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# **204.01 Introduction**

(Eff. 01/01/14)

Modified Adjusted Gross Income (MAGI) methodology applies to the following eligibility categories:

* [Pregnant Women and Infants (PW)](#PW)
* [Partners for Healthy Children (PHC)](#PHC)
* [Parent/Caretaker Relative (PCR)](#PCR)
* [Healthy Connections Family Planning (HCC)](#FP)
* [Regular Foster Care](#RFC)
* [Former Foster Care (FFC)](#FFC)
* [Subsidized Adoption](#SA)

The household composition of an Applicant applying to an eligibility category listed in this section will be determined pursuant to MAGI methodologies. For more information, see MPPM 202.

The ACA creates a protected period allowing individuals eligible for Medicaid under the aforementioned MAGI categories (and their equivalent policy predecessors) to continue receiving services for a limited period of time after new eligibility criteria go into effect. To qualify, the individual must have been eligible to receive services on December 31, 2013. Protected persons will remain eligible until the later of (i) April 1, 2014 or (ii) the individual’s next review date. However, while this protected period delays application of MAGI methodology to re-determine eligibility, eligibility may still be lost as a result of moving out of state, death, loss of a qualifying child, etc.

# **204****.02 Pregnant Women and Infants**

(Eff. 01/01/14)

This section discusses the eligibility requirements and procedures for Pregnant Women and Infants (PW), whose eligibility determination is based on MAGI criteria.

## 204.02.01 Pregnant Women

(Eff. 01/01/14)

The Patient Protection and Affordable Care Act (ACA) provides for Medicaid coverage to pregnant women with low income. Eligibility will be based on the income of the MAGI household, which must be less than or equal to 194% of the Federal Poverty Level (FPL) in the initial month of application, or in one of the three prior months. Additional eligibility criteria must be met if requesting retroactive coverage. (Refer to MPPM 103.01.)

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| **Procedure for Determining Pregnant Woman Eligibility** |
| **MEDS Procedure**1. If the applicant is eligible under MAGI rules for January 2014, virtually print the MAGI workbook into the case record in OnBase.
2. From the HMS49 screen, press the PF3 key to access the HMS07 screen.
3. Select the members that you want included in the January 2014 budget group. Use the household composition under current policy when entering this information into MEDS. Press the F16 key to access the HMS59 screen.
4. On the HMS59 screen, enter the Payment Category, the members that are applying and non-applying. Enter “ADD” in the action field.
5. Enter $0.00 on the Countable Income field on the ELD01 screen.
6. On the MEDS Notes screen, enter the actual countable income and Federal Poverty Level from the MAGI Workbook.
	1. Because the countable income is listed on ELD01 as $0.00 it is important for auditing purposes to document the actual countable income and the FPL on the notes screen
7. Complete Make Decision on ELD01.
8. Complete Act on Decision. The applicant will receive an approval notice with the appropriate eligibility start date.
9. Virtually print the MAGI Workbook into the case record on OnBase.
10. If the applicant is ineligible for full Medicaid benefits under the 2014 Medicaid rules, but is being approved under the Former Foster Care coverage category, see the Former Foster Care Coverage section or if they are being approved for Family Planning, see the Eligible Family Planning Only under 2014 MAGI Rules section.
 |

### 204.02.01A Eligibility Criteria

(Eff. 04/22/22)

To be eligible under the PW category, the woman must be pregnant, and the pregnancy, including the expected date of delivery or the date of the pregnancy ended, must be documented by self-reporting. SC DHHS can require verification from a medical provider for information such as due date, number of expected babies, or validation of pregnancy if there is a reason to expect incorrect or falsified data.

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| **Procedure for Documenting Self-Report of Pregnancy** |
| An individual applying as a pregnant woman must self-report the pregnancy and the expected date of delivery. If the pregnancy is indicated on Form 3400 but the (i) estimated date of delivery or (ii) number of babies is not documented, send Applicant the [DHHS Form 3310](http://medsweb.scdhhs.gov/EligibilityForms/FM%203310.pdf), Statement of Pregnancy. |

Coverage for pregnancy includes the 12-month postpartum period. The postpartum period begins either on the date of delivery or the date the pregnancy ends. The postpartum period extends through the end of the month in which the 12-month period ends..

The woman must also meet non-financial criteria that are discussed in MPPM Chapter 102, referenced below:

* Identity MPPM 102.02
* State Residency MPPM [102.03](https://team.scdhhs.gov/pmo/ProjectRepository/1211207/Decision%20and%20Policy%20Log/Policy%20Manual%20Working%20Documents/Section%20200%20working%20document/Section%20100%20General/Chapter%20102%20-%20Non-Finc.doc#MPPM_102_03)
* Citizenship/Alienage MPPM [102.04](https://team.scdhhs.gov/pmo/ProjectRepository/1211207/Decision%20and%20Policy%20Log/Policy%20Manual%20Working%20Documents/Section%20200%20working%20document/Section%20100%20General/Chapter%20102%20-%20Non-Finc.doc#MPPM_102_04)
* Enumeration/Social Security Number MPPM [102.05](https://team.scdhhs.gov/pmo/ProjectRepository/1211207/Decision%20and%20Policy%20Log/Policy%20Manual%20Working%20Documents/Section%20200%20working%20document/Section%20100%20General/Chapter%20102%20-%20Non-Finc.doc#MPPM_102_05)
* Assignment of Rights to Third Party Medical Payments MPPM 102.07

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
	+ DHSID evidence must added for application processed in Cúram,
	+ Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

### 204.02.01B Assumptive Eligibility

(Rev. 09/01/17)

Assumptive Eligibility must be used in processing applications for the Pregnant Women program. Assumptive Eligibility is not used for any other Medicaid program. If a pregnant woman applies for Medicaid, and she does not have all the necessary information needed to make a decision on her case, the Eligibility Worker must approve the case assumptively, provided the information given by the client is sufficient to determine eligibility and is not questionable.

Assumptive Eligibility cannot be used to process applications for the Pregnant Women program, for applicants eligible for emergency services only. Refer to MPPM Section 204.02.01F for more information.

It is important that a pregnant woman have coverage to access prenatal care as quickly as possible. An initial budget based on the Applicant's attestation of income, pregnancy, citizenship, and family circumstances must be completed on the day an application is received to determine eligibility for Pregnant Women. If the Eligibility Worker cannot process the application on the date received, a decision must be made by the end of the next business day, and include the reason the application could not be processed must be documented in the case record.

* The application must be approved if the initial budget indicates the Applicant is eligible, and she self-reports meeting all other eligibility criteria, unless the worker has reason to question the information provided by the Applicant.
	+ If the Eligibility Worker has reason to question the Applicant's allegations, the Eligibility Worker must discuss the case with his/her supervisor before deciding whether to withhold action on the case pending verification.
	+ The record must be documented with the decision and the reason the Eligibility Worker and supervisor is questioning the Applicant's self-reported information.
	+ If it is determined that the application cannot be approved until verification of income and/or family circumstances is received, the Eligibility Worker must give the Applicant 15 days to return the required information. A [DHHS Form 1233-ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, listing the verification needed to determine eligibility, must be given to the Applicant and a copy scanned into OnBase with a follow up of 15 days.
* The application may be denied if the applicant reports income that is over the income limit.

For cases approved assumptively, the remaining information necessary to confirm eligibility must be verified within 30 days of requesting the needed information to allow the application to be processed within 45 days. However, an Applicant required to submit documentation of Citizenship and/or Identity for the first time can be eligible for 90 days, provided that all other required verifications are returned within 30 days of approval. Refer to MPPM 102.04.03.

If a baby is born to a pregnant woman who has been Assumptively Approved and all verifications have not been received within 30 days of request, the baby cannot be deemed automatically. The baby can be deemed automatically so long as the woman (i) has filed a complete Medicaid application, including but not limited to meeting residency, income and resource requirements; (ii) has been determined Medicaid eligible; (iii) is receiving Medicaid on the date of the child's birth; and (iv) remains (or would remain if pregnant) Medicaid eligible. If the child cannot be deemed automatically, a parent must complete an application.

If, after all verifications have been received, the pregnant woman loses eligibility due to income, citizenship and/or identity, the baby cannot be deemed automatically. An application must be made to determine the baby’s eligibility. If the Eligibility Worker is unable to obtain verification within 30 days of requesting the information necessary for the application to be processed within 45 days, the Eligibility Worker must close the case on the 31st day. If the Applicant/beneficiary reapplies within six months of the date on the closure notice, the application cannot be Assumptively Approved; all verification must be obtained before the case can be approved. In this case, the 3400 Healthy Connections Application is not approved at the initial filing unless ALL necessary verifications are provided at the interview. If all verifications are received within 30 days of closure, the original application can be used to determine eligibility. A baby born to a mother Assumptively Approved for 90 days based on Citizenship and/or Identity can be deemed as long as a parent has provided all other required verifications prior to the child’s birth.

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| **Procedure for Determining Assumptive Eligibility** |
| **MEDS Procedure**Pregnant Women program cases Assumptively Approved can be flagged by entering the end of the 30 days in the “Anticipated Closure Date” field on MEDELD01. This will generate an alert at the end of the 30 days. This must be done after entering the information on this screen and completing the “Make Decision” process by pressing PF15. This process will cause expected delivery + 2 months date to show on the “Anticipated Closure Date.” The postpartum date must be replaced with the end of the 30 days date. Enter the end of the 30 days date, <MOD> in the action field and press <Enter>. Do not Make Decision again. Then, “Act On Decision” by pressing PF24 after making sure the eligibility end date on the MEDELD02 screen is correct.Cases Assumptively Approved must be closed if verification is not provided timely. To close the case, go to the Eligibility Decision Menu, select “Eligibility Decision” and enter the budget group number in the operand field and press <Enter>. Press PF3 to go to the next “Eligibility Decision Screen” (MEDELD01), enter reason code 004 in the first “Reason for Denial/Closure” field, to remove the PPED (Protected Period End Date), <MOD> and press <Enter>. Make Decision is automatically called. Change the reason code to 014 (You did not send the needed information). <MOD> the screen and press <Enter>. Press PF3 to go to Eligibility Decision screen (MEDELD02) to verify that the eligibility end date is correct. If the end date is not correct, change by entering the correct end date, go to the Action field and <MOD>. Do not “Make Decision.” “Act on Decision” by pressing PF24. The system will generate the appropriate notice and send it to the Applicant.Note: Medicaid benefits will not terminate for at least 10 days. For example: If an Eligibility Worker closes the case on November 15, the notice sent by MEDS will inform the Applicant/ beneficiary that the case will close effective December 1. If the Eligibility Worker closes the case on November 23, then the notice sent by MEDS will inform the Applicant/ beneficiary that the case will close effective January 1. MEDS will give the appropriate 10-day notice.If the Applicant re-applies for the Pregnant Women program within 30 days, the Eligibility Worker may use the same application. The case must not be approved until all verification of income and questionable information has been provided. The case cannot be Assumptively Approved. |

### 204.02.01C Continuous Eligibility through Postpartum Period

(Eff. 04/22/22)

Once a pregnant woman is determined eligible and is certified for assistance, she receives benefits throughout the postpartum period, which continues through the end of the 12th month from date of either the child’s birth or the end of pregnancy. Eligibility will continue during the postpartum period regardless of changes in circumstances that may affect eligibility such as a change in income, household composition, or categorical eligibility (e.g., reaching an age milestone). An eligibility specialist can end coverage before the end of the postpartum period for one of the following reasons:

* the beneficiary requests voluntary termination,
* the beneficiary moves out of state,
* the beneficiary dies, or
* the agency determines the eligibility was authorized incorrectly (not validly enrolled) at the most recent determination/redetermination of eligibility because of worker error, fraud, abuse, or false claims by the beneficiary

In general, a minor who is pregnant and otherwise eligible should be placed in PHC. If a person under age 19 is eligible in the PW category, and her baby is born or pregnancy otherwise ends before she attains the age of 19, she should be reviewed for PHC coverage for one year or until her 19th birthday, whichever comes first. If the child is listed under CHIP/PHC at that time pregnancy begins, the child will continue under the CHIP/PHC program until the end of the postpartum period.

