TITLE 479
CHILD WELFARE PAYMENT (CWP) AND MEDICAL SERVICES PROGRAM

CHAPTER 1-000 INTRODUCTION: Assistance may be provided to children under the Child Welfare Payment and Medical Services Program if they are in the custody of the Nebraska Department of Health and Human Services (NDHHS), NDHHS - Office of Juvenile Services, or a public agency that has a written agreement with NDHHS. The children may be removed from their homes or placed in their own homes with the provision of services and supervision.

1-001 Legal Basis

1-001.01 Non-IV-E Funds (Child Welfare): If no other source of funds is available, non-IV-E funds (which are state funds) may be used to meet the needs of:

1. Department wards;
2. Former wards;
3. Families of wards;
4. Foster parents;
5. Families in child protective services cases before the child(ren) is made a ward;
6. Adoption assistance for eligible children (see 479 NAC 8-000); and
7. Subsidized guardians (see 479 NAC 7-000).

Neb. Rev. Stat., sections 68-1202 and 68-1205, authorize the use of state funds for these children.

1-001.02 Title IV-E: The Adoption Assistance and Child Welfare Act of 1980 created the Title IV-E program. Title IV-E provides foster care maintenance and adoption assistance for eligible children. The Adoption and Safe Families Act of 1997 required states to use pre-August 22, 1996 rules. The Foster Care Independence Act of 1999 provides assistance to individuals age 18 through 20 who are transitioning from foster care.

1-001.03 Title XIX: Title XIX provides medical care and services to children who do not have sufficient income to meet their medical needs and who qualify according to the medical assistance guidelines.

1-002 Purpose: The purpose of the Child Welfare Payment and Medical Services Program is to provide payments and/or medical assistance for wards, former wards, children who are being adopted with a subsidy, families of wards or children at risk of becoming wards, foster parents, and families receiving guardianship subsidy.

{Effective 02/23/04}

1-003 Administration: The Child Welfare Payment and Medical Services Program is administered by the Nebraska Department of Health and Human Services in accordance with state laws and with rules, regulations, and procedures established by the Director of the Nebraska Department of Health and Human Services.

1-004 Definition of Terms: For use within CWP, the following definitions of terms will apply unless the context in which the term is used denotes otherwise.

Adequate Notice: Notice of case action which includes a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s) (see 479 NAC 1-007).

Approval Date: The date that the new or reopened case is determined eligible.

Budgetary Need: The amount determined to meet the child's needs as the result of the budget calculation.

Categorical Assistance: Assistance administered by the Nebraska Department of Health and Human Services (NDHHS). For the purposes of this program, it includes Aid to Dependent Children (ADC)/MA; Title IV-E payments; Assistance to Aged, Blind, or Disabled (AABD)/MA); State Disability Program (SDP)/MA; Refugee Resettlement Program (RRP)/MA; and Children's Medical Assistance Programs (CMAP).

Child Care Institution: A facility that is licensed by the State, including a:

1. Private facility. The private child care institution may be either nonprofit or for profit; or
2. A public child care facility which accommodates no more than 25 children.

Detention facilities, forestry camps, training schools, or any other facilities that are operated primarily for the detention of children who are determined to be delinquent are not licensed as child care institutions.

Child Support: Support ordered by a court of competent jurisdiction on behalf of a minor child.

Constructive Removal: A paper or nonphysical removal of a child from the home. This may be used when a child lives with an interim caretaker relative between the time s/he lives with the custodial parent and enters foster care, but the court removal is from the parent's home.

Contributions: Verified payments which are paid to or for a foster child. This includes money received from a parent when no order for child support exists.

Court Order: A document signed by a judge and entered in a court of competent jurisdiction.

Department: The Nebraska Department of Health and Human Services.

Discharged Ward: An individual who has been discharged as a ward of the court or NDHHS or NDHHS – Office of Juvenile Services (OJS).

Emergency Shelter Care: A short-term service that is intended to support children and families that are experiencing a crisis situation that requires a break from the home in a safe, secure place for less than 30 days.

Equity: The fair market value of property minus the total amount owed on it.

Fair Market Value: The price an item of a particular make, model, size, material, or condition will sell for on the open market in the geographic area involved.

Former Ward: An individual age 18 through 20 who has been discharged as a ward by NDHHS or NDHHS-OJS and who is in a continuing educational program.

Foster Care Payment Determination Checklist: A checklist that indicates the needs and behaviors of a child in order to determine the foster care payment for the child.

Foster Home: A private home, including a relative's home, which has been licensed or approved and evaluated by means of a home study for the 24-hour-a-day care of foster children.

Foster Parent: An adult who provides a home and manages and maintains a household which may be used for placement of children.

Guardian Ad Litem: An adult appointed by a court to protect the best interests of a minor child in a specific legal action.

Parent: Wherever the term parent, father, or mother is used, it includes birth, adoptive, and stepparents.

Physical Removal: A bodily removal of the child from the home.

Prorated Payment: A grant divided according to the number of days in the month (see 479 NAC 2-002.10).

Prudent Person Principle: The practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information.

Relinquishment of Parental Rights: Voluntary surrendering of all legal rights and responsibilities of a parent. Relinquishment of a child to the Department is effective upon written acceptance by the Department. Relinquishment to the Department is irrevocable and transfers guardianship and full parental rights to the Department. (See 390 NAC 8-004.01 for special circumstances on relinquishing a Native American child.)

Retroactive Payment: A payment made for services provided in the previous month(s).

Runaway: A ward who has left the designated residence without approval.

Share of Cost: A client's financial out-of-pocket obligation for medical services when countable income exceeds the medical maintenance income level. The share of cost amount is the difference between the unit's countable income and the appropriate medical maintenance income level. This amount must be obligated or paid to medical providers before Medicaid will pay on the remaining medical bills.

Temporary Custody: Custody granted by a court of competent jurisdiction, or through properly executed voluntary placement agreement, voluntary relinquishment, or a law enforcement pickup.

Termination of Parental Rights: The legal separation of a parent-child relationship with accompanying transfer of custodial rights over a child through assignment of legal custody and guardianship by:

1. Voluntary relinquishment, the surrender of a child by parent(s), the Department, or licensed child placement agency (Neb. Rev. Stat., sections 43-104.02 through 43-106.01); or
2. Judicial determination, an order of the county, district, or separate juvenile court or tribal court (Neb. Rev. Stat., Chapter 43, Article 2).

Third Trimester of Pregnancy: Three calendar months prior to the month in which the child is expected to be born and the month of birth.

Voluntary Placement Agreement: An agreement signed by the parent(s) or guardian of a child placing the child in the Department's custody.

Ward: A child whose custody by judicial determination has been retained by the court or assigned to the Nebraska Health and Human Services.

Workforce Investment Act (WIA): Legislation designed to prepare youth and unskilled adults for entry into the labor force, previously known as JTPA.

{Effective 02/23/04}

1-005 Eligibility Worker Responsibilities: The eligibility worker has the following reponsibilities.

1-005.01 Duties at Intake Application or Review of Eligibility: At the time of intake application or review of eligibility, the eligibility worker shall -

1. Collect and review the information entered on Form CWI-10 for Department wards, Form DA-100 for non-Department wards;
2. Monitor the eligibility and payment factors and any changes that affect eligibility and payment;
3. Obtain verification of the eligibility and payment factors that require verification;
4. Uphold the child's legal rights, including filing an appeal if the child's application for government benefits has been denied;
5. Explore income that may be currently or potentially available such as Retirement, Survivors, and Disability Insurance (RSDI); Supplemental Security Income (SSI); veteran's assistance benefits (VA); Railroad Retirement; etc.;
6. Ensure that programs for which the child is eligible are used, such as social services; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); family planning; and other categorical programs;
7. Inform the child, the foster parent(s), and/or the child caring agency that s/he must show the child's medical card to all providers and must inform the worker of any health insurance plan, any individual(s), or any group that may be liable for the child's medical expenses;
8. Inform the child, the foster parent(s), and/or the child caring agency of the requirement to participate in the Nebraska Health Connection, if applicable (see 477 NAC 4-013 ff.);
9. Complete necessary reports and information forms;
10. Act with reasonable promptness on the determination of eligibility for the ward;
11. Provide adequate notice of any action affecting the ward's maintenance amount or medical assistance.

{Effective 7/25/95}

1-005.02 Continuing Responsibilities: The eligibility worker has the continuing responsibility to -

1. Provide adequate notice of any action affecting the child's assistance case;
2. Treat the child's information confidentially;
3. Uphold the child's civil rights; and
4. Refer a foster parent or child caring agency to the State Claims Board if the parent or agency wants to file for reimbursement for injury or damages caused by a ward. The address is Risk Management/State Claims Board, P.O. Box 94931, State Capitol Building, Room 1212, Lincoln, NE 68509.

1-006 Prompt Action: The worker shall act with reasonable promptness making a determination of program eligibility. If circumstances beyond the control of the worker prevent action within 45 days, the worker shall record the reason for the delay in the case record.

1-007 Notice of Action: After consulting with the child's other worker(s), the eligibility worker must send adequate notice of any action affecting the child's grant and/or medical assistance. For Department wards, the placement worker decides to whom a copy must be sent, i.e., foster parent, child caring agency, etc.

1-007.01 Non-Department Wards: For non-Department wards, the worker must send the notice to the appropriate agency. If the case is approved, the worker must send a copy of the notice along with any case plan information provided by the contractor to the permanency plan reviewer.

The notice must include a statement of what action(s) the IM worker has taken, the reason(s) for the action(s) taken, and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s).

1-008 Right to Appeal: The agency that has custody of a non-Department ward has the right to appeal any action, inaction, or failure to act with reasonable promptness with regard to assistance from the Department; a former ward has these appeal rights for medical assistance. See 465 NAC 2-001.02 ff. for appeal procedures.

1-008.01 Right to Grieve: The foster parent of a Department ward has the right to grieve if the Department denies his/her request for payment or fails to act with reasonable promptness with regard to financial assistance from the Department.

The foster parent also has the right to grieve the decision to complete the Foster Care Payment Determination Checklist or the accuracy of the checklist. A former ward has the right to grieve the Department's denial or failure to act with reasonable promptness on his/her application for an assistance grant. See 479 NAC 2-002.03J ff. for complaint and grievance procedures for foster parents.

1-009 Authorization for Investigation: The worker uses Form IM-27FC to obtain verification for Department wards. For non-Department wards, Form ASD-46 is used to obtain verification and the individual who signed Form EA-117 signs the form.

1-010 Eligibility Review: The worker must review the child's eligibility:

1. Every 6 months for FC-10 cases; or
2. Every 12 months for FC-30 cases.

{Effective 9/20/05}

1-011 Prudent Person Principle: When the facts of the case are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the IM worker shall must obtain additional verification.

1-012 Local Office of Responsibility: The payment case is handled by the local office that is responsible for the child's service case.

1-013 Transfer of Cases: The eligibility case for a ward "follows" the Protection and Safety case. When required, the case must be transferred within ten working days. To transfer the case, the worker must:

1. Notify the receiving unit of the anticipated transfer as far in advance as possible;
2. Bring the case up to date and prepare a summary narrative of the case status. Redetermine eligibility if the review is due before the transfer; and
3. Forward the entire case record.

{2/23/04}

1-014 Ward in Institution for Mental Disease (IMD): The medical case remains open when a ward is placed in an IMD. For treatment of a ward in an IMD, see 479 NAC 4-000.

1-015 Payment Policy: Foster care payments are made in arrears, i.e., payment at the beginning of one month is for the care provided in the previous month.

Payments to former wards and wards in independent living are made prospectively; the payment is made for the first of the month for that month's care.

1-016 Protective Payee: If a grant is paid directly to the ward and the worker documents that the ward is mismanaging the money, a protective payee may be assigned temporarily. The protective payee must be an interested third party who is concerned with the welfare of the ward. See 465 NAC 2-008 ff. for procedures for assigning a protective payee.

1-017 Forms: Instructions for the forms used in this program are contained in the Public Assistance Forms Manual.

1-017 Summary of Forms: The following forms are used in the Child Welfare Payment and Medical Services Program. Instructions for the forms are contained in the appendix.

NDSS Form #	Form Title	PAF Reference
ASD-17	Question Referral Form	1-2
ASD-19	Client Referral	1-3
ASD-46	Authorization for Investigation	1-4
	Overview of the Insurance information system	1-5
ASD-59	Insurance Information	1-6
ASD-60	Health Insurance Verification Form	1-7
CSE-12	Acknowledgement of Paternity	3-4
CWI-10	Child Welfare Information System	3-7
DA-3M	Medical Budget and Record	4-1
DA-100	Application for Assistance	4-5
DA-100A	Supplemental to the Application for Assistance	4-6
DAS-02-09	Disbursement Document	4-9
DM-5	Physician's Confidential Report	4-10
DSS-5	Authorization and Billing Document	4-16
DSS-58	Relinquishment of a Child by Parents	4-19
DSS-0857	Voluntary Placement Agreement	4-23
DSS-0859	Interstate Compact on Adoption and Medical Assistance Notice of Transfer	4-24
DSS-0866	Request and Authorization for Use of State Ward Trust Funds	4-25
EPSDT-3FC	EPSDT Request and Treatment	5-2
EPSDT-4FC	EPSDT Follow-up	5-3
FA-62	Maintenance Assistance Cancellation/Refund Transmittal	6-3
I-94	Arrival-Departure Record	9-1
IM-2	IM Referral to Vocational Rehabilitation	9-6
IM-5	Notice to the Child Support Enforcement Unit of a Good Cause Claim	9-7
IM-5FC	Notice to the Child Support Enforcement Unit of a Good Cause Claim	9-9

DHHS Form #	Form Title	PAF Reference
IM-6FC	State Ward Status Change	9-10
IM-8	Notice of Finding	9-12
IM-8FC	Notice of Action	9-14
IM-17E	Interim Assistance Reimbursement Authorization Eligibility	9-17
IM-17P	Interim Assistance Reimbursement Authorization - Post Eligibility	9-18
IM-18AFC	Family Financial Information, Initial Eligibility and Review	9-19
IM-18FC	State Ward Income and Resources Data	9-20
IM-19AFC	Follow-up Overpayment Notification	9-22
IM-19FC	Overpayment Notification	9-21
IM-20	Educational Benefits and Housing Verification	9-23
IM-21FC	Manual Payments Notice	9-24
IM-22	Certificate Request	9-26
IM-24	Notice of Excess Income Obligation	9-27
IM-25FC	Payment Computation Budget	9-28
IM-26FC	Payment Computation Budget, Independent Living, Former Wards	9-29
IM-27	Authorization for Release of Information	9-32
IM-50	Retroactive Payment	9-37
IM-53	Form Letter for Subsidized Adoption	9-41
IM-54	Form Letter for Foster Care	9-42
IM-57FC	Rights and Responsibilities	9-44
IM-58FC	Third Party Payment for Medical Care/Adoption	9-45
IM-59FC	Third Party Payments for Medical Care/Foster Care	9-46
IM-60	Medical Assistance Notice of Requirement to Cooperate and Right to Claim Good Cause	9-47
IM-65	Out-of-State Recertification of Need Letter	9-51
MC-5	Periodic Screening, Report and Claim Statement	10-1
MC-10	Prior Authorization Document Adjustment	10-3
MC-12	Excess Income Obligation Claims	10-4
MC-13	Dentist's Pretreatment Plan and Service Statement	10-5
	Nebraska Medicaid Identification Card	11-3

NDSS Form #	Form Title	PAF Reference
PDS-113	Adjustment Request for Client Medical Eligibility Record	11-4
QC-1	Quality Control Review Findings	12-1
SS-5	Application for a Social Security Card	13-2
SSA-491TC	Automated Third Party Query	13-3
SSA-1610	Social Security Public Assistance Agency Information Request	13-4
SSA-4681	Case Report on Good Cause for Refusing to Cooperate in Establishing Paternity and Securing Child Support	13-6

CHAPTER 2-000 REQUIREMENTS FOR A MAINTENANCE PAYMENT FOR A DEPARTMENT WARD

2-001 Considerations for Payment: The following elements must be considered for all Department wards:

1. Definition of a ward (see 479 NAC 2-001.01);
2. Service plan (see 479 NAC 2-001.02);
3. Application (see 479 NAC 2-001.03);
4. Residence (see 479 NAC 2-001.04);
5. Plan for self-support (see 479 NAC 2-001.05);
6. Social Security number (see 479 NAC 2-001.06);
7. Child support (see 479 NAC 2-001.07);
8. Resources (see 479 NAC 2-001.08);
9. Income (see 479 NAC 2-001.09);
10. Receipt of other assistance (see 479 NAC 2-001.11); and

The Nebraska Department of Social Services is responsible for providing maintenance payments for Department wards.

Family Support Funds are available to prevent the removal of a ward from his/her home or to allow his/her return to the home.

2-001.01 Definition of a Ward

2-001.01A Department Ward: A child may become a Department ward by means of a -

1. Judicial determination;
2. Voluntary relinquishment;
3. Voluntary placement; or
4. Law enforcement pickup (not to exceed 48 hours).

2-001.01A1 Judicial Determination: A child becomes a Department ward when s/he is committed to the custody of the Nebraska Department of Social Services by means of a court order entered by a court of competent jurisdiction. The date of commitment to the Department is the date stated in the court order granting custody to the Nebraska Department of Social Services.

2-001.01A2 Voluntary Relinquishment: A child becomes a Department ward when his/her parent or legal guardian voluntarily relinquishes custody to the Department. This is accomplished by means of a signed Form DSS-58, "Relinquishment of Child by Parents." The relinquishment is valid only if it is accepted by the Department. The designated adoption staff at the local office sends a copy of the acceptance letter to the local office worker. The relinquishment then becomes effective with the date Form DSS-5B was signed.

{Effective 9/20/95}

2-001.01A3 Voluntary Placement: A child becomes a Department ward if the parent(s) or legal guardian(s) completes and signs Form DSS-0857, "Voluntary Placement Agreement." The placement is valid only if it is accepted by the Department. A copy is forwarded to the IM worker. While the agreement is in effect, the Department is responsible for the child's care to the extent provided in the agreement.

The legal status of a parent or guardian is not affected by a "Voluntary Placement Agreement." The parent or guardian may withdraw the agreement at any time.

If a parent contributes to the cost of care, the worker shall forward the payment along with Form FA-62, "Maintenance Assistance Cancellation/Refund Transmittal," to Finance and Accounting, Central Office.

2-001.01A3a Time Limits: A copy of the agreement, Form CWI-10, and FCPAY is submitted to the eligibility worker if there is more than one worker for the child. Payment may be made for a voluntary placement for a maximum of six months.

{Effective 9/20/95}

2-001.01A4 Law Enforcement Pickup: Any law enforcement official who takes a child who is not a ward of the Nebraska Department of Social Services into temporary custody for the child's protection may deliver the child to the Department. The worker may make payment via Form DAS-02-09 for the temporary placement (48 hours or less) of the child. The payment rate is determined by the type of placement.

If the Department is granted custody beyond 48 hours, the worker shall determine the child's eligibility for foster care payments. Eligibility begins with the date of pickup.

2-001.01A5 Emergency Shelter Care: A child is eligible for payment of emergency shelter care upon entering emergency custody. This is an initial placement and not a change of placement for a child already in foster care. Emergency shelter care may be provided in a licensed foster home or a group-type setting.

Payment for a child in emergency shelter care may be made only if NDSS is given custody under one of the following:

1. There is a law enforcement pickup in effect;
2. There is a properly executed detention order from a court;
3. There is a properly executed voluntary placement agreement in effect;
4. The child is a current ward of the Department.

The parent(s) should pay according to his/her ability as an incentive to ensure continued acceptance of parental responsibility. Department funds are used to make up the difference if the parent(s) cannot pay the full amount.

{Effective 9/20/95}

2-001.01A5a Maximum Continuous Days: Emergency shelter care is limited to 30 days. No payment can be made for this service beyond 30 days without a written exception from the Service Area Protection and Safety Administrator or designee. This exception must be approved on a form designated by the Department.

{Effective 02/23/04}

2-001.02 Service Plan Information: A service plan is required for all cases.

2-001.03 Application Forms: See 479-000-328 for the form that constitutes the application for assistance and the application procedure. IM-18 FC is used for a ward who is applying for his/her child (see 479 NAC 2-002.02A).

2-001.04 Residence: A ward is considered a resident as long as s/he is under the jurisdiction of a Nebraska court or is a ward of the Department by relinquishment of parental rights. A ward retains Nebraska residence even if s/he is placed in another state as long as the ward is under the jurisdiction of a Nebraska court. For regulations on runaways, see 479 NAC 2-002.07.

2-001.04A Placement in an Out-of-State Institution: If a state arranges for a ward to be placed in an institution located in another state, the state making the placement is responsible for the maintenance payment for the ward.

2-001.04B Continuation of Foster Care (FC) While Absent From Nebraska: The Department may not deny assistance because a ward under the jurisdiction of a Nebraska court has not resided in the state for a specified period. It also may not terminate a resident's eligibility because of that ward's absence from the state, unless another state has determined that the ward is a resident there for assistance purposes.

A Department ward who is IV-E eligible and is living in another state is eligible for Medicaid coverage from the state in which she or he resides. The protection and safety worker is responsible to determine if it is in the child's best interest to retain Nebraska Medicaid coverage or receive coverage from the resident state. If the decision is that coverage should be from the resident state, the eligibility worker must complete the appropriate form and send it to the Department's designated ICAMA/COBRA Coordinator for processing. See 479-000-304 for procedures.

{Effective 02/23/04}

2-001.05 Plan for Independent Living: A ward age 16 or older who is not a full-time student attending an educational or training program must have a plan for independent living. The protection and safety worker develops the plan with the ward. See 479 NAC 2-001.09A for the treatment of income.

Employment First services are available to the wards.

2-001.05A Full-Time Student: A full-time student must have a school schedule that is equal to a full-time curriculum for the school s/he is attending.

2-001.05B Continued Enrollment: The worker must consider enrollment as continued through normal periods of class attendance, vacation, and recess unless the student graduates, drops out, is suspended or expelled, or does not intend to register for the next normal school term (excluding summer school).

2-001.05C Effective Birthdate if Information Is Incomplete: When birth information is incomplete, a birthdate is designated as follows:

1. If the year but not the month is known, July is used; or
2. If the day of the month is not known, the 15th is used.

2-001.05D Verification of Age: The ward's age must be verified. If the ward is otherwise eligible, assistance is not delayed, denied, or discontinued while verification of the ward's age is being obtained. See 479-000-300 for sources of verification.

2-001.06 Social Security Number (SSN): The worker must complete Form SS-5 if:

1. The ward does not have an SSN; or
2. The Social Security Administration, through the Numident exchange, is unable to verify the SSN furnished by the ward.

If the ward is otherwise eligible, assistance is not delayed, denied, or discontinued pending the verification or assignment of an SSN.

2-001.07 Child Support

2-001.07A Referral to the Child Support Enforcement Unit: The worker makes a referral to the IV-D unit no later than two working days after the payment case is opened. When no support has been ordered, the IV-D unit attempts to get an order for support.

The worker makes a referral on each parent. A copy of all court orders must be forwarded to CSE. The worker must forward any financial information to CSEU within two days of receipt.

2-001.07A1 Exception to Referral: A referral is not made to the IV-D unit when:

1. A child is placed in foster care as a result of a voluntary placement; or
   Note: If a voluntary placement results in a court-ordered placement, the case is referred to the IV-D unit.
2. Parental rights have been terminated.

