If reported income is greater than $2000, go to **Income Trust** script. If Income Trust script is not required, continue **Application Script** |
| [ ]  None[ ]  Additional Income:Source Amount

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| *→* Do you have any deductions taken out of your check? Anything such as health/dental insurance premiums or taxes withheld? If you have medical deductions, we may be able to not count the premiums.[ ]  No Deductions[ ]  Deductions (List all deductions)      | [ ]  1233 – Verification Requested*→* If taxes are being withheld, you have the option to ask whoever is paying the income to stop withholding taxes.Medicaid must use the full amount even if taxes are being deducted. |
| **Income** – Spouse or other dependent relativeComplete before call. Make any notes or corrections as necessary: |  |
| *→* You listed the following income on your application:Source Amount[ ]  SSA/RRB      [ ]  Veterans Benefits      [ ]  Retirement/Pension      [ ]  Other:

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| --- | --- |
|       |       |
|       |       |

 | [ ]  1233 – Income Verification Requested      |
| *→* Is there any other income that may not have been listed? | [ ]  1233 – Income Verification Requested      |
| [ ]  None[ ]  Additional Income:Source Amount

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|       |       |

 |
| **Resources**Complete on-line property check Complete before call. Make any notes or corrections as necessary. Follow up on discrepancies |  |
| *→* You listed the following resources on your application: | [ ]  1233 – Resource verification requested     If an applicant reports a Trust Fund or Trust Account, request a copy of the trust documents.If an applicant reports a Direct Express account, ask for the balance but do not request any hard copy verification. |
| [ ]  Homestead Property Intent to Return Home [ ]  Yes [ ]  No[ ]  Other Real Property     [ ]  Checking Account     [ ]  Savings Account     [ ]  Vehicles     [ ]  Life Insurance     [ ]  Trust Fund or Trust Account     [ ]  Burial Fund/Contract     [ ]  Direct Express account     [ ]  Other      |
| If the applicant lists home property but either did not answer the intent to return home question or answered no:*→* Normally when you have property we have to count its value. With homestead property you can decide if we have to count it or not. If you tell us that you want to return to your home if you ever get better, then we would not count the value of the home. If you say that you do not want to go back home even if you got better, then we would have to count the value of the home.*→* Even if you think you will never be able to go home, would you want to go back to your home if you could? | [ ]  Declined Intent to Return Home[ ]  Requested change for Intent to Return Home. DHHS Form 1277 sent. |
| If there is a checking or savings account listed, ask either:*→* Which account is your Social Security check (or other income) deposited into?*→* Is your Social Security check (or other income) deposited into this account? | [ ]  1233 – Resource verification requested      |
| [ ]  Account listed above[ ]  Other Account(s)      |
| *→* Are there any other resources that may not have been listed? | [ ]  1233 – Resource verification requested      |
| [ ]  None[ ]  Additional Resources      |
| **Medical Insurance***→* Are you currently covered by medical insurance? | If Yes, confirm the details shown on the application or request the company and policy number.[ ]  1233 – Requested Verification of coverage and premium      |
| [ ]  No[ ]  YesDetails:      |
| **Allocation**If the allocation question is blank or No and the person is going into a nursing home:*→* Would you like to allocate, or give, part of your income to your:* Spouse,
* Child, or
* Other dependent relative who was living with the applicant prior to admission?
 |  |
| [ ]  No Change[ ]  Allocation Change      |
| **Other Financial Accounts***→* Does anyone have any financial accounts for you or is holding money for you that has not been listed? Have you added any names to any accounts? | [ ]  1233 – Verification Requested      |
| [ ]  No[ ]  YesDetails:      |
| **Closed Financial Accounts***→* In the past five years have you or your spouse closed or transferred any type of financial account such as bank, investment, or retirement accounts? | [ ]  1233 – Verification Requested      |
| [ ]  No[ ]  YesDetails:      |
| **Real Property***→* In the past five years have you or your spouse sold or given away your home or any other property? This includes transferring your home into a life estate.[ ]  No[ ]  YesIf a transfer is indicated:*→* When did you transfer the property and in what county and state did the transfer take place?Or*→* Where have you lived in the past five years? | [ ]  1233 – Verification Requested      |
| Details:      |
| **Vehicles***→* In the past five years have you or your spouse given away any motor vehicles including cars, boats, RVs, etc.? | [ ]  1233 – Verification Requested     The transfer of one vehicle that is otherwise excluded is not subject to the transfer of assets penalty and no further verification is needed. |
| [ ]  No[ ]  YesDetails:      |
| **Other Transfers***→* In the past five years have you given away money or anything else to anyone in the past five years that we may not have asked about? | [ ]  1233 – Verification Requested      |
| [ ]  No[ ]  YesDetails:      |
| **Inheritance***→* Have you received an inheritance from anyone within the past five years? | [ ]  1233 – Verification Requested      |
| [ ]  No[ ]  Yes – Person, when and where probated, and descriptionDetails:      |

105.02.04 Income Trust Script

(Eff. 08/01/15)

|  | Income Trust Script 105.02.04 |
| --- | --- |
|  | Step | Script | Actions |
|  **INCOME TRUST SCRIPT** | **Why an Income Trust is needed**  | Based on the income information you have given us, it appears the gross income before deductions may be at or above the Income Limit or Medicaid Cap of $\_\_\_\_. The applicant may still qualify for Medicaid by setting up a special Income Trust for their income to flow through.  If an Income Trust is set up, the income deposited into the trust does not count toward the Medicaid Cap but is considered when determining how much he/she as to pay toward their cost of care each month.  |  |
| **INCOME TRUST SCRIPT** | **Income Trust paperwork**  | You do not have to have an attorney to set up this trust. We will send you a packet. It needs to be completed as soon as possible. The earliest possible date of eligibility is the first day of the month the document is signed. * The packet you receive will include: Income Trust Document to fill out and sign.
* Instructions on how to fill it out.
	+ You do not have to have an attorney unless you want to.
	+ It does have to be signed, witnessed and notarized.