Once the 12-month postpartum period ends, the Eligibility Worker must determine if the Applicant/beneficiary is eligible for Medicaid under any other coverage group with full benefits, i.e. PCR or PHC. If the Applicant/beneficiary is not eligible for a full benefit category then the Eligibility Worker must check eligibility for Family Planning, ex parte the application to Family Planning if eligible, and transfer the Applicant/beneficiary to the FFM. If a pregnant woman self-reports meeting categorical requirements in a new payment category, but not all information is available to make the decision, the Eligibility Worker should continue eligibility in the current category and contact the beneficiary by phone or mail a 1233E for the necessary information to make a decision in the potential category. Refer to MPPM Section 101.09.06 regarding ex parte policy and procedures.

Continuous eligibility rules (MPPM 101.09.07) also apply to pregnant women Assumptively Approved who have returned all required verifications within 30 days from the application date, or 90 days in the case of reasonable opportunity for Citizenship and/or Identity. If an application is approved in error, the Eligibility Worker must close the case allowing appropriate notice.

### 204.02.01D Retroactive Coverage

(Eff. 03/01/19)

If a pregnant woman was eligible in one or more months of the retroactive period, her eligibility begins the first month eligibility can be established through the end of the postpartum period without regard to income changes.

To be eligible for a retroactive determination, the beneficiary must have been: (i) pregnant during the retroactive month(s) requested, and (ii) her actual gross countable income received in the month(s) must satisfy the income criteria. Refer to MPPM 101.04.

### 204.02.01E Termination of Pregnancy

(Eff. 04/22/22)

When an Applicant/beneficiary reports a miscarriage or that she is no longer pregnant, she is still entitled to the 12-month postpartum period. If an applicant or beneficiary reports to the agency that a pregnancy has ended, use the attested date to establish the postpartum period. No additional documentation is required.

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| **Procedure for Termination of Pregnancy** |
| **MEDS Procedure*** Go to HMS06. Put N for “Not Pregnant”.
* Delete EDC and # of Children.
* MOD Screen.
* **Go to ELDO1- Put in Reason Code 004 (Manual Closure)**
* MOD Screen.
* Once you have initiated a Manual Closure, do not “Act on Decision.”
* Replace Reason Code 004 with Reason Code 078 (Postpartum Period Ended).
* Once you MOD Screen, follow rules for the Ex Parte Process.

Note**:** For Pregnant Women cases, once the 12 month post-partum period ends, the Eligibility Worker must determine if the Applicant/beneficiary is eligible for Medicaid under any other coverage group with full benefits (ex. PCR, PHC). If the Applicant/beneficiary is not eligible for a full benefit category then the Eligibility Worker must ex parte the case to Family Planning. Refer to MPPM Section 101.09.06 |

### 204.02.01F Case Processing for Aliens Eligible for Emergency Services Only

(Rev. 12/01/21)

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
	+ DHSID evidence must added for application processed in Cúram,
	+ Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

At the time of application, the Eligibility Worker must explain to any non-citizen or qualified alien Applicants that Medicaid may only reimburse for Emergency Services (including labor and delivery). The Eligibility Worker should process the application to establish the individual’s alien status and then determine whether the individual is categorically and financially eligible (except for enumeration). Aliens eligible for emergency services only do not receive Medicaid cards.

An alien only eligible for emergency services does not receive a Medicaid card, therefore the Applicant/Beneficiary should be told to share this notification with the medical provider of the service. If the Applicant/Beneficiary fails to do this, the medical provider may request the Medicaid identification number by (i) completing [DHHS Form 900](http://medsweb.scdhhs.gov/EligibilityForms/FM%20900.pdf), Request for Medicaid Information – Coverage of Emergency Services for Aliens, and (ii) forwarding it to the county Eligibility Worker.

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| **MEDS Procedure*** The effective date of the application is the date the signed and dated application is received.
* The Service Type field on ELD02 in MEDS **MUST** be set to “E” for Emergency Services and the EDC date must be keyed in MEDS.
* Individuals will be eligible for payment of Emergency Services only for one year from the date of approval. This does not prevent the individual from applying for and being approved for payment of services at a future date.
* After the year of coverage is over, the Eligibility Worker will get alert #582, Certification Period Ended, Verify Eligibility Decision. The case will soft close.
* The Eligibility Worker must close the BG. The infant should be deemed in PCAT 12.
 |

## 204.02.02 Infants

(Eff. 01/01/14)

Deemed Infants are infants automatically deemed eligible for Medicaid because they were born to a:

1. Medicaid-eligible pregnant woman, including those eligible for Emergency Services only;
2. Woman approved for Medicaid after she has given birth;
3. Medicaid eligible inmate; or
4. Medicaid eligible mother, who placed the infant for adoption.

The infant continues to be eligible for Medicaid for one year after delivery as long as the infant remains a South Carolina resident. Eligibility continues during the child’s first year without regard to changes in income. A Deemed Infant does not require a separate application.

204.02.02A Deeming Process

(Rev. 02/10/21)

The Eligibility Worker may be notified of the infant’s birth by the parent or a medical provider. If the medical provider notifies the Eligibility Worker via [DHHS Form 1716 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201716%20ME.pdf), Request for Medicaid ID Number of Newborn, eligibility for the infant is added as soon as the mother’s eligibility is verified. The Eligibility Worker should update the documentation template with the deeming information and return the completed DHHS Form 1716 ME to the provider.

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| **Procedure for Deeming Infants** |
| **MEDS Procedure**Upon receipt of the DHHS Form 1716 ME, Request for Medicaid ID Number of Newborn, the Eligibility Worker should research MEDS to verify the mother’s eligibility. * If an active case is found, the Eligibility Worker will follow MEDS procedure and enter “Y” for a new application on HMS03. The Limited Data Collection (LDC) field on HMS04 must be set to 12 (deemed infant). On HMS91 (HHMBR/Parents/ Citizenship/Identity Detail) screen, if the mother of the newborn is in the home, update the “Mother in Home” field to Y and enter the mother’s recipient ID. The worker will set the citizenship indicator on HMS91 to “Y”. The Eligibility Worker must enter “DEEMB” (deemed newborn) in the source document field on HMS91. This process satisfies the requirement for citizenship on the newborn. If the mother of the newborn is not in the home, update the “Mother in Home” field to N. The mother’s recipient ID is not required.
* If after completing a beneficiary search and the mother’s eligibility cannot be found in MEDS, a paper application is required on the newborn. Once the completed application is received, the Eligibility Worker should proceed with the MEDS process beginning with HMS03 (Create Household) screen. On HMS04 under Reason for Application, the Infant under Age 1 field must be set to “Y”. (This will indicate non-deemed infant).
* Infants born to Medicaid eligible mothers are permanently exempt from the citizenship and identity documentation requirements. A completed 1716 and/or indication in MEDS that the baby was deemed eligible is sufficient proof of citizenship and identity. For babies deemed Medicaid eligible in another state, any indication on that state’s letterhead or other official document is acceptable proof.

Note**:** Infants are covered for one year regardless of changes in income. The infant has to remain a resident of the state.**Timeline**At 1 month: A system-generated letter (TTR001) will be sent to the Payment Category 12 (Deemed Infant) household. The letter informs the parent that the child will receive Medicaid through his/her first birthday regardless of changes.At 4 months: A systems-generated letter (TTR003) will be sent to Payment Category 12 (Deemed Infant) household requesting the infant’s SSN.At initial application for the deemed infant, the Next Review Date (NRD) is set to the child’s Protective Period End Date (PPED). The budget group is placed in REVIEW status 60 days before the NRD. Once the budget group goes into REVIEW status, a review form is generated. The parent must complete and return the review form if they want the child to be considered for continued Medicaid eligibility.The Eligibility Worker must deem the newborn within five (5) working days of receiving the report of the child’s birth. If the DHHS Form 1716 ME or other reporting source does not have the newborn's name, the Eligibility Worker must try to call the mother to get the newborn's name before deeming. If the worker is unable to get the newborn's name within five days, deem the newborn using Baby Boy or Baby Girl as the name. MEDS will allow Baby Boy or Baby Girl as an unnamed type entry on HMS03. Do not delay the deeming process beyond five days. When the Eligibility Worker receives the notification of the child's name, update HMS03 with the child's name, and authorize a replacement Medicaid card.Once a child has been deemed, enter the Child’s Medicaid ID Number and Effective date of eligibility in the DHHS Use Only box in Section III of the DHHS Form 1716 and return to the reporting health care provider. |
| **Cúram Procedure**The process for deeming an infant in Cúram is outlined in the job aid, [Adding a Deemed Baby to a Case](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/ACA%20%20Access%20Training/Add%20a%20Deemed%20Baby%20to%20a%20Case.pdf?csf=1&web=1&e=O1upL1). DHHS Form 1716 provides the necessary information to deem the infant in Cúram. The form can be completed by a health care provider and submitted to DHHS by mail or fax. The form can also be completed by a DHHS worker, based on information provided by a health care provider or the mother of the infant by phone or in-person.The process of adding a deemed baby involves registering the newborn in Cúram and either using the Deemed Baby Wizard ,which only adds coverage for the baby, or adding and updating evidence on the Insurance Affordability Case (Integrated Case) of the birth mother that will fully add the newborn as a member of the household.**Reminders:*** Some evidence that is normally required when adding a person to a case may not immediately be required when adding a deemed baby.
* When the Deemed Baby Wizard is used, minimal evidence is added to the case, the child is not counted in household number calculations, and none of the evidence related to other household members is updated. To fully incorporate a child into a household all evidence required in Section 4: Add Evidence to Insurance Affordability Case in the job aid.
* Manual Eligibility evidence is used as part of this process to assure that a deemed baby’s eligibility is protected regardless of changes of circumstance in the Insurance Affordability Case. Because this evidence type overrides most other system rules, workers must exercise caution and enter data accurately to assure that policy is strictly adhered to.
* Manual Eligibility determinations supersede all other eligibility categories. Because of this, when the process is complete, the deemed baby is listed as Ineligible in the Streamlined Medicaid Case containing the birth mother and a CHIP Case is not generated.