2-001.07A2 Termination of Parental Rights: If a parent voluntarily relinquishes parental rights or a court orders termination of parental rights after the case has been referred to IV-D, the protection and safety worker forwards a copy of the court order or Form DSS-58A, "Relinquishment of a Child by Parents," and acceptance letter to the eligibility worker. The eligibility worker forwards a copy of the court order or relinquishment and acceptance letter to the IV-D worker.

2-001.07B Opportunity to Claim Good Cause

2-001.07B1 Eligibility Worker's Responsibilities if Good Cause Claimed: If the protection and safety worker claims good cause, the eligibility worker forwards a copy of Form IM-5FC to the IV-D unit.

2-001.07C Termination of Assignment

2-001.07C1 Partial Termination: A partial termination of assignment is automatically transmitted by the Central Office to the appropriate clerk of the district court when:

1. The Child Support Enforcement Unit has been notified that an order for child support has been vacated or terminated; or
2. A case has been closed or the assistance grant has been zeroed.

2-001.07C2 Final Termination: A final termination of assignment automatically transmitted by the Central Office to the appropriate clerk of the district court when the assigned child support debt is satisfied.

2-001.08 Resources: The total equity value of available non-exempt resources of the ward is determined and compared with the established maximum for available resources which the ward may own and still receive a payment from the Department. If the ward's available resources exceed the established maximum, payment is made from the resources.

The following are examples of resources:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Stocks;
4. Bonds;
5. Certificates of deposit;
6. Investments;
7. Collectable unpaid notes or loans;
8. Promissory notes;
9. Mortgages;
10. Land contracts;
11. Land leases;
12. Revocable burial funds;
13. Trust or guardianship funds;
14. Cash value of insurance policies;
15. Real estate;
16. Trailer houses;
17. Burial spaces;
18. Life estates;
19. Farm and business equipment;
20. Livestock;
21. Poultry and crops;
22. Household goods and other personal effects; and
23. Federal and state tax refunds.

{Effective 9/20/95}

2-001.08A Verification of Resources of the Ward: The worker must verify and document in the case record all resources. Verification of resources consists of but is not limited to the following information:

1. A description of the type of resource to include account or policy number(s), legal descriptions (for property), etc.;
2. The location of the resource (i.e., name and address of the bank, insurance company, etc.);
3. Current value of the resource, encumbrances against the resource, and the resulting equity value;
4. Description of current ownership; and
5. Source of verification and the date the verification is obtained.

If the ward has a guardian, the worker may use the guardian's report to the court for verification. The guardian's report applies only to the period covered by the report. The worker must follow regular verification procedures if there is no guardian's report or the report does not coincide with the date of review.

The worker must also note any additional information that may affect resource eligibility.

2-001.08B Definition of Available Resources: For the determination of payment or medical coverage, available resources include cash or other liquid assets or any type of real or personal property or interest in property that is actually available to the ward and may be converted into cash to be used for support and maintenance.

2-001.08B1 Unavailability of Resource: Regardless of the terms of ownership, if it can be documented in the case record that the resource is unavailable to the ward, the value of that resource is not used. The worker must consider the feasibility of the responsible person taking legal action to make the resource available. If the worker determines that legal action can be taken, the worker must allow the responsible person 60 days to initiate legal action. After 60 days, if the responsible person has not initiated legal action, the worker must contact the Legal Services Division.

For trust, conservatorship, or guardianship funds, see 479 NAC 2-001.08G1a and 2-001.08G1b.

In evaluating the availability of benefit funds, such as funds raised by a benefit dance or auction, the worker must determine the purpose of the funds and if the ward has access to them. If the client cannot access the funds to pay normal maintenance needs, the funds are not considered available.

The worker must determine a reasonable period of unavailability based on the circumstances of the case. The worker must monitor the status of the resource.

2-001.08B2 Excluded Resources: Disregarded income is also disregarded as a resource unless there is regulation stating otherwise. The following resources are excluded in determining the amount of available resources:

1. Clothing;
2. Certain trusts (including guardianships) and conservatorships set up for the ward (see 479 NAC 2-001.08G1b);
3. Certain life estates in real property;
4. Irrevocable burial trusts up to $3,000 per individual and the interest if irrevocable (see 468 NAC 2-008.07A3a);
5. Proceeds of an insurance policy that is irrevocably assigned for the purpose of burial of the ward (see 468 NAC 2-008.07A3b);
6. Payments from the Indian Claims Commission;
7. One motor vehicle;
8. U.S. savings bonds (excluded for the initial six-month mandatory retention period);
9. The cash value of life insurance policies; and
10. An Individual Development Account (an account set up for postsecondary education, purchase of a client's first home, or establishment of a business).

{Effective 02/23/04}

The worth of resources, both available and excluded, is determined on the basis of their equity.

For any of these funds to be excluded as a resource, they must be segregated in a separate account or recorded separately so that they can be identified. If the funds are not in a separate account or recorded separately, the worker must allow the responsible person 30 days from notification to identify each source of funds. After 30 days the resource is included in the resource limit if the funds are not in a segregated account. Several excludable resources may be combined in a single account. See 479 NAC 2-001.08H for more information on the resource limit.

{Effective 02/23/04}

2-001.08C Determination of Ownership of Resources: A resource which appears on record in the name of a ward must be considered belonging to the ward.

2-001.08C1 Jointly Owned Resources: When a ward has a jointly owned resource that is considered available, the worker must use the guidelines in the following regulations.

2-001.08C1a Resources Owned With Other Clients: If a ward owns a resource with another client who is on categorical assistance, the worker must divide the value of the resource by the number of owners, regardless of the terms of ownership. The appropriate value is counted for each unit.

2-001.08C1b Resources Owned With Non-Clients: If a ward owns a resource with an individual who is not receiving categorical assistance, the worker must determine the appropriate value to be assigned to the ward in accordance with the following regulations.

2-001.08C1b(1) General Rule: As a general rule, the words and/or or or appearing on a title or other legal contract denote joint tenancy. This means that either owner could sign and turn the resource to cash without the other; therefore, the total resource is considered available to either owner.

The term and generally refers to "tenancy in common." This means that each owner holds an undivided interest in the resource without rights of survivorship to the other owner(s). Only the proportionate share based on the number of owners of the resource is available to each owner.

If the worker substantiates that the ward is not the true owner of a resource, it is permissable to allow the responsible person to remove the ward's name from the title of ownership in order to reflect true ownership. The responsible person is allowed 60 days to make this change; if the change is not made, the worker must refer the case to the Legal Services Division.

2-001.08C1b(1)(a) Real Property: Regardless of the terms of ownership of real estate, only the proportionate share is counted as a resource.

2-001.08C1b(1)(a)[1] Real Estate: The worker must verify ownership of real estate through records in the offices of the register of deeds or county clerk. The worker must verify the terms on which property is held in cases of joint ownership. Records of the court have information in regard to estates which have not been settled or which are in probate. The worker must consult the records of the court if the property has come to the holder as a part of an estate; if by joint purchase, the facts will appear in the record of the deed.

2-001.08C1b(1)(b) Bank Accounts: The worker must verify the terms of the account with the bank. If any person on the account is able to withdraw the total amount, the full amount of the account is considered the ward's. If all signatures are required to withdraw the money, the proportionate share must be counted toward the ward.

If the responsible person verifies that none of the money belongs to the ward, the responsible person must be allowed 60 days to remove the ward's name from the account. The responsible person must provide proof of the change. After the ward's name is removed from the bank account, the money is not considered in the ward's resources. If the ward's name is not removed in 60 days, the worker must refer the case to the Legal Services Division. The money is not counted in the ward's resources.

If a portion is the ward's, the worker must notify the ward of the requirement to put the money in a separate account.

2-001.08D Consideration of Relative Responsibility: When a client (i.e., a spouse or parent) has relative responsibility for a client in another assistance unit and the responsible relative owns the resource(s), the worker must divide the value by the number of units to determine the amount to be counted to each. An AABD/MA or SDP/MA couple is considered one unit.

Exception: If the responsible relative receives SSI, none of the value of the resource is considered to the other unit(s).

When a client (i.e., a spouse or parent) has relative responsibility for a client in another assistance unit and both clients own the resource, regulations in 479 NAC 2-001.08C1a are followed and the resource is divided by the number of owners only. This meets the requirements of relative responsibility.

2-001.08E Inheritance: When a ward receives property through inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement. The balance is considered a resource. If the remainder is placed in a trust fund, see 479 NAC 2-001.08G1b.

2-001.08F Value and Equity: Equity is the actual value of property (the price at which it could be sold) less the total of encumbrances against it (mortgages, mechanic's liens, other liens and taxes, and estimated selling expenses).

If the encumbrances against the property equal or exceed the price for which the property could be sold, the client has no equity and the property is not an available resource.

2-001.08F1 Determination of Value: The worker may use public tax records to determine the sale value of a resource. If there is a question as to the accuracy of the sale value determined by tax records, the local worker must contact a real estate agent, or other appropriate individual.

2-001.08G Types of Resources: Resources may be divided into two categories: liquid and non-liquid.

2-001.08G1 Liquid Resources: Liquid resources are assets that are in cash or financial instruments which are convertible to cash. They include resources such as:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Certificates of deposit;
4. Stocks;
5. Bonds;
6. Investments;
7. Collectable unpaid notes or loans;
8. Promissory notes;
9. Mortgages;
10. Land contracts;
11. Land leases;
12. Revocable burial funds;
13. Trust or guardianship funds; and
14. Other similar properties.

For further explanation of liquid resources, see 468 NAC 2-008.07A ff.

2-001.08G1a Trust, Guardianship, or Conservatorship Funds: The worker must determine if the trust, guardianship, or conservatorship funds are available for the ward's use. If the ward has a guardian or conservator, the worker must contact him/her. If the guardian or conservator refuses access to the funds, the worker, with supervisory approval, must refer the case to the Central Office, Legal Services Division.

2-001.08G2 Non-Liquid Resources: Non-liquid resources are tangible properties which need to be sold if they are to be used for the maintenance of the client. They include all properties not classified as liquid resources, such as:

1. Real estate; and
2. Household goods and other personal effects.

For further explanation of non-liquid resources, see 468 NAC 2-008.07B ff.

2-001.08G2a Goods and Personal Effects: Goods and personal effects of a moderate value are exempt. Goods and personal effects include clothing, jewelry, items of personal care, stereos, bicycles, etc.

2-001.08H Maximum Available Resources: The established maximum for available resources (real and personal property) which the ward may own and still receive payment from the Department is $10,000.

For the resource level for NMAP, see 479 NAC 4-007.03.

According to Neb. Rev. Stat., sec. 43-907, if a Department ward is over the resource limit, the ward's excess resources must be used for his/her maintenance needs. If excess resources are not made available, the Legal Services Division determines if legal action is warranted. The Department continues to make payment.

Once resources have accumulated to the $10,000 limit, the ward's resources are used for the ward's needs (see 479 NAC 2-001.09).

{Effective 02/23/04}

2-001.09 Income: When a child is made a ward of the Department and is placed in out of home care, all unearned income is disregarded until the child has accumulated resources of $1,000. Once resources of $1,000 have been accumulated, income of a ward is treated according to the following regulations.

Note: Once resources have been allowed to accumulate to the maximum, all countable unearned income is used toward the needs of the ward even if the Guardianship Account or total available resources drop below $1,000 due to other expenditures for personal items for the ward.

{Effective 6/8/98}

2-001.09A Earned Income: Earned income of a ward age 18 or younger is disregarded unless the ward is in an independent living situation.

Earned income of a ward in an independent living situation is counted, regardless of the ward's full or part-time school attendance.

Earned income is money received from wages, tips, salary, commissions, profits from activities in which an individual is engaged as a self-employed person or as an employee, or items of need received at no cost in lieu of wages.

Earned income also includes earnings over a period of time for which settlement is made at one given time, as in the instance of farm crops or poultry. Earnings so received are prorated for the same number of ensuing months as was included in the earning period.

{Effective 9/20/95}

2-001.09A1 Work Allowance: A $90 work allowance is subtracted from the earned income of a ward in independent living.

{Effective 9/20/95}

2-001.09B Unearned Income: Unearned income is any cash benefit that is not the direct result of labor or service performed by the individual as an employee or a self-employed person. Unearned income includes, but is not limited to:

1. Retirement, Survivors, and Disability Insurance (RSDI) under the Social Security Act;
2. Supplemental Security Income (SSI);
3. Railroad Retirement;
4. Veteran's or military service benefits;
5. Unemployment compensation or disability insurance benefits;
6. Disability benefits paid by the employer (this does not include sick leave);
7. Worker's compensation;
8. Child support;
9. Voluntary contributions;
10. Gifts;
11. Lease income;
12. Annuities; and
13. Pensions, or returns from investments or securities in which the individual is not actively engaged.

2-001.09B1 RSDI, SSI, or VA Benefits: When a Department ward is receiving benefits, such as RSDI, SSI, or VA, the Department is usually made representative payee. When the youth is discharged as a Department ward, the payee must be changed if the Department has been receiving the benefit. The eligibility worker forwards Form PS-0866 to Finance and Accounting, Central Office. The worker must notify the Social Security Administration or Veterans Administration of the ward's discharge and advise the responsible person or the ward (if age 19) to apply as payee for the benefits at the nearest Social Security or Veterans Administration Office.

At the time of discharge if the Department has a guardianship fund on behalf of a ward, see 479 NAC 2-006.01.

{Effective 9/20/95}

2-001.09B1a Benefits for 18 Year Olds: When a ward reaches age 18, RSDI and SSI benefits are paid directly to the ward unless s/he has been determined legally incompetent. The ward is then responsible for all or a portion of payment to the foster parent or child caring agency.

2-001.09C Lump Sum Benefits: When a ward receives a nonrecurring payment, the lump sum is deposited in the ward's account and the Department is reimbursed for past and/or current maintenance from the account. If the lump sum is not countable income, the worker sends Form IM-6FC to Finance and Accounting, Central Office, to notify them that it is not used for reimbursement. For availability of a resource, see 479 NAC 2-001.08B1.

2-001.09C1 Insurance Settlements: When a ward is a beneficiary of life insurance or receives property through inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

The worker must document in the case record the availability of settlement or inheritance funds to the ward.

When a ward receives an insurance settlement or other lump sum, the worker deducts from the lump sum any bills relating to the cause of the settlement that the ward is obligated to pay.

2-001.09C2 Accumulated Benefit Payments: Generally an accumulated benefit payment of RSDI is paid to the Department if the ward is age 17 or younger. If the ward is age 18 or older, the payment is made to the ward. In that case, the accumulated payment is considered income in the month in which it is received or reported. The balance remaining after consideration of the ward's needs for a particular month is considered an available resource in the subsequent month.

2-001.10 Receipt of Other Assistance: A ward must not receive assistance in two categorical units at the same time. This does not preclude the client of another type of assistance from being the payee for a foster care payment made on behalf of a ward in that client's care. A ward may also be the payee for his/her ADC or AABD child.

If there is a choice of programs, the worker should use funds in the following order: IV-E first and non-IV-E second. If the ward is placed in the home of a specified relative, the relative has the choice of receiving ADC or a foster care payment. The ADC grant must not be supplemented with non-IV-E funds unless a ward is in his/her parent's home and the parent is receiving ADC and would be unable to keep the ward without special assistance (see 479-000-307).

2-001.11 Computation of Payment: Except for wards in independent living, the worker computes payment using the ward's income from all sources. If the ward is eligible for a grant payment, s/he is also eligible for medical assistance without a separate application or budget computation.

Provisions in the following material govern the computation of payment. The payment is computed by subtracting the child's countable income from the child’s needs. This figure is compared to the standard. The payment is the lower of the figures. When the Department is the recipient of the child's unearned income, the Department reimburses itself from the child's account. If the ward is responsible for the payment to the foster parent or child caring agency and does not make the payment within five days from the date specified on the service plan, the Department issues a payment by manual payroll (see PAF 9-24).

The worker computes payment for a ward in an independent living situation on Form IM-26FC. See PAF 9-29 for instructions on computing the budget.

{Effective 02/23/04}

2-001.11A Treatment of Income: The worker determines the ward's prospective eligibility from the ward's anticipated income and circumstances using the ward's (or the ward's representative's) declaration and any available verification. If a ward reports beginning employment, verification is provided by the ward or obtained by the worker. Verification consists of the date the employment began, anticipated hours, rate of pay, pay periods, and when the first check will be received. If employment verification cannot be obtained from the ward (or the ward's representative) or the employer, the worker computes one month's budget, based on employment information provided by the ward (or his/her representative).

If the first month's budget is based on a statement of income, the worker must obtain employment verification from the ward (or his/her representative) or employer before computing the second month's budget. Only one budget may be based on declaration of income.

{Effective 02/23/04}

2-001.11A1 Changes in Circumstances: A ward (or his/her representative) must report the following changes:

1. Change or receipt of a resource including cash on hand, stocks, bonds, money in a checking or savings account, or a motor vehicle;
2. Change in residence;
3. New employment;
4. Termination of employment; and
5. Change in the amount of monthly income, including -
   a. All changes in unearned income; and
   b. Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for CWP, 30 hours per week is considered full-time.

The ward (or his/her representative) is required to report all changes within ten days.

{Effective 12/17/95}

2-001.11A2 Notice Provisions: If a ward (or his/her representative) reports a change timely, the worker recomputes the budget for the month of change if there is an underpayment. If the change would result in an overpayment, the worker makes the change effective with the first month that timely notice is possible.

2-001.11A3 Income as It Applies to Resources: Income received by a ward during any one month for maintenance costs must not be considered a resource for that month. Any income not spent for maintenance is considered a resource in the subsequent month.

2-001.11A5 Income Listing

TYPES OF INCOME	TREATMENT OF INCOME
1. Declared cash winnings, a gift that marks a special occasion, etc., small and insignificant children's cash allowances	1. Disregard $10 a month for each income type. If more than $10 a month, count the amount that exceeds $10 as unearned income.
2. Payments from Title I Workforce Investment Act (WIA) for classroom training	2. Disregard.
3. Earnings received from the employer or compensation in lieu of wages under a Title I WIA program	3. Disregard for a student regardless of age.
4. Title I WIA program allowance paid to the ward or responsible relative or vendor payments made to the provider for supportive services, such as transportation, meals, special tools, and clothing. This includes temporary Welfare-to-Work payments made through Workforce Development.	4. Disregard for all ages.
5. Interest on Series E savings bonds and other bonds which accrue interest	5. Consider as unearned income when redeemed.
6. Interest on Series H savings bonds and other bonds which pay dividends or interest	6. See number 1.

TYPES OF INCOME	TREATMENT OF INCOME
7. Any student financial assistance	7. Disregard
8. A bona fide loan from any source	8. Disregard
9. Payments for participating in training or school attendance subsidized by the Division of Vocational Rehabilitation	9. Disregard. Any expenses that the grant or loan covers must not be considered as an educational need on Form IM-26FC.
10. Unpredictable gifts of indeterminate Value	10. Disregard.
11. Agent Orange settlement payments	11. Disregard.
12. Readjustment allowance that is Issued when Job Corps participants leave the program	12. Consider as earned income.

{Effective 02/23/04}

2-002 Payments for Assistance: Money payments are made in behalf of a ward to the foster parent(s), group home, or child caring agency in which the ward resides; payment may be made to the ward if s/he is living independently. Only the ward is included in the standard of need. The standard filing unit does not apply to foster care cases.

With the exception of bedholding, a child must not receive foster care assistance in two foster care facilities for the same period of time.

2-002.01 Payment According to Living Arrangement

2-002.01A Foster Home and Adoptive Home Payments

2-002.01A1 Traditional Foster Home: When the child is placed in a Traditional Foster Home or an adoptive home (prior to finalization of adoption), the payment is determined by using the Foster Care Payment Determination Checklist. A "Traditional Foster Home" is one that works directly with the Department and is paid directly by the Department rather than providing care under the umbrella of a child placing agency.

{Effective 02/23/04}

2-002.01A2 Agency Based Foster Home: When the child is placed in an Agency Based Foster Home, payment is made to the child placing agency rather than directly to the foster parent. Rate is established in the contract between the child placing agency and the Department and is based on the Department's standardized rate for this type of service. The rate includes recruitment, training, and support of the foster parent by the agency, as well as maintenance related payments for the child. Payment to the foster parent is made by the child placing agency.

{Effective 02/23/04}

2-002.01B Group Home and Emergency Shelter Payments: Rate of payment for these living arrangements is determined in the contract between the contractor and the Department. Any payments in addition to the per diem are made only as stated in the contract. For example, a contract might include allowance for payment of mileage beyond a given number of miles, or might allow for authorization of an initial clothing purchase when the child enters the placement. Before making payments beyond the contracted per diem, the eligibility worker should check the contract to determine if the payment is allowable under the contract.

If a facility does not have a contract with the Department, the rate will be established by Office of Protection and Safety, Central Office, and entered on the N-FOCUS system.

{Effective 02/23/04}

2-002.01C Placement in Home of Relative: When a child is placed in the home of a relative who is not financially responsible for the child, the relative, whether licensed or approved, must be given the choice of payment as a foster parent or of applying for ADC-Relative Payee. The worker must explain the choices to the relative foster parent and allow the relative foster parent to make the decision. If the relative foster parent chooses the foster care payment, the rate is determined just as it would be for any other foster or adoptive parent. In most situations, the foster care payment will be a larger amount than if the relative foster parent chose to apply for ADC-Relative Payee.

When the placement is out of state, and the child is not IV-E eligible, the relative foster parent will have to determine if it is more beneficial to accept that state's ADC-Relative Payee payment, which also entitles the child to that state's Medicaid program, or to continue to receive a foster care payment from Nebraska and have to locate providers who will accept the Nebraska Medicaid card. In either case, the related foster parent has the right to make the choice.

{Effective 7/11/09}

2-002.01D Placement in Home of a Parent(s): A ward can live with his or her legal or putative parent either because no removal has occurred or because the family has been reunified. No payment can be made to the parent for the child's care. The parent can apply for any assistance that would be available to the public, e.g., ADC or child care. If the worker authorizes payment for any services for the parent or child (with the exception of Medicaid), payment must be made from the Service Area's flexible funding allocation. See 479 NAC 4-007.02A for the ward's medical eligibility.

When a child is placed with a parent whose rights have been terminated, that parent is considered to be a foster parent, and 479 NAC 2-002.01A is applicable. In these instances, payment cannot be claimed from IV-E funds.

{Effective 02/23/04}

2-002.01E Jails and Locked Detention Centers: Payment for an HHS-OJS ward for placement in a detention facility always is made by the Office of Protection and Safety, Central Office. Payment for HHS wards (those who are not HHS-OJS) is made by the eligibility worker, at the rate established by Office of Protection and Safety, Central Office. When a ward has both adjudications, the most current adjudication resulting in the detention determines whether the bill is paid by the eligibility worker or the Office of Protection and Safety, Central Office.

{Effective 02/23/04}

2-002.01F Independent Living: A payment may be made to or on behalf of a ward of HHS or HHS-OJS who is preparing for an independent living situation based on the written plan developed by the protection and safety worker. The payment maximum is the basic payment for a child age 12 or older (see 479-000-206). Normally payment is made to the ward; however, the service plan may specify that a portion of the payment is paid to a landlord. If a deposit is required for rent, the youth's guardianship account is used first if available.

The ward is allowed a $90 work allowance from any earned income. With the exception of disregarded income listed in 479 NAC 2-001.11A4, all earned and any unearned income must be used to meet the ward's needs. The following expenses are considered in determining payment:

{Effective 02/23/04}

1. Clothing;
2. Housing;
3. Transportation;
4. Food;
5. Savings;
6. Educational needs; and
7. Personal needs.

2-002.01F1 Rent Payment: With supervisory approval, the worker may authorize a one-time vendor payment for a rent deposit and/or one month's rent for a Department ward who is preparing for independent living. The rent deposit must not exceed $210.