Mr/Mrs Last Name sign themselves or their Power of Attorney or Conservator can sign for them. | If the applicant is unable to sign and does not have a Power of Attorney or Conservator, explain someone may need to pursue obtaining conservatorship. They will need an attorney. |
| **INCOME TRUST SCRIPT** | **Trustee**  | Someone will need to serve as trustee for you or the applicant. This person will be responsible for putting the money in the trust and paying the cost of care. It can be a: * Spouse
* Child
* Friend
* Legal Representative
* Nursing Home

Do you or Mr/Mrs Last Name have someone who can do this?  |  |
| **INCOME TRUST SCRIPT** | **Separate account**  | A separate account must be designated or opened to have Mr/Mrs Last Name’s income to flow through.It can be a regular checking account. You do not need to set up an account with the Bank’s Trust Department. The information you receive will explain how the account needs to:* Must have applicant and trustee’s names only on the account
* Only the applicant’s income can be deposited into the account.
* Only allowed expenses can be paid from the account.
* The information you receive will explain how to use the account.
 |  |
| **INCOME TRUST** | **Cost of Care**  | **Nursing Home:**Depending on the amount of your income and the deductions we are able to give you may have to pay the Nursing Home. If we are able to approve your application, we will let you know how much you will have to pay to the nursing home for the medical services and care you receive. | [ ]  1233 – Income Trust Information and Forms sent |
| **INCOME TRUST** |  | **Waiver Services:** Depending on the amount of your income and the deductions we are able to give, you may have to pay part of your income. If we are able to approve your application, we will let you know how much you will have to pay. You will get a bill each month. |  |

105.02.05 Release of Application/Case Information

(Eff. 11/01/15)

| Step | Script | Action |
| --- | --- | --- |
| Provider RequestProvider is making a request for specific case information about an individual such as if an application has been filed or the status of an application. | Please hold one moment while I check the record to see if Individual has filled out the proper documentation giving us permission to share this information with you. | Check OnBase, MEDS notes and Access Notes. Is a DHHS Form 1282 on file?**Yes –** Does the 1282 name the provider as AR or in the release of information section?**Yes –** Go to **Provide Information****No –** Go to **1282 Explanation****No –** Go to **1282 Explanation** |
| Provide Information | I see we have documentation on file which gives us permission to share information with you. How can I help you? | Help the provider with the information needed. |
| 1282 Explanation | When someone applies for or is receiving Medicaid, that person can name someone to act as an Authorized Representative. We use the DHHS Form 1282 for this designation. This form allows the individual to give a trusted person permission to:* Talk with DHHS staff about an application,
* See the applicant’s information,
* Get information about the application, and
* Act on behalf of the applicant during the application, appeals, review or managed care process.

Another option for the applicant is to give permission for a more limited role where the agency can release information to a person or organization. The DHHS Form 1282 is also used for this designation. If the applicant selects this option, the agency is able to share information with the person or organization, such as the status of an application, but the person or organization cannot act on behalf and does not receive notices or other client communication.We use this process to help protect the individual’s private information by adhering to HIPAA requirements and Medicaid confidentiality laws.As a provider, you have an excellent opportunity to assist the individual and their family.  | Go to **Offer** |
| Offer | We can send you a copy of the DHHS Form 1282 and you can discuss with the individual about how they may want you to help them. Would you like me to tell you how you can get a copy from our website or would you rather I send you a copy? | **Yes –**  **Website** Go to [www.scdhhs.gov](http://www.scdhhs.gov). Select [Getting Medicaid](https://www.scdhhs.gov/Getting-Started). Near the bottom of the page, select the link [For additional forms, please click here.](https://www.scdhhs.gov/forms-and-applications) **Mail** Get the provider’s contact information and send a DHHS Form 1282. **No – End Call** |

105.03 Documentation Template

(Rev. 02/10/21)

The documentation template is a tool used to consistently document an application or redetermination from the time it is received until a final disposition is completed. The template must be completed in OnBase for all applications and redeterminations except for cases that are processed straight through without any worker.

105.03.01 Instructions for Completing Documentation Template

(Eff. 07/01/16)

Below are general instructions for the template by each section. A single instance will be shown where there may be multiple lines or rows and formatting may be slightly altered for display purposes in the manual.