**Using the Deemed Baby Wizard**The Deemed Baby Wizard allows workers to quickly process eligibility for a child born to a woman who was receiving Medicaid benefits at the time the baby was born. In order to use the wizard, the child should reside with his or her birth mother and the Insurance Affordability case which the child is added to must not have any in-edit evidence before initiating this process.The Deemed Baby Wizard MUST NOT be used if: * There is in-edit evidence on the Insurance Affordability case that cannot be activated.
* The child is NOT living in the same household as the birth mother.

Refer to Section 3: Manually Adding a Deemed Baby to a Case section of the job aid if any of the above apply. **Note:** When using the Deemed Baby Wizard, no other evidence is updated or added to the case through this process (e.g. Member Relationship, Tax Filing Status, Pregnancy, etc.). Therefore, the benefit determinations of other members of the household will not change as a result of the baby being deemed. For example, a pregnant woman is the only member of an Insurance Affordability case and has no income. Her post-partum period will be determined by the due date listed on her Pregnancy evidence and she will receive Family Planning benefits at the end of her post-partum period, even though the child is now present on the case. Additional evidence must be added or updated before the eligibility of other members will be reassessed. **Social Security Number:** Once an infant turns age one, an SSN is required and will be requested at review to determine if eligibility can continue. If an SSN is reported before the review, it must be added to the infant’s record.**Manually Adding a Deemed Baby to a Case**When a deemed baby cannot be added to a case using the Deemed Baby Wizard, the child must be manually added to the case. Follow procedures step-by-step in the job aid, [Adding a Deemed Baby to a Case](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/ACA%20%20Access%20Training/Add%20a%20Deemed%20Baby%20to%20a%20Case.pdf?csf=1&web=1&e=O1upL1).The process assumes that in most situations only one newborn child will be added to a case at a time. If multiple children are born at the same time, all evidence steps must be followed for each newborn child.Adding a Deemed Baby to a case manually requires updating the birth mother’s Pregnancy evidence and adding the following evidence to the birth mother’s Insurance Affordability case for the child:* Member Relationship
* Participant Address
* Tax Filing Status
* Tax Relationship (if applicable)
* Citizen Status
* SSN Details
* Manual Eligibility

Once a child has been deemed, enter the Child’s Medicaid ID Number and Effective date of eligibility in the DHHS Use Only box in Section III of the DHHS Form 1716 and return to the reporting health care provider. |

### 204.02.02B Newborns Placed for Adoption

(Eff. 01/01/14)

A newborn infant, born to a Medicaid-eligible mother and placed in an adoptive home is deemed under the birth name for one year.

The Medicaid application for a newborn not born to a Medicaid-eligible mother that are placed in an adoptive home should be filed in the county where the newborn is placed. The Medicaid application should be made in the name given to the infant by the adoptive parents.

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| **Procedure for Processing Adopted Children Without a Social Security Number** |
| Some hospitals do not obtain a Social Security Number for an infant if they are aware the child has been released for adoption. A pseudo Social Security Number should not be entered into MEDS or Cúram. When the adoptive parents provide the Social Security Number, the correct number should be entered into MEDS or Cúram. |

Medical records established under the name given to the infant by the adoptive parents should be used to verify age if age is questionable.

Since no parent has a legal responsibility for the infant, neither the [DHHS Form 2700 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%202700%20ME.pdf), Medical Support Referral Form, or the DSS Form 2738, Foster Care – Child Support Referral Form, need to be completed.

If the adoption placement is disrupted before the adoption is finalized, the DSS adoption specialist must notify the DHHS Medicaid Eligibility Worker to close the case that was established for the child under the name given by the adoptive parents. Any new application made for the child should be established under the child’s birth name, and verification of an application for a Social Security Number must be provided. If the infant’s age is questionable, a copy of the original birth certificate must be provided.

If the adoption placement is not disrupted and the infant remains Medicaid-eligible after the adoption is finalized, the adoptive parent must provide the child’s Social Security Number to the DHHS Medicaid Eligibility Worker. The adoptive parent must also provide the child’s amended birth certificate when:

* The infant’s age is questionable, or
* Eligibility for the Parent/Caretaker Relative (PCR) category is being considered for the adult and the relationship to the qualifying child is questionable.

Once determined eligible, eligibility continues for one year from the date of the decision, regardless of changes in circumstances. Exceptions would be if the child dies or moves out-of-state. If the adoption becomes final after the child has reached age one, the income of the adoptive parents will have to be counted.

If the child becomes ineligible for Medicaid after adoption, the DHHS Medicaid Eligibility Worker must close the case.

### 204.02.02C Hospitalized Children

(Eff. 01/01/14)

If a child is hospitalized during the month in which his Medicaid coverage is scheduled to end due to his first birthday, his Medicaid benefits will continue until the last day of the month in which the hospital stay ended, provided the following conditions are met:

* Eligibility would have ended because the child reached his first birthday;
* The child is otherwise eligible, except for age; and
* Inpatient hospital services were received on the day the child reached his first birthday.

### 204.02.02D Non-Deemed Infants

(Eff. 01/01/14)

An application for Partners for Healthy Children (PHC) is necessary for infants who were born to a non-Medicaid eligible pregnant woman. Refer to MPPM Chapter 204.02.01B.

# **204.03 Partners for Healthy Children**

(Eff. 01/01/14)

This section discusses a range of health insurance plans for children who live in families with income at or below 208% of the FPL. The available plans include Medicaid and Medicaid Expansion through the Children’s Health Insurance Program (M-CHIP). If approved, PHC beneficiaries are eligible for full Medicaid benefits.

Effective January 1, 2014, the ACA expanded CHIP coverage as discussed below.

204.03.01 Eligibility Criteria

(Rev. 12/01/21)

Children must be under age 19 and may be eligible if they meet both the non-financial and financial criteria for this program. The financial criteria are discussed in MPPM Chapter 203. The non-financial criteria are discussed in this MPPM Chapter 204 and are referenced below:

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/Social Security Number MPPM 102.05
* Assignment of Rights to Third Party Medical Payments MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
	+ DHSID evidence must added for application processed in Cúram,
	+ Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

204.03.02 Health Insurance

(Rev. 11/01/22)

At approval, review, or ex parte determination, Eligibility Workers must check for any indication of creditable health coverage by reviewing the Applicant’s [DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application, appropriate review forms, and the TPL Policy Inquiry on MMIS. Creditable health coverage is defined as insurance with, at minimum, coverage for hospitalization, doctor visits, X-rays, and lab work. A child who currently has health insurance may be eligible for PHC.

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|  |  | **ABOVE 208% FPL (213% w/ 5%) NOT ELIGIBLE FOR ANY COVERAGE GROUPS** |
|  |  | **Has Health Insurance Coverage** |
|  |  | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **Poverty Level** | 208%(213%) FPL | Medicaid | CHIP | Medicaid | CHIP | Medicaid | CHIP |
| 194% FPL | Medicaid |
| 143% FPL | Medicaid |
| 133% FPL | Medicaid w/ CHIP |
| 107% FPL | Medicaid |
|  | **Age Range** | **< 1 yr** | **1-5 yrs** | **6-18 yrs** |

The determination of whether a child should be receiving Streamline Medicaid or CHIP is based on the age, household income, and Third-Party Liability status. Reference the above chart when checking the Individual Eligibility tab to confirm if a child has been placed in the correct Product Delivery Case.

204.03.03 Third Party Liability Insurance Coding Procedure

(Rev. 11/01/22)

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| **Procedure for Third Party Liability Insurance Coding**  |
| **MEDS Procedure**On the HMS06 (Household Member Detail) screen, update the “TPL INSURANCE” field with the appropriate code. This is a required field.* Enter “Y” in the “TPL INSURANCE” field for a child with creditable health insurance coverage from any source (MPPM 204.03.01).
* Enter “N” in the “TPL INSURANCE” field for a child with no creditable health insurance coverage.

**Cúram Procedure**Refer to job aid for instructions: [Insurance Evidence (Third Party Liability).pdf](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Insurance%20Evidence%20%28Third%20Party%20Liability%29.pdf?csf=1&web=1&e=eYgjWx) |

204.03.04 Express Lane Eligibility (ELE)

(Eff. 01/01/14)

SC DHHS has an automated monthly data match with the SC Department of Social Services (SC DSS) to identify children not currently receiving Medicaid, but who are receiving benefits from the Supplemental Nutrition Assistance Program (SNAP) and/or Family Independence (FI). Children who are not on Medicaid and receiving SNAP and/or FI are automatically made eligible for Medicaid under PHC.

**ELE New Enrollment Process:**

The families of all eligible children receive (i) a cover letter explaining ELE; (ii) the Medicaid Approval Letter, ELD014, indicating their enrollment into Medicaid; and (iii) instructions on how to use the Medicaid Card. Initially all children are enrolled into Fee for Service (FFS) Medicaid and are not assigned to a Managed Care Plan. After receiving a Medicaid card, families will be notified through the enrollment broker about the importance of well-care visits for children and other preventative medical services. They will receive a choice enrollment package which will ask them to choose a Managed Care Plan. If the family uses the Medicaid card but does not pick a plan, they will become assignable and will have to choose a Managed Care plan. The enrollment broker will send an updated enrollment package. The family will have at least 30 days to pick a plan. If a plan is not chosen, one will be chosen for them.

If a family wishes to discontinue Medicaid coverage for their child, the request is made by calling the Healthy Connections Consumer Portal Support toll-free at 1-888-549-0820. Once notification of the request is received, the Healthy Connections Consumer Portal Support must document the request for closure on the MEDS NOTES Screen (HMS63)/ Cúram and complete the following procedure.

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| **Procedure for ELE New Enrollment Process** |
| **MEDS Procedure**1. Document the request with the following:
* Date of the call
* Child’s Name
* Name of the person that called
* The Beneficiary, Household and/or Budget Group Number
1. On the same day, the request must be sent via email to the Member Information Management (MIM) email group. The subject line must state: **“ELE Opt Out”.**
2. MIM will close the Budget Group with reason code **0L1** (*You have declined Express Lane Eligibility Medicaid coverage*).

MEDS will send the appropriate notice to the family.Note**:** If the family should contact the Local Eligibility Office, the same procedures will apply. |

A new application is required if a family member calls and requests that other children be added to Medicaid or requests Medicaid for themselves. The worker will mail the family an application along with DHHS Form 1233, Medicaid Eligibility Checklist. The family will have 30 days from receipt of requesting needed information to return the necessary information. Once all of the necessary information is received, the Eligibility Worker must perform the following procedure.

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| **Procedure for ELE Necessary Information**  |
| **MEDS Procedure**1. Determine eligibility using the Budget Workbook.

 1. If the child/family is eligible, determine the appropriate category.

Note: If the addition of the family member (s) causes the case to be denied or become ineligible, the current budget group *cannot* be closed. The children in the budget group are protected for one year from their eligibility decision date.1. The Eligibility Worker will then take a new application in MEDS to create a new budget group for the appropriate category. Make sure each active member of the budget group and the new family member (s) are applying in the budget group.

MEDS will set the next review date for one year from the decision date for all of the active budget group members.Note**:** The application must be entered and approved in MEDS by the next business day. |

DHHS plans to track those children enrolled into Managed Care or FFS, through claims submitted during a 12-month period. If a child is not enrolled in one of South Carolina’s Managed Care programs and does not use the Medicaid card after 12 months, SC DHHS will not automatically enroll the child for a second year. A closure notice, ELD020, will be sent explaining that the child is no longer eligible for the Medicaid Program.