2-002.01F2 Living in a Dormitory: If a Department ward is going to school and living in a dormitory, the Department pays the dorm fees, including a deposit, either directly to the school or as reimbursement to the ward. The ward may receive a grant of $100 maximum for his/her other needs, including meals that are not provided by the dorm. To determine the grant amount, the worker shows shelter and food costs as expenses and the monthly amount for dorm fees as unearned income.

2-002.01G Alternate Living Arrangements

2-002.01G1 Developmental Disabilities Services: Payment for services provided by Developmental Disabilities providers is based upon rates and service authorizations established by HHS's Developmental Disabilities System (see 479-000-329 for procedures).

{Effective 6/8/98}

2-002.01G2 Medical Settings:

2-002.01G2a Hospital: When a ward is receiving treatment in a hospital and the child is eligible for Medicaid or Medicaid Managed Care, the payment is made by Medicaid or Medicaid Managed Care. When the child is not Medicaid eligible, or payment must be made from child welfare funds, payment is made at the Medicaid rate, by State Ward Medical.

The worker may authorize payment for incidentals for the ward on an "as needed" basis. Incidentals include (but are not limited to) recreation, snacks, hair care items, haircuts, or clothing. The Medicaid or Mental Health Managed Care rate includes basic health items such as toothpaste, soap, deodorant, female hygiene items, and shampoo. Therefore, basic health items are to be supplied to the ward by the facility; payment cannot be made from child welfare funds.

{Effective 02/23/04}

2-002.01G2b Residential Treatment Center (RTC): When a ward is receiving treatment in an RTC and the ward is eligible for Medicaid or Medicaid Managed Care, the payment is made by Medicaid or Medicaid Managed Care. When the child is not Medicaid eligible, or RTC care has been approved due to the need for structure rather than medical treatment (lack of medical necessity), payment is made at the Medicaid rate, by State Ward Medical. When the child is IV-E eligible, IV-E funds can be used to pay for the portion of the rate which is related to maintenance and supervision. The portion which usually would be considered treatment is paid from non-IV-E funds.

The worker may authorize payment for incidentals for the ward on an as needed basis. Incidentals include (but are not limited to) recreation, snacks, hair care items, makeup, haircuts, or clothing. The Medicaid or Medicaid Managed Care rate includes basic health items such as toothpaste, soap, deodorant, female hygiene items, and shampoo. Therefore, basic health items are to be supplied to the ward by the facility. Payment cannot be made from child welfare funds.

{Effective 02/23/04}

2-002.01G2c Treatment Group Home or Enhanced Treatment Group Home: When a ward is receiving treatment in a Treatment Group Home or Enhanced Treatment Group Home and the ward is eligible for Medicaid or Medicaid Managed Care, the payment is made by Medicaid or Medicaid Managed Care. When a child is not Medicaid eligible or the Treatment Group Home or Enhanced Treatment Group Home has been approved for reasons other than medical necessity, payment is made at the Medicaid rate, by State Ward Medical. When the child is IV-E eligible, IV-E funds can be used to pay the Department's usual group home rate. The remainder of the payment must be made from non-IV-E funds.

Basic health care items and incidentals are expected to be provided by the facility and cannot be paid from child welfare funds.

{Effective 02/23/04}

2-002.01G2d Treatment Foster Care: When a ward is receiving treatment in a Treatment Foster Home and the child is eligible for Medicaid or Medicaid Managed Care, the payment is made from two separate funding sources. Medicaid or Medicaid Managed Care makes payment for the treatment portion of care. In addition, payment is made for the child's maintenance at the lowest FCPAY need level for that child's age. This maintenance payment source is either IV-E or non-IV-E, whichever is appropriate.

Basic health care items, incidentals, recreation, and clothing are expected to be provided as part of maintenance. Authorization for payment for any additional items generally covered in the basic maintenance payment is possible only if it is allowed under the guidelines for payments for foster care.

{Effective 02/23/04}

2-002.01H Temporary Situations

2-002.01H1 Runaways: When a ward is determined a runaway, the worker changes the address on the system to the local office where the worker is located. The worker closes the grant case but may leave the Social Service Block Grant case open for 90 days. At the end of the 90 days if the ward has not returned, the eligibility worker reviews the case and, after conferring with the protection and safety worker, determines if the medical assistance case should be closed. If bedholding is approved, see 479 NAC 2-002.01H2.

2-002.01H2 Bedholding

2-002.01H2a Authorization of a Bedhold: A bedholding fee may be authorized only when:

1. There is a written plan for the child to return to the placement;
2. The worker has authorized the bedhold; and
3. The provider has agreed to accept the child back into the placement.

{Effective 02/23/04}

2-002.01H2b Bedholds in Contracted Placements: Any bedhold in a facility or program with which the Department has a contract must be authorized within the parameters of the contract.

{Effective 02/23/04}

2-002.01H2c Bedholds in Non-Contracted Placements: Bedholds in facilities, programs, or placements not controlled by a contract and in traditional foster care are limited to five days, at a rate no greater than the rate for the ongoing placement.

Exception: When a ward is placed in a Developmental Disabilities program and payment is being made from Child Welfare funds, the Developmental Disabilities guidelines for approval of and payment for absences from the program must be used.

{Effective 02/23/04}

2-002.01H3 Law Enforcement Pickup: Payment may be made for a law enforcement pickup for 48 hours only. After 48 hours, the child must be returned to his/her home unless the court orders continued placement or the responsible parent or guardian has signed a voluntary placement or relinquishment.

2-002.02 Minor Parent: If a Department ward (including a ward of HHS-OJS) who is receiving a foster care grant has a child (including an unborn) who is living with the ward in a foster home, group home, or child caring institution, the child is not eligible for ADC but may receive a foster care grant. The unborn is eligible for a grant beginning with the first day of the mother's third trimester of pregnancy. The ward and each child are separate units, but the ward may be the payee for his/her child(ren). If the ward is pregnant, the maximum payment she can receive for her unborn is the basic FCPAY amount for a child age 0 to 5 (see 479-000-206). After the child is born, the child's payment is determined by FCPAY. It is the ward's responsibility to pay the foster home, group home, or child caring institution.

If the ward loses his/her eligibility for a foster care grant or the ward and his/her child are separated, the child is no longer eligible for a foster care grant. The worker must determine if the child is eligible for another program, e.g., ADC, or Children's Medical Assistance.

This provision does not apply to wards who are living independently. If a ward is living independently with his/her child, the worker determines the child's eligibility for ADC or Children's Medical Assistance. The child's eligibility for payment is determined separately from the ward's eligibility. It also does not apply to a ward who is placed in the home of a specified relative who is receiving ADC for the ward. In this situation, the ward's child is included in the ADC unit.

{Effective 6/8/98}

2-002.02A Application for the Child: The worker obtains eligibility information for the ward's child. The worker completes a separate budget for the child, using only the child's income. If the ward receives child support for his/her child, the child support is considered in the child's budget.

{Effective 6/8/98}

2-002.02B SSN Application for a Newborn: If Enumeration at Birth was not done as verified by a Vital Statistics Alert, the worker refers the parent or payee to the Social Security office via a Referral for Social Security Number Application by the first day of the second month following the mother's discharge from the hospital after the birth. If the child is not born in a hospital, a Referral for Social Security Number Application must be completed by the first day of the second month following the birth regardless of where the child is born.

2-002.02C Protective Payee: If a ward is the payee for his/her child and the worker documents that the assistance is being mismanaged and is not being used in the best interests of the child, the worker may temporarily assign a protective payee. See 468 NAC 3-008.04 ff. for regulations regarding protective payees.

2-002.03 Amount of Maintenance Payment: The amount of the maintenance payment is determined using the FCPAY system.

The foster family payment amount includes all usual costs of maintaining a child and carrying out activities that are within the realm of ordinary parental duties, including but not limited to:

1. Board and room;
2. Personal needs, including recreation and activities;
3. School needs, including school trips and graduation expenses;
4. Transportation up to 100 miles a month (for transportation not covered in the maintenance payment see 479 NAC 2-002.03E);
5. Clothing (for clothing not covered in the maintenance payment see 479 NAC 2-002.03F); and
6. Allowance.

If additional assistance is needed with any of these expenses, the worker should explore resources such as the legal parents, the child's guardianship account, or Nebraska Friends of Foster Children Foundation, Inc.

See 479-000-206 for FCPAY amounts.

{Effective 02/23/04}

2-002.03A Definitions of Payments:

Grandfathered Payment: These are monthly maintenance payments which were approved before February 1, 1998. These payments will not be reduced as long as the foster child remains with the foster parent(s) for whom the payment was approved. The monthly ma intenance payment may be increased if the Total Payment as calculated on the FCPAY system is higher than the grandfathered payment. If the foster child changes placement (for example, moves to another foster family), the grandfathered payment will no longer be applicable.

Time-Limited Payment: When a payment is designated for a specific period of time, it should be identified as time limited on FCPAY.

{Effective 6/8/98}

2-002.03B Age Change: Payments are increased on the first day of the month of the child's birthday when a child moves from one age level to another, unless the child has a grandfathered payment.

{Effective 6/8/98}

2-002.03C (Reserved)

2-002.03D Child Care: Child care may be approved under the following guidelines:

1. Child care may be authorized for the hours when the foster parent(s) works or attends school. In two-parent foster families, both foster parents must work outside the home or attend school during the hours for which child care is provided. Child care may be authorized during the working hours or school hours (to include reasonable travel time) of the foster parent(s). Child care cannot be authorized for foster parents who provide child care services in their home. (Child care for this purpose is IV-E reimbursable.)
2. Child care may be approved for brief periods of time, consisting of a few hours, to provide supervision for a ward when the foster parent must be absent in order to meet the needs of another ward in his/her care (for example, foster parent is attending a team meeting or court review) and:
   a. The other foster parent is employed and at work at that time; and
   b. The child needing supervision cannot accompany the foster parent.
3. Pre-school child care may be provided for the purpose of improving socialization skills. (Child care for this purpose is not IV-E reimbursable.)

Except in exceptional circumstances, payment for child care is made directly to the child care provider based on child care subsidy regulations (see Title 392). The provider must be licensed or approved.

In an exception to child care subsidy regulations, if the provider charges private pay families based on enrollment rather than attendance, the Department will pay for enrollment.

{Effective 02/23/04}

2-002.03D1 Reimbursement to Foster Parent: In exceptional circumstances, the worker may approve a payment to the foster family on a one-time basis. If the foster parent must be reimbursed for child care, a billing or receipt must accompany the request for payment. The foster parent may be reimbursed for payment of child care if:

1. The foster parent(s) paid for child care during this time;
2. The rate is within the child care subsidy maximums and meets the need for child care as outlined in 479 NAC 2-002.03G2; and
3. The care was provided.

{Effective 6/8/98}

2-002.03E Transportation: The foster parents may provide transportation themselves or purchase transportation from a provider.
Note: Transportation provided or purchased by a foster parent is exempt from Public Service Commission certification requirements.

Transportation is a reimbursable IV-E expense only when it is for purposes of visitation with a parent, siblings, other relative, or other caretaker. Other transportation that is allowable but is presumed to be included in the basic foster care maintenance payment includes:

1. Transportation of a child to and from child care;
2. Transportation of a child for extracurricular activities that substitute for daily supervision; or
3. Transportation of a child for sports and cultural events.

Transportation for preplacement visits with a prospective adoptive parent is not allowable as a IV-E expense.

{Effective 02/23/04}

2-002.03E1 Provided by Foster Parent: One hundred miles of transportation is presumed to be included in the monthly rate.

If the foster parent(s) requests reimbursement for transportation beyond 100 miles a month, s/he should estimate the number of miles regularly traveled for services for the child as listed in the case plan. The estimate of miles and purpose for the transportation must be documented in the case file.

The foster parent(s) may receive monthly reimbursement at the Department-established rate for each increment of 50 miles over the initial 100 miles. The estimate must be rounded to the next highest 50 miles. The estimate of miles should be in the plan for transportation in the case file. The transportation must meet the following guidelines:

1. The foster parent(s) would not be doing the driving if the child were not there, i.e., s/he would not be taking his/her birth child to the same location or driving himself/herself;
2. If more than one foster child is being transported, the transportation payment is divided evenly between the children; and
3. The transportation need is documented in the case file on the services documentation form.

The worker should discuss the transportation expectations with the foster parent(s) and determine the number of approximate miles the foster parent(s) travels for each child in the home and the purpose of the travel.

{Effective 02/23/04}

2-002.03E2 Purchased by the Foster Parent(s): The foster parent(s) may be reimbursed if s/he pays transportation providers more than $21 a month. The foster parent(s) may be reimbursed when a transportation need dictates the use of public or specialized transportation such as a taxi, bus, or a handicapped accessible van or bus. The following should be documented in the case file:

1. The child's handicapping condition;
2. The fact that the foster family's vehicle will not accommodate the child's handicap or that both foster parents are unable to provide transportation and cannot find someone to do it.

Reimbursement must be actual costs with receipts or verification through the transportation plan prepared with the protection and safety worker and be consistent with the child's needs and services in the case plan.

If the child's unique transportation needs exceed 100 miles or $21 on a monthly basis, the amount within the guidelines may be added to the monthly payment. The child's unique transportation needs should be clearly documented in the case file. This includes an estimate of miles and frequency of trips needed in order to provide the services for the child in the case plan. If it causes a hardship for the foster family to make payment above $21 a month for a taxi, van, or bus, the worker may issue an advance payment.

{Effective 9/20/95}

2-002.03E3 Purchased by the Department: The worker may approve purchased transportation or escort services for:

1. Visits with or return to parents;
2. Placement of child;
3. Therapy or special medical care;
4. Return of child from runaway; or
5. Ongoing preplacement visits with parents, foster parents, relatives, or pre-adoptive family.

This transportation includes public transportation such as taxis, bus, train or plane or private providers. The worker must use the least expensive form of transportation that is appropriate for the child.

The worker must explore funds in the child's guardianship account and other potential funding source such as relatives or community organizations before payment is authorized.

For Public Service Commission certification requirements for transportation providers, see 479-000-317. If the child requires an escort to the service, see 474 NAC 5-011.10D1.

{Effective 9/20/95}

2-002.03E3 Department Authorized Public or Contracted Transportation

2-002.03E3a Introduction: The guidelines in this section provide direction for:

1. The authorization and provision of Transportation Service for Families; and
2. The evaluation and approval of transportation providers, including individual providers as authorized by Neb. Rev. Stat. § 75-303.03.

2-002.03E3b Transportation Definitions: For the purposes of these regulations the following definitions will apply to 479 NAC 2-002.03E3 and 2-002.03E4.

Common Carrier means any person who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).

Department means the Department of Health and Human Services. (DHHS) as established by the Health and Human Services Act (Laws 2007, LB296).

Department staff means employees of the Department of Health and Human Services or contractors of the Department of Health and Human Services assigned those responsibilities.

Escort Service means an attendant or caregiver accompanying a minor or person(s) who are physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision.

Exempt Provider means carriers exempted from Public Service Commission (PSC) licensure by law including those that:

1. Transport for hire persons who are aged and their spouses and dependents under a contract with a municipality or county;
2. Are owned and operated by a non-profit organization that has been exempted from the payment of federal income taxes as provided by Section 501(c) 4, Internal Revenue Code and transporting solely those persons over age 60, their spouses and dependents, and/or persons experiencing disabilities;
3. Are operated by a municipality or county as authorized by law in the transportation of persons who are aged;
4. Are operated by a governmental subdivision or a qualified public purpose organization having motor vehicles with a seating capacity of 20 or less and are engaged in the transportation of passengers in the state;
5. Are engaged in the transportation of passengers and are operated by a transit authority created under and acting pursuant to the laws of the State of Nebraska; and
6. Provide escort services under contract with the Department of Health and Human Services or with any agency under the Nebraska Community Aging Services Act.

Individual Provider means a person who is not in the business of providing transportation for hire; for example, a friend, neighbor, or non-legally responsible relative.

Medical Escort means an attendant or caregiver accompanying a minor or persons who are physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision to receive a Nebraska Medicaid coverable service.

Nebraska Medicaid Coverable Services means a medical service that could be covered by Nebraska Medical Assistance Program (NMAP) as specified in Nebraska Administrative Code (NAC) Title 471 (see 479-000-XXX).

Public or Contracted Transportation means public transportation such as a taxi, bus, train, or plane.

Tariff means the geographic and rate parameters of operation assigned to a particular carrier by the Public Service Commission.

2-002.03E3c Clients Served

2-002.03E3c(1) Eligibility: Department staff may authorize public or contracted transportation for clients who are:

1. State wards;
2. Custodial parents;
3. Non-custodial parents;
4. Relatives;
5. Foster families; and
6. Pre-adoptive families.

2-002.03E3d Transportation Service Need: Department staff must determine a client haws the need for transportation services. Transportation services are not provided based on the demand of the client. Need for a service implies that the provision of that service will assist the client in achieving program goals, the case plan and/or the safety/case plan. Eligible clients must:

1. Have no access to a working licensed vehicle or a valid driver's license;
2. Be unable to drive due to physical or cognitive limitation;
3. Be unable to secure transportation from relatives, friends or other organizations at no cost;
4. Require transportation in relationship to a defined area of need (see 479 NAC 2-002.03E3e);
5. Have a current safety plan or case plan; or
6. Accept the current safety plan or case plan.

2-002.03E3e Reasons the Department Authorizes Public or Contracted Transportation: The worker may authorize public or contracted transportation to:

1. Enable a family member or caregiver to visit a hospitalized child who is included in the family unit or in foster care;
2. Visit with either the custodial or non-custodial parent;
3. Place a child;
4. Attend therapy or special medical care;
5. Return a child from runaway;
6. Participate in ongoing pre-placement visits with parents, foster parents, relatives or a pre-adoptive family;
7. Allow a state ward and his/her parent or caregiver placed out-of-state to attend court hearings for the purpose of meeting their permanency plan; or
9. Allow a youth, parent, or foster parent to access services related to meeting goals established in the safety and/or case plan.

2-002.03E3f Worker Responsibility: Before authorizing public or contracted transportation as defined in 479 NAC 2-002.03E3b, the worker must explore funds in the child's guardianship or excess child support accounts and any other potential funding sources such as relatives, community organizations, flexible funding, private insurance, Medicaid, Medicare, or Employment First (for EF see 468 NAC 2-002.02). The worker must use the least expensive form of transportation that is appropriate for the client.

2-002.03E3g Public Service Commission Certification Requirements: The Public Service Commission certifies common carriers (see 479-000-317 for PSC requirements) Taxis and van companies are certified by the PSC as common carriers. Staff must:

1. Verify that the carrier is certified by the Public Service Commission;
2. Request and receive a copy of the carrier's tariff; and
3. Verify that the carrier has a special Department designation.

Transportation provided by child care providers, family support providers, and foster parents is exempt from Public Service Commission (PSC) certification requirements since it is incidental to the service provided.

2-002.03E3h Authorization of Escort Services: If the child requires escort services, see 474 NAC 5-018.

2-002.03E4 Private Transportation Providers and Services Requested by the Child or Family

2-002.03E4a Transportation Services for Families: Transportation service is a means of transporting eligible clients to and from allowable community resources when the client has no other transportation. The client must actually be in the vehicle for a trip or mile to be considered a transportation service unit. Transportation services may be provided by an individual, exempt provider, or by common carriers.

2-002.03E4a(1) Introduction: The guidelines contained in this section provide directions for:

1. The authorization and provision of Transportation Service for Families; and
2. The evaluation and approval of transportation providers, including individual providers as authorized by Neb. Rev. Stat. § 75-303.03.

2-002.03E4a(1)(a) Outcomes: Department staff must select one of the following outcomes in order to authorize transportation services:

1. Client is able to experience the optimal level of health, safety, and independence in a healthy and safe home environment;
2. Client is able to receive ongoing support from unpaid caregivers; or
3. Client's risk of abuse, neglect, and/or exploitation is prevented, reduced, or eliminated.

2-002.03E4b Transportation Definitions: For purposes of these regulations see 479 NAC 2-002.03E3b.

2-002.03E4c Clients Served

2-002.03E4c(1) Eligibility: Local staff may authorize transportation services under 479 NAC 2-002.03E4 for clients who are:

1. State wards;
2. Non-state wards in an investigation or voluntary case only;
3. Custodial parents;
4. Non-custodial parents;
5. Relatives; and
6. Pre-adoptive families.

2-002.03E4d Transportation Need for Service: Department staff must determine a client has the need for transportation services. Transportation services are not provided based on the demand of the client. Need for service implies that the provision of that service will assist the client in achieving program outcomes. Eligible clients must:

1. Be unable to provide needed transportation (i.e. have no access to a licensed working vehicle or be unable to drive);
2. Be unable to secure transportation by a family member, relative, friend, organization, or agency (other than the Department) at no cost;
3. Require transportation in relation to a defined area of need (see 479 NAC 2-002.03E4f);
4. Have a current safety plan or case plan; and
5. Accept the authorized case plan.

2-002.03E4d(1) Medicaid Managed Care Enrollees: If the client is enrolled in one of the Medicaid Managed Care HMO plans, the HMO is responsible for authorizing transportation for the client's medical services and Department staff must not authorize medical transportation. Exception: Department staff may authorize transportation for adult day care or mental health day rehab services and for dental-related appointments and pharmacy services under Medical Transportation codes. Staff may authorize non-medical transportation for Medicaid Managed Care enrollees if the client meets the program guidelines. If the client is enrolled in one of the Medicaid Managed Care "Primary Care" plans then the responsibility for transportation authorizations remain with Department worker.

2-002.03E4d(2) Medicaid Mental Health Managed Care Enrollees: If the client is enrolled in the Medicaid Mental Health/Substance Abuse Managed Care Plan, the Mental Health/Substance Abuse Plan is responsible for authorizing transportation for mental health/substance abuse services and Department staff must not authorize mental health or substance abuse related transportation. Exception: Department staff may authorize transportation for adult day care or mental health day rehab services, and for other medical appointments under Medical Transportation codes, unless the client is enrolled in the Medicaid Managed Care HMO Program. Staff may authorize non-medical transportation for Medicaid Mental Health Managed Care enrollees if the client meets the program guidelines.

2-002.03E4d(3) Residents of Nursing Facilities or ICF/MR's: Residents of nursing facilities or ICF/MR's are not eligible to receive transportation through the Child Welfare Program, except discharge transportation. All other transportation is the responsibility of the nursing facility or ICF/MR. Transportation, including moving the client's household goods or personal property, may not be authorized for these clients.

2-002.03E4e Reserved

2-002.03E4f Defined Areas of Transportation Need: Staff may authorize transportation for families only to meet client needs in the following areas. Transportation/Escort Service for Families means service which enables:

1. Children to travel to:
   a. Child care;
   b. Health-related treatment or care; or
   c. Department or other community resource to receive services as a part of a child protective services safety plan and/or case plan; and
2. Parents or usual caregivers to travel to:
   a. Health services;
   b. Department or a community resource to receive services as a part of a child protective services safety plan and/or case plan; or
   c. Visit a hospitalized child included in the family unit or in foster care; and
3. Biological parents or usual caregivers with children in foster care to receive services directed toward returning the child home.

2-002.03E4f(1) Child Protective Services Transportation: Transportation may be authorized as part of a child protective services safety plan and/or case plan.

2-002.03E4f(2) Child Care Transportation: The worker may only authorize transportation under the following circumstances:

1. The child care is necessary for any of the reasons listed in 392 NAC 3-007.01 and 474 NAC 5-011.02;
2. Transportation costs are not included in the total child care rates (for guidelines see 392 NAC 4-003.05); and
3. The child care is licensed or license-exempt.