105.03.01A Header and General Information

(Rev. 11/01/18)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| The header of the document is used to show the cycle for the template, identifying information, and if a ticket has been submitted. A documentation is intended to be active for an application or review cycle. A template is started at application and remains active until the next review. Reported changes and other contacts are saved near the end of the document.This section has a checkbox to document that an applicant has requested a retroactive determination for themselves or another household member on the application. This section also shows any tickets sent to Technical Assistance or the Helpdesk. If there is a ticket, refer to the scanned copy of the ticket in OnBase before creating a new ticket to prevent duplicate requests. When a worker creates a Technical Assistance or Helpdesk ticket, record the Ticket Number and select the type of request under Ticket Type. Record the date the ticket is created and the Worker ID. When an answer is scanned into OnBase and placed into Workflow, the eligibility worker picking up the case will record the date of the answer and his or her Worker ID. Medicaid Eligibility Date corrections will be marked as resolved by the individual making the change in the systemThe date a template is created, either at application or at review

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| **Documentation Template** Start a new template at application and at each annual review🞏 Initial Application 🞏 Review Application/Review Date: Template Start Date:  🞏 Retro Requested Template End Date: The date a template is replaced by a new template**HH Information**

|  |  |  |
| --- | --- | --- |
| **HH#/App ID** | **Primary Individual First Name** | **Primary Individual Last Name** |
|   |   |   |

Pick from a list to show the type of ticket submittedEnter when an answer is provided or issue is resolved**Technical Assistance/Helpdesk Tickets**

|  |  |  |  |
| --- | --- | --- | --- |
| **Ticket Number** | **Ticket Type** | **Created** | **Resolved/Completed** |
| **Date**  | **Worker ID** | **Date** | **Worker ID** |
|   |  ⇩ |   |   |   |   |
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| **General – Authorized Representative/Power of Attorney/Information Release** |
| This section is used to document an Authorized Representative, Power of Attorney, Guardianship or someone for whom the Applicant/beneficiary has given permission to release information* **Authority**⇩
	+ **1282 – Authorized Representative**
	+ **1282 – Information Release Only**
	+ **Power of Attorney**
	+ **Guardianship**

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| **General – Authorized Representative/Power of Attorney/Information Release** |
| **Name** | **Authority** | **Start Date** | **End Date** |
|   |  ⇩ |   |   |

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| **General – Voter Registration** |
| This section is used to document that Voter Registration was offered to applicants and beneficiaries according to policy detailed in MPPM 101.18. Check * **Voter Registration Application (VRA)**
	+ Checked when an eligibility worker gives or mails a Voter Registration form to an applicant or beneficiary
* **Voter Registration Declination (VRD)**
	+ Checked when an eligibility worker receives a completed declination form from an applicant or beneficiary

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| **General – Voter Registration** |
|  🞏 Voter Registration Application (VRA) 🞏 Voter Registration Declination (VRD) |

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| **General – Categorical Eligibility** |
| This section is used to indicate the categorical basis for individuals applying for coverage. Check all that apply for any member of the household. For instance, if a pregnant woman with a child is applying for Medicaid, you would check both Under Age 19 (for the child) and Pregnant, filling in the Expected Date of Delivery and the Number of Children Expected. Include any notes that may be needed to explain special situations

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| **General – Categorical Eligibility** |
| Check all that applies to members of the household

|  |  |
| --- | --- |
| 🞏 Under Age 19🞏 Dependent Child in Home🞏 Pregnant Expected Date of Delivery:  Number Expected: 🞏 Former Foster Care | 🞏 Aged 65 or Older🞏 Blind/Disabled  🞏 MAO99 🞏 System Match/ SSA Letter🞏 Breast and Cervical Cancer🞏 Tuberculosis 🞏 Form 3400-E – Tuberculosis (TB) Referral |
| **Notes:**  |

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| **General – HH Composition** |
| This section is used to document the composition of the household applying to coverage.* **Number of Adults**
	+ Used to document the number of adults in the household
* **Number of Children**
	+ Used to document the number of children under age 19 in the household
* **Has Tax Filing Status Been Determined?**
	+ Used for MAGI determinations
* **Filing Status**
	+ Used for MAGI determinations
* **List Other Household Members and Relationship**
	+ Used to document other household members such as a spouse or child
		- Include the relationship if known
		- For MAGI determinations, show individuals who are not listed on the application or do not live in the household who may have an impact on an eligibility decision
		- For Non-MAGI cases, show other individuals for whom an allocation has been considered
* **Immigration Status Details**
	+ Used to document the immigration status or other citizenship and identity information about an applicant or beneficiary. Items such as Document Type, Alien Number, Classification Code, and SAVE Results should be documented below in General – Electronic Verifications

|  |
| --- |
| **General – HH Composition** |
|

|  |  |
| --- | --- |
| **Number of Adults**   | **List Other Household Members and Relationship** |
| **Number of Children**   |   |
| **Has Tax Filing Status Been Determined?** (MAGI Only) |
|  🞏 Yes 🞏 No |
| **Filing Status** (MAGI Only) |
|  🞏 Married Filing Jointly 🞏 Single 🞏 Married Filing Separately 🞏 Non-Tax Filer |
| **Immigration Status Details:**  |

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| **General – Electronic Verifications** |
| This section is used to document the system matches that have been completed. Include any notes related to the information found that may not be documented elsewhere or that may require additional explanation. Document any details used to validate an alien’s status in SAVE, such as Document Type, Alien Number, Classification Code, and SAVE Result.