At review, if the child (i) has enrolled into a Managed Care Plan or used the Medicaid card and (ii) continues to be receiving SNAP and/or FI, eligibility will automatically continue for another year. If the child (i) has enrolled in a Managed Care Plan or has used the Medicaid card and (ii) is no longer receiving SNAP and/or FI, the regular review process will be followed. See MPPM Section 204.06.04 concerning PHC reviews.

204.03.05 PHC Reviews

(Eff. 01/01/14)

For PHC households, in which allmembers receive SNAP benefits and/or FI benefits from the Department of Social Services (DSS), reviews will be automated. Eligibility in either the SNAP and/or FI program at Medicaid review will result in another year of continued eligibility for the beneficiary. The beneficiary will receive the Notice of Annual Review, ELD068, notifying him that Medicaid eligibility will continue for another year.

For PHC budget groups in which all members do notreceive SNAP and/or FI, the regular review process will be followed. The WKR002 (Non-Institutional FI) Review Form will be mailed. The beneficiary must complete and return the form within sixty (60) days in order to continue receiving Medicaid benefits.

204.03.06 Adding New Members to an Existing PHC Integrated Case

(Eff. 01/01/14)

When it is necessary to add new members to an existing Integrated Case, the following procedures must be used.

A new application is not needed if an additional MAGI household member causes the MAGI household to remain eligible for PHC. The Eligibility Worker must gather all appropriate information needed to add the household member to the household.

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| **Procedure for Adding New Members to PHC Budget Group/Integrated Case**  |
| **MEDS Procedure**1. Close the current PHC budget group with RC004. The family will not receive a notice.
2. Take a new application in MEDS to create a new budget group for PCAT 88. Make sure each active member of the PHC budget group and the new family member are applying in the PHC budget group.

MEDS will set the next review date for one year from the decision date for all of the active PHC budget group members.**Cúram Procedure:**Cúram will set the next review date for one year from the decision date for all of the active integrated case members. |

# **204.04 Parent/Caretaker Relative**

(Eff. 01/01/14)

## 204.04.01 Eligibility Criteria

(Rev. 07/01/22)

The basic eligibility requirements for the Parent Caretaker Relative program are:

* Income limits must be less than or equal to established standard. (Refer to MPPM 103.03.)
* A dependent child must be living in the home.
	+ The child must either be Medicaid eligible and enrolled OR enrolled in health insurance the provides Minimum Essential Coverage.

To be eligible for the PCR eligibility group, parents/caretaker relatives and children must meet MAGI income eligibility criteria. Effective January 1, 2014, applicants and beneficiaries are not required to participate in the FI Work Program with DSS in order to be eligible for PCR. A DSS work support sanction **does not** make an individual ineligible for PCR.

An individual must also meet the following non-financial requirements that are referenced in MPPM Chapter 102.

## 204.04.02 Change in Earned Income

(Added. 09/01/16)

Eligibility for Transition Medicaid Assistance (TMA) must be determined for a family who loses eligibility for PCR due to a change in earned income for any of the following reasons:

* An increase in the earnings of the parent or caretaker relative;
* An increase in the number of hours the parent/caretaker relative is employed; or
* The addition of a parent or caretaker relative with earned income

Refer to MPPM Chapter 205 – Transitional Medicaid Assistance.

# **204.05 Healthy Connections Family Planning**

(Rev. 01/01/23)

42 C.F.R. § 435.214

Through the Family Planning (FP) program, family planning services, family planning-related services, coverage for a biennial physical examination, and some preventative health screenings are available to individuals whose family income is at or below 194% of the Federal Poverty Level (FPL).

Men and women of any age may be approved for Family Planning if they:

* Apply for benefits:
	+ Submit an application Online, OR
	+ Submit a DHHS Form 3400 and check “Yes” for family planning coverage, OR
	+ Submit a DHHS Form 400, Family Planning Application
* Meet categorical and income requirements; and
* Are not approved for Medicaid under any other full or limited eligibility category. This includes individuals approved for SLMB (PCAT 52) and QI (PCAT 48).

Individuals approved for Family Planning are eligible for 12 months. A re-determination is required at the end of the eligibility period.

204.05.01 Family Planning Application Process

(Rev. 01/01/23)

The [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application, can be used to apply for FP benefits. For an individual to be considered for Family Planning, the applicant must check “Yes” for Family Planning on the application. If the individual answers “No” and does not have current Family Planning coverage, or if the question is not answered, eligibility for Family Planning will not be determined.

If the beneficiary has current Family Planning coverage and marks “No” or does not mark the question, the eligibility specialist should complete collateral calls to verify the beneficiary’s intentions.

**Note:** For Account Transfer and prior versions of paper applications that do not provide an opt-in for Family Planning, do not make an eligibility determination for Family Planning.

If an individual only wants to apply for Family Planning and not be considered for any other coverage, he/she may complete the DHHS Form 400, Family Planning Only Application. For eligibility purposes, the applicant is considered a household of one and only his/her income is considered.

Minors under 19 years old applying for Family Planning may list DHEC as their address if they do not want correspondence sent to their home address. The applicant completes the DHHS Form 400, Family Planning Only Application, with the assistance of a DHEC employee, and DHEC submits the application via fax.

Family Planning provides limited benefit coverage and is not minimum essential coverage.

* If an applicant applies for coverage using the DHHS Form 3400 and is not eligible for full Medicaid benefits but is approved for Family Planning based on a full MAGI determination, the individual’s application will be sent to the Federally Facilitated Marketplace (FFM).
* If an applicant applies for coverage using the DHHS Form 400 and is approved for Family Planning, the individual’s application will not be sent to the FFM. Coverage will be approved using manual eligibility.

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| **Procedure for Transferring Applications to the FFM** |
| Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM. An email must be sent to SP\_FFMTransfer@scdhhs.gov.1. Subject Line of the email: Household Number
2. Body of the email: First and Last Name

**Note**: Do not refer individuals who apply for limited benefits using the Family Planning Only Applications to the FFM. |

204.05.02 Filing the Family Planning Application

(Rev. 01/01/23)

Follow the procedures outlined below for applications submitted by DHEC using the DHHS Form 400, Family Planning Only application. For all other applications, normal processing procedures will apply. Refer to SC MPPM 101.03.

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| **DHEC Application Procedure** |
| **For applications received from DHEC, the following procedures apply:** * DHEC must enter the date of receipt in the top right corner of the DHHS Form 3400, which includes the opt-in provision for Family Planning or the DHHS Form 400. The date of receipt is the date the Applicant completed and signed the application form at DHEC. The DHEC date of receipt is considered the date of application.
* When Family Planning applications sent by DHEC staff are accompanied by the DHEC 1591, Family Planning Applications MAILED to DHHS, use the following procedure:
	+ On the DHEC 1591, place a check beside the name of each application received.
	+ Sign and return the DHEC 1591 to the originator acknowledging receipt of the applications.
* DHEC must make every effort to ensure that each application is signed, all questions are answered, and the applications are completed legibly.
 |

204.05.03 Family Planning Eligibility Criteria

(Eff. 08/01/14)

The Family Planning eligibility requirements include non-financial and financial requirements.

**Non-financial requirements:**

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/SSN MPPM 102.05
* Assignment of Rights to Medical Support MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08

If the Applicant/beneficiary does not meet citizenship/alienage requirements, eligibility for Family Planning services cannot be approved.

**Financial requirements:**

* Family income cannot exceed 194% of the FPL MPPM 103.01

204.05.04 Family Planning Eligibility Decisions

(Eff. 04/01/17)

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| **Procedure for Determining Family Planning Eligibility**  |
| **Scanning Procedure*** Scan DHHS Form 400, Family Planning Only Application into OnBase under the “FP Only” claim type.

**MEDS Procedure**Eligibility Decisions1. If Applicant is eligible for full benefits under MAGI rules (not applicable for the Family Planning Only Application), the worker will:
	1. Virtually print the MAGI workbook into the case record in OnBase
	2. From the HMS49 screen, press the PF3 key to access the HMS07 screen
	3. Select the members that you want to include in the budget group. Press the F16 key to access to HMS59 screen.
	4. On the HMS59 screen, enter the PCAT, the members that are applying and non-applying. Enter “ADD” in the action field
	5. Enter $0.00 on the Countable Income filed on the ELD01 screen.
	6. On the MEDS NOTES screen, enter the actual countable income and FPL from the MAGI workbook.
	7. Complete Make Decision on ELD01.
	8. Make sure the begin date for all members is correct on ELD02.
	9. Complete Act on Decision.
	10. Virtually print the MAGI workbook into the case record on OnBase.
2. If Applicant is ineligible for full benefits under MAGI rules, the worker will:
	1. Annotate the MEDS NOTES screen to indicate that the application was reviewed for eligibility.
		1. Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM unless the approval is based solely upon a Family Planning Only Application. An email must be sent to SP\_FFMTransfer@scdhhs.gov.
			1. Subject Line of the email: Household Number
			2. Body of the email: First and Last Name

**Cúram Procedures:**If the applicant applied with Form 3400, see Job Aid: [Entering a Paper Application](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Application%20Process/Entering%20a%20Paper%20Application.pdf?csf=1&web=1&e=7KSsJ4).If the applicant applied with Form 400, see Job Aid: Working Family Planning Only Applications. |

204.05.05 Family Planning Special Case Considerations

(Eff. 04/01/17)

Since Family Planning is not an emergency service, emergency services are not covered for an individual in the Family Planning payment category. (Refer to MPPM 102.04.20.)

204.05.06 Family Planning Verification and Budgeting

(Rev. 01/01/23)

If an applicant applied with the DHHS Form 400, Family Planning Only application, the eligibility specialist must accept the applicant/beneficiary’s declaratory statement regarding income. The eligibility specialist must complete systems checks (PCS, Wage Match, SCDEW). If the eligibility specialist discovers a discrepancy, the applicant/beneficiary must be contacted for an explanation. The eligibility specialist must complete systems checks (IEVS, SDX, Wage Match, and BENDEX). If the eligibility specialist discovers a discrepancy, the Applicant/beneficiary must be contacted for an explanation. If the applicant applied with the DHHS Form 3400 application, the eligibility would be based on a full MAGI determination and require proper income verification, refer to MPPM 203.04.02.

The net monthly income is measured against 194% of the FPL. If income is at or below 194% of the FPL, the Applicant is income eligible. (Refer to MPPM 103.01.) For more information regarding household composition, refer to MPPM 202.

204.05.07 Family Planning Retroactive Coverage

(Eff. 08/01/14)

For FP, if retroactive benefits are requested, a separate determination must be made for each month using the reported income for each month. Retroactive benefits may be considered for up to three calendar months before the month of application. (Refer to MPPM 101.05).

204.05.08 Family Planning Annual Review

(Rev. 01/01/23)

An annual review is required.

If a Family Planning Beneficiary is found ineligible at an annual review:

* If the beneficiary applied with the DHHS Form 3400, the eligibility specialist should determine if that individual would be eligible in any other payment category. If so, appropriate action must be taken to follow the ex parte process. Refer to MPPM 101.10.03.
* If the beneficiary applied with the DHHS Form 400, the eligibility specialist should not consider any payment categories other than Family Planning.