2-002.03E4f(3) State Ward and Foster Care Transportation: The worker may authorize transportation to allow biological parent(s) or usual caregivers with a child who is a Department ward to receive services directed toward the return of the child to the home or the maintenance of the child in the home. For authorized public or contracted transportation for foster care see 479 NAC 2-002.03E3.

2-002.03E4f(4) Medical Transportation or Escort: The worker may authorize transportation or escort to enable the eligible child to receive a Nebraska Medicaid-coverable service. This includes transportation for a child to receive services identified through HEALTH CHECK. For Medicaid-coverable services see 474-000-503.

2-002.03E4f(5) Transportation for Visit: The worker may authorize transportation or escort to enable a family member or caregiver to visit a hospitalized child who is included in the family unit or in foster care as specified in 479 NAC 2-002.03E3e.

2-002.03E4g Transportation Services Provider Standards: Department contracts annually with common carriers, exempt providers, escort providers, and individual providers. Providers must meet all general provider standards in addition to the service specific standards.

2-002.03E4g(1) Common Carrier Standards: The Public Service Commission certifies common carriers. Taxis and van companies are certified by the PSC as common carriers. Department staff must:

1. Verify that the carrier is certified by the Public Service Commission;
2. Request and receive a copy of the carriers tariff; and
3. Verify that the carrier has a special Department designation.

Transportation provided by child care providers, family support providers, and foster parents is exempt from PSC certification requirements since it is incidental to the service provided.

2-002.03E4g(2) Exempt Provider Standards: Exempt providers must ensure that their employees meet the individual provider standards in 479 NAC 2-002.03E4g(3).

2-002.03E4g(3) Individual Provider Standards: Department staff is authorized to contract with individual providers under Neb. Rev. Stat. § 75-303.03 only if the following driver and vehicle standards are met at all times when the individual is providing transportation for a client.

2-002.03E4g(3)(a) Driver Standards: The individual provider must:

1. Have been chosen by the client or the usual caregiver to provide transportation;
2. Be age 19 or older;
3. Possess a current and valid driver's license;
4. Have no more than three points assessed against his/her Nebraska driver's license, or meet a comparable standard in the state where s/he is licensed to drive;
5. Currently have no limitations that would interfere with safe driving;
6. Personally drive his/her own vehicle to transport the client;
7. Use seat belts and child passenger restraint devices as required by law;
8. Not smoke while transporting the client;
9. Not transport the client while under the influence of alcohol or any drug that impairs the ability to drive safely;
10. Not provide transportation if s/he has a communicable disease which may pose a threat to the health and well-being of the client;
11. Have and maintain the minimum automobile liability and medical insurance coverage as required by law; and
12. Report disqualification from any Department program for intentional program violations.

2-002.03E4g(3)(b) Vehicle Standards: The individual provider's vehicle must be:

1. Currently licensed and registered as required by law;
2. Kept at all times in proper physical and mechanical conditions;
3. Equipped with operable seat belts, turn signals, lights, and horn;
4. Equipped with proper child passenger restraint devices as required by law when transporting children; and
5. Equipped to provide comfortable temperature and ventilation conditions.

2-002.03E4g(3)(c) Registry Checks and Criminal Background Checks: Department staff or designee must complete and document registry checks and criminal background checks on each potential individual provider.

2-002.03E4g(3)(c)(1) Registry Checks: Department staff must check:

1. Adult Protective Services Central Registry;
2. Central Register of Child Protection Cases; and
3. The Nebraska State Patrol Sex Offender Registry.

If the potential provider does not reside in Nebraska or has resided in Nebraska for less than one year, Department staff must check registries in the state of residence or previous residence, if possible.

2-002.03E4g(3)(c)(2) Department staff must not contract with a potential individual provider if a report of abuse or neglect concerning the individual provider has been determined to be "Court Substantiated" or "Department Substantiated on the APS Central Registry or "Court Substantiated", "Court Pending" or "Inconclusive" on the Central Register of Child Protection Cases.

2-002.03E4g(3)(c)(3) Department staff must not contract with a potential individual provider if the individual's name appears on the Nebraska State Patrol Sex Offender Registry.

2-002.03E4g(3)(c)(4) Criminal Background Checks: Department staff must:

1. Obtain a criminal history statement from the potential individual provider; and
2. Perform a criminal history check of the potential individual provider.

2-002.03E4g(3)(c)(5) General Criminal History : Department staff must not contract with a potential individual provider if a history of convictions for misdemeanor or felony actions that endanger the health and safety of any client is indicated. This includes crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, crimes involving moral turpitude on the part of the potential provider, or any major traffic violations.

2-002.03E4g(3)(c)(6) Specific Criminal History: Department staff must deny or terminate service provider approval when conviction has occurred in the following areas:

1. Child pornography;
2. Child or adult abuse;
3. Driving under the influence: a DUI conviction within the past eight years;
4. Domestic assault;
5. Shoplifting after age 19 and within the last three years;

6. Felony fraud within the last 10 years;
7. Misdemeanor fraud within the last five years;
8. Termination of provider status for cause from any HHS program within the last 10 years;
9. Possession of any controlled substance within the last five years;
10. Possession of a controlled substance with intent to deliver within the last 10 years;
11. Felony or misdemeanor assault without a weapon in the last 10 years;
12. Felony or misdemeanor assault with a weapon in the last 15 years;
13. Prostitution or solicitation or prostitution within the last five years;
14. Felony or misdemeanor robbery or burglary within the last 10 years;
15. Rape or sexual assault; or
16. Homicide.

Pending charges must be reviewed by Department to determine whether the client's safety is in jeopardy. Other convictions must be considered using the guidance in 479 NAC 2-002.03E4g(3)(c)(5) and weighted to similar offenses included in this list.

2-002.03E4g(3)(d) Individual Provider Approval Process: Department staff must obtain a copy of the individual's current driver's license, insurance card, and vehicle registration. The provider must complete and sign the provider self-certification and the provider agreement. In addition to having no more than three points assessed against his/her driver's license, each provider's past eight year driving history must be considered. If a license has been suspended or revoked, the provider must not be approved for eight years from the date of suspension or revocation.

2-002.03E4g(3)(d)(1) Renewal: The provider self-certification and the provider agreement must be renewed annually. The registry checks and criminal history checks required under 479 NAC 2-002.03E4g(3)(c) must be completed for each renewal. Department staff must obtain a copy of the individual's current driver's license, insurance card, and vehicle registration. Department staff must not renew any contract with a provider whose name appears on the registries or whose criminal history check indicates a history of any convictions as specified in 479 NAC 2-002.03E4g(3)(c).

2-002.03E4g(3)(d)(2) Termination: Department staff must terminate the provider agreement if the individual provider is found to be in violation of any of the standards in 479 NAC 2-002.03E4g(3)(a) and (3)(b). Department staff must terminate any contract with a provider whose name appears on the registries or whose criminal history check indicates any convictions as specified in 479 NAC 2-002.03E4g(3)(c).

2-002.03E4h Authorization Procedures: Before authorizing Transportation/Escort Services, Department staff must explore with the client the use of family, neighbors, friends, or community agencies that will provide this service without charge whenever possible. Department staff must discuss types and options of providers with the client before authorizing transportation services. Department must assure the client is aware of the associated costs.

2-002.03E4h(1) Medical Transportation: Department staff must offer the client choice of providers for medical transportation/escort services.

2-002.03E4h(1)(a) Transportation for Out-of-State Medical Treatment: See 474 NAC 5-018.07B.

2-002.03E4h(2) Non-Medical Transportation: For areas where exempt providers are available or the client has chosen to use an individual provider, the client may only use a common carrier when the exempt provider or individual provider cannot provide the service.

2-002.03E4h(3) Authorization of Exempt Providers: Department staff may contract with and authorize services for a provider who is exempt from PSC licensure as appropriate to meet a client's needs. The availability of a common carrier does not limit the use of an exempt provider.

2-002.03E4h(4) Individual Providers: Department staff may authorize an individual provider if the following criteria are met:

1. The client has chosen the individual provider;
2. The individual will personally drive the vehicle; and
3. The individual meets provider standards as specified in 479 NAC 2-002.03E4g(3).

2-002.03E4i Transportation Services Rates, Frequency and Maximum Allowable Units

2-002.03E4i(1) Conditions for Payment: The Department will pay for transportation services only:

1. When the client is actually in the vehicle; and
2. Using the most direct and logical route from the client’s residence to the service location.

2-002.03E4i(2) Upper Limits: DHHS Central Office establishes transportation rates according to the following limits. Department staff assigned RD responsibilities may negotiate rates lower than the established rates.

2-002.03E4i(2)(a) Common Carriers: Neb. Rev. Stat. § 75-303.02 limits the distance rates for common carriers at a rate no greater than three times the state employee mileage rate. The maximum reimbursement rate does not apply when the carrier:

1. Transports the client wholly within the corporate limits of the city or village where the transportation of the client originated; or
2. Transports a disabled person as defined by the federal Americans with Disabilities Act of 1990 in a vehicle that is compliant with the regulations for the transportation of the disabled person.

2-002.03E4i(2)(b) Taxis: Taxi rates may be no greater than 95% of published rates.

2-002.03E4i(2)(c) Exempt Providers: DHHS Central Office will establish the rates for exempt providers.

2-002.03E4i(2)(d) Individual Providers: As provided by Neb. Rev. Stat. § 75-303-03, the Department of Health and Human Services will reimburse the individual provider for costs incurred in transportation at a rate no greater than that paid for reimbursement of state employees under Neb. Rev. Stat. § 81-1176 only for mileage.

2-002.03E4i(3) Frequency: The frequency for medical and non-medical transportation is by miles or trip. Department staff must authorize time and miles traveled separately.

2-002.03E4i(4) Maximum Allowable Units: Department staff must authorize transportation units based on client need not to exceed the following limits:

1. Non-medical Transportation:
   a. 500 miles per one way trip;
   b. To and from child care; and
   c. To and from community services based on child protective services safety plan and/or case plan; or
2. Medical Transportation: Based on needed treatment and care.

2-002.03E4j Transportation Forms and Instructions: In addition to forms for General Provider Approval MC9-LTC and MILTC-1700, Provider Self Certification Checklist, the worker must use forms required by the Public Service Commission for exempt providers.

2-002.03F Clothing Allowance

2-002.03F1 Initial Clothing Purchases: The child entering out-of-home care may need clothing. A maximum of $200 may be used to purchase clothing over a maximum period of six months after the child comes into care. This authorization is based on the individual needs of the child who is entering foster care or group home care and is not automatically authorized for all wards. A ward is eligible for the initial clothing allowance based on his/her needs each time s/he is placed out of his/her family home.

The case manager must provide documentation to the eligibility worker. The worker may authorize an initial clothing expenditure within these guidelines. A child in a group home may receive clothing under these guidelines.

If the ward has a guardianship account with the Department, the funds may be used to purchase additional clothing.

{Effective 02/23/04}

2-002.03F2 Special Clothing Allowance: The child may receive a special clothing allowance up to $200. This may be authorized for clothing required because of:

1. The child's sudden weight loss or gain not associated with normal growth;
2. The child's loss of clothing due to being AWOL. The care provider and worker will assess the child's needs upon his/her return;
3. The child's placement in a facility where clothing replacement is not in the contract or where it is not part of the expected care, such as hospitals;
4. The child's move from one foster home to another or into a group home if documented why the previous foster parent did not purchase or send clothing. Documentation must include that appropriate action was taken by Resource Development or other staff regarding the foster family's failure to purchase or send clothing; or
5. The child's clothing has been destroyed in a disaster such as a fire or flood or by vandalism.

This special clothing allowance may be authorized once in 12 months and only if the worker documents that one of these situations exists. A child in a group home may receive clothing under these guidelines. It may be authorized even if an initial clothing purchase was provided within the same 12 months. Authorization of clothing purchases due to seasonal changes or because a school year is starting is not allowed.

{Effective 02/23/04}

2-002.03G (Reserved)

2-002.03H Other Needs

2-002.03H1 Driver's Education Classes: The worker may approve costs of Driver's Education classes if:

1. The school does not provide Driver's Education free of charge for other students and the fee is the same as for other students;
2. The legal parents have been asked and cannot pay or only paid part of the cost; and
3. There is insufficient money in the ward's guardianship account and the ward is willing and able to attend and participate in every class session.

This payment of these classes is allowed only one time. Independent living grant funds may be used for these classes.

{Effective 02/23/04}

2-002.03H2 Summer School: For students not eligible for state ward education funds, the worker may approve the amount billed by the school within the following guidelines:

1. The school does not offer summer school free to others;
2. The child's need to attend is documented by the school;
3. The low income family rate will be paid, if the school has one; and
4. The child attended the summer school sessions as billed.

This payment may be entered on N-FOCUS as a one-time only payment.

{Effective 9/20/95}

2-002.03H3 Furniture: Furniture such as beds, dressers, tables, or chairs may be paid for under the following guidelines:

1. Furniture is needed in order for a provider to accept the placement, such as a sibling group being placed together; or
2. Adolescents moving into an independent living arrangement need furniture.

This is intended to provide minimum adequate furniture necessary to set up a household.

The worker, provider, or adolescent should explore donations, garage sales, or thrift stores. Payment for furniture must be based on the lowest of estimates for similar products from at least two stores. The furniture should go with the ward if the ward moves. In some cases this will not be possible so the furniture could remain with the provider for future placements, be given to another provider, or be sold with the money returning to the state, designated for the care of that child.

{Effective 9/20/95}

2-002.03J Checklist and Payment Review: The Foster Care Payment Determination Checklist and payment must be reviewed at the following times:

1. Every year, preferably in conjunction with the development and review of the case plan;
2. When a child moves to another foster family home;
3. When the child's needs have changed significantly; and
4. At foster parents' request. The foster parents may request a review at any time. If the worker disagrees, s/he will discuss the decision with the supervisor and either complete the checklist or notify the foster parents why the decision was made not to review the payment. If the foster parents disagree with the decision, they may complete the grievance procedures.

In all of the cases described in numbers 1 and 2, if the review indicates that the child changes from one level to another, the payment will change accordingly, either up or down. This does not include grandfathered payments unless the foster parents request that the checklist be completed.

{Effective 9/20/95}

2-002.03J1 Grievance Procedure for Checklist: The grievance procedures for foster parents when they disagree with the decision to complete the checklist or the accuracy of the checklist are as follows:

1. Discuss concerns and comments with the worker;
2. If there is disagreement, the foster parents will contact the worker's supervisor; and
3. If the issue is not resolved, the foster parents may contact the service area designee who will make the decision.

The worker will inform the foster parents of their right to grieve.

{Effective 9/20/95}

2-002.03K Contract Foster Family Care or Group Home Care: See 479 NAC 2-002.01A and 2-002.01B.

{Effective 02/23/04}

2-002.03L Child Placed in Home of Relative: See 479 NAC 2-002.01C.

{Effective 02/23/04}

2-002.03M Medicaid Waiver: When a ward is accepted for the Medicaid Waiver Program, the Department continues to pay the child's room and board and personal needs based on the rate the facility is licensed or certified for (see 479 NAC 2-002.01B and 2-002.01G). The Department retains custody of the ward and continues to be payee for any benefits that the ward receives, such as SSI.

2-002.04 Prorated Payment: Except for law enforcement pickups, voluntary placements, and voluntary relinquishments, the first month's payment is prorated from the date of court-ordered placement. Payment is prorated for ongoing cases if the child moves from one facility, foster home, or group home to another. For law enforcement pickups, payment is prorated from the date of the pickup. For voluntary placements and relinquishments, payment is prorated from the date of the agreement.

The prorated payment is determined by dividing the maintenance payment by the actual number of days in the month and multiplying by the number of days in placement. Payment is made for the date of placement but not for the date of removal. When there is a contract with a child caring agency that specifies a per diem rate, the per diem rate is used for prorating. For date of medical eligibility, see 479 NAC 4-004.

2-002.05 Revision of Budget and Payment: The worker revises the assistance budget at the time of review and whenever changes in the ward's income occur.

2-002.06 Incorrect Payments: The following regulations apply to incorrect payments made to foster parents and child caring agencies.

2-002.06A Underpayments: All underpayments must be corrected promptly.

2-002.06B Overpayments: The agency must take all reasonable steps necessary to promptly correct overpayments. Overpayments over $50 are recouped. Overpayments may be recouped from future payments for the same or different children.

{Effective 02/23/04}

2-002.07 Flexible Use of Child Welfare Funds: A specific amount of child welfare funds is available to each Service Area for purchase of goods or services that are expected to enhance safety, permanency, or wellbeing of the child. The process for approval to use these child welfare funds is determined by each Service Area. The funds can be used when:

1. The need for the goods or service is documented in the safety or case plan;
2. There is no other funding source available, including but not limited to the family's personal funds, other assistance programs, or other programs available to the community;
3. The expenditure is anticipated to enhance safety, permanency, or wellbeing of the child; and
4. The need for assistance from the Department for the payment is short term, either because the family anticipates having another funding source within a short period of time or the need itself is short term. Payment from this source is not appropriate when it is anticipated that making the payment could result in the need for continued involvement by Protection and Safety.

Payment can be made directly to the parent or child or to the service provider. When the service to be provided is medical, the Nebraska Medicaid or Managed Care rate will be paid.

The funds can be used for wards or their families or for children and their families when there is an open CPS case.

{Effective 02/23/04}

2-002.08 Funds From Other Sources

2-002.08A Guardianship Accounts: If a ward has a guardianship account that is deposited with the Department, special purchases may be made from the account. The worker completes Form PS-0866 and forwards it to Finance and Accounting, Central Office.

2-003 Case Records: The case record must be complete and must contain facts to substantiate each action with respect to assistance payments.

2-004 Fraud: See 465 NAC 2-007 ff.

2-005 Eligibility Review: An eligibility review for a grant is required every 12 months.

The worker reviews the information on Form IM-18FC. At the time of the review, the worker determines if deprivation exists based on the parent(s)' situation (see 479-000-327). All other elements of the review, including income and resources, are based on the ward's circumstances.

Note: If, after all applicable information is received, a case is determined ineligible for IV-E in the initial determination, it remains ineligible for IV-E until the case is closed with the following exceptions: If a case is ineligible for IV-E because of the living arrangement or if the living arrangement changes or reasonable efforts finding is obtained, the case may be changed to IV-E. A case may be changed from IV-E to non-IV-E if it no longer meets all of the requirements listed in 479 NAC 2-009.01A through 2-009.01D.

{Effective 02/23/04}

2-006 Discharge of a Ward: Before a ward age 18 or older is discharged, the worker must determine if s/he would be eligible for Extended Assistance for Former Department Wards, formerly known as The Former Ward Program.

2-006.01 Disbursement of Guardianship Funds: When a Department ward is discharged or adopted, funds that are held in the State Ward Guardianship Account are dispensed of as follows:

1. When the source of the funds is Social Security (SSI or RSDI), the funds are returned to the Social Security Administration.
2. When the source of the funds is not Social Security, the funds are given to:
   a. The ward if s/he has reached the age of majority;
   b. The ward's parent(s) if the ward is still a minor;
   c. The adoptive parent(s) if there has been an adoption; or
   d. A guardian or conservator if one has been appointed by the court.

{Effective 02/23/04}

2-007 Burial of a Ward: When payment by the Department is necessary for burial of a Department ward, the worker obtains the billing from the mortuary, verifies that the charge is consistent with the rate negotiated with the mortuary, and processes through N-FOCUS. A headstone based on usual and customary charges may be provided by the Department if no other funds are available. If the child has a guardianship account, it will be used to defray the funeral and burial expenses. See also 390 NAC 11-002.01I.

{Effective 02/23/04}

2-008 (Reserved)

2-009 IV-E Eligibility

2-009.01 Initial Determination: Wards who meet the requirements in the following material at the time the maintenance case is opened qualify for payment from federal funds under Title IV-E of the Social Security Act.

{Effective 6/8/98}

2-009.01A Family's Eligibility for ADC: To be eligible for payment from federal funds, the ward must have been eligible for ADC under the state's regulations that were in place July, 1996. Eligibility is determined for the month court proceedings leading to the removal of the child from the home were initiated (petition was filed or the court order, whichever initiated the ruling). If the ward was not eligible during the month of initiation of court proceedings leading to the removal (constructive or physical) of the child, the worker must determine if the ward would have been eligible sometime within the six months before the month in which the petition was filed. During the month of court proceedings (or within the six preceding months), the ward must have been:

1. Receiving an ADC grant; or
2. Eligible to receive an ADC grant if an application had been made.

{Effective 02/23/04}

2-009.01A1 ADC Eligibility Requirements Effective July, 1996: The requirements include:

1. Income: The family's gross income must be equal to or less than 185 percent of the ADC standard of need for the family size.
2. Resources: The family's resources must have totaled $10,000 or less.
3. Deprivation: The child must have been deprived of parental support or care because of a parent or caretaker relative's:
   a. Death;
   b. Continual absence from the home;
   c. Physical or mental incapacity; or
   d. Partial or total unemployment.

{Effective 02/23/04}

2-009.01A1a Parental Deprivation: The child must have been deprived of parental support or care because of a parent's:

1. Death, if the remaining parent has not remarried;
2. Continued absence from the home;
3. Physical or mental incapacity of a parent in a two-parent family: A physical or mental incapacity is defined as any physical or mental illness, impairment, or defect which is so severe as to substantially reduce or eliminate the parent's ability to provide support or care for a child(ren). The incapacity must be expected to last at least 30 days. Deprivation may be based on either parent's incapacity; or
4. Partial or total unemployment of the principal wage earner in a two-parent family. See 479-000-324 for further guidelines for unemployment.

{Effective 6/8/98}

2-009.01A1b Living in the Home of a Parent or Relative: The child must have been living in the home of his/her parent or relative. Relatives with whom the child could have been living include father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, second cousin, nephew, or niece. These relatives may be half blood, related by adoption, or from a preceding generation as denoted by prefixes of grand, great, great-great, or great-great-great. The relative may also be the spouse of any persons previously named even after the marriage has been terminated by death or divorce.

If the child was not living in the home of a parent or relative, see 479 NAC 2-009.01A2a.

{Effective 6/8/98}

2-009.01A1c Income: The computation of need based on income is a two-step process. The unit's countable income is compared to 185 percent of the ADC standard of need that was in effect in July, 1996 (see 479-000-204 for the 185 percent chart).

{Effective 6/8/98}

2-009.01A1c(1) Allowable Disregards: After the unit passes the 185 percent test, the following disregards are deducted from the gross earned income:

1. A $90 work allowance is allowed for each employed person for expenses incurred in producing income.
2. $30 plus 1/3 of the balance of gross earnings is disregarded for each employed person.
3. See 479-000-326 for disregards for self-employment.

Note: If the child was living with relatives other than his or her parents, eligibility is based on the child's income only.

See 479-000-325 for the list of excluded income.

{Effective 6/8/98}

2-009.01A1c(2) Age Requirement for a Dependent Child: An individual is considered a dependent child beginning with the first day of the mother's third trimester of pregnancy through the month of the child's 18th birthday. An 18-year-old is considered a dependent child if s/he is a full time student regularly attending school other than college, and if s/he is expected to complete the program by the time s/he reaches age 19.

{Effective 6/8/98}

2-009.01A1c(3) Resources: The total value of available countable resources cannot exceed $10,000. Available resources include cash or other liquid assets or any type of real or personal property or interest in property that the individual owns and may convert into cash to be used for support and maintenance. See 479-000-325 for the list of excluded resources.