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| --- |
| **General – Electronic Verifications** |

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| --- | --- | --- |
| ESC – Wage Match🞏 Hit 🞏 No Hit 🞏 N/A | BENDEX – Social Security🞏 Hit 🞏 No Hit 🞏 N/A | SDX – SSI |
| 🞏 Hit 🞏 No Hit 🞏 N/A |
| SC State Retirement System🞏 Hit 🞏 No Hit 🞏 N/A | SVES – Citizenship🞏 Hit 🞏 No Hit 🞏 N/A | Unemployment Compensation |
| 🞏 Hit 🞏 No Hit 🞏 N/A |
| PCS Wage Verification🞏 Hit 🞏 No Hit 🞏 N/A | MMIS/TPL – Health Insurance🞏 Hit 🞏 No Hit 🞏 N/A | SAVE – Immigration Status |
| 🞏 Hit 🞏 No Hit 🞏 Required 🞏 Not Required  |
| CHIP – DSS Eligibility System🞏 Hit 🞏 No Hit 🞏 N/A | MMIS/RSP – Waiver/Special Programs |
| 🞏 Hit 🞏 No Hit 🞏 N/A | \* Some verifications may be part of PCS |
| Notes:  |

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| **General – Action Summary (One through Six)** |
| This section is used to document who has worked on a case, the date and the type of action completed* **Action Taken**⇩
	+ **Eligibility Decision** means that the worker has made a decision (Approval, Denial, Continued Eligible, Terminated)
	+ **Pended–1233 Given** means the worker has requested additional information from the applicant or beneficiary that is required before a decision can be completed
	+ **Pended–3rd Party Verification** means the worker has requested additional information from a third party that is required before a decision can be completed
	+ **Pended–Admission/Enrollment** means the worker is waiting for the applicant to be admitted to a facility or be enrolled in waiver services
	+ **Pended–30 Day Requirement** means to worker must wait for the applicant to be admitted to a hospital, nursing facility, waiver or combination for 30 consecutive days
* Include any notes or other explanation related to the action

| **General – Action Summary** |
| --- |
| **Action One**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  ⇩ |
|   |   |
| **Date** |
|   |

 |

 |

|  |
| --- |
| **General – Collateral Calls (One through Five)** |
| This section is generally used to document collateral calls to collect information. Document the date and time the call is made. Include the name of the person who provides the information. Examples are:* Requesting information from an applicant or beneficiary before sending a DHHS 1233
* Completing a LTC Application Script or VR Script
* Clarifying information that has been received
* Documenting a failed attempt to verify income or resources. If a worker is able to verify income or resource with a collateral call, it will be documented in the income or resource section.

| **General – Collateral Calls** (Do Not use for Successfully Verified Income and Resources) |
| --- |
| **Call One Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Call Details** |
|   |   |   |
| **Person Contacted** | **Phone** |
|   |   |

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105.03.01B Financial Information – Income and Resources

(Eff. 07/01/16)

|  |
| --- |
| **Financial – Income (One through Six)** |
| This section is used to document income received in the household* **Income Verification is Complete** is checked by the worker once an income source has been appropriately verified either through a collateral call, electronic data source, hard copy verification or client statement
* **Worker ID** is the worker who completes the verification of an income
* **Whose Income?** Used to document to whom the income belongs. If income is received by someone for another person, show the name of the person for whom the income is intended.
* **Income Type**⇩ is a drop list of different types of income, such as wages and Social Security
* **Source of Income** is used to document where the income comes from. For instance, if the applicant reports wages, this is the name of the employer. If the source is the same as the payer, Social Security for instance, this field does not have to be completed
* **Income Verified (List Dates)** is the date the income is verified
* **Income Amount** is the gross income
* **Frequency**⇩ is used to show how often an income is received
* **Verified w/ Collateral Call** is checked when a worker is able to verify income with a collateral call. Enter the name of the person, the name of the company or agency (include the person’s title if it would be helpful to identify the verification source) the phone number, and the date and time of the call
* **Verification Details and Comments** is used to document any additional details related to the income source. Include the source of the verification if a collateral call was not used. This could be an electronic data source (such as BENDEX), copies of paychecks (including the paid dates), or an award letter. If multiple members of the household receive income from the same source, the specifics for each person could be documented in this field if the space is needed

|  |
| --- |
| **Financial – Income** |
| **Income Source One** 🞏 **Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|   |  ⇩ |   |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|   |   |  ⇩ |
| 🞏 **Verified w/ Collateral Call** | **Person & Business:**   | **Call Date:**   |
| **Phone Number:**  | **Call Time:**   |
| **Verification Details and Comments:**   |

 |

 |

|  |
| --- |
| **Financial – Resources (One through Twelve)** |
| This section is used to document resources in the household* **Resource Verification Complete** is checked by the worker once a resource has been appropriately verified either through a collateral call, electronic data source, hard copy verification or client statement
* **Worker ID** is the worker who completes the verification of a resource
* **Whose Resource?** Used to document to whom the resource belongs. If a resource is held by someone for another person, show the name of the person to whom the resource belongs and enter the additional details in the comments.
* **Type (General Description)**⇩ is a general description of a resource, such as checking account, savings account, life insurance policy, property, etc.
* **Source/Name/Location/Account** is the location of the resource, the name of the bank, brokerage, Life Insurance Company, account numbers, etc.
* **Resource Verified (List Dates)** is the date the resource is verified
* **Resource Requested (List Dates)** is the date(s) verification is requested from the individual/AR or third party
* **Verified Value** is the current market value of the resource
* **Countable Value** is the amount to be budgeted in the eligibility determination. The resource could be excluded or the value reduced due to an outstanding loan
* **Verified w/ Collateral Call** is checked when a worker is able to verify a resource with a collateral call. Enter the name of the person, the name of the company or agency (include the person’s title if it would be helpful to identify the verification source) the phone number, and the date and time of the call
* **Verification Details and Comments** is used to document any additional details related to the resource. This may include how a resource is verified when a collateral call is not used, or detailing an exclusion or other reduction in value of a resource.