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| **Procedure for Conducting a Family Planning Annual Review** |
| **MEDS Procedure**MEDS generates a review form based on the Next Review Date shown on the ELD01 screen in MEDS. It is the responsibility of the eligibility specialist to acknowledge receipt of the review form in MEDS.Select Worker Menu, select Regular Review, and put “R” for Review Status. The system will pull up all cases associated with the eligibility specialist’s User ID scheduled for review.Select the beneficiary’s name and place the date in the “Form Received Column,” then MOD screen. This procedure will acknowledge that you have received the review form from the beneficiary and will not allow the case that you have selected to be closed until you have actually completed the review.**Note:** Once you have acknowledged receipt of the review form in MEDS, an eligibility decision must be made within 60 days from receipt of the review form so that the beneficiary’s case can be processed in a timely manner during the review period. |
| **Procedure*** Make sure the beneficiary’s review form is complete.
* Note any alleged changes or discrepancies.
* Complete a budget sheet to determine continued eligibility.
 |
| **If continued eligible*** Update MEDS information by going to ELD01 and updating the necessary fields and the Date of Next Review (which is equal to 12 months from the Decision Date).
* MOD screen, press pf15 “Make Decision,” and then press pf24 “Act on Decision.”

 Case should now be in Maintenance Status. |
| **If ineligible*** Begin closure procedures in MEDS.
* Go to ELD01 and enter updated information in the necessary fields. Put in the correct closure code, so that a notice will be sent to the beneficiary explaining the reason for case closure.
* Go to ELD02 to make sure the appropriate month the case is to close is properly displayed. Press pf24 “Act on Decision.” Do not “Make Decision.”
 |
| **Cúram Procedure**See Job Aid: [MAGI Annual Case Renewal Script](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Reviews/MAGI%20Annual%20Case%20Renewal%20Script%20Process.pdf?csf=1&web=1&e=ePc79v) |

204.05.09 Family Planning and Reported Pregnancy

(Eff. 03/01/18)

If an individual eligible for Family Planning reports she is pregnant:

* If a DHHS Form 3400 was used to determine FP eligibility, the eligibility worker will be able to process the pregnancy as a change. Information related to the pregnancy, household changes and current income must be collected, but a new application is not needed.
* If the DHHS Form 400, Family Planning Only Application, was used to determine FP eligibility, then a new DHHS Form 3400 will be needed to apply for full Medicaid coverage.

# **204.06 Regular Foster Care**

(Rev. 12/01/21)

This section addresses Medicaid eligibility requirements for children in special living arrangements such as the following:

* Residing in Foster Care (children in the custody of the Department of Social Services (DSS));
* Receiving adoption assistance because the child has special needs;
* Living in other out-of-home placements. (Refer to MPPM 207.01.01.)

For applications filed on or after January 1, 2018, children who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. Unless the child attains satisfactory immigration status, eligibility must be terminated once the child turns age 19.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
	+ DHSID evidence must added for application processed in Cúram,
	+ Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

A child who is placed into DSS care and control through emergency protective custody, ex parte order, consent and waiver, or a voluntary placement agreement is considered to be in DSS custody. Foster Care children are not restricted to the Foster Care coverage group. Foster Care children may be eligible under any Medicaid coverage group as long as they meet the requirements for that group, regardless of placement.

Foster Care children under age 21, who are in DSS custody, and children under age 21, living in other out-of-home placements (group homes and residential treatment facilities), may be eligible in Foster Care Payment Category 60 if they meet certain requirements. To be eligible in this category, the individual must reside in a licensed foster home, or other approved facility, and must have income below 62% the FPL. (Refer to MPPM 103.04.)

Eligibility for this coverage group must be re-determined annually for Foster Care children under the age of 18. Children between the ages of 18 and 21 must meet additional requirements for eligibility to continue under this payment category.

The Department of Social Services (DSS) has custody of Foster Care children and is responsible for their welfare. Children placed in an out-of-state living arrangement and remaining in the custody of DSS are considered residents of South Carolina. Therefore, the review form should be sent directly to the County DSS Office to ensure that the review is being done in a timely manner.

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| Procedure for Determining Regular Foster Care Eligibility |
| MEDS ProcedureEnter the County DSS Office address on the Primary Individual Screen (HMS04). This procedure sends the review form directly to the County DSS Office and allows the DSS human services worker to complete and return the form in a timely manner to the DHHS Medicaid Eligibility Worker for processing. |

204.06.01 Types of Placements

(Eff. 01/01/14)

An out-of-home placement is defined as one in which a child is in a setting other than with his/her parents. The following are examples of out-of-home placements:

* Foster Home
* Group Home
* Marine Institute
* Inpatient Psychiatric Hospital
* Private Child Care Institution
* Relative Placement
* Residential Treatment Facility (RTF)

Note: For a listing of RTFs, refer to the Appendix at the end of this chapter.

204.06.02 Placing and Sponsor Agencies

(Eff. 01/01/14)

The Department of Social Services is only one agency from which the DHHS Medicaid Eligibility Worker will receive applications for children in special living arrangements. Children’s placements may be facilitated by other agencies.

The type of placement, rather than the placing agency, determines how a child is treated in the eligibility determination process. An exception to this rule is children placed by the Department of Juvenile Justice (DJJ). These children are treated as individuals although legal custody resides with their parent(s) because DJJ exercises control.

Listed below are some of the agencies that place or sponsor children in special living arrangements.

* Continuum of Care for Emotionally Disturbed Children (CCEDC)
* Department of Disabilities and Special Needs (DDSN)
* Department of Education (DOE)
* Department of Juvenile Justice (DJJ)
* Department of Mental Health (DMH)
* Department of Social Services (DSS)

The two major agencies that place or sponsor children are the Continuum of Care for Emotionally Disturbed Children and the Department of Juvenile Justice. Listed below is a brief explanation of these agencies roles in placing or sponsoring children.

Continuum of Care for Emotionally Disturbed Children (CCEDC)

 The Continuum of Care for Emotionally Disturbed Children is a division of the Governor’s Office that works with severely emotionally disturbed children throughout the state. The agency works to coordinate services among all agencies to secure the best and most appropriate services for the child. Efforts are made to keep children in their home environment.

 CCEDC is a direct provider of Medicaid case management services. More than one third of the children served by CCEDC are in the custody of DSS.

 CCEDC may place children in residential treatment facilities, inpatient psychiatric facilities, or high or moderate management group homes. The children may be placed by DSS or by the parents through CCEDC.

Department of Juvenile Justice (DJJ)

 The Department of Juvenile Justice has a mission to protect the public from juvenile crime and provide troubled children with opportunities to obtain the skills necessary to become productive members of society. To accomplish this mission, DJJ is authorized to provide both community-based and institutional services.

 Community services range from prevention to parole and focus on meeting the needs of children and their families within their homes, schools, and community neighborhoods. DJJ may also place children in group homes, residential treatment facilities, inpatient psychiatric facilities, or high or moderate management group homes. The Marine Institutes are used almost exclusively by DJJ for placement as an alternative to incarceration.

Children who are remanded to the Willow Lane facility for girls or the John G. Richards facility for boys are considered inmates and are not eligible for Medicaid. (Refer to MPPM 102.09.01 for exceptions.)

204.06.03 Rules for Determining Eligibility in Different Living Arrangements

(Eff. 01/01/14)

1. Only those children whose custody is held by DSS are considered Foster Care children. Eligibility is determined without consideration of the parent’s income.
2. Children living in the Department of Mental Health (DMH) facilities, including those group homes licensed by DSS, who are not in foster care (see #1) and who are not Medicaid-eligible at the time of entry, should have their eligibility determined as an individual in other applicable categories such as Partners for Healthy Children (PHC). This would include children in facilities licensed primarily for the care of the mentally ill.
3. Children who are included in a Parent/Caretaker Relative (PCR) or Foster Care MAGI household at the time of entry into a DMH facility, are considered as individuals beginning the month their PCR or Foster Care eligibility terminates.
4. Children in residential treatment facilities who are not in foster care are treated as a member of their family, if the stay in the facility is 30 days or less. If the stay is longer than 30 days, these children are considered as individuals effective with the beginning of the month in which the 31st day falls.
5. Children who are in individual or group homes sponsored by the DJJ are treated as individuals. These children are not considered under the custody or control of their parents, even though custody has not been taken away from the parents by the court. Each placement must be evaluated on its own merits to determine if the child meets the definition of an inmate.
6. To determine the status of children placed in wilderness camps under the auspices of DJJ. (See # 4.)
7. A child in a public or private hospital or ward/section thereof, is to be treated as if he/she were still part of his/her living arrangement before hospitalization. This absence is considered temporary. If the child meets Social Security disability criteria, after 30 days in a general hospital, he/she is considered an individual.
8. Children in Intellectual Disabilities and Related Disabilities (ID/RD) facilities structured for custodial care are treated as individuals. (Most of these individuals are SSI-eligible.)
9. Children in ID/RD facilities structured primarily for educational or training purposes are considered as part of their family.
10. Pregnant women in maternity homes are treated as individuals. Eligibility for Medicaid should be determined under the Optional Coverage for Pregnant Women/Infants (OCWI), designated as Payment Category 87.
11. A child in an alcohol or drug treatment (detoxification) facility who is not in DSS custody is treated as a member of his/her family if the stay in the facility is 30 days or less. If the stay is longer than 30 days, the child is considered as an individual effective with the beginning of the month in which the 31st day falls.
12. Children in educational facilities are to be treated as if they are still a part of their family unit. These absences are considered temporary for receiving an education.
13. An adoptive parent’s income is not counted in determining the adopted child’s eligibility before the adoption becomes final.

204.06.04 Effect of Living Arrangement

(Eff. 01/01/14)

The type of arrangement in which the individual lives determines if (i) he/she is treated as (a) an individual or (b) a member of the household in which the individual’s parents live, and if (ii) the parent’s income of the individual is counted for him/her.

A child who is included in a MAGI household at the time of entry into a facility will be looked at as an individual beginning the month their Medicaid eligibility terminates.

204.06.05 Application Procedures for DJJ Children in Out-of-Home Placement Facilities

(Eff. 01/01/14)

Children in out-of-home placement facilities that are not considered inmates may be eligible for full Medicaid benefits. When the DJJ-sponsored Medicaid worker is notified of a placement, a new Medicaid application must be completed for the child.