{Effective 02/23/04}

2-009.01A2 No Active ADC Case: If there was no active ADC case at the time the petition was filed that led to the child's physical or constructive removal from the home, the eligibility worker must determine from information on the application if the ward would have been eligible to receive ADC in the month of court proceedings or within six months of court proceedings if an application for ADC had been made.

If information is not received from the parents within ten days, the eligibility worker notifies the protection and safety worker. If it is not possible to determine eligibility for federal funds from the service case, payment is made from non-IV-E funds. If information is received at a later date, the worker goes back to determine ADC eligibility.

If the ward would have been eligible for ADC, the funding is changed to IV-E effective the first of the month following the month that IV-E eligibility is determined.

If a ward is physically or constructively removed from the home of a specified relative other than the parent, the parent's income and resources are not considered in determining the ward's eligibility for ADC in the month of judicial determination. Only income and resources actually available to the ward are taken into account in determining the ward's eligibility.

{Effective 02/23/04}

2-009.01A2a Not Living in Specified Relative's Home: If the ward was not living in a specified relative's home during the month in which the petition was filed that led to the child's physical or constructive removal from the home, the ward must have lived with a specified relative sometime within the six months before the month in which the petition was filed. The worker must determine if the ward would have been eligible for ADC in the month in which the petition was filed that led to the child's physical or constructive removal from the home if s/he had been living with the specified relative that month. For the list of specified relatives, see 479 NAC 2-009.01A1b.

{Effective 02/23/04}

2-009.01A3 Review of Deprivation: At the time of the annual review, the worker must review the home situation. For examples of continued deprivation, see 479-000-327.

{Effective 6/8/98}

2-009.01B Custody of the Child: To be eligible for IV-E, the ward must have been placed in foster care by court order, voluntary placement, or voluntary relinquishment (see 479 NAC 2-009.01B1 through 2-009.01B3).

2-009.01B1 Placement by Court Order: Payment may be made from IV-E funds if a ward has been physically or constructively removed from the home of a specified relative (see 479 NAC 2-009.01B1a) by a court. It may be a county, district, separate juvenile, or Indian tribal court.

The court order must state that:

1. Continuation in the home would be contrary to the welfare of the child, or that placement would be in the best interest of the child.

   The "contrary to the welfare determination" must be in the first court ruling sanctioning the removal of a child from home. If the determination regarding "contrary to the welfare" is not made in the first court ruling pertaining to the removal, the child is not eligible for IV-E for the duration of that stay in foster care. The order must be child specific and detail why the child cannot remain in the home.

   If the judicial determination references an exhibit in part or whole, the exhibit must be attached to the order regarding the removal. Nunc pro tunc orders or affidavits cannot be used.

2. Reasonable efforts:
   a. Were made to prevent or eliminate the need for removal;
   b. Were not possible because an emergency situation existed which indicated it was not in the child's best interests to prevent removal;
   c. Are currently being made to reunite the child with his/her family; or

      A judicial determination of reasonable efforts must be made no later than 60 days from the date the child is removed. The finding must be child specific and detail why the child cannot remain in the home.

      If a judicial determination is not made within 60 days of the date of removal, the child is not eligible for IV-E for the duration of that stay in foster care.

   d. Reasonable efforts were not required because a court of competent jurisdiction determined that:
      (1) The parent of the ward subjected the ward to aggravated circumstances, including, but not limited to, abandonment, torture, chronic abuse, or sexual abuse;
      (2) The parent of the ward has:
         (a) Committed first or second degree murder of another child of the parent;
         (b) Committed voluntary manslaughter of another child of the parent;

(c) Aided or abetted, attempted, conspired, or solicited to commit murder, or aided or abetted voluntary manslaughter of the ward or another child of the parent; or
(d) Committed a felony assault which resulted in serious bodily injury to the ward or another minor child of the parent; or

(3) The parental rights of the parent to a sibling of the ward have been terminated involuntarily.

A judicial determination of reasonable efforts to finalize a permanency plan must be made within 12 months of the child's entry into foster care and within every subsequent 12 months while the child is in foster care.

If no judicial finding regarding reasonable efforts to finalize a permanency plan is made, the child becomes ineligible for IV-E from the end of the 12th month following the date the child entered foster care. The child remains ineligible for IV-E until a judicial determination to finalize a permanency plan is made.

Nunc pro tunc orders or affidavits cannot be used.

{Effective 02/23/04}

2-009.01B1a Permanency Hearing: A permanency hearing must be held within 12 months of a child's entry into foster care and subsequently every 12 months thereafter. When the court finds reasonable efforts are not required, a permanency hearing must be held within 30 days of that determination.

A permanency hearing must be a full hearing, not a paper review. The court must approve the child's permanency plan, which may be one of the following:

1. Reunification;
2. Adoption;
3. Legal guardianship; or
4. Another planned permanent living arrangement, which may include
   a. Long term foster care;
   b. Independent living;
   c. Self-sufficiency with supports.

{Effective 02/23/04}

2-009.01B1b Child's Return Home and Subsequent Removal: If a child is returned to the home and subsequently removed after six months or more, it is considered a new placement. There must be a new court order and a new determination of deprivation.

{Effective 02/23/04}

2-009.01B2 Placement by Voluntary Placement Agreement: Payment may be made for up to 180 days from IV-E funds if a ward is placed in the Department's custody by a voluntary placement agreement (see 479 NAC 2-001.01A3). IV-E payment must be discontinued if by the 180th day there is not a court order stating that continued placement of the child outside his/her home is in the child's best interests.

A reasonable effort requirement is not required.

2-009.01B3 Placement by Voluntary Relinquishment: A child must be in the custody of the Department by means of a court order at the time of voluntary relinquishment to be eligible for payment from IV-E funds. If the child is not in the Department's custody at the time of the relinquishment, payment is made from child welfare funds.

2-009.01C Residing in a Licensed or Approved Home: To receive payment, a ward must be in a licensed child care institution (see 479 NAC 1-004), licensed group home, or a licensed foster home. The ward must not be in a detention facility or any facility operated primarily for youth who have been determined to be delinquent.

Note: A biological parent is not eligible for IV-E foster care.

{Effective 02/23/04}

2-009.01D Age Requirement: The ward is eligible for IV-E through the entire month of his/her 19th birthday if s/he is a full-time student regularly attending a secondary school, or the equivalent level of vocational or technical training (this does not include college) and reasonably expected to complete the program before reaching age 19. An 18 year old is IV-E eligible through the month of graduation from high school or the equivalent level of vocational or technical training. Assistance for an 18 year old who has completed high school and who is in a vocational training program that will be completed before s/he reaches age 19 is funded from child welfare.

2-009.01D1 Definition of a Student: A student is an individual who is:

1. Age 17 or younger and attending a school, college or university or a course of vocational or technical training designed to fit him/her for gainful employment, and includes a participant in the Job Corps Program; or

Note: Assistance for child who is not yet age 18 is paid from child welfare funds while the child is attending a college or university until the month of his/her 18th birthday.

2. Age 18, registered full time, and regularly attending a secondary school (or the equivalent level of vocational or technical training) and reasonably expected to complete the program before his/her 19th birthday.

Note: Assistance for an 18 year old who is attending a college or university is paid from child welfare funds.

2-009.01D2 Continued Enrollment: The worker must consider enrollment as continued through normal periods of class attendance, vacation, and recess unless the student graduates, drops out, is suspended or expelled, or does not intend to register for the next normal school term (excluding summer school).

2-009.01E Citizenship and Alien Status: A ward is eligible for IV-E if s/he is:

1. A citizen of the United States; or
2. An alien lawfully admitted for permanent residence.

Any individual who is born in the United States is considered a U.S. citizen. This includes children whose parents are not U.S. citizens, such as illegal alien parents or parents with student visas.

Receipt of SSI is sufficient proof of citizenship or lawfully admitted alien status.

{Effective 6/8/98}

2-009.01E1 Verification of Alien Status: When a ward is an alien, the worker must obtain verification.

For further verification procedures, see 479-000-300 and 479-000-309.

Assistance must not be delayed, denied, or discontinued while awaiting verification. Until verification is received, the ward is non-IV-E.

CHAPTER 3-000 REQUIREMENTS FOR A MAINTENANCE PAYMENT FOR COURT AND TRIBAL WARDS: Court and tribal wards are eligible for payment if determined IV-E eligible.

{Effective }

3-001 Definition of a Court or Tribal Ward: A child becomes a court or tribal ward when his/her custody is committed to a court or other public agency. In order to receive payment from the Department, the agency must have a written agreement with the Department, ensuring that Title IV-E requirements are met. The agreement may be with a court or other public agency authorized under state law for the placement and supervision of children.

{Effective }

3-002 Application Form: Form EA-117 must be completed. It may be completed by a representative designated by the agency having custody of the ward.

3-003 Payment: To receive payment, a child shall meet the following requirements:

1. Custody of the child (see 479 NAC 3-003.01);
2. Service plan (see 479 NAC 3-003.02);
3. Living in a licensed foster care home or facility (see 479 NAC 3-003.03);
4. Residence (see 479 NAC 3-003.04);
5. Plan for self-support (see 479 NAC 3-003.05);
6. Social Security number (see 479 NAC 3-003.06);
7. Child support (see 479 NAC 3-003.07);
8. Resources (see 479 NAC 3-003.08);
9. Income (see 479 NAC 2-001.09);
10. Citizenship or alien status (see 479 NAC 2-001.10);
11. Deprivation (see 479 NAC 2-009.01A); and
12. Age (see 479 NAC 3-003.12).

3-003.01 Custody of the Child: To receive payment, the ward must have been placed in out of home care as the result of a physical or constructive removal from the home of a specified relative (see 479 NAC 2-009.01B1a) by means of a judicial determination by a county, district, separate juvenile, or tribal court that continuance in the home would be contrary to the child's welfare. (See 479 NAC 2-009.01B1.)

Note: If a child is returned to the home and subsequently removed again after six months or more, it is considered a new placement. There must be a new court order and a new determination of deprivation.

For payment for the child of a ward, see 479 NAC 2-002.10.

{Effective }

3-003.01A Specified Relatives: See 479 NAC 2-009.01B1.

3-003.01B Not Living in Specified Relative's Home: See 479 NAC 2-009.01B16.

3-003.02 Service Plan Information: The agency that has custody of the ward must have a service plan for the child that complies with the terms of the agreement with the Department. For procedures for permanency plan reviews, see 479-000-309.

3-003.03 Living in a IV-E Eligible Living Arrangement: See 479 NAC 2-009.01C.

3-003.04 Residence: To be eligible for assistance, the ward must be a Nebraska resident. A resident is defined as:

1. An individual living in the state; or
2. An individual who has been placed out-of-state but is under the jurisdiction of a Nebraska court that has a written agreement with the Department. The ward must be in a licensed child caring institution, licensed group home, or a licensed foster home.

{Effective }

3-003.05 Plan for Independent Living: The agency with custody of the child is responsible for the plan for independent living. See 479 NAC 2-001.05 ff.

3-003.06 Social Security Number (SSN): See 479 NAC 2-001.06 ff.

3-003.07 Child Support: Application for and acceptance of a IV-E payment results in a referral to CSE authorities who:

1. Establish a support obligation when none exists; and
2. Enforce support obligations.

3-003.07A Good Cause Claim:

3-003.07A1 Notification of Right to Claim Good Cause: The eligibility worker must inform the worker in the agency with custody of the right to claim good cause for pursuing child support.

The eligibility worker must accomplish this by giving the agency worker the pamphlet, CSE-PAM-50, explaining right to claim good cause for child support.

3-003.07A2 IM Worker's Responsibilities if Good Cause Claimed: If the agency worker claims good cause, the eligibility worker forwards a copy of Form IM-5 to the IV-D unit.

3-003.07B Termination of Assignment:

3-003.07B1 Partial Termination: A partial termination of assignment is automatically transmitted by the Central Office to the appropriate clerk of the district court when:

1. CSEU has been notified that an order for child support has been vacated or terminated; or
2. The ward's case has been closed or the assistance grant has been zeroed if child support payments were assigned or directed to the Department.

3-003.07B2 Final Termination: A final termination of assignment is automatically transmitted by the Central Office to the appropriate clerk of the district court when the assigned child support debt is satisfied.

3-003.07B3 Referral to the Child Support Enforcement Unit: The eligibility worker makes a referral to the IV-D unit no later than two working days after determination of eligibility. The worker makes a referral on each parent. A copy of all court orders must be forwarded to CSEU. When no support is ordered, the IV-D unit attempts to get an order for support.

3-003.08 Resources: The total equity value of available non-exempt resources of the ward is determined and compared with the established maximum for available resources which the ward may own and still receive a payment from the Department.

For examples of resources see 479 NAC 2-001.08.

3-003.08A Verification of Resources of the Ward: See 479 NAC 2-001.08A.

3-003.08B Definition of Available Resources: See 479 NAC 2-001.08B.

3-003.08B1 Unavailability of Resource: Regardless of the terms of ownership, if it can be documented in the case record that the resource is unavailable to the ward, the value of that resource is not used. The worker must consider the feasibility of the responsible person taking legal action to make the resource available. If the worker determines that legal action can be taken, the worker must allow the responsible person 60 days to initiate legal action. After 60 days, if the responsible person has not initiated legal action, the resource is counted. The resource is not considered available until the legal action is completed.

In evaluating the availability of benefit funds, such as funds raised by a benefit dance or auction, the worker must determine the purpose of the funds and if the ward has access to them.

The worker must monitor the status of an unavailable resource.

3-003.08B2 Excluded Resources: See 479 NAC 2-001.08B2.

3-003.08C Determination of Ownership of Resources: See 479 NAC 2-001.08C through 2-001.08C1b(1)(b).

3-003.08D Inheritance: See 479 NAC 2-001.08E.

3-003.08E Value and Equity: See 479 NAC 2-001.08F and 2-001.08F1.

3-003.08F Types of Resources: See 479 NAC 2-001.08G through 2-001.08G2a.

3-003.08F1 Non-Liquid Resources: See 479 NAC 2-001.08G2 and 2-001.09G2a.

3-003.08G Maximum Available Resources: The established maximum for available resources (real and personal property) which the ward may own and still receive payment from the Department is $10,000.

For the resource level for NMAP, see 479 NAC 4-007.03

{Effective}

3-003.09 Income: See 479 NAC 2-001.09 through 2-001.09B. Court and tribal wards are not allowed to accumulate income before it is counted against the child's needs.

{Effective }

3-003.09A Receipt of SSI: A ward who is receiving SSI is ineligible for payment from the Department.

3-003.09B Lump Sum Benefits: When a ward receives a nonrecurring payment, the lump sum is not considered income. Any unspent remainder is considered a resource in the month following the month of receipt or report.

{Effective 6/8/98}

3-003.09B1 Income-Producing Policies: Income received from an insurance policy that supplements the ward's income while s/he is hospitalized or receiving medical care is treated as unearned income. These policies provide income regardless of the type of service being provided or the condition of the ward. If it is verified that the income was applied to medical bills, the income is not counted in the ward's budget.

Income is not counted from health insurance policies which pay the client directly for the purpose of reimbursement to the provider and which cover a specific service(s).

3-003.09B2 Financial Settlements: Insurance payments for damage to personal property caused by a disaster are not treated as a lump sum. The ward is allowed a reasonable period of time to repair or replace the property.

When a ward is a beneficiary of life insurance or receives property through inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

The worker shall document in the case record the availability of settlement or inheritance funds to the ward.

When a ward receives an insurance settlement or other lump sum, the worker deducts from the lump sum any bills relating to the cause of the settlement that the ward is obligated to pay.

3-003.09B2a Overpayment Due to Lump Sum: Any overpayment caused by a delay in reporting the lump sum must be recouped.

3-003.10 Receipt of Other Assistance: A ward must not receive assistance in two foster care units at the same time. This does not preclude the ward from being the payee for a payment made on behalf of the ward's child.

A payment may be authorized from IV-E funds for the initial month of placement in foster care even if the child was included in an ADC payment with a specified relative for the same month. The foster care payment is prorated from the date of placement. This is an exception to 468 NAC 2-022.01.

3-003.11 Computation of Payment: The worker computes payment using the ward's income from all sources. If the ward is eligible for a IV-E grant, s/he is also eligible for medical assistance without a separate application or budget computation. The following provisions govern the computation of payment. The payment is computed by subtracting the child's countable income from the standard.

3-003.11A Treatment of Income: See 479 NAC 2-001.11A.

3-003.11A1 Changes in Circumstances See 479 NAC 2-001.11A1.

3-003.11A2 General Rules: See 479 NAC 2-001.11A2.

3-003.11A3 Income as It Applies to Resources: See 479 NAC 2-001.11A4.

3-003.12 Age: A ward is eligible through the entire month of his/her 19th birthday if s/he is a full-time student regularly attending a secondary school, or the equivalent level of vocational or technical training (this does not include college). An 18-year-old is eligible through the month of graduation from high school or the equivalent level of vocational or technical training.

3-003.12A Definition of a Student: A student is an individual who is:

1. Age 17 or younger and attending a school, college, or university or a course of vocational or technical training designed to fit him/her for gainful employment, and includes a participant in the Job Corps Program; or

   Note: A ward who is not yet age 18 is eligible while attending a college or university until the month of his/her 18th birthday.

2. Age 18 and registered full time and regularly attending a secondary school (or the equivalent level of vocational or technical training).

{Effective 6/8/98}

3-003.12B Continued Enrollment: The worker must consider enrollment as continued through normal periods of class attendance, vacation, and recess unless the student graduates, drops out, is suspended or expelled, or does not intend to register for the next normal school term (excluding summer school).

3-004 Payments for Assistance: Money payments are made in behalf of a ward to the foster parent(s), group home, or child caring agency in which the ward resides. Only the ward is included in the standard of need. The standard filing unit does not apply to foster care cases.

A child must not receive foster care assistance in two foster care facilities for the same period of time.

3-004.01 Foster Home Payments: See 479 NAC 2-002.01.

3-004.02 Group Home or Child Caring Agency Payments: See 479 NAC 2-002.02.

3-004.03 Runaways: When a ward is determined a runaway, the worker must close the case.

3-004.04 Minor Parent: See 479 NAC 2-002.02.

3-004.05 Prorated Payment: Payment is made from the first of the month for the month of application, but no earlier than the date of court-ordered placement.

Payment is prorated for ongoing cases if the child moves from one facility, foster home, or group home to another.

The prorated payment is determined by dividing the maintenance payment by the actual number of days in the month and multiplying by the number of days in placement. Payment is made for the date of placement but not for the date of removal. When there is a contract with a child caring agency that specifies a per diem rate, the per diem rate is used for prorating. For date of medical eligibility, see 479 NAC 4-004.

3-004.06 Maintenance Payment: The representative of the court or agency completes the Foster Care Payment Determination using the same guidelines as Department workers.

3-004.07 Revision of Budget and Payment: See 479 NAC 2-002.05.

3-004.08 Incorrect Payments: See 479 NAC 2-002.06.

3-004.08A Underpayments: See 479 NAC 2-002.06A.

3-004.08B Overpayments: The agency must take all reasonable steps necessary to promptly correct overpayments. Overpayments over $50 are recouped. The worker must record in the case record all steps taken to recoup any overpayments.

{Effective 6/8/98}

The worker must first send a demand letter, giving the responsible person the choice of reimbursing all or part of the overpayment or having future assistance reduced. If the responsible person reimburses part of the overpayment, the remainder must be recouped by grant reduction. The worker must allow the responsible person ten days to respond to the demand letter. If the responsible person requests recoupment within the ten days, the worker must take necessary action at that time. If the responsible person does not respond within ten days, the worker must begin recoupment procedures in the first month possible, taking into account adequate and timely notice.

If the responsible person chooses to repay but fails to do so, the worker must immediately take necessary action to recoup the overpayment.

When the evidence clearly establishes that a responsible person willfully withheld information which resulted in an overpayment, the worker must refer the case to the Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker must take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker must complete normal case actions. Normal case actions include closing a case that is found to be ineligible and recovering overpayments.

If a case with an overpayment is closed or becomes MA only or MA with a share of cost, the agency must collect the overpayment if the ward becomes eligible for a grant at a future date. The worker must send a demand letter advising the responsible person that s/he is still liable for the overpayment.

3-005 Case Records: The case record must be complete and must contain facts to substantiate each action with respect to assistance payments.

3-006 Fraud: See 465 NAC 2-007 ff.

3-007 Annual Review: An eligibility review is required every 12 months. At the time of the review, the worker uses information provided by the agency with custody to determine if deprivation still exists based on the parent(s)' situation (see 479 NAC 2-009.01A2). Except for deprivation, all elements of the review, including income and resources, are based on the ward's circumstances. The worker in the agency with custody completes a new Income and Resources Data Form.

{Effective 6/8/98}

3-007.01 Examples of Continued Deprivation: See 479-000-327.

3-007.02 Examples Where Deprivation No Longer Exists: See 479-000-327.

3-008 IV-E Eligibility: Court and tribal wards must be eligible for IV-E.

{Effective }

3-008.01 Family's Eligibility for ADC: See 479 NAC 2-009.01A ff.

3-008.01A No Active ADC Case: If there was no active ADC case at the time the petition was filed that led to the child's removal from the home, the eligibility worker must determine if the ward would have been eligible to receive ADC in the month of court proceedings or within six months of court proceedings if an application for ADC had been made. If information is not received from the court or other agency within 30 days, eligibility cannot be determined.

If a ward is physically or constructively removed from the home of a specified relative other than the parent, the parent's income and resources are not considered in determining the ward's eligibility for ADC in the month of judicial determination. Only income and resources actually available to the ward are taken into account in determining the ward's eligibility.

{Effective }

CHAPTER 4-000 MEDICAL ELIGIBILITY: The Nebraska Medical Assistance Program (NMAP provides medical care and services to children who do not have sufficient income to meet their medical needs and who qualify according to the guidelines in this chapter.

Payments for medical care are made by state warrant directly to the provider from federal and state funds. The regulations and standards established for the Nebraska Medical Assistance Program are contained in Title 471.

4-001 (Reserved)

4-002 (Reserved)

4-003 Review: MA cases for wards must be reviewed every six months.

4-004 Effective Date of Medical Eligibility: Medical eligibility is effective the first day of the month in which custody was first granted if the ward was eligible for NMAP in that same month. A child may be eligible earlier than the month of custody according to requirements in 477 NAC 3-000 or 4-000. For six months' continuous eligibility, see 477 NAC 1-013.

{Effective 10/7/98}

4-005 Use of Budget Form DA-3M: The worker uses Form DA-3M or N-FOCUS to determine eligibility for medical assistance only and medical share of cost cases.

4-006 Eligible Children: This chapter deals with:

1. Wards of the Nebraska Department of Health and Human Services who are:
   a. Eligible for an assistance payment from the Department; or
   b. Ineligible for an assistance payment due to income or resources in excess of program standards but who meet the guidelines in this chapter;
2. Wards of another state who are determined IV-E eligible by the other state and are living in Nebraska;
3. Youth who are eligible for the IV-E subsidized adoption program from another state and living in Nebraska; and
4. Wards of the court.

4-007 Eligibility Requirements: To be eligible for medical assistance, the child must meet the following requirements:

1. U.S. citizenship or alien status (see 479-000-305 and 479-000-306);
2. Social Security number (see 479 NAC 2-001.06);
3. Age (see 479 NAC 4-007.01);
4. Resources (see 479 NAC 2-001.08); and
5. Income (see 479 NAC 2-001.09).

4-007.01 Age: A ward may be eligible for medical assistance through the month of his/her 19th birthday, regardless of school attendance. If a medical need exists for a ward who is being discharged, the medical assistance case may remain open but the program is changed on the system to the appropriate program (see 477 NAC 3-000 or 4-000 and 469 NAC 4-000).