|  |
| --- |
| **Financial – Resources** |
| **Resource Item One** 🞏 **Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|   |  ⇩ |   |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |
|   |   |
| **Verified Value** | **Countable Value** | 🞏 **Verified w/ Collateral Call** | **Phone Number:**  |
|   |   | **Person & Business:**   |
| **Verification Details & Comments** | **Call Date:**   | **Call Time:**   |
|   |

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105.03.01C Long Term Care and OSS Information

(Eff. 07/01/16)

|  |
| --- |
| **Long Term Care/Optional State Supplementation** |
| This section is used to document details related to Long Term Care and Optional State Supplementation (OSS)* **Type of Care** documents the type of care received by the individual
	+ **Nursing Home** – Must meet 30-day requirement unless eligible under another full Medicaid benefit category. A 60 month look-back is required
	+ **In-Home Care (Waiver)** – Home and Community Based (Waivered) Services. Must meet 30-day requirement unless eligible under another full Medicaid benefit category. A 60 month look-back is required
	+ **PACE** –
	+ **General Hospital** – Must meet the 30-day requirement but a 60 month look-back is not required
	+ **Optional State Supplementation (OSS)/Community Residential Care Facility (CRCF)**
* **Hospital/Nursing Facility/Waiver Program/CRCF** is the name of the hospital, nursing facility, waiver program or community residential care facility where the individual has been admitted or enrolled. Up to three consecutive admissions can be documented
* **Date of Entry/Enrollment Date** is when the individual is admitted to a facility or enrolled into a waiver
* **Level of Care**⇩ is used to document the individual’s Level of Care (Intermediate, Skilled, Medicare Skilled, or Hospital) and the effective date. This is required for Nursing Home and Waiver
* **OSS Slot Date** is the date an OSS slot is assigned to an individual
* **Must Meet 30 Consecutive Day** is selected when an individual must meet the 30 Consecutive Day requirement in order to be approved
* **30 Consecutive Days Met** is selected when an individual has satisfied the 30 Consecutive Day requirement if necessary for approval
* **Phoenix Checked** is selected when a worker has checked the Phoenix system to see the individual’s involvement with CLTC
* **Phoenix Updated** is selected when a worker has updated Phoenix as appropriate
* **Transfer of Assets** documents if a sanctionable transfer was discovered. If there is a transfer, details can be entered in the **Notes** field
* **Look-Back** documents if the 60 month look-back has been completed OR is not required
	+ **Worker ID** records the worker who completes the 60 month Look-Back
	+ **Status**⇩records the progress of the Look-Back
		- **In Progress** is selected when a worker has begun the look-back but not able to complete it because additional information had to be requested. Record the details in the **Notes** field
		- **Completed** is selected when a worker has all of the information required to complete the look-back and can make a decision
		- **Not required** is selected when a look-back is not required. For instance, the individual may be SSI eligible or be moving from a facility out-of-state and the look-back has already been completed
	+ **Transfer of Assets**⇩ records the results of the look-back
		- **No Transfer** – No transfer of assets was found
		- **Transfer-Penalty** – A transfer occurred and a penalty is assessed. Record the details of the transfer and the penalty calculation in the **Notes** field
		- **Transfer-No Penalty** – A transfer occurred but no penalty is assessed because it meets an exception. Record the details of the transfer and the reason for the exception in the **Notes** field
	+ **Penalty Period** shows the start and end date of a transfer penalty
		- **Start**
		- **End**
* **Spousal Allocation** and **Dependent Relative Allocation** is used to indicate if an allocation is allowed from the individual’s income. Details can be entered in the **Notes** field
* **Health Insurance Premium** is used to show if health insurance premiums are being deducted from the individual’s income and the amount. Additional details can be entered in the **Notes** field
* **Home Maintenance Allowance** is selected if being budgeted for an individual. The **Start** and **End** dates are also recorded. Additional details can be entered in the **Notes** field
* **Income Trust** is selected if an income trust is required to establish eligibility
* **Trust Document Approved** is selected if there is a valid signed and dated income trust document that has been approved by Policy and Planning
* **Effective Date** is the date the income trust is effective
* **Account Designated** means that an specific account has been selected as the trust account
* **Account Funded** means the income specified in the income trust is/has been deposited into the designated account