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| **Procedure for Processing an Application for a Child in a DJJ Out-of-Home Placement Facility** |
| * The DJJ Sponsored Medicaid Worker receives a referral from DJJ.
* The DJJ Sponsored Medicaid Worker checks MEDS to determine if the child is currently eligible in the community.
* If the child is eligible in the community, the DJJ Sponsored Medicaid Worker notifies the appropriate county that the child has been placed in a DJJ Out-of-Home Placement Facility and is currently in an active BG (Budget Group) in their county with other family members.
* Upon verification of the Out-of-Home Placement, the local non-DJJ Sponsored Medicaid worker is responsible for terminating eligibility and removing the child from the BG and/or HH (Household). Eligibility for the remaining family members is determined and maintained by the local non-DJJ Sponsored Medicaid worker. The DJJ Sponsored Medicaid Worker must annotate the NOTES screen (HMS63) in MEDS with the household information for the other family members so that it is readily accessible in the future.
* Note: The Division of Central Eligibility Processing is responsible for terminating eligibility for any TEFRA child that may be placed in an out-of-home placement.
* Communication between the DJJ Sponsored Medicaid worker and the non-DJJ Sponsored Medicaid worker is important. Written correspondence, e-mail or telephone is a proper way for these workers to communicate.
* The DJJ Sponsored Medicaid Worker takes a new application for the child in a new household using the [DHHS Form](http://medsweb.scdhhs.gov/EligibilityForms/FM%20505-A.pdf) 3400, Healthy Connections Application.
* Any system generated notices should be directed to SCDJJ. The DJJ Sponsored Medicaid Worker will enter the following address as the mailing address of the child:
 |
| Mailing Address: South Carolina Department of Juvenile JusticePost Office Box 21069Columbia, South Carolina 29221-1069 |
| **MEDS Procedure*** The DJJ Sponsored Medicaid Worker enters the application in MEDS.
* On HMS04 (Primary Individual Screen), the DJJ Sponsored Medicaid Worker must enter the Sponsor Code of 4013 (Richland County DJJ). The sponsor code is a designation given to each facility to capture Medicaid work.
* On HMS04, enter “40” (Richland County Code) as the Applicant’s county, regardless of which Out of Home Placement Facility the child is in.
* The address of the DJJ Out of Home Placement Facility should be entered in the Residence Address on HMS04 (Primary Individual Screen).
* The mailing address should be entered on HMS04 as:

South Carolina Department of Juvenile JusticePost Office Box 21069Columbia, South Carolina 29221-1069* All correspondence must be sent to the mailing address listed on HMS04 (Primary Individual Screen).
* The HMS05 (Authorized Representative) screen must be completed.
* On HMS06, (Household Member Detail) screen, the Living Arrangement of GHOM (Group Home) must be entered.
* On HMS07 (Household Members) screen, category 88 must be entered in the CAT1 field.
* If an application is withdrawn due to worker error, the DJJ Sponsored Medicaid Worker should ALWAYS enter “W” at the WITHDRAW APPLICATION (W/C/N) prompt on HMS04. This will not generate a notice unnecessarily.
* Once the application is locked in MEDS, the DJJ Sponsored Medicaid Worker will proceed to ELD00 to determine eligibility for the child.
* The DJJ Sponsored Medicaid Worker will ensure that the Sponsor Code on ELD00 (Medicaid Eligibility Decision) is 4013 (Richland County DJJ).
* Set the next review date on ELD01 for one year from the current date. The child’s case will be reviewed annually as long as the individual is in the out of home placement facility.
* Do not set an anticipated closure date.
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| **Procedure for the Release of a Child from a DJJ Out-of-Home Placement Facility:** |
| * DJJ will notify the DJJ Sponsored Medicaid Worker of the child’s release.
* The DJJ Sponsored Medicaid Worker will check MEDS to see if there is an active BG (Budget Group) related to the child that has other family members in it. The child’s former household information should have been annotated on the NOTES screen (HMS63).
* If there is an active BG, the DJJ Sponsored Medicaid Worker will close the DJJ related case using reason code 004 on ELD01. A closure notice will not be generated. The DJJ Sponsored Medicaid Worker will notify the appropriate county by written correspondence, e-mail or telephone call, that the child is no longer in the DJJ Out of Home Placement Facility.
* Upon notification, the non-DJJ Sponsored Medicaid Worker will close the non-DJJ related case for the other family members using reason code 004 on ELD01. A closure notice will not be generated. The DJJ Sponsored Medicaid Worker will transfer the child released from the DJJ Out of Home Placement Facility to the HH (Household) with the other family members. The non-DJJ Sponsored Medicaid Worker will create a new BG to include the appropriate members in the budget group.

Note: If the family is ineligible and the child is in a protected period (PPED), eligibility must continue for the child through the protected period.* If there is not an active BG related to the child that has other family members in it, the DJJ Sponsored Medicaid Worker will:
* Close the DJJ-related case using reason code 004 on ELD01. A closure notice will not be generated.
* Create a new application in MEDS for the child. Note: A paper application is not required.
* Update the sponsor code to 4000 on HMS04 and change the living arrangement to “HOME” on HMS06.
* Perform Make Decision from the ELD01 screen.
* Perform Act on Decision from the ELD02 screen, making sure eligibility dates are correct.
* Transfer the new budget group to the appropriate county.

Note: If there are other family members in the household who wish to be considered for Medicaid, then the family should be given the opportunity to apply. |

204.06.06 Regular Foster Care Procedure

(Eff. 01/01/14)

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| **Procedure for When a Child is Taken Out of the Home and Placed in Foster Care** |
| When a child is taken out of a home situation and placed in Foster Care, the case must be reviewed to see if the family remains eligible in that current category or qualifies under any other Medicaid coverage group. The Eligibility Worker must re-budget the case using information that is readily available (including case record documentation and system interfaces information) with minimal contact with the Applicant/beneficiary.  |

204.06.07 Eligibility of Foster Care Children

(Eff. 01/01/14)

Effective February 1, 2013, SC DHHS began a streamlined eligibility process for Foster Care children. The Foster Care Health Initiative is a collaborative effort between SC DSS and SC DHHS to expedite Medicaid enrollment and to provide the best care possible for foster children. SC DSS will provide a daily file of children currently enrolled in SC DSS’ Foster Care Program, who are assigned to a licensed Foster Care home. The file is retrieved electronically and placed into the Foster Care Database at SC DHHS. These children will either be in Payment Category 31, 60, or 80. A specialized unit and SC DSS-sponsored workers will be responsible for enrolling these children in Medicaid.

The file sent by SC DSS must include the following for all Foster Care Children:

* A SC DSS unique ID # for the Foster Child,
* SSN,
* First name,
* Last name,
* Date of birth,
* A valid mailing address (including city, state, and zip) to reflect the foster home address and foster parent name,
* A valid residence address (including city, state, and zip),
* Foster Care Effective Date,
* County of residence,
* License number/type of facility and address, and
* Change Indicator to reflect any changes made on the foster care case record.

Other information:

* The Eligibility Worker must also update changes in address, living arrangements, etc. for children already eligible for Medicaid.
* The Eligibility Worker must make and act on decision for all of the new members loaded into the system.

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| **Procedure for Determining Eligibility of Foster Children** |
| **MEDS Procedure*** The eligibility start date for MEDS will be provided in the file from DSS. The Eligibility Worker will make the child eligible as of the first day of the month indicated by the start date field (i.e. 08/16/2012 Start Date would equal to an eligibility start date in MEDS of 08/01/2012). The payment category for the child will not be limited to a foster care Payment Category and may include Payment Category 80.
* The child will be enrolled into a health plan with an enrollment start date the same as the eligibility start date for Medicaid coverage.
* DSS must report in a timely manner any changes necessary to establish or terminate eligibility for those children approved for Foster Care.
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204.06.08 Foster Care Children, Ages 18-21

(Eff. 01/01/14)

Children between the age of 18 and 21 may be eligible in the Foster Care category if they meet certain requirements. Should eligibility be determined in the Foster Care category, the individual must reside in a licensed foster home or other approved facility, and the income must be below 62% of the FPL. The determination to allow a child to continue in foster care after he/she reaches the age of 18 is made by the DSS human services worker.

For a child who remains in foster care after age 18, Medicaid may continue in Payment Category 60 only if the following conditions are met:

* The child is totally dependent on DSS for care, and meets one of the following:
	+ The child is a full-time student, or
	+ The child is physically or emotionally handicapped.

Annual reviews are not required between the ages of 18 and 21.

204.06.09 Foster Care Children, Ages 18-21, Who Leave Foster Care

(Eff. 01/01/14)

Children who (i) were in foster care, (ii) Medicaid-eligible on their 18th birthdays, and (iii) have not yet reached age 21 may continue to be eligible for Medicaid benefits in Payment Category 60 until their 21st birthdays if they are not eligible under any other Medicaid coverage group. Eligibility may continue until age 21 without regard to the individual’s living arrangement, income, and/or resources.

Eligibility should be terminated if the individual moves out of South Carolina or dies. Eligibility should be re-instated if the individual returns to the state before his 21st birthday. These cases are not subject to annual reviews; however, when the individual reaches age 21, an ex parte determination must be completed to determine if the individual may continue to receive Medicaid under another payment category.

204.06.10 Coordination between DSS and DHHS Workers

(Eff. 01/01/14)

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| **Procedure of DSS and DHHS Workers’ Process** |
| The following is a description of the process that must be followed when a child in Foster Care is referred to the SC DHHS Medicaid Eligibility Worker for an eligibility determination:* If a child remains in the care of DSS, or DSS retains custody after the 72-hour Probable Cause hearing, the DSS human services worker completes the DHHS Form 3400, Healthy Connections Application, or the DSS Form 3068, Foster Care Medicaid Application (even if the child is already a Medicaid beneficiary). The worker attaches a copy of the DSS Form 2738, Foster Care-Child Support Referral Form, and forwards to the Medicaid Eligibility Worker.
* Within 45 days of the receipt of the application, the DHHS Medicaid Eligibility Worker will obtain the required verification and approve or deny the application. Notification of the case decision must be sent to the DSS human services worker.
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204.06.11 Reporting Changes

(Eff. 01/01/14)

The DSS human services worker is responsible for reporting changes in the child’s status to the DHHS Medicaid Eligibility Worker. For example, a worker should report a change if:

* The child becomes eligible for SSI or Title IV-E,
* DSS relinquishes custody, or
* The child returns home.

# **204.07 Former Foster Care**

(Rev. 04/01/23)

Former Foster Care (FFC) is a MAGI group that offers Medicaid coverage to individuals who were previously in foster care. FFC is designated as Payment Category 61. There is no income threshold for this coverage group.

204.07.01 Former Foster Care prior to January 1, 2023

(Rev. 04/01/23)

If an individual turned age 18 prior to January 1, 2023, and aged out of Foster Care coverage:

An individual is eligible for this group if he/she:

1. is under the age of 26,
2. was in foster care in South Carolina,
3. was enrolled in Medicaid on his/her 18th birthday, or at the time he/she aged out of foster care, and
4. is ineligible for any other Medicaid group.
* An applicant does not have to provide income or other eligibility information to be approved for Former Foster Care.
* The eligibility specialist must confirm the applicant received Foster Care Medicaid at the age of 18.
* If the applicant indicates being pregnant or being a Parent/Caretaker Relative, all other eligibility information must be requested:
	+ The applicant can be approved for Former Foster Care while the information request is outstanding.
	+ If the applicant returns the requested information, determine eligibility for the indicated categories.
		- Approve the applicant for PW or PCR if he/she meets the criteria.
		- If the applicant is not eligible for PW or PCR, he/she remains eligible for FFC.
	+ If the applicant does not return the requested information, he/she remains eligible for FFC.

Once eligible, the FFC beneficiary will receive Medicaid coverage until the individual turns 26 years old. Therefore, no review is required for the FFC eligibility category. If a blended household includes a FFC beneficiary at review, the FFC beneficiary will not receive a review. The other beneficiaries within the household will receive a review. If a review form is required from another beneficiary within the household and not returned, the beneficiary’s case must be closed; however, the FFC beneficiary will remain eligible.