Exception: A ward who is in an IMD is eligible for medical assistance through the month of his/her 21st birthday.

4-007.02 Department Ward in Home of Parent(s): When a Department ward remains in his/her parent(s)' home or is placed back in the home on a trial basis, the child is Medicaid eligible if the Department continues to have custody and the ward meets the other eligibility requirements listed in 479 NAC 4-007. The worker must determine if the ward has a medical need and if so, if the parent(s) is financially able to meet the medical need. If the court order states the extent of the parent(s)' financial responsibility for the child's medial care, the court order is followed. After 90 days, the eligibility worker must contact the protection and safety worker to determine if the child will remain in the home or has been discharged as a ward.

Non-IV-E funds may be used to pay those medical expenses of the ward that are not covered by Medicaid if the child remains a Department ward, the child is not eligible for any other program, and the parent(s) is not able to meet the needs through his/her own resources or any other third party coverage. Payment of these medical expenses must be authorized by the protection and safety worker or supervisor and are paid by state ward medical.

The eligibility worker must consider the family's eligibility for other categorical assistance if the child is discharged as a ward, the case is closed, and the family requires financial assistance.

{Effective 02/23/04}

4-007.03 Resources: The established maximum for available resources which a 19 or 20-year-old ward may own and still be considered eligible is $4,000. For the treatment of resources for MA only cases, the criteria outlined in 479 NAC 2-001.08 ff. are used. For wards age 18 or younger, there is no resource test.

{Effective 02/23/04}

4-007.03A Excess Resources: An application for a ward with excess resources may be held pending until the resources are reduced. Excess resources may be reduced by paying obligations for medical costs. Medical eligibility begins with the first day of the month of the incurred obligation which was used to reduce the resources to the allowable maximum (see 479 NAC 2-001.08H). Medical eligibility may not be established earlier than the three-month retroactive period.

4-007.04 Treatment of Income: For the treatment of income in NMAP, the criteria outlined in 479 NAC 2-001.09 ff. are used, with the exceptions in the following material. Only income actually available to the ward is considered.

4-007.04A Medical Insurance Disregards: The cost of medical insurance premiums is deducted if the ward is responsible for payment.

Exception: The cost of premiums for policies which supplement the ward's income while the ward is hospitalized or receiving medical care is not allowed as a medical deduction. This does not apply to those health insurance policies which pay directly to the ward for the purpose of reimbursement by the ward to the vendor.

4-007.04A1 Health Insurance: The eligibility worker must determine if the ward has health insurance coverage; if so, the worker enters the information on the Third Party Liability system.

4-007.04B Lump Sum Treatment: A lump sum is counted as income in the month of receipt or report. The following month any remainder is considered a resource.

4-008 Medically Needy Income Level (MNIL): The net income is compared to the income level to determine eligibility for MA only.

If the net income is equal to or less than the MNIL, the ward may be eligible for MA only; if the net income is more than the MNIL, see Title 477.

4-009 Department Wards With SSI: If a ward is receiving SSI, s/he is considered categorically eligible and therefore eligible for medical without a share of cost.

4-010 Providers: Medicaid providers must be used whenever possible. Payment can be made from non-IV-E funds for a Department ward if a non-Medicaid provider is used or a non-Medicaid service is provided by a Medicaid provider.

4-011 Enrollment in Health Insurance: The Department will pay premiums, deductibles, coinsurance, and other cost sharing obligations if there is an available health plan that will cover the ward and if the Department has determined it is cost effective. This may be a policy in which the ward is able to enroll on his/her own behalf or coverage under the parent's or foster parent's insurance. If the worker has determined that there is available insurance, s/he must make a referral to the Third Party Liability Unit, Central Office.

4-012 Nebraska Health Connection (NHC): Managed care is required for all active Medicaid-eligible individuals except those excluded groups listed at 479-000-329. For more information, see Title 482.

4-013 Ward Placed in Jail or Detention Facility: A ward placed in one of these settings remains eligible for Medicaid. However, Medicaid cannot be used as a funding source for medical care during the placement.
Exception: When a ward placed in jail or detention leaves that setting and goes to an acute medical treatment setting for at least 24 hours, medical treatment in the acute setting may be paid by Medicaid.

{Effective 02/23/04}

Chapter 5-000 HEALTH CHECKS and Treatment Services for Conditions Disclosed During HEALTH CHECKS (EPSDT)

5-001 Introduction

5-001.01 Legal Basis: HEALTH CHECKS are covered under the Early and Periodic Screening, Diagnosis, and Treatment Program which was established by Title XIX of the Social Security Act. Section 1905(r) of the Social Security Act was added by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

5-001.02 Purpose and Scope: HEALTH CHECK, the Nebraska Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a service available to all individuals age 20 and younger eligible for medical assistance. The purpose of EPSDT is to provide for the early detection of illness or defects through a screening examination, to provide for follow-up of the condition detected during the screening, to provide continuity of care, and to promote healthy lifestyles. It is intended to encourage and ensure that treatment is available and received by those eligible and in need of treatment by the application of medical knowledge and technology to cure, correct, or alleviate health problems. Preventive health care provides the following benefits:

1. Early detection and treatment of health problems to prevent serious impairment and to increase the chance of successful treatment;
2. Protection from certain preventable diseases by immunization for children at an early age;
3. Maintenance of good health and assurance of normal development through periodic check-ups and the establishment of a "medical home." In most cases, this will be a continuing relationship with a primary care physician; and
4. Savings of future medical costs.

The EPSDT program's objectives are ensuring the availability and accessibility of required health care resources and helping Medicaid clients and their parents or caretakers effectively use them. This may be accomplished through care coordination. The purpose of care coordination is to ensure continuing and comprehensive health care beginning with the screening through diagnosis and treatment for conditions identified during screening. This includes activities of locating, coordinating, and monitoring necessary screening and other health services. Care coordination must include a system to track, document, and ensure that all HEALTH CHECK (EPSDT) services are delivered within established time frames according to the periodicity schedule. This may be accomplished through interagency agreement or fee for service with qualified Medicaid-enrolled providers as determined by the NMAP and for EPSDT participating children in need of and without care coordination services to ensure access and delivery of health care services. Examples of EPSDT participants in particular need of care coordination may be pregnant adolescents, children with special health care needs, medically fragile children, foster care children, and children environmentally at risk.

5-001.03 Definition of Terms: The following terms are defined in relation to HEALTH CHECK and treatment services under the EPSDT program.

Early: As soon as an individual's or a family's eligibility for assistance has been established; or, in the case of a family already receiving assistance, as early as possible in the individual's life.

Periodic: Intervals established for examination or screening to ensure continued health and to detect conditions requiring treatment. Annual dental screening examinations are recommended for children three and older. If a dental problem is suspected before age three, a dental screening should occur at that time. Medical, visual, and hearing exams are to begin with a neonatal exam and follow, at a minimum, the periodicity schedule based on the American Academy of Pediatrics schedule for health supervision visits (see 471 NAC 33-002.03). The physician may establish an alternate periodicity schedule based on medical necessity. The initial examination of a newborn is considered an initial HEALTH CHECK (EPSDT) examination and the child is considered participating in the program. Well-baby and well-child examinations are to be reported as HEALTH CHECK examinations through the EPSDT program.

Screening Services: Periodic child health assessments which are regularly scheduled to examine and evaluate the general physical and mental health, growth, development and nutritional status of eligible children. The screenings are performed to identify those who may require diagnosis, further examination, and/or treatment. The following screening services are included in the EPSDT benefit:

1. Health Screening Services:
   a. Comprehensive health and developmental history (including assessment of both physical and mental health development);
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations for age and for health history;
   d. Appropriate laboratory procedures for age and populations groups; and
   e. Health education (including anticipatory guidance);
2. Dental Screening Services: For children age three and older, dental screening services are furnished by direct referral to a dentist. Children age two and younger are screened by the screening physician as part of the health screening exam. If a dental problem is suspected before age three, a dental screening should occur earlier. Medically necessary and reasonable diagnosis and treatment including relief of pain and infections, restoration of teeth, and maintenance of health are covered;
3. Vision Screening Services: An age-appropriate visual assessment. Medically necessary and reasonable diagnosis and treatment for defects in vision are covered; and
4. Hearing Screening Services: An age-appropriate hearing assessment. Medically necessary and reasonable diagnosis and treatment for defects in hearing are covered.

Diagnosis: The determination of the nature or cause of a physical or mental disease or abnormality. A diagnosis enables a physician to make a plan for treatment specific to the EPSDT participant's problems. Under certain circumstances, diagnosis may be provided at the same time as screening. In other circumstances, diagnosis may be provided during a second appointment. The diagnosis may or may not require further follow-up. It may result in referral for treatment.

Treatment Services: HEALTH CHECK (EPSDT) follow-up services necessary to diagnose or to treat a condition identified during a HEALTH CHECK (EPSDT) health, visual, hearing, or dental screening examination are covered under the following conditions:

1. The service is required to treat the condition (i.e., to correct or ameliorate defects and physical or mental illnesses or conditions) identified during a HEALTH CHECK (EPSDT) screening examination and documented on the screening claim form (Form MC-5 for health screening; Form HCFA-1500 for vision or hearing services performed outside of the health screening; or Form MC-13 for dental services);
2. The provider of services is a Medicaid-enrolled provider;
3. The service is consistent with applicable federal and state laws that govern the provision of health care;
4. The service must be medically necessary, safe and effective, and not considered experimental/investigational;
5. Services currently covered under the Nebraska Medical Assistance Program will be governed by the guidelines of NMAP;
6. Services not covered under the Nebraska Medical Assistance Program but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 4 (above). Criteria and requirements for certain services are outlined in 471 NAC 33-000. Unless otherwise outlined, all services not covered under NMAP must be prior authorized by the Medical Services Division, Department of Social Services. Requests for prior authorization must be sent to: Nebraska Department of Social Services, Medical Services Division, EPSDT Coordinator. The screening practitioner shall submit the request which must include -
    a. A copy of the screening exam form or the name of the screening practitioner and the date of the screening exam which identified the condition; and
    b. A plan of care which includes -
        (1) History of the condition;
        (2) Physical findings and other signs and symptoms, including appropriate laboratory data;

(3) Recommended service/procedure, including (if unknown) the potential provider of service (e.g., equipment, supplies) or where the services will be obtained;
(4) Estimated cost, if available; and
(5) Expected outcome(s).

The plan of care may be submitted on Form EPSDT-5, "Plan of Care," or as a statement by the screening practitioner. The Medical Director or designee shall make a decision on each request in an expeditious manner. Appropriate health care professionals may be consulted during the decision-making process. A copy of the decision will be sent to the screening practitioner and the client's worker in the local Social Services office. For wards of the Department, a copy of the decision is sent to the client's case manager in the local office. If the initial request is denied, additional information may be sent for reconsideration.

5-002 HEALTH CHECKS (EPSDT Screening Evaluations): The screening examination is performed to identify those health problems which require further examination and/or treatment. Form MC-5, "Periodic Screening Report and Claim Statement," (see 471-000-83) is designed to -

1. Report the screening findings during the screening examination;
2. Report services associated with the screening exam as defined in 471 NAC 33-003, HEALTH CHECK (EPSDT) Special Services; and
3. Claim charges for these services.

The Recommendations for Preventive Pediatric Health Care published by the American Academy of Pediatrics (see 471 NAC 33-002.03) are recommended as guidelines for content and minimum frequency for HEALTH CHECK (EPSDT) examinations.

5-002.01 Screening Providers: Screening services are to be performed by or under the supervision of a physician, dentist, or other provider qualified under State and Federal law to furnish primary medical and health services. Periodic examinations shall, at a minimum, include the health screening services defined in 479 NAC 5-001.03 (see item 1 of the definition of Screening Services). Vision and hearing screening examinations cannot be limited to the screening physician but may be obtained directly from an ophthalmologist or optometrist for vision services and licensed audiologist for the hearing service. In an effort to support the "medical home" concept or a permanent primary care relationship and to avoid fragmentation or duplication of services, the provision of vision and hearing screening provided within the context of the health screening is encouraged. If not performed with the health screening, care coordination with the primary physician is recommended.

5-003 Worker Responsibilities

5-003.01 Informing Client: The IM worker shall inform the client of HEALTH CHECK (EPSDT) at the time of application and redetermination. The worker shall accomplish this by giving the client -

1. A verbal explanation of HEALTH CHECK (EPSDT), including a review of the HEALTH CHECK (EPSDT) pamphlet;
2. A pamphlet explaining HEALTH CHECK (EPSDT); and
3. The opportunity to ask questions.

Special emphasis is to be placed on informing for first time eligibles, mothers and families with infants or adolescents, or those not participating for over two years, or other eligible children considered 'at risk' for health care. A Medicaid-eligible woman's positive response to an offer of HEALTH CHECK (EPSDT) services during her pregnancy, in behalf of her unborn child, constitutes a request for services for the child at birth. For a child eligible at birth, the request for HEALTH CHECK (EPSDT) services is effective with the birth of the child.

These informing procedures are to be adapted to meet the needs of persons who are illiterate, blind, deaf, or who cannot understand the English language.

In addition, notifications are sent to clients informing them of when they are due for health and dental exams according to the periodicity schedule. All Claims Inquiry (CICS4 Job 045) is a resource for the eligibility worker to determine when the last screening examination was covered by Medicaid.

For those families requesting HEALTH CHECK (EPSDT) and also requesting support services, the IM worker shall provide assistance or refer to the social service (Title XX) unit for assistance in arranging transportation, locating a doctor, dentist or other screening practitioner, or setting appointments. If the client has entered into a continuing care formal agreement, the continuing care provider may be responsible for some or all of the support services and follow-up (see 471 NAC 33-002.07A). For wards, see 471 NAC 41-004.

5-003.02 Assisting With Appointments: The designated worker shall -

1. Offer and provide, if requested and necessary, assistance or referral in scheduling appointments and providing transportation for the screening exam and treatment services. A request for support services applies to screening, diagnosis, and treatment services unless otherwise indicated on Form DA-100 or narrative. To ensure timely delivery of services, the worker shall have available, upon request, the names and locations of Medicaid providers (physicians, clinics, dentists, including Title V providers);

2. Upon request for HEALTH CHECK (EPSDT) dental and/or health screening (including vision and hearing screens), provide the client or send to the screening physician, the Form MC-5 (many physician offices have a supply), and/or send Form MC-13 to the screening dentist. The screening exams are to be performed within 120 days of the initial and periodic request. If the screening is overdue, one follow-up contact, documented and dated, is considered a good faith effort to provide timely delivery of services. This may be accomplished by the worker or by an automated client notice. A personal contact is the most effective method;
3. As follow-up, inform the client of the need for further diagnosis or treatment services and provide assistance in transportation and appointment scheduling, if requested and necessary to enable the client to receive necessary diagnosis and treatment within 120 days after the date of the initial request for screening. This is accomplished by the worker or by an automated client notice. A personal contact is the most effective method. One follow-up contact, documented and dated, is considered a good faith effort to ensure initiation of treatment.

5-003.03 Documenting Contact and Assistance: Written documentation in the client file is necessary to show -

1. That the client has been informed and offered HEALTH CHECK (EPSDT) by written and oral explanation at the eligibility determination or redetermination. This is accomplished by answering questions 107 through 110 on Form DA-100 and by the appropriate entry on the PAE 3 screen.
2. That the supportive services of appointment scheduling and transportation assistance have been offered to the client and are provided at the client's request if necessary. This is accomplished by answering questions 111 and 112 on Form DA-100 and by the appropriate entry on the PAE 3 screen.
3. The steps taken by the designated worker to -
   a. Assist the client to receive a screening examination(s);
   b. Ensure that treatment has begun within 120 days of the screening request for those who needed further diagnosis and treatment. The local office copy of Form MC-5 is the record of the completed health screening, and the local office copy of Form MC-13 is the record of a completed dental screening for children or verification of health and/or dental screening or need for further diagnosis and treatment may be accomplished by utilizing All Claims Inquiry, Job 045; and
   c. Assist clients to receive periodic services according to the periodicity schedules in 471 NAC 33-002.03.

5-004 Coordination With Other Requirements for Physical Examinations: Efforts must be made to coordinate screening with programs such as required physicals in the public schools, Head Start, and other programs which require examinations. Form MC-5 is to be used by physicians to avoid duplication.

5-005 Referral For Services Not Covered by Medical Assistance: Referral assistance must be provided for treatment not covered by NMAP (i.e., those services not covered under 1905(a) of the Social Security Act) but found to be needed as a result of conditions disclosed during the screening exam.

This includes giving the family or client the names, addresses, and the telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. Workers may contact the EPSDT coordinator in the Medical Services Division for referral resources. Workers may utilize the Nebraska Resource Referral System to attempt to provide referral assistance.

5-006 Relations With Special Supplemental Food Programs for Women, Infants, and Children (WIC): Coordination with the WIC program is required. WIC provides specific nutritious supplemental food and nutrition education at no cost to Medicaid-eligible pregnant, postpartum, and breast-feeding women, infants, and children up to their fifth birthday. Referrals, when appropriate for the family, are required to local WIC agencies to access nutritional services and education.

5-007 Payment Procedure: For payment procedure, see 471 NAC 33-002.08.

CHAPTER 6-000 EXTENDED ASSISTANCE FOR FORMER DEPARTMENT WARDS

6-001 General Background: The Nebraska Legislature passed LB216 in 2013, which defunds the program described in this chapter (Former Ward program). Effective January 1, 2014, no new participants will be allowed to enter the Former Ward program or receive services described in this chapter. Any participants who are enrolled in the Former Ward program as of December 31, 2013, will be transitioned in the Bridge to Independence program (see 395 NAC 10), if eligible, when the program becomes operative. Any participants who are enrolled in the Former Ward program as of December 31, 2013, who are not eligible for the Bridge to Independence program may continue to receive services as described in this chapter until they lose eligibility under the regulations in this chapter.

6-001.01 Legal Basis: Assistance to former Department wards was established by the Nebraska Legislature in Neb. Rev. Stat. section 43-905.

6-001.02 Purpose: The program provides assistance, including maintenance payments and medical assistance to former wards of the Department who are age 18 through 20 and are regularly attending a school, college, or a course of vocational or technical training designed to prepare the youth for gainful employment.

For former wards age 19 and 20 who are not in school and have a medical need, see Title 467, Medically Handicapped Children's Program, and Title 477, Children's Medical Assistance Program.

6-001.03 Administration: The program is administered by the Nebraska Department of Health and Human Services in accordance with state laws and with rules, regulations, and procedures established by the Director.

6-001.04 Definition of Terms: For use within this program, the following definitions of terms will apply unless the context in which the term is used denotes otherwise.

Adequate Notice: Notice of case action which includes a statement of what action(s) the worker intends to take and the reason(s) for the intended action(s).

Application: The action by which the individual indicates in writing the desire to receive assistance.

Application Date: For new and reopened cases, the date a properly signed Application for Assistance is received.

Educational Institution: A school, college, university or vocational or technical training facility.

Prudent Person Principle: The practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information before determining initial or continuing eligibility.

Timely Notice: A notice of case action dated and mailed at least ten calendar days before the date the action becomes effective.

6-001.05 Worker Responsibilities: The designated worker must:

1. Collect and review information entered on Form EA-117 or other application form;
2. Give an explanation of the program requirements;
3. Explain the eligibility and payment factors and how changes will affect eligibility and payment;
4. Explain the eligibility and payment factors that require verification;
5. Obtain the former ward's or his/her representative's written consent on Form ASD-46 for needed verification;
6. Explore income that may be currently or potentially available, such as RSDI, SSI, Veteran's Assistance benefits (VA), etc.;
7. Give information about the social and other financial services available through the agency, such as social services; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); family planning; NMAP; and AABD;
8. Provide information and referral services to help the youth handle education-related problems as outlined in the written agreement;
9. Inform the former ward or his/her representative about his/her rights and responsibilities (see 479 NAC 6-001.06 and 6-001.07);
10. Inform the former ward or his/her representative that s/he must show his/her medical card to all providers and must inform the worker of any health insurance plan, any individual(s), or any group that may be liable for the former ward's medical expenses;
11. Explain the assignment of third party medical payments and refund any payments received directly;
12. Inform the former ward or his/her representative of the requirement to participate in the Nebraska Health Connection, if applicable (see 479 NAC 6-005 ff.);
13. Complete necessary reports and information forms;
14. Act with reasonable promptness on the former ward's application for assistance;
15. Provide adequate notice to the former ward or his/her representative of:
    a. Approval for a grant and the amount;
    b. Approval for medical assistance;
    c. Denial of payment or medical assistance; and
16. Explain the appeal process.

{Effective 7/25/95}

6-001.06 Client Responsibilities: The former ward or his/her representative is required to:

1. Provide complete and accurate information;
2. Report any change in circumstances no later than ten days following the change. This includes information regarding:
   a. Change or receipt of a resource including cash on hand, stocks, bonds, money in a checking or savings account, or a motor vehicle;
   b. Changes in residence;
   c. New employment;
   d. Termination of employment; and
   e. Changes in the amount of monthly income, including:
      (1) All changes in unearned income; and
      (2) Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for assistance for former wards 30 hours per week is considered full-time;
3. Present his/her medical card to providers;
4. Inform the medical provider and worker of any health insurance plan, any individual or any group that may be liable for the former ward's medical expenses;
5. Cooperate in obtaining any third party medical payments;
6. Reimburse to the Department or pay to the provider any third party medical payments received directly for services which are payable by the Nebraska Medical Assistance Program;
7. Enroll in a health plan and maintain enrollment if:
   a. One is available to the former ward;
   b. The former ward is able to enroll on his/her own behalf;
   c. The Department has determined that enrollment in the plan is cost effective;
8. Pay any required medical copayment (see 479 NAC 6-004.02);
9. Meet the requirements of the Nebraska Health Connection, if applicable (see 479 NAC 6-005 ff.); and
10. Sign a written agreement with the protection and safety worker and meet the requirements of the agreement (see 479 NAC 6-002.11).

{Effective 02/23/04}

6-001.07 Client Rights: The client has the right to:

1. Apply. Anyone who wishes to request and/or apply for assistance must be given the opportunity to do so. No one may be denied the right to apply for public assistance;
2. Reasonably prompt action on his/her application for assistance (see 479 NAC 6-001.08B2);
3. Adequate notice of any action affecting his/her application or assistance case (see 479 NAC 6-001.08C1 ff. to determine if timely notice is necessary);
4. Appeal to the NDHHS Director for a hearing on any action or inaction with regard to an application, the amount of the assistance payment, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the action or inaction;

5. Have his/her information treated confidentially;
6. Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, or political belief;
7. Have the program requirements and benefits fully explained;
8. Be assisted in the application process by the person of his/her choice;
9. Receive medical assistance without a separate application if another unit member is eligible for categorical assistance; and
10. Referral to other agencies.

6-001.08 Application Processing

6-001.08A Request: A request for assistance may be made in an interview, by letter, or by telephone, and may be made by the applicant, his/her guardian or conservator, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant.

A request is terminated:

1. When a properly signed Application for Assistance is received;
2. When the applicant or his/her representative notifies the worker of withdrawal; or
3. After 30 days if the worker has heard nothing further from the applicant or his/her representative. However, the worker may continue to hold a request pending if there is reason to believe the applicant intends to complete his/her application.

6-001.08B Application: A request becomes an application when a properly signed Application for Assistance is received. A properly signed application contains:

1. Name;
2. Address; and
3. Proper signature, as defined by the appropriate program.

An application for medical assistance may be signed by an individual for himself/herself or by an individual acting on behalf of the applicant. The worker must use prudent person principle in deciding who may sign the application.