|  |
| --- |
| **LONG TERM CARE/OPTIONAL STATE SUPPLEMENTATION** |
| **Type of Care**🞏 Nursing Home 🞏 In-Home Care (Waiver) 🞏 PACE 🞏 General Hospital🞏 Optional State Supplementation (OSS)/Community Residential Care Facility (CRCF) |
| **Hospital/Nursing Facility/****Waiver Program/CRCF** | **Date of Entry/ Enrollment Date** | **Level of Care** (For Nursing Home and In-Home Care only) | **OSS Slot Date** |
|   |   |  ⇩ Eff. Date:  |   |
| 🞏 Must Meet 30 Consecutive Day 🞏 30 Consecutive Days Met 🞏 Phoenix Checked 🞏 Phoenix Updated |
| **Notes:**   |
| **Look-Back** | **Transfer of Assets** | **Penalty Period** |
| **Worker ID:**  **Status:** ⇩ |  ⇩ | **Start:**   **End:**   |
| **Notes:**   |
| 🞏 **Spousal Allocation** | 🞏 **Dependent Relative Allocation** | 🞏 **Health Insurance Premium Deduction** | 🞏 **Home Maintenance Allowance**  |
|  |  | **Amount:**   | **Start:**  **End:**   |
| **Notes:**  |
| 🞏 **Income Trust** | 🞏 **Trust Document Approved** | **Effective Date:**   | 🞏 **Account Designated** |
| **Notes:**   | 🞏 **Account Funded** |

 |

105.03.01D Disability Information

(Eff. 07/01/16)

|  |
| --- |
| **Disability Report** |
| This section is used to document the process for a disability determination* **Collateral Call Completed** is used to document that the eligibility worker has contacted the individual and completed the Disability Script. Also, document the **Date** the call was completed, and the Disability Packet was sent to the applicant.
* **Requested Via 1233** is checked if the eligibility worker was unable to contact the applicant and complete the Disability Script. Also document the **Date** the Disability Packet was sent to the applicant
 |
| **MAO99**This section is used to document the result of the disability determination by Vocational Rehabilitation Disability Determination Services.* **Result** – Record the result shown on the MAO99.
	+ **Denied**
	+ **Approved**
		- **Coordinated** – Means that there is a decision for the Social Security Administration. Check BENDEX and SDX for income
		- **Independent** – Means there has not been a decision for SSA. Contact the applicant for an explanation. If there is a reasonable explanation or documentation, record the **Diary Date**
 |
|

|  |
| --- |
| **Complete The Following If A VR Disability Determination Is Needed** |
| **Disability Report:**

|  |  |
| --- | --- |
| 🞏 **Collateral Call Completed (VR Script)** | 🞏 **Requested Via 1233** |
|  **Date:**   |  **Date:**   |
| **Notes** |
|   |

 |
| **MAO99:****Result**

|  |  |
| --- | --- |
| 🞏 Denied | 🞏 Approved🞏 **Coordinated** 🞏 **Independent Diary Date:**   |

 |

 |

|  |
| --- |
| **SCDHHS Support Staff at Vocational Rehabilitation** |
| This section is used by the SCDHHS support staff located at Vocational Rehabilitation to record the receipt of the Disability Packet from an applicant.* **Is Disability Packet Complete?** Support staff are responsible for ensuring that the Disability Packet has been completed by the applicant with all identifying and contact information provided and legible and a signed DHHS Form 921.
	+ **If Yes: Date Given to VR** Record the date the packet is printed and sent to VR
	+ **If No: Why Incomplete?** Enter what items need to be completed in the Disability Packet
* **Incomplete – Information Requested** Support staff will indicate the method used to request the required information/form to complete a disability packet
	+ **Collateral Call** – Provide the details of the collateral call in the **Notes** field
	+ **DHHS Form 1233** – Indicate the date the DHHS Form 1233 is sent to the applicant
* **Follow-Up Completed** – Indicates how the Support Staff member obtained the information to complete the Disability Packet
	+ **Completed via Collateral Call** – Missing information was obtained through the collateral call
	+ **Completed via Paper Verification** – Missing information was obtained by hardcopy verification
 |
|

|  |
| --- |
| **To Be Completed By SCDHHS Support Staff at Voc Rehab Only:** |
|

|  |  |
| --- | --- |
| **Is Disability Packet Complete?** | **If YES: Date Given to VR** |
| 🞏 Yes 🞏 No |   |
|  | **If NO: Why Incomplete?** |
|  |   |
| 🞏 **Incomplete – Information Requested** | 🞏 **Follow-Up Completed** |
|  🞏 Collateral Call | 🞏 Completed Via Collateral Call |
|  🞏 Additional 1233 Sent | 🞏 Completed Via Paper Verification |
|  Date:  |  Date:  |
| Notes: |
|   |

 |

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105.03.01E Comments and Escalations

(Rev. 11/01/18)

|  |
| --- |
| **General Comments/Reported Changes/Contact Center/Other Contacts** |
| This section is used to capture general comments, reported changes and other information provided to a SCDHHS Staff Member. **Date** and **Worker ID** will be entered by the SCDHHS staff member. |
|

| **General Comments/Reported Changes/Contact Center/Other Contacts** |
| --- |
| Date: Worker ID:  | Note/Comment:   |

 |

| **Escalations****For Member Relations, Member Services Center Escalations Team and State Office Use Only** |
| --- |
| This section is used by Member Relations, Member Services Center Escalations Team and other State Office Staff to record the circumstances and details around escalating a case. |
|

| **Escalations****For Member Relations, Member Services Center Escalations Team and State Office Use Only** |
| --- |
| Date: Worker ID:  | Note/Comment:   |

 |

105.03.02 Documentation Template

(Eff. 11/01/18)