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| **Procedure for Assessing for Former Foster Care Coverage** |
| **MEDS Procedure**Eligibility specialists will process Former Foster Care applications in MEDS until instructions are issued to begin processing them in the Cúram HCR system. In MMIS the payment category will show as PCAT 61.Note: * MEDS was updated to allow coverage for those individuals under the Former Foster Care (FFC) Coverage group through the month that they turn age 26.
* A new closure code reason – “026 - You have reached age 26 and are over the age limit for this program” was added.
* You cannot approve someone with an application date entered in the same month they turn age 26. Eligibility for that month must be added with the correction process.
1. If the applicant is not eligible for full Medicaid benefits effective January 1, 2014, under another MAGI Category, determine their eligibility under FFC Coverage. Do not use the MAGI workbook because their determination is not based on the workbook since there is no income test. Use MEDS Screen HMS54.

Note: Prior to January 1, 2023, FFC is a coverage category for individuals who are not eligible for any other coverage category.1. Retrieve the application from OnBase for processing. Review the application to determine if the applicant is eligible for coverage based on the FFC category if the applicant reports they were enrolled in SC Medicaid in a Foster Care Coverage group on their 18th birthday.
2. Check MEDS forinformation that indicates eligibility for FFC coverage.
	1. Review the HMS54 screen to verify their Foster Care Status. The Foster Care PCAT would be 31 or 60;
	2. Review the HMS06 Household Member Detail for Living Arrangement, which should reflect Foster Care if the information was updated to Living Arrangement to Foster Care. Remember, the individual could have been eligible in another PCAT, but had a foster care living arrangement.
	3. Check the case notes in MEDS Notes or OnBase;
3. If verified, applicant will be eligible for Medicaid up to age 26. There is no income test, but the applicant must attest that they are currently a SC resident.
4. Is the applicant eligible for Medicaid under the 2014 MAGI rules for the FFC category?

If yes, then:* 1. In MEDS, pend the individual in a household of one and a PCAT of 60.
	2. Approve the case in MEDS. Set the next review date to one year from the act on decision date. Enter “Home” as the living arrangement. Enter “$9.99” on the Countable Income field on the ELD01 screen.

Note: MEDS still requires entry of a review date even though persons age ~~22~~19-26 in the FFC coverage group do not have to be reviewed.* 1. Send an approval notice
	2. Virtually print the approval notice into OnBase
	3. Annotate on the MEDS and OnBase notes screen, that the “Applicant (First and Last Name) is eligible for FFC. Include the application effective date.

If no, then proceed to Step 6. 1. Determine if the applicant is eligible for Family Planning, see the Eligible Family Planning Only under 2014 MAGI Rules section
2. Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM. An email must be sent to SP\_FFMTransfer@scdhhs.gov.
	1. Subject Line of the email: Household Number
	2. Body of the email: First and Last Name

**Cúram Procedure****NOTE:** As of April 1st, 2023, Former Foster Care cases should be worked in Cúram going forward. 1. Assess for eligibility under Former Foster Care Coverage.
	1. To qualify for Former Foster Care Coverage prior to January 1, 2023, the Applicant must have been a Medicaid recipient in the State of South Carolina at the time they aged out of the Foster Care System. Do not use the MAGI workbook for the FFC applicant because there is no income test for eligibility. However, a MAGI workbook may need to be done for additional members of the household.
	2. Applicants who report that they were eligible for Medicaid as a Foster Care Recipient in South Carolina at the time they aged out of Foster Care are to be verified by a SOR search for prior eligibility under any PCAT with a living arrangement of Foster Home. If the SOR was MEDS, review the HMS54 screen to verify their Foster Care status. The FC PCAT would be 31 or 60. Then, review the HMS06 Household Member Details for the living arrangement which should reflect Foster Care.
	3. The individual is eligible through the end of the month of their 26th birthday as long as they are a resident of South Carolina.
2. If the Applicant is eligible for Former Foster Care coverage, the eligibility specialist should check the Communications tab in Cúram. If a notice is not generated, the eligibility specialist shouldsend a manual ELD 084 and annotate the NOTES screen in the SOR and the documentation template. The manual notice should be virtually printed into OnBase.
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204.07.02 Former Foster Care after January 1, 2023

(Rev. 04/01/23)

If the individual turned age 18 and aged out of Foster Care coverage on or after January 1, 2023:

An individual is eligible for this group if he/she:

1. Is under the age of 26,
2. Was in Foster Care under the responsibility of any U.S. state or territory in which the individual resided on his/her 18th birthday or at the time he/she aged out of foster care on or after January 1st, 2023,
3. Was enrolled in Medicaid in the state or territory in which they resided while in Foster Care, and
4. Is not enrolled in another mandatory eligibility group (even if they meet the eligibility requirements) at the time of application.
* An applicant does not have to provide income or other eligibility information in order to be approved for Former Foster Care.
* The eligibility specialist must consider the applicant for Former Foster Care if they attest to receiving Foster Care and Medicaid at the age of 18 either in the state of South Carolina or another state or territory.
	+ - For applicants age 18 or older on or after January 1st, 2023, who state they received Foster Care and Medicaid in any US state or territory, their self-attestation of aging out at 18 or older, their Medicaid eligibility status, and the state in which they resided at the time will be accepted.
* If the applicant indicates being pregnant or being a Parent/Caretaker Relative, the information pertaining to the household should be collected, if known.
	+ If the applicant is not currently active under another full coverage category at the time of application, he/she must be approved for FFC coverage.
	+ If the applicant does not return requested information about the household, he/she remains eligible for FFC.

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| **Cúram Procedure**Assess for eligibility under Former Foster Care Coverage. 1. To qualify for Former Foster Care Coverage, the Applicant must have been a Medicaid recipient in any state at the time they aged out of the Foster Care System on or after January 1,2023. Do not use the MAGI workbook because there is no income test for eligibility. However, a MAGI workbook may be needed for additional members of the household.
2. Applicants who report that they were a Foster Care Recipient in any US state or territory at the time they aged out of Foster Care on or after January 1, 2023, will be considered if they attest:
	1. To being under foster care of any US state of territory
	2. To an age of 18 or older when they aged out of Foster Care,
	3. That they were covered by a Medicaid coverage category with a living arrangement of Foster Home.
3. The individual can remain eligible under the FFC category through the end of the month of their 26th birthday as long as they are a resident of South Carolina.
4. Former Foster Care evidence must be entered on the evidence dashboard in Cúram.

Job Aid: [Adding Former Foster Care Evidence.pdf](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Adding%20Former%20Foster%20Care%20Evidence.pdf?csf=1&web=1&e=D00nyg) |

# **204.08 Subsidized Adoption**

(Eff. 01/01/14)

204.08.01 Special Needs Children Receiving an Adoption Subsidy

(Rev. 02/01/20)

Medicaid is available to children with special needs who receive an adoption subsidy. To qualify under this coverage group, the following requirements must be met:

* A Medicaid application must be filed;
* The child must be under age 21;
* The child must have a medical or rehabilitative need that existed before entering into a state adoption assistance agreement;
* The adoption assistance agreement must verify the medical or rehabilitative need;
* The adoptive placement would not have been made without an adoption subsidy; and
* The income must be below 62% of the FPL for one person that was in effect at the time the adoption assistance agreement was executed. Only the income of the child is considered. The adoptive parent’s income is not counted. The adoption subsidy is never counted as income in determining Medicaid eligibility for the child, regardless of category.

The non-financial criteria such as residence, citizenship, and Social Security Number must also be met. Citizenship and Identity do not have to be verified. Refer to MPPM 102.04.09 through 102.04.14 to determine the alien status of non-citizen children.

Note: If siblings reside in the same adoptive home, they are treated as individuals. Each child’s income is measured against the FPL for one person that was in effect at the time the adoption assistance agreement was executed.

Under the Child Citizenship Act of 2000, children adopted abroad automatically acquire U.S. citizenship if:

* At least one of the child's adoptive parents is a U.S. citizen;
* The child is under 18;
	+ The child lives in the legal and physical custody of the American citizen parent;
	+ The child is admitted into the United States as an immigrant for lawful permanent residence; and
	+ The adoption is final.

204.08.01A Verification

(Eff. 01/01/14)

The Adoption Subsidy Agreement, DSS Form 3052, can be used to identify the child’s special needs. A money payment is not required for Medicaid purposes. Verify that the child had special medical or rehabilitative needs before entering the adoption agreement, and the adoption would not have been made without an adoption subsidy may be addressed in the agreement.

204.08.01B The Virtual Record

(Eff. 01/01/14)

The virtual record for State Subsidized Adoptive Children with Special Medical or Rehabilitative Needs must contain:

* DHHS Form 3400, Healthy Connections Application
* SSN or proof of application for a Social Security Number
* Copy of adoption assistance agreement
* Verification of special medical or rehabilitative need (could be addressed in the adoption assistance agreement)
* Verification of child’s income
* [DHHS Form 1250A-ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201250-A%20ME.pdf), Regular Foster Care Worksheet and Budgeting Record
* IEVS documentation

204.08.01C Annual Review and Eligibility Determination

(Eff. 01/01/14)

If the child is eligible at the initial determination, the DHHS Medicaid Eligibility Worker enters data into Cúram to authorize Medicaid benefits, and eligibility does not need to be reviewed. As long as the adoption agreement is in effect, the child will remain eligible until age 21. The Eligibility Worker must close the case effective the month following the month in which the child reaches age 21.

If the child is not eligible at the initial determination because of the child’s income, eligibility should be determined in another category, and the adoptive parents’ income is counted. The parents’ income is not counted in Special Needs and IV-E Adoptions

204.08.02 Children Placed for Adoption from Foster Care

(Eff. 01/01/14)

A child placed in foster care before adoptive placement is likely to have an active Medicaid case. When the adoptive placement is made, the DSS adoption specialist must notify the DHHS Medicaid Eligibility Worker. The DHHS Medicaid Eligibility Worker must terminate eligibility for the child and send the case record to the DSS county/regional adoption office. The DSS county/regional adoption office will keep the case record until the adoption is finalized and then seal the Medicaid case along with other records.

When an application is made for Medicaid benefits for the child, the application must be filed in the county where the adoptive placement is made, using the child’s birth name. If age is questionable, medical records under the child’s birth name should be used as verification. Since no parent has legal responsibility for the child, neither the DHHS Form 2700 ME, Medical Support Referral Form, nor the DSS Form 2738, Foster Care–Child Support Referral Form, is necessary.

An adoptive parent’s income is not counted in determining the adopted child’s eligibility before the adoption is final. If the adoptive placement is disrupted before the adoption is finalized, the DSS adoption specialist must notify the DHHS Medicaid Eligibility Worker to close the case that was established for the child. The DSS adoption specialist must return the original Medicaid case record to the DHHS Medicaid Eligibility Worker. A new application may be filed due to the child being returned to a foster care placement.

If the adoptive placement is not disrupted and the child continues to be eligible for Medicaid after the adoption is finalized, the adoptive parents must provide the DHHS Medicaid Eligibility Worker with the child’s adopted name and Social Security Number. The adoptive parent must also provide the child’s amended birth certificate when:

* The child’s age is questionable; or
* Eligibility for the Parent/Caretaker Relative (PCR) category is being considered, and relationship to the qualifying child is questionable.