6-001.08B1 Alterations: The application, when completed and signed by the former ward or his/her representative, constitutes his/her own statement in regard to the former ward's eligibility. If the worker adds information received from a former ward or his/her representative to a properly signed application, the worker must date the information and:

1. Request that the former ward or his/her representative initial the change, if present; or
2. Identify the source of the information, if the former ward or his/her representative is not present.

If a substantial amount of information is added during the face-to-face interview, the worker may request that the former ward or his/her representative sign and date the application again.

The worker may alter an initial application up to the date of approval. An application for a redetermination may be altered up to the date the redetermination has been completed.

6-001.08B2 Prompt Action on Applications: The worker must act with reasonable promptness on all applications for assistance. The worker must make a determination of eligibility on an application within 45 days from the date of the request. If circumstances beyond the control of the worker prevent action within 45 days, the worker must record the reason for the delay in the case record. The worker must send a Notice of Action informing the applicant of the reason for the delay. The 30-day time period must not be used as a routine waiting period before approving assistance.

6-001.08B3 MA Application With a Share of Cost (SOC): An application for medical assistance for an individual with an SOC who has a medical need may be approved with no medical payments authorized until the applicant has met his/her obligation.

6-001.08B4 Application With Excess Resources: An application for assistance for an individual who has excess resources may be held pending until the resources are reduced (see 479 NAC 6-002.06H).

6-001.08B5 Place of Application: The local office in the area where the individual resides is responsible for taking the application. Applications may be taken in the local office, in the applicant's home, or another place that is convenient for the applicant.

6-001.08B6 Withdrawals: The applicant may voluntarily withdraw an application. If the applicant verbally withdraws the application, the worker must request a written statement of withdrawal. The worker must make note of the withdrawal in the case record and give written confirmation of withdrawal to the applicant on a Notice of Action (see 479 NAC 6-001.08C.

If the applicant does not provide written confirmation of the withdrawal within 30 days from the application date, the worker must reject the application. The worker must send a Notice of Action to the applicant notifying him/her of the rejection.

6-001.08B7 Authorization for Investigation: For some sources the worker asks the client to sign Form ASD-46 when it appears that information given is incorrect, when the client is unable to furnish the necessary information, or for sample quality control verification. A copy of the authorization for release of information from Form the Application for Assistance may be used if the source will accept it.

6-001.08C Notice of Action: The worker must send adequate notice to notify the client of any action affecting his/her assistance case. A Notice of Action must be sent to the last-reported address. If the form is inadvertently sent to the wrong address, the worker must send a new form, allowing the client ten days from the date the corrected form is sent (if adequate and timely notice is required).

6-001.08C1 Types of Notices

6-001.08C1a Adequate Notice: An adequate notice must include a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s). The worker must send an adequate notice no later than the date of action.

6-001.08C1b Timely Notice: A timely notice must be dated and mailed at least ten calendar days before the date that action would become effective, which is always the first day of the month.

6-001.08C2 Adequate and Timely Notice: In cases of intended adverse action (action to discontinue, terminate, or reduce assistance or to change the manner or form of payment or service to a more restrictive method, i.e., protective payee, medical lock-in), the worker must give the former ward or his/her representative adequate and timely notice.

6-001.08C3 Situations Requiring Adequate Notice: In the following situations, the worker may dispense with timely notice but must send adequate notice no later than the effective date of action.

1. The agency has factual information confirming the death of a former ward;
2. The agency receives a written and signed statement from the former ward or his/her representative:
   a. Stating that assistance is no longer required; or
   b. Giving information which requires termination or reduction of assistance, and indicating, in writing, that the former ward or his/her representative understands the consequence of supplying the information;
3. The former ward has been admitted or committed to an institution, and no longer qualifies for assistance;
4. The former ward has been placed in skilled nursing care, intermediate care, or long-term hospitalization;
5. The former ward's whereabouts are unknown and agency mail directed to the former ward has been returned by the post office indicating no known forwarding address. The agency must make the former ward's check available to the former ward if his/her whereabouts become known during the payment period covered by a returned check; or
6. The former ward has been accepted for assistance in another state and that fact has been established.

6-001.08C4 Waiver of Notice: If a former ward or his/her representative agrees to waive his/her right to a timely notice in situations requiring timely notice, the worker must obtain a statement signed by the former ward or his/her representative to be filed in the case record.

6-001.08C5 In Fraud Cases: At least five days' advance written notice must be given if:

1. The agency has facts indicating that action should be taken to discontinue, terminate, or reduce assistance because of probable fraud by the former ward or his/her representative; and
2. The facts have been verified where possible through collateral sources.

6-001.08C6 Continuation of Benefits: In cases of adverse action where the worker is required to send timely and adequate notice, if the former ward or his/her representative requests an appeal hearing within ten days following the date the Notice of Action is mailed, the worker must not carry out the adverse action until a fair hearing decision is made. This regulation does not apply to those situations outlined in 479 NAC 6-001.08C3 where the worker is required to send adequate notice only.

This regulation does not restrict the worker from continuing normal case activities and implementing changes to the assistance case that are not directly related to the appeal issue.

6-001.09 Redetermination of Eligibility: The worker must conduct a face-to-face interview and redetermination of eligibility annually. Whenever there is reported or suspected ineligibility of a former ward, the worker must take immediate action.

School registration and attendance for the former ward must be recorded in the narrative and kept up to date in accordance with changes as they occur. Form IM-20 is used to verify information from the educational institution.

6-001.09A Complete Redetermination: The worker must do a complete redetermination of eligibility annually. The worker may use either a new or a previously completed Form Application for Assistance. At this time the worker must conduct a face-to-face interview with the former ward or the former ward's guardian, conservator, or individual acting under a duly executed power of attorney.

6-001.10 Prudent Person Principle: When the statements of the former ward or his/her representative are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the worker must obtain additional verification before eligibility is determined. The former ward or his/her representative has primary responsibility for providing verification of information relating to eligibility.

Verification may be supplied in person, through the mail, or from another source (as an employer). If it would be extremely difficult or impossible for the former ward or his/her representative to furnish verification in a timely manner, the worker must offer assistance.

6-001.11 Local Office Responsible for Case Handling: The local office in the area where a former ward resides is responsible for handling the case.

When a former ward attends an educational program in another state, his/her case must be maintained in the service area to which s/he returns periodically. If the former ward does not return to the state, the case is maintained in the service area where the former ward last resided.

6-001.11A Transfer to New County of Residence: When a former ward moves to another service area, his/her case may be transferred to the local office in the new service area.

Note: It is not necessary to do a complete redetermination when receiving a transfer.

6-001.11A1 Case Handling of Temporary Absences: The case of an individual in an institution or a care facility for a temporary stay remains with the original local office in the area where the client resides and intends to return. Similarly, if a former ward is out of his/her area of residence for a brief visit the case is not forwarded. It remains the responsibility of the local office in the area where the former ward intends to return.

6-002 Eligibility Requirements: If the ward desires to continue his/her education upon discharge, s/he must do so immediately and must enroll in the next available school term. Former Department wards may continue to receive maintenance payments and medical assistance if the following eligibility requirements are met. The former ward must:

1. Have a face-to-face interview (see 479 NAC 6-002.01);
2. Be a U.S. citizen or alien (see 479 NAC 6-002.02 ff.);
3. Have a Social Security number (see 479 NAC 6-002.03 ff.);
4. Be within the age limits (see 479 NAC 6-002.04 ff.);
5. Have been a ward of the Department immediately before entering the program for former wards;
6. Have been in out-of-home care at the time of discharge and continue to be in out of home care while in the program (see 479 NAC 6-002.11);
7. Be single;
8. Be attending or enrolled in a secondary educational program, college or vocational program and maintaining a passing average (see 479 NAC 6-002.05 ff.);
9. Complete a written agreement with the protection and safety worker outlining the responsibilities of the Department and the youth and meet the requirements of the agreement (see 479 NAC 6-002.13);
10. Be within resource limits (see 479 NAC 6-002.06 ff.);
11. Be within income limits (see 479 NAC 6-002.07 ff.);
12. Cooperate in obtaining third party medical payments (see 479 NAC 6-002.08 ff.);
13. Enroll in an available health plan (see 479 NAC 6-002.09); and
14. Meet other eligibility requirements (see 479 NAC 6-002.10).

{Effective 02/23/04}

6-002.01 Face-to-Face Interview: A former ward wishing to apply for assistance, or his/her legal guardian, conservator, or an individual acting under a duly executed power of attorney is required to have a face-to-face interview. At this time the worker completes the Application for Assistance or reviews the information already entered on the application.

If a relative or a person acting for the client applies, using the prudent person principle (see 479 NAC 6-001.04), the worker may require a personal contact with the former ward.

6-002.02 Citizenship and Alien Status: In order to be eligible for public assistance, an individual must be either:

1. A citizen of the United States; or
2. An immigrant lawfully admitted for permanent residence (see 479-000-305 and 479-000-306).

Any individual born in the United States is considered a U.S. citizen. This includes children whose parents are not U.S. citizens, such as illegal immigrant parents or parents with student visas.

Receipt of SSI is sufficient proof of citizenship or lawfully admitted alien status.

{Effective 6/8/98}

6-002.02A Verification of Immigrant Status: When a former ward is an immigrant, the worker must obtain verification of immigrant status using the SAVE system (see 479 NAC 2-009.01E1).

6-002.03 Social Security Number (SSN): A former ward must furnish a Social Security number. The SSN, in conjunction with other information, provides evidence of identity of the individual.

6-002.04 Age: A former ward is eligible for assistance from age 18 through the month of his/her 21st birthday.

6-002.05 School Enrollment: The worker must verify that the former ward is enrolled in a secondary or post-secondary school. The educational program may be part or full-time. The worker must consider enrollment as continued through normal periods of class attendance, vacation, and recess unless the student graduates, drops out, is suspended or expelled, or is not registered for the next normal school term (excluding summer school). If the youth does not attend summer school, a monthly payment will not be made for those months. During the school term, the former ward must attend school except in the situations described in 479 NAC 6-002.05B. In order to receive maintenance payments over the summer months, the former ward must be registered or intending to register for the next available term.

The worker must consult with the former ward regarding the educational program; the worker must agree that the program is appropriate for the former ward.

Participation in the GED program meets eligibility for this program if:

1. The youth has a time frame (not to exceed three months) for anticipated completion of the GED program before enrollment; and
2. The youth provides verification of regular participation in the GED program every month.

At the end of the anticipated time frame or on completion of the program, the youth will need to provide verification of completion of the GED program.

{Effective 6/8/98}

6-002.05A Temporary Absence: Payment may be continued up to 90 days if a former ward must temporarily leave school because of illness, injury, or a situation that is beyond the control of the former ward. To continue assistance beyond 90 days, the worker must obtain approval from Protection and Safety, Central Office.

{Effective 02/23/04}

6-002.05B Exceptions to School Enrollment Requirement: If a youth is discharged between school terms, s/he must be enrolled for the next school term unless the plan was for the youth to "sit out" that semester. The youth may continue to receive benefits and not attend school under the following exceptions:

1. When the youth's attendance is postponed due to a mental or physical incapacity which prevents participation in a school program for a temporary period of time. Documentation must be provided by the youth's health care provider before the discharge.
2. When the youth is attending an educational program and there is an interruption in attendance due to a mental or physical incapacity which prevents participation in a school program for a temporary period of time. Documentation must be provided from the youth's health care provider at the time of the interruption.
3. The youth may "sit out" one school term from the time of discharge from wardship through age 20 or until discharge from this program. The youth may "sit out" the semester immediately following discharge if that was the plan before discharge.

If the youth's physician determines that the youth is unable to work or attend school for a period of time, the youth may receive a monthly payment if s/he provides the doctor's statement of his/her incapacity and the expected time frame for recovery. Six months is the maximum time that can be provided.

Under the first two exceptions, the youth may receive one month's payment to avoid losing his/her apartment if the youth is in the hospital. A doctor's statement of incapacity is required. If the youth is still hospitalized after one month, only the personal needs allowance will be paid for a maximum of six months. The youth may be eligible for medical assistance. After the youth's hospitalization s/he is expected to work until the next school term.

Under the third exception, the youth will not receive a monthly payment and is expected to support himself/herself. The youth will not lose eligibility for this program by not attending one school term over the time s/he is eligible for the former ward program.

{Effective 6/8/98}

6-002.05C School Performance: A former ward must regularly attend classes and maintain a passing average. The worker must verify the ward's grades at the end of each school term. The school's definition of passing is used.

6-002.06 Resources: The total equity value of available non-exempt resources of the former ward is determined and compared with the established maximum for available resources. If the total equity value of available non-exempt resources exceeds the established maximum, the former unit is ineligible for assistance. The following are examples of resources:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Certificates of deposit;
4. Stocks;
5. Bonds;
6. Investments;
7. Collectable unpaid notes or loans;
8. Promissory notes;
9. Mortgages;
10. Land contracts;
11. Land leases;
12. Revocable burial funds;
13. Trust or guardianship funds;
14. A home;
15. Additional pieces of property;
16. Trailer houses;
17. Burial spaces;
18. Life estates;
19. Farm and business equipment;
20. Livestock;
21. Poultry and crops;
22. Household goods and other personal effects;
23. The contents of a safe deposit box; and
24. Federal and state tax returns.

6-002.06A Verification of Resources: Before determining eligibility of a former ward, the worker must verify and document in the case record all resources. Verification of resources consists of but is not limited to the following information:

1. A description of the type of resource to include account or policy number(s), legal descriptions (for property), etc.;
2. The location of the resource (i.e., name and address of the bank, insurance company, etc.);
3. Current value of the resource, encumbrances against the resource, and the resulting equity value (see 479 NAC 6-002.06E);
4. Description of current ownership (see 479 NAC 6-002.06C); and
5. Source of verification and the date the verification is obtained.

If the former ward has a guardian, the worker may use the guardian's report to the court for verification. The guardian's report applies only to the period covered by the report. The worker shall follow regular verification procedures if there is no guardian's report or the report does not coincide with the date of redetermination.

The worker must also note any additional information that may affect resource eligibility.

6-002.06B Definition of Available Resources: For the determination of eligibility, available resources include cash or other liquid assets or any type of real or personal property or interest in property that the former ward owns and may convert into cash to be used for support and maintenance.

6-002.06B1 Unavailability of Resource: Regardless of the terms of ownership, if it can be documented in the case record that the resource is unavailable to the former ward, the value of that resource is not used in determining eligibility. The worker must consider the feasibility of the former ward's taking legal action to make the resource available. If the worker determines that legal action can be taken, the worker must allow the former ward 60 days to initiate legal action. After 60 days, if legal action has not been initiated, the resource is counted. The resource is not considered available until the legal action is completed.

In evaluating the availability of benefit funds, such as funds raised by a benefit dance or auction, the worker must determine the purpose of the funds and if the former ward has access to them.

The worker must determine a reasonable period of unavailability based on the circumstances of the case. The worker must monitor the status of the resource.

6-002.06B2 Excluded Resources: Disregarded income is also disregarded as a resource unless there is regulation stating otherwise. In addition, the following resources are excluded in making a determination of eligibility:

1. Real property which the former ward occupies as a home;
2. Goods of moderate value used in the home;
3. Clothing;
4. Certain trusts (including guardianships) set up for one or more children. These trusts are in some instances limited to the particular beneficiary(ies) and may render this beneficiary(ies) ineligible even though another child(ren) remains eligible (see 479 NAC 6-002.06F1c);
5. Certain life estates in real property (see 479 NAC 6-002.06F2c);
6. Burial spaces (see 479 NAC 6-002.06F2f);
7. Irrevocable burial trusts up to $3,000 per individual and the interest if irrevocable (see 468 NAC 2-008.07A3a);
8. Proceeds of an insurance policy that is irrevocably assigned for the purpose of burial of the ward (see 468 NAC 2-008.07A3b);
9. Income received annually, semi-annually, or quarterly which is prorated on a monthly basis and included in the budget. This is excluded over the period of time it is considered income; and
10. One motor vehicle.

The worth of resources, both available and excluded, is determined on the basis of their equity.

For any of these funds to be excluded as a resource, they must be segregated in a separate account so that they can be identified. If the funds are not in a separate account the worker must allow the former ward or his/her representative 30 days from notification of the requirement to set up a new account. After 30 days the resource is included in the resource limit if the former ward or his/her representative fails to segregate the funds. If this makes the former ward ineligible and the funds are subsequently segregated, the worker must determine eligibility for MA for the month of segregation.

Several excludable resources may be combined in a single account.

{Effective 02/23/04}

6-002.06C Determination of Ownership of Resources: A resource which appears on record in the name of a former ward must be considered.

6-002.06C1 Jointly Owned Resources: When a former ward has a jointly owned resource that is considered available, the worker must use the guidelines in the following regulations.

6-002.06C1a Resources Owned With Other Clients: If a former ward owns a resource with another client who is on categorical assistance, the worker must divide the value of the resource by the number of owners, regardless of the terms of ownership. The appropriate value is counted for each unit.

This reference also applies to resources owned with a spouse or child.

6-002.06C1a(1) Resources Owned With Non-Clients: If a former ward owns a resource with an individual who is not receiving categorical assistance, the worker must determine the appropriate value to be assigned to the former ward in accordance with the following regulations.

6-002.06C1a(1)(a) General Rule: As a general rule, the words and/or or or appearing on a title or other legal contract denote joint tenancy. This means that either owner could sign and turn the resource to cash without the other; therefore, the total resource is considered available to either owner.

The term and generally refers to "tenancy in common." This means that each owner holds an undivided interest in the resource without rights of survivorship to the other owner(s). Only the proportionate share based on the number of owners of the resource is available to each owner.

If the worker substantiates that the former ward is not the true owner of a resource, it is permissable to allow the former ward or his/her representative to remove his/her name from the title of ownership in order to reflect true ownership. The former ward or his/her representative is allowed 60 days to make this change without affecting eligibility.

6-002.06C1a(1)(a)[1] Real Property: Regardless of the terms of ownership, only the proportionate share of real estate is counted as a resource.

The worker must verify ownership of real estate through records in the offices of the register of deeds or county clerk. The worker must verify the terms on which property is held in cases of joint ownership. Records of the court have information in regard to estates which have not been settled or which are in probate. The worker must consult the records of the court if the property has come to the holder as a part of an estate; if by joint purchase, the facts will appear in the record of the deed.

6-002.06C1a(1)(a)[2] Bank Accounts: The worker must verify the terms of the account with the bank. If any person on the account is able to withdraw the total amount, the full amount of the account is considered the client's. If all signatures are required to withdraw the money, the proportionate share must be counted toward the former ward.

If the former ward verifies that none of the money belongs to him/her, s/he must be allowed 60 days to remove his/her name from the account. The former ward must provide proof of the change. If the former ward does not remove his/her name in 60 days, the money is counted as a resource.

If a portion is the former ward's, the worker must notify him/her of the requirement to put the money in a separate account.

6-002.06C1b Consideration of Relative Responsibility: When the client (i.e., a spouse or parent) has relative responsibility for a client in another assistance unit and the responsible relative owns the resource(s), the worker must divide the value by the number of units to determine the amount to be counted to each. An AABD/MA or SDP/MA couple is considered one unit.

Exception: If the responsible relative receives SSI, none of the value of the resource(s) is considered to the other unit.

When the client (i.e., a spouse or parent) has relative responsibility for a client in another assistance unit and both clients own the resource(s), regulations in 479 NAC 6-002.06C1a are followed and the resource is divided by the number of owners only. This meets the requirements of relative responsibility.

6-002.06D Inheritance: When a former ward receives an inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

6-002.06E Value and Equity: Equity is the actual value of property (the price at which it could be sold) less the total of encumbrances against it (mortgages, mechanic's liens, other liens and taxes, and estimated selling expenses).

If the encumbrances against the property equal or exceed the price for which the property could be sold, the former ward has no equity and the property is not an available resource.

6-002.06E1 Secured Debts: The total value of unpaid personal taxes and other personal debts secured by mortgages, liens, promissory notes, and judgments (other than those on which the statute of limitations applies) is subtracted from the gross value of the encumbered property, to find the equity. The worker must document in the case record the type of debt and plan under which payment was made. The former ward's statement of debts may usually be accepted unless information to the contrary is available.

6-002.06E2 Determination of Value: The worker may use public tax records to determine the sale value of a resource. If there is a question as to the accuracy of the sale value determined by tax records, verification may be obtained from a real estate agent or other appropriate individual.

6-002.06F Types of Resources: Resources can be divided into two categories: liquid and non-liquid.

6-002.06F1 Liquid Resources: Liquid resources are assets that are in cash or financial instruments which are convertible to cash. They include resources such as:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Certificates of deposit;
4. Stocks;
5. Bonds;
6. Investments;
7. Collectable unpaid notes or loans;
8. Promissory notes;
9. Mortgages;
10. Land contracts;
11. Land leases;
12. Revocable burial funds;
13. Trust or guardianship funds;
14. Cash value of insurance policies;
15. Other similar properties; and
16. Federal and state tax refunds.

6-002.06F1a Cash, Savings, Investments, Money Due: Cash on hand, cash in checking and savings accounts, salable stocks or bonds, certificates of deposit, promissory notes and other collectable unpaid notes or loans and other investments are available resources.

6-002.06F1b Life Insurance

6-002.06F1b(1) Definitions

Burial Insurance: Insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

Cash surrender value: Amount which the insurer will pay (usually to the owner) upon cancellation of the policy before death of the insured or before maturity of the policy.

Face value: Basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions.

Insured: The person whose life is insured.

Insurer: The company that insures others.

Owner: The person who has the right to change the policy.

Term Insurance: A form of life insurance that has no cash surrender value and generally furnishes insurance protection for only a specified or limited period of time.

6-002.06F1b(2) Cash Surrender Value: The cash surrender value of life insurance is considered an available resource. All available cash value of the policy(s) must be taken into consideration when determining total available resources. A policy that will not accrue any cash surrender value is not considered in determining the value of insurance.

6-002.06F1b(3) Adjustment: The client can usually adjust a large insurance policy to a smaller amount providing limited protection and allowing the client to benefit from accumulated savings.

6-002.06F1b(4) Interest and Dividends: Interest and dividends of all life insurance policies are treated according to 479 NAC 6-002.08A8, item 1.

6-002.06F1c Trust or Guardianship Funds: When a guardianship or trust fund that has been established on behalf of a former ward puts him/her over the resource limit (see 479 NAC 6-002.06G) the worker must verify if the guardianship or trust fund money is available for the care and maintenance of the former ward.

6-002.06F1c(1) Written Notice: The former ward is ineligible for extended assistance until the trustee or guardian gives the local office written notice of refusal to spend guardianship or trust fund monies for the care and maintenance of the former ward. In order to be considered current notice, it must be given within one year of its use in determining eligibility for categorical assistance. After current notice has been given, the former ward, if otherwise eligible, may receive benefits if all judicial remedies are pursued to determine the availability of the funds.

6-002.06F1c(2) Judicial Remedies: A former ward or his/her guardian is allowed up to 60 days from the approval date to file a request for access to the funds in a court of competent jurisdiction. A recipient is allowed 60 days from the date of notification. At the time the case is approved, the worker must inform the former ward and the guardian on a Notice of Action of the 60-day time limit. Benefits must not be withheld pending the filing.

If a petition has not been filed after 60 days, the client is no longer eligible for MA.

All questions and notices involving guardianship or trust funds should be addressed to the Central Office, Attn: General Counsel.

6-002.06F2 Non-Liquid Resources: Non-liquid resources are tangible properties which need to be sold if they are to be used for the maintenance of the former ward. They include all properties not classified as liquid resources, such as:

1. A home;
2. Additional pieces of property;
3. Trailer houses;
4. Burial spaces;
5. Life estates;
6. Farm and business equipment;
7. Livestock;
8. Poultry and crops; and
9. Household goods and other personal effects.

6-002.06F2a Liquidation of Real Property: When a former ward has excess resources because of real property, s/he may receive assistance pending liquidation of the resource, according to the following regulations.

Note: The former ward may be prospectively eligible with excess resources because of real property if s/he or the responsible relative signs Form IM-1.

6-002.06F2a(1) Definition of Real Property: Real property is defined as land, houses, or buildings.

6-002.06F2a(2) Time Limits for Liquidation: The worker must exclude real property which the former ward is making a good faith effort to sell. First the worker shall determine if the individual has the legal authority to liquidate the property. If not, the former ward is allowed 60 days to initiate legal action to obtain authority to liquidate (see 479 NAC 6-002.06B1). If the former ward owns the property with other persons who are not on assistance, see 479 NAC 6-002.06F2a(2)(b).

Once the former ward has the legal authority to liquidate the property, the worker must obtain the former ward's or responsible relative's signature on Form IM-1. The former ward or responsible relative is allowed six calendar months to liquidate the real property. If the former ward or responsible relative refuses to sign Form IM-1, the former ward is immediately ineligible because of excess resources.

One liquidation period is allowed for each piece of real property that is determined to cause excess resources, even if the case is closed and subsequently reopened.

6-002.06F2a(2)(a) Extension of Time Limit: If the former ward or responsible relative is unable to liquidate the property in six calendar months, the service area administrator may authorize an additional three calendar months. In determining whether to allow a three-calendar-month extension, the service area administrator must consider:

1. If the property has been placed on the market;
2. If the former ward or responsible relative is asking a fair price for the property;
3. If the asking price has been reduced;

4. If the former ward or responsible relative understands the requirement for liquidation of the property;
5. If the former ward or responsible relative has not refused a reasonable offer to purchase; and
6. The economic conditions in the area and if real estate is selling.

Before the three-month extension ends, if the former ward or responsible relative has exhausted all possibilities for selling the property but it is not sold, the worker must submit all information regarding the property and its salability on Form ASD-17 to Protection and Safety, Central Office, to determine if the resource is available, in accordance with the guidelines previously listed.

6-002.06F2a(2)(b) Joint Ownership: If the former ward owns the property with other persons who are not on assistance, the worker contacts the other owners to determine if they are willing to liquidate their interest in the property. If all parties are willing to liquidate, the worker proceeds with the liquidation process. If one or more of the parties do not wish to liquidate, the worker applies 479 NAC 2-001.08A and requires the former ward or responsible relative to take legal action to force a sale of the property. The worker may obtain a written statement from the other parties and file it in the case record. After a legal determination is made regarding the availability of the former ward's interest in the property, the worker takes the appropriate action.

6-002.06F2b Trailer Houses and Other Portable Housing Units: Trailer houses and other portable housing units, unless occupied by the former ward as home, constitute available resources.

6-002.06F2c Burial Spaces: The value of burial spaces held for the purpose of providing a place for the burial of the former ward is not counted as an available resource. A burial space includes a crypt, mausoleum, or other repository for the remains of a deceased person. This exemption also applies to markers, vaults, etc., but does not include services, burial fees, etc.

If the former ward has a life insurance policy for the purchase of burial items, the cash value is included in the $3,000 limit if the policy is irrevocably assigned (see 479 NAC 2-008.07A3). If the policy is not irrevocably assigned, it is considered life insurance and the cash surrender value is considered a resource (see 479 NAC 6-002.06F1b(2)).

6-002.06F2d Loans: A bona fide loan is disregarded as income or a resource. A bona fide loan is defined as one that must be repaid. The agreement for repayment may be verbal or written and the loan may be owed to an individual or to an organization or agency. Using prudent person principle the client's statement is adequate verification that the loan must be repaid.

6-002.06F2e Household Goods and Personal Effects: Household goods and personal effects of a moderate value used in the home are exempt. Household goods are defined as including household furniture and furnishings, tools, and equipment used in the operation, maintenance and occupancy of the home or in the functions and activities of the home and family life, as well as those items which are for comfort and accommodation. Personal effects include clothing, jewelry, items of personal care, etc.

6-002.06G Maximum Available Resource Levels: The former ward may have a maximum of $2,000 in resources, and remain eligible for a maintenance payment.

6-002.06H Reduction of Resources: The former ward or his/her representative may reduce available resources to the maximum without affecting eligibility if the case record contains documentation that the resources have been reduced and the former ward is within the resource limits. The former ward's or representative's statement of debts may be acceptable. Unsecured debts do not reduce the value of resources unless they are actually paid.

An application for an individual who has excess resources may be held pending until the resources are reduced.

Medical eligibility is effective the first day of the month in which excess resources have been expended if all other eligibility factors are met.

6-002.07 Income: The designated worker must explore all available or potential income. The worker shall take into account any assistance that the parent(s) makes available to the former ward. For deeming for medical assistance, see 479 NAC 6-002.09A.

If a former ward lives with a parent who is receiving ADC/MA, RRP/MA, AABD/MA, or SDP/MA, the budgets must be computed separately.

Neither the needs nor the income of the MA former ward may be considered in the parent's budget.

6-002.07A Types of Income

6-002.07A1 Earned Income: After application of the $90 work allowance, all earned income is budgeted.

6-002.07A2 Unearned Income: All unearned income is counted. Unearned income includes, but is not limited to:

1. Retirement, Survivors, and Disability Insurance (RSDI) under the Social Security Act;
2. Railroad Retirement;
3. Veteran's or military service benefits;
4. Unemployment compensation or disability insurance benefits;
5. Disability benefits paid by the employer (this does not include sick leave);
6. Worker's compensation;
7. Voluntary contributions;
8. Lease income;
9. Annuities;
10. Pensions, or returns from investments or securities in which the individual is not actively engaged;
11. Civil Service benefits; and
12. SSI.

6-002.07A2a Grants and Scholarships: The designated worker must file a copy in the case record of any award or denial letters for grants, scholarships, benefits, etc.

6-002.07A2b Contributions: Contributions are verified payments which are regularly paid to or for the former ward. Contributions received regularly to aid in the support of the client, either in the form of money payments or the provision of shelter, including taxes and insurance, are considered unearned income.

When another individual is paying the entire expense(s) the worker must consult the chart in 468 NAC 2-009.04B4 to determine the amount to consider as unearned income. If the amount paid is equal to or greater than the amount(s) on the chart, the worker uses the amount(s) on the chart. If the amount(s) paid is less than the amount on the chart, the worker uses the actual amount. When another individual is paying a portion of the expenses, it is not considered a contribution.

The following are not considered contributions:

1. Payments for utilities;
2. Energy asssistance;
3. Emergency assistance;
4. General assistance; or
5. Crisis assistance from a community agency, service agency, or an individual.

{Effective 9/20/95}

6-002.07A2c Third Party Medical Payments: Income received from a third party that pays the former ward directly is:

1. Disregarded if it is refunded to the provider or the Department as reimbursement for a specific service; or
2. Counted as unearned income if the former ward fails or refuses to refund these payments.

If the former ward receives a third party medical payment directly and the medical expense for which the third party medical payment is intended is payable by NMAP, the worker must send a demand letter advising the former ward that s/he must reimburse the Department or the provider up to the amount of payment which has been or will be made for the specific service. The former ward is allowed ten days from the date of notification to reimburse the Department or pay the provider.

If the former ward refunds within ten days, the worker must take no further action. If the former ward fails or refuses to refund within ten days, the worker must consider the entire third party payment as unearned income in the first month possible, taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month.

6-002.07A2c(1) Income-Producing Policies: Income received from an insurance policy that supplements the former ward's income while s/he is hospitalized or receiving medical care is treated as unearned income. These policies provide income regardless of the type of service being provided or the condition of the former ward. If it is verified that the income was applied to medical bills, the income is not counted in the former ward's budget.

Income is not counted from health insurance policies which pay the former ward directly for the purpose of reimbursement to the provider and which cover a specific service(s).

6-002.07A3 Accumulated Benefit Payments: Accumulated payments of Retirement, Survivors, and Disability Insurance (RSDI); Railroad Retirement; veteran's pensions; worker's compensation; or other benefit payments which are received in a single sum are considered income in relation to the recipient's need in the month in which they are received or reported. The payment must be shown in the following month's budget, if observance of the cutoff date and ten days' notice allow. If not, the grant change may take place no later than the second month following the month in which the accumulated payment is received or reported. The balance remaining after consideration of the unit's needs for a particular month is considered an available resource in the subsequent month.

6-002.07A4 Potential Income: Potential income is defined as income based on entitlement or need which is usually determined by an administering agency as a result of an application for benefits by the individual. Potential income includes, but is not limited to, RSDI, categorical assistance, Railroad Retirement, veteran's or military service benefits, unemployment compensation, disability insurance benefits, and worker's compensation. Medicare is not considered a potential benefit.

The worker must explore each individual's potential entitlement for benefits. The former ward is required to apply for any benefits for which s/he appears to be entitled within 60 days of the date the worker notifies the former ward of the requirement. The worker must not delay determination of eligibility for assistance and authorization of payment pending determination of entitlement for benefits. After the worker has determined the former ward's eligibility for categorical assistance s/he must notify the former ward in writing of the requirement to apply for a benefit for which the former ward appears eligible and inform the former ward of the number of days left in which to apply.

6-002.07A4a Refusal to Apply: A former ward is expected to make application for and accept benefits promptly after the worker has discussed the former ward's apparent entitlement to the benefits. When an application for assistance is approved, the former ward is notified on a Notice of Action of the number of days left in which to apply. The worker must document in the case record when the former ward was informed of the possibility of benefits. The worker must set up a special review to see if the former ward is eligible for or already receiving benefits. If the individual fails or refuses to make application within 60 days after notification by the worker or refuses to accept benefits for which s/he has been determined eligible, eligibility cannot be determined.

6-002.07A5 Verification of Income: The worker must verify irregular unearned income every three months, and regular unearned income every six months.

This review may be eliminated for cases where the only source of income is RSDI, or another similar stable source, and there is no reason to believe the amount will change.

6-002.07A6 Budgeting Procedures: When income is irregular, the worker must use an average of income for the three most recent consecutive months. When income is regular, the worker must use one month's income. The worker must use the following procedures:

1. List all earned and unearned income periods used. If there is a particularly high or low check, disregard it in the average;
2. Add gross income amounts for each earned and unearned income period. Divide by the number of earned or unearned income periods used for verification to arrive at the average amount per earned and unearned income period; and

3. Convert the figure from step 2 to a monthly figure using conversion tables for weekly or bi-weekly earned and unearned income periods (see 479-000-201). For a figure not shown on the conversion tables, multiply the average weekly figure by 4.3 and the average bi-weekly figure by 2.15. If income is received semi-monthly, add the two figures. If the income is monthly, use the actual monthly figure.

6-002.07A6a Significant Changes: The following circumstances are considered significant changes:

1. Change in job;
2. Promotion;
3. New employment;
4. Termination of employment;
5. Change in the amount of monthly income, including:
   a. All changes in unearned income; and
   b. Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for assistance for former wards, 30 hours per week is considered full-time.
      {Effective 12/17/95}

6-002.07A6b General Rules Governing Significant Changes: The following procedures are used in handling significant changes in unearned income:

1. Initiate action to verify the change;
2. Determine anticipated unearned income;
3. Estimate income on information available, recompute the budget for the following month. When projecting income, use the conversion tables and convert weekly or bi-weekly payments to a monthly amount (see 479-000-201). If the former ward or responsible relative is paid semi-monthly or monthly, use actual verified amount;
4. Send a ten-day notice for reduction, termination, or suspension. The effective date of change depends on when the change is reported;
5. Obtain verification of income within 30 days of reported change, if possible;
6. Compute the budget for the month following receipt of verification. Use the conversion tables to compute income received weekly or bi-weekly (see 479-000-201); and
7. After three months of receipt of unearned income, determine if income is regular or irregular and apply the appropriate rules.

The worker must record in the case record the date of reported change, method of estimating income, and the date verification was made. If verification cannot be made within 30 days of reported change, the reason must be recorded in the narrative.

{Effective 4/11/95}

6-002.07A7 Income as It Applies to Resources: Income received by a former ward during any one month for maintenance costs may not be considered a resource for that month. Any income not spent for maintenance is considered a resource in the subsequent month.

6-002.07A8 Income Listing

TYPES OF INCOME	TREATMENT OF INCOME
1. Declared cash winnings, gifts, interest, dividends (may be prorated on a monthly basis), etc.	1. Disregard $10 a month for each income type. If more than $10 a month, count the amount that exceeds $10 as unearned income.
2. Unpredictable gifts of indeterminate value	2. Disregard.
3. Payments from Title I, for Workforce Investment Act (WIA) classroom training	3. Disregard.
4. Earnings received from the employer or compensation in lieu of wages under a Title I WIA program	4. Disregard for a student regardless of age.
5. Title I, WIA program allowance paid to the former ward or vendor payments made to the provider for supportive services, such as transportation, meals, special tools, and clothing. This includes temporary Welfare-to-Work payments made through Workforce Development.	5. Disregard for all ages.
6. Interest on Series E savings bonds and other bonds which accrue interest	6. Consider as unearned income when redeemed.

7.	Interest on Series H savings bonds and other bonds which pay dividends or interest	7. Consider as unearned income in month dividend received or reported.
8.	Any student financial assistance	8. Disregard.
9.	A bona fide loan from any source	9. Disregard.
10.	Payments for participating in training or school attendance subsidized by the Division of Vocational Rehabilitation	10. Disregard. Any expenses that the grant or loan covers must not be considered as an educational need on Form IM-26FC.
11.	Agent Orange settlement Payments	11. Disregard.
12.	Payments to AmeriCorps Volunteers	12. Disregard.
13.	Benefits under Public Law 104-204 for children of Vietnam veterans who were born with spina bifida	13. Disregard.

{Effective 02/23/04}

6-002.07A9 Treatment of Income: Unearned income is counted in full toward the budgeted basic living expense. If the income is equal to or exceeds the basic living expense, there is no eligibility for a grant payment but there may be eligibility for medical assistance.

6-002.08 Assignment of Third Party Medical Payments: Application for medical assistance constitutes an automatic assignment to the Nebraska Department of Health and Human Services of the former ward's rights to third party medical payments.

This assignment gives the Department the right to pursue and receive payments from any third party liable to pay for the cost of medical care and services of the former ward and which otherwise would be covered by NMAP.

The assignment of the rights to third party medical payments is effective with the date of eligibility for medical assistance. For MA cases with a share of cost, the assignment becomes effective the first day of the cycle when the case status changes to 450, "obligation met."

6-002.08A Individuals Who May Legally Assign Rights: The former ward or his/her representative may legally assign rights to third party and medical support payments.

6-002.08B Third Party Payments Not Assigned: The following third party payments are not subject to the automatic assignment provision:

1. Medicare benefits; and
2. Payments from income-producing policies which subsidize the client's income while s/he is hospitalized or receiving medical care, regardless of the type of medical service being provided.

6-002.08C Cooperation in Obtaining Third Party Payments: As a condition of eligibility for medical assistance, the former ward or his/her representative must cooperate in obtaining third party payments unless s/he has good cause for noncooperation (see 479 NAC 6-002.08E). Cooperation includes any or all of the following:

1. Providing complete information regarding the extent of third party coverage which s/he has or may have. This includes coverage provided by an individual or by an agency;
2. Providing any additional information or signing claim forms which may be necessary for identification and collection of potential third party payments;
3. Appearing as a witness in a court or another proceeding, if necessary;
4. Notifying the Department of any action s/he is initiating to recover money from a liable third party for medical care or services. This includes the identity of the third party as well as the entire amount of any settlement, court award, or judgment;
5. Reimbursing the Department or paying to the provider any payments received directly from a third party for any services payable by NMAP; and
6. Taking any other reasonable steps to secure medical support payments.

6-002.08D Refusal to Cooperate: The worker is responsible for determining noncooperation by the former ward or his/her representative. This determination is based on the former ward's or his/her representative's failure or refusal to fulfill the requirements listed in 479 NAC 6-002.08C.

6-002.08E Opportunity to Claim Good Cause

6-002.08E1 Notification of Right: The worker must notify the former ward or his/her representative of the right to claim good cause for noncooperation at the intake interview, redetermination, and whenever cooperation becomes an issue.

The worker must give the former ward or his/her representative a verbal explanation of good cause and the opportunity to ask questions.

At the initial interview the former ward or his/her representative must sign a written explanation of good cause, Form IM-60.

6-002.08E2 Worker's Responsibilities If Good Cause Claimed: If the former ward or his/her representative claims good cause, the worker must:

1. Explain that the former ward or his/her representative has the burden of establishing the existence of a good cause circumstance; and
2. Obtain a signed statement from the former ward listing the reason(s) for claiming good cause. The former ward or his/her representative is allowed 20 days to present evidence of the claim.

6-002.08E3 Acceptable Circumstances for Good Cause: Good cause claims must be substantiated by signed statements. When documentary evidence is not available the client must furnish sufficient information as to the location of the information.

To establish good cause, the evidence must show that cooperation would not be in the best interest of the client or another unit member for whom assignment is sought. Good cause includes the following circumstances, provided proper evidence is obtained.

6-002.08E3a Physical or Emotional Harm to the Former Ward: Good cause exists if the former ward's cooperation in assigning benefits is reasonably anticipated to result in physical or emotional harm to the former ward. Emotional harm must only be based upon a demonstration of an emotional impairment that substantially reduces the individual's functioning.

6-002.08E3a(1) Documentary Evidence: Documentary evidence which indicates these circumstances includes:

1. Medical records which document emotional health history and present emotional health status of the former ward;
2. Written statements from a mental health professional indicating the diagnosis or prognosis concerning the emotional health of the former ward;
3. Court, medical, criminal, protective services, social services, psychological, or law enforcement records which indicate that the third party might inflict serious physical or emotional harm on the former ward; or
4. Signed statements from individuals other than the former ward with knowledge of the circumstances which provide the basis for the claim.

6-002.08E3a(2) Evidence Not Submitted by the Former Ward or His/Her Representative: When the claim is based on the former ward's anticipation of physical harm and corroborative evidence is not submitted in support of the claim the worker must:

1. Investigate the good cause claim when s/he believes that the claim is credible without corroborative evidence and corroborative evidence is not available; and
2. Find good cause if the former ward's or his/her representative's statement and the investigation indicate that the former ward has good cause for refusing to cooperate.

6-002.08E3a(3) Worker Considerations: If the determination of good cause is not substantiated by documentary evidence, the worker must consider and document the following evidence:

1. The present physical or mental state of the former ward;
2. The physical or mental health history of the former ward;
3. Intensity and probable duration of the physical or mental upset; and
4. The degree of cooperation required by the former ward or his/her representative.

6-002.08E4 Decision on Good Cause: The worker must determine good cause and notify the former ward or his/her representative of the decision on a Notice of Action. If the worker determines that good cause does not exist, s/he allows the former ward or his/her representative ten days to respond from the date that the Notice of Action was mailed. If the former ward or his/her representative does not cooperate, withdraw the application, or request the case closed, a sanction is imposed (see 479 NAC 6-002.08F).

6-002.08E5 Delay of Assistance Pending Determination: The agency must not deny, delay, or discontinue assistance pending a determination of good cause if the former ward or his/her representative has complied with the requirements of providing acceptable evidence or other necessary information. In most instances, a good cause determination must be made within 30 days following the receipt of a claim.

6-002.08E6 Review of Good Cause: At the time of each redetermination, the worker must review a good cause claim based on a circumstance that is subject to change.

If circumstances remain the same, no action is required. A new determination is necessary if circumstances have changed. If good cause no longer exists, the requirement to cooperate must be enforced.

6-002.08F Sanction for Refusal to Cooperate: If the former ward or his/her representative fails or refuses to cooperate and there is no good cause claim or determination, the appropriate sanction is applied.

If the reason for noncooperation is the former ward's or his/her representative's failure or refusal to provide information about or obtain third party medical payments (see 479 NAC 6-002.08C), the former ward is ineligible for MA. Ineligibility continues for the former ward until s/he cooperates or cooperation is no longer an issue. The former ward is ineligible for MA but continues to receive a grant as long as all other eligibility requirements are met.

6-002.08G Third Party Payments Received Directly: If the former ward receives a third party medical payment directly and the medical expense for which the third party medical payments is intended is payable by NMAP, the worker must take the following actions:

1. Send a demand letter advising the former ward or his/her representative that s/he must reimburse the Department or the provider. The former ward or his/her representative is allowed ten days from the date of notification to reimburse the medical payment. For an applicant, the worker must not delay determination of eligibility for assistance and authorization for payment pending the applicant's reimbursement. At the time the application is approved, the worker must notify the former ward or his/her representative of the number of days left in which to reimburse the payment;
2. If the former ward or his/her representative refunds within ten days, take no further action; or
3. If the former ward or his/her representative fails or refuses to refund within ten days, consider the entire third party payment as unearned income in the first month possible, taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month.

If the insurance payment exceeds NMAP rates, the excess is considered unearned income unless paid out on other medical services or supplies.

Regardless of the existence of a good cause claim, any third party medical payment that is received directly by the former ward must be reimbursed.

6-002.08H Willfully Withheld Information: When the evidence clearly establishes that a former ward or his/her representative willfully withheld information regarding a third party medical payment which resulted in an overpayment of NMAP expenditures, the worker must refer the case to the Special Investigation Unit, Central Office, or in the Omaha Office to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker must take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker must complete normal case actions which include applying the appropriate sanction in this section.

6-002.08J Termination of Assignment: When a former ward's grant and medical case is rejected or closed, the assignment provision is terminated. The former ward's rights to any future third party and medical support payments are automatically restored effective with the date of ineligibility. However, the assignment remains in effect for the time period during which the former ward was on medical assistance.

6-002.09 Cooperation in Obtaining Health Insurance: As a condition for eligibility for MA, a former ward is required to enroll in an available health plan if the Department has determined that it is cost effective and the former ward is able to enroll on his/her own behalf. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations.

6-002.10 Ineligibility of Fleeing Felon: An individual is ineligible for former ward assistance during any period in which the individual is:

1. Fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of the place from which the individual is fleeing; or
2. Violating a condition of federal or state probation or parole.

{Effective 6/8/98}

6-002.11 Living Arrangement: The former ward must continue to be in an out-of-home situation to remain eligible for the program.

{Effective 02/23/04}

6-002.12 Written Agreement: The former ward must complete a written agreement outlining the responsibilities of the Department and the former ward, and meet the requirements of the agreement. The agreement must include the highest level of activity that the youth is capable of achieving. For example, if a youth is working for a GED, the student needs to be enrolled in classes frequently enough to complete the program in a reasonable period of time or be taking vocational classes too.

The agreement must be reviewed whenever circumstances change, but at least every 12 months.

6-002.13 Termination of Wardship: A ward who is otherwise eligible but has excess income or resources at the time of discharge may be accepted into the program. No benefits are paid until the ward becomes eligible financially. The worker must contact the former ward at least once every six months. The contact may be face to face or by phone. If the ward becomes financially eligible before reaching age 21, s/he may receive assistance.

6-003 Maintenance Payment: A monthly maintenance payment is paid to the former ward unless the designated worker determines that payment should be made directly to an educational institution.

Except in situations described in 479 NAC 6-003.02, the maintenance payment must not exceed the basic payment for a child age 12 or older (see 479-000-206).

6-003.01 Determination of Maintenance Payment: The former ward and worker should complete a budget together to prepare the former ward for budgeting his/her own finances. The budget is completed by subtracting any earned and unearned income from the total living expenses to arrive at