**Documentation Template** Start a new template at application and at each annual review

[ ]  Initial Application [ ]  Review Application/Review Date:      Template Start Date:

[ ]  Retro Requested Template End Date:

**HH Information**

|  |  |  |
| --- | --- | --- |
| **HH#/App ID** | **Primary Individual First Name** | **Primary Individual Last Name** |
|       |       |       |
|  |
| **Technical Assistance/Helpdesk Tickets** (Please Check Existing Tickets Before Submitting a New Ticket) |
| **Ticket Number** | **Ticket Type** | **Created** | **Resolved/Completed** |
| **Date**  | **Worker ID** | **Date** | **Worker ID** |
|       |  |       |       |       |       |
|       |  |       |       |       |       |
|       |  |       |       |       |       |
|       |  |       |       |       |       |

|  |
| --- |
| **General – Authorized Representative/Power of Attorney/Information Release** |
| **Name** | **Authority** | **Start Date** | **End Date** |
|       |  |       |       |
|       |  |       |       |
|       |  |       |       |

|  |
| --- |
| **General – Voter Registration** (MPPM 101.18) |
|  [ ]  Voter Registration Application (VRA) [ ]  Voter Registration Declination (VRD) |

|  |
| --- |
| **General – Categorical Eligibility** |
| Check all that applies to members of the household

|  |  |
| --- | --- |
| [ ]  Under Age 19[ ]  Dependent Child in Home[ ]  Pregnant Expected Date of Delivery:        Number Expected: [ ]  Former Foster Care | [ ]  Aged 65 or Older[ ]  Blind/Disabled  [ ]  MAO99 [ ]  System Match/SSA Letter[ ]  Breast and Cervical Cancer[ ]  Tuberculosis  [ ]  Form 3400-E – Tuberculosis (TB) Referral |
| **Notes:**       |

 |

|  |
| --- |
| **General – HH Composition** |
|

|  |  |
| --- | --- |
| **Number of Adults**       | **List Other Household Members and Relationship** |
| **Number of Children**       |       |
| **Has Tax Filing Status Been Determined?** (MAGI Only) |
|  [ ]  Yes [ ]  No |
| **Filing Status** (MAGI Only) |
|  [ ]  Married Filing Jointly [ ]  Single [ ]  Married Filing Separately [ ]  Non-Tax Filer |
| **Immigration Status Details:**       |

 |

|  |
| --- |
| **General – Electronic Verifications** |
|

|  |  |  |
| --- | --- | --- |
| **ESC – Wage Match**[ ]  Hit [ ]  No Hit [ ]  N/A | **BENDEX – Social Security**[ ]  Hit [ ]  No Hit [ ]  N/A | **SDX – SSI** |
| [ ]  Hit [ ]  No Hit [ ]  N/A |
| **SC State Retirement System**[ ]  Hit [ ]  No Hit [ ]  N/A | **SVES – Citizenship**[ ]  Hit [ ]  No Hit [ ]  N/A | **Unemployment Compensation** |
| [ ]  Hit [ ]  No Hit [ ]  N/A |
| **PSC Wage Verification**[ ]  Hit [ ]  No Hit [ ]  N/A | **MMIS/TPL – Health Insurance**[ ]  Hit [ ]  No Hit [ ]  N/A | **SAVE – Immigration Status** |
| [ ]  Hit [ ]  No Hit [ ]  Required [ ]  Not Required  |
| **CHIP – DSS Eligibility System**[ ]  Hit [ ]  No Hit [ ]  N/A | **MMIS/RSP – Waiver/Special Programs** |
| [ ]  Hit [ ]  No Hit [ ]  N/A | **\***Some verifications may be part of PCS |
| **Notes:**       |

 |

| **General – Action Summary** |
| --- |
| **Action One**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  |
|       |       |
| **Date** |
|       |

 |
| **Action Two**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  |
|       |       |
| **Date** |
|       |

 |
| **Action Three**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  |
|       |       |
| **Date** |
|       |

 |
| **Action Four**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  |
|       |       |
| **Date** |
|       |

 |
| **Action Five**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  |
|       |       |
| **Date** |
|       |

 |
| **Action Six**

|  |  |
| --- | --- |
| **Worker ID** | **Action Taken**  |
|       |       |
| **Date** |
|       |

 |

| **General – Collateral Calls** (Do Not use for Successfully Verified Income and Resources) |
| --- |
| **Call One Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Call Details** |
|       |       |       |
| **Person Contacted** | **Phone** |
|       |       |

 |
| **Collateral Call Two Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Call Details** |
|       |       |       |
| **Person Contacted** | **Phone** |
|       |       |

 |
| **Collateral Call Three Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Call Details** |
|       |       |       |
| **Person Contacted** | **Phone** |
|       |       |

 |
| **Collateral Call Four Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Call Details** |
|       |       |       |
| **Person Contacted** | **Phone** |
|       |       |

 |
| **Collateral Call Five Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Call Details** |
|       |       |       |
| **Person Contacted** | **Phone** |
|       |       |

 |

| **Financial – Income** |
| --- |
| **Income Source One [ ]  Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|       |  |       |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|       |       |  |
| [ ]  **Verified w/ Collateral Call** | **Person & Business:**       | **Call Date:**       |
| **Phone Number:**       | **Call Time:**       |
| **Verification Details and Comments:**       |

 |
| **Income Source Two [ ]  Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|       |  |       |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|       |       |  |
| [ ]  **Verified w/ Collateral Call** | **Person & Business:**       | **Call Date:**       |
| **Phone Number:**       | **Call Time:**       |
| **Verification Details and Comments:**       |

 |
| **Income Source Three [ ]  Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|       |  |       |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|       |       |  |
| [ ]  **Verified w/ Collateral Call** | **Person & Business:**       | **Call Date:**       |
| **Phone Number:**       | **Call Time:**       |
| **Verification Details and Comments:**       |

 |
| **Income Source Four [ ]  Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|       |  |       |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|       |       |  |
| [ ]  **Verified w/ Collateral Call** | **Person & Business:**       | **Call Date:**       |
| **Phone Number:**       | **Call Time:**       |
| **Verification Details and Comments:**       |

 |
| **Income Source Five [ ]  Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|       |  |       |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|       |       |  |
| [ ]  **Verified w/ Collateral Call** | **Person & Business:**       | **Call Date:**       |
| **Phone Number:**       | **Call Time:**       |
| **Verification Details and Comments:**       |

 |
| **Income Source Six [ ]  Income Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Income?** | **Income Type** | **Source of Income** |
|       |  |       |
| **Income Verified (List Dates)** | **Income Amount** | **Frequency** |
|       |       |  |
| [ ]  **Verified w/ Collateral Call** | **Person & Business:**       | **Call Date:**       |
| **Phone Number:**       | **Call Time:**       |
| **Verification Details and Comments:**       |

 |

| **Financial – Resources** |
| --- |
| **Resource Item One [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Two [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Three [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Four [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Five [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Six [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Seven [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Eight [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Nine [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Ten [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Eleven [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |
| **Resource Item Twelve [ ]  Resource Verification Complete Worker ID:**

|  |  |  |
| --- | --- | --- |
| **Whose Resource?** | **Type (General Description)** | **Source/Name/Location/Account** |
|       |  |       |
| **Resource Verified (List Dates)** | **Resource Requested (List Dates)** |  |
|       |       |
| **Verified Value** | **Countable Value** | [ ]  **Verified w/ Collateral Call** | **Phone Number:**       |
|       |       | **Person & Business:**       |
| **Verification Details and Comments** | **Call Date:**       | **Call Time:**       |  |
|       |

 |

| **LONG TERM CARE/OPTIONAL STATE SUPPLEMENTATION** |
| --- |
| **Type of Care**[ ]  Nursing Home [ ]  In-Home Care (Waiver) [ ]  PACE [ ]  General Hospital [ ]  Optional State Supplementation (OSS)/Community Residential Care Facility (CRCF) |
| **Hospital/Nursing Facility/****Waiver Program/CRCF** | **Date of Entry/ Enrollment Date** | **Level of Care** (For Nursing Home and In-Home Care only) | **OSS Slot Date** |
|                 |                 |  Eff. Date:       Eff. Date:       Eff. Date:       |       |
| [ ]  Must Meet 30 Consecutive Day [ ]  30 Consecutive Days Met [ ]  Phoenix Checked [ ]  Phoenix Updated |
| **Notes:**       |
| **Look-Back** | **Transfer of Assets** | **Penalty Period** |
| **Worker ID:**       **Status:**  |  | **Start:**       **End:**       |
| **Notes:**       |
| [ ]  **Spousal Allocation** | [ ]  **Dependent Relative Allocation** | [ ]  **Health Insurance Premium Deduction** | [ ]  **Home Maintenance Allowance**  |
|  |  | **Amount:**       | **Start:**       **End:**       |
| **Notes:**       |
| [ ]  **Income Trust** | [ ]  **Trust Document Approved** | **Effective Date:**       | [ ]  **Account Designated** |
| **Notes:**       | [ ]  **Account Funded** |

|  |
| --- |
| **Complete The Following If A VR Disability Determination Is Needed** |
| **Disability Report:**

|  |  |
| --- | --- |
| **[ ]  Collateral Call Completed (VR Script)** | **[ ]  Requested Via 1233** |
|  **Date:**       |  **Date:**       |
| **Notes** |
|       |

 |
| **MAO99:****Result**

|  |  |
| --- | --- |
| [ ]  Denied | [ ]  Approved **[ ]  Coordinated [ ]  Independent Diary Date:**  |

 |
| **To Be Completed By SCDHHS Support Staff at Voc Rehab Only:** |
|

|  |  |
| --- | --- |
| **Is Disability Packet Complete?** | **If YES: Date Given to VR** |
| [ ]  Yes [ ]  No |       |
|  | **If NO: Why Incomplete?** |
|  |       |
| [ ]  **Incomplete – Information Requested** | [ ]  **Follow-Up Completed** |
|  [ ]  Collateral Call | [ ]  Completed Via Collateral Call |
|  [ ]  Additional 1233 Sent | [ ]  Completed Via Paper Verification |
|  Date:       |  Date:       |
| Notes: |
|       |

 |

| **General Comments/Reported Changes/Other Contacts** |
| --- |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |

| **Escalations****For Member Relations, Member Services Center Escalations Team and State Office Use Only** |
| --- |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |
| Date:      Worker ID:        | Note/Comment:       |