204.08.03 Children Placed for Adoption and Not Placed in Foster Care

(Eff. 01/01/14)

If a Medicaid-eligible pregnant woman plans to release her baby for adoption as soon as it is born, the infant placed for adoption is deemed Medicaid-eligible for one year. If the adoption becomes final after the child has turned one year old and the child has received continuous coverage (12 months of eligibility), the income of the adoptive parents must be counted. However, the adoptive parents’ income is not counted in Special Needs and IV-E Adoptions. If the child is ineligible for Medicaid after the adoption is finalized, the DHHS Medicaid Eligibility Worker must close the case.

204.08.03A Application

(Eff. 01/01/14)

A pregnant woman, who is not eligible for Medicaid at the time of the birth of the baby, may plan to release her baby for adoption as soon as it is born. A Medicaid application for the child could come from various adoption agencies, attorneys, or even the adoptive parents. In this case, the child is treated as an individual. When the application is made for Medicaid benefits for the child, the application must be filed in the county where the adoptive placement is made. The Medicaid application should be made in the name given to the infant by the adoptive parents.

Since no parent has legal responsibility for the child, neither the DHHS Form 2700 ME, Medical Support Referral Form, nor the DSS Form 2738, Foster Care–Child Support Referral Form, is necessary. If the adoption becomes final after the child has turned one year old and the child has received continuous coverage (12 months of eligibility), the income of the adoptive parents will be counted. If the child is ineligible for Medicaid after the adoption is finalized, the DHHS Medicaid Eligibility Worker must close the case.

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| **Procedure for Children Placed for Adoption and Not Placed in Foster Care** |
| **MEDS Procedure**The deemed infant that is being released for adoption should be in his/her own Household. Document on the MEDS NOTES screen the biological mother’s Household number in case the mother changes her mind regarding releasing the infant for adoption. The adoptive parent’s address should be used for the infant’s address. There should also be documentation in the mother’s Household NOTES screen to explain the adoption of her infant. |

204.08.04 SSI-Eligible Children Who Are Adopted

(Eff. 01/01/14)

If a child is covered by an adoption subsidy agreement, and the SSI payment is made in the child’s birth name, the adoptive parent should contact the Social Security Administration (SSA) and provide SSA with the amended birth certificate.

204.08.05 Interstate Compact on Adoption and Medical Assistance (ICAMA)

(Eff. 01/01/14)

Special needs children who receive a state-funded adoption subsidy that provides for Medicaid benefits are not automatically eligible for Medicaid in a state other than the one providing the subsidy. However, states providing such subsidies are permitted to enter into agreements with other states providing the same benefits.

If a child receiving state adoption assistance moves to South Carolina, his/her eligibility for Medicaid is determined as if the child is a resident of this state provided all of the following conditions are met:

* The state providing the subsidy is a member of ICAMA;
* The child has special medical or rehabilitative needs; and
* The child could not have been placed without Medicaid.

The Medicaid Eligibility Worker should see a copy of the Adoption Assistance Agreement to verify this information.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ICAMA Member States**

|  |  |  |  |
| --- | --- | --- | --- |
| Alabama | Alaska | Arizona | Arkansas |
| California | Colorado | Connecticut | Delaware |
| District of Columbia | Florida | Georgia | Hawaii |
| Idaho | Illinois | Indiana | Iowa |
| Kansas | Kentucky | Louisiana | Maine |
| Maryland | Massachusetts | Michigan | Minnesota |
| Mississippi | Missouri | Montana | Nebraska |
| Nevada | New Hampshire | New Jersey | New Mexico |
| New York | North Carolina | North Dakota | Ohio |
| Oklahoma | Oregon | Pennsylvania | Rhode Island |
| South Carolina | South Dakota | Tennessee | Texas |
| Utah | Virginia | Washington | West Virginia |
| Wisconsin |  |  |  |

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Additional information about the ICAMA can be accessed at <http://aaicama.aphsa.org/>. The current list of state signatories can be accessed at [AAICAMA Site - Signatories of the Compact](http://aaicama.org/cms/index.php/icama-aaicama/the-icama/signatories).

204.08.06 Annual Review

(Eff. 11/01/18)

Annual reviews are required for Regular Foster Care cases (Payment Category 60) and Former Foster Care (Payment Category 61). If determined ineligible, the Eligibility Worker should determine if the individual would be eligible in any other payment category. If so, the Eligibility Worker should take appropriate action to follow the ex parte process. Refer to MPPM 101.11.

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| **Procedure for Regular Foster Care Annual Review** |
| * Make sure the beneficiary’s review form is complete, ensuring that you have all required verifications of income because income must be verified.
* Note any alleged changes or discrepancies.
* If necessary, obtain necessary information/verification from third parties. Be sure to document the following: Date of Contact, Company/Business Name, Phone Number, and the Name and Title of the individual who provided the verification.
* Check all wage match systems for possible income (that is IEVS, Bendex, SDX, State Retirement, SCDEW, Unemployment, CHIP, and PCS Wage Verification).
* Once all verifications have been obtained and documented, complete a budget sheet to determine continued eligibility.
 |
| **MEDS Procedure**Select Worker Menu, select Regular Review, and put “R” for Review Status. The system will pull up all cases associated with the DHHS Medicaid Eligibility Worker’s PAT# scheduled for review.Select the beneficiary’s name and place the date in the “Form Received Column,” then MOD screen. This procedure will acknowledge that you have received the review form from the beneficiary and will not allow the case that you have selected to close until you have actually completed the review.Note**:** Once you have acknowledged receipt of the review form in MEDS, an eligibility decision must be made within 60 days from the receipt of the review form so that the beneficiary’s case can be processed in a timely manner during the review period. |
| **If continued eligible*** Update MEDS information by going to ELD01 and updating the necessary fields and the “Date of Next Review,” which is equal to 12 months from the “Decision Date.”
* MOD screen, press pf15 to “Make Decision,” then pf24 to “Act on Decision.”
* Case should now be in Maintenance Status.
 |
| **If ineligible*** Begin closure procedures in MEDS.
* Go to ELD01 and enter updated information in the necessary fields. Put in the correct closure code so that a notice is generated to the beneficiary explaining the reason for case closure. Once you have entered the appropriate closure code, this will make the case ineligible.
* Go to ELD02 to make sure the appropriate month the case is to close is properly displayed. Do pf24 to “Act on Decision.” Do not “Make Decision.”
 |

# **204.09 Ribicoff**

(Eff. 01/01/14)

Section 1902(a)(10)(A)(ii) of the Social Security Act provides for the Medicaid coverage of children up to age 18 who qualify for TANF. South Carolina covers children up to age 19 at 208% of the FPL, which would include any children qualifying for Ribicoff.

The Ribicoff program is a non-MAGI category and does not follow MAGI rules. Refer to MPPM [204.03](#_204.03_Partners_for) for information on the Partners for Healthy Children program.

# **204.10 Appendix A: Out-of-Home Placement Chart**

LIST OF APPROVED OUT-OF-HOME PLACEMENT[[1]](#footnote-2)

*MEDICAID PROVIDERS FOR PSYCHIATRIC/MENTAL HEALTH SERVICES*

* Facilities must be licensed by SCDHEC and maintain licensure to qualify as an approved Medicaid Out-of-Home Placement.
* Facilities not included on this list must contact Behavioral Health Services program staff prior to placement of a Medicaid beneficiary, to determine if the facility qualifies for Medicaid.

| **PROVIDER** | **NPI NUMBER** | PROVIDER LEGACY# |
| --- | --- | --- |
| **RIVERSIDE BEHAVIORAL HEALTH AT WINWOOD FARM** | 1033437801 | RTF036 |
| **PINELANDS PRTF** | 1770890485 | RTF037 |
| **LIGHTHOUSE CARE CENTER OF AUGUSTA** | 1376633578 | RTF030 |
| **CAROLINA CHILDREN’S HOME** | 1699812453 | RTF035 |
| **VENICE** | 1083852511 | RTF033 |
| **NEW HOPE CAROLINAS** | 1831114735 | RTF032 |
| **WILLOWGLEN ACADEMY** | 1124260427 | RTF034 |
| **HAMPTON PRTF** | 1508017476 | RTF031 |
| **COASTAL HARBOR TREATMENT CENTER (Savannah, GA)** | 1679543672 | RTF022 |
| **MARSHALL I. PICKENS CHILDREN’S PROGRAM (GHS)** | 1629017983 | RTF007 |
| **PALMETTO PINES****(North Charleston, SC)** | 1356362784 | RTF003 |
| **THREE RIVERS MIDLANDS** | 1144253824 | RTF004 |
| **PALMETTO LOW COUNTRY BHS** | 1134232671 | RTF021 |
| **PALMETTO PEE DEE** | 1508979956 | RTF024 |
| **SPRINGBROOK BEHAVIORAL HEALTH** | 1386603793 | RTF001 |
| **THREE RIVERS** | 1073509055 | RTF023 |
| **WILLIAM S. HALL PSYCHIATRIC (DMH)**  | 1932124096 | RTF011 |
| **YORK PLACE** | 1114984812 | RTF005 |
| **LIGHTHOUSE CARE CENTER OF CONWAY** | 1194826081 | RTF029 |
| **G WERBER BRYAN PSYCH HOSPITAL** | 1265452619 | A00515 |
| **PALMETTO LOWCOUNTRY BHS** | 1134232671 | A00729 |
| **THREE RIVERS** | 1427044957 | A00808 |
| **HHC/LIGHTHOUSE CARE CENTERS (Conway, SC)** | 1093867525 | A00898 |
| **THE CAROLINA CENTER FOR BEHAVIORAL HEALTH** | 1881664407 | A00806 |
| **PATRICK HARRIS** | 1245255389 | A00503 |
| **WILLIAM S HALL INSTITUTE** | 1437174919 | A00514 |
| **SPRINGBROOK** | 1386603793 | 119917 |
| **G WERBER BRYAN PSYCH HOSPITAL** | 1265452619 | A00515 |

# **204.11 Appendix B: Crosswalk**

The following Table displays the recent changes to Medicaid eligibility groups, income standards, and the rules for accounting resources. This Table aligns 2013 eligibility categories with 2014 MAGI categories.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2013 Category | Pre MAGI FPL Limit | Resources Counted? | 2014 Category | 2014 FPL Limit | Resources Counted? |
| Optional Coverage for (Pregnant) Women/Infants (OCWI) | 185% | YES | **Pregnant Women and Babies** | 194% | NO |
| Family Planning | 185% | YES | **Healthy Connections Family Planning** | 194% | NO |
| Partners for Healthy Children (PHC)\* | 200% | YES | **Children** | 208% | NO |
| Low Income Families (LIF) | 50% | YES | **Parent and Caretaker Relatives** | 62% | NO |
| Regular Foster Care-RFC | 50% | YES | **Regular Foster Care-RFC** | 62% | NO |
| Subsidized Adoption | 50% | YES | **Subsidized Adoption** | 62% | NO |
| N/A | N/A | N/A | **Former Foster Care up to age 26** | No financial test | NO |

1. As of July 22, 2011 [↑](#footnote-ref-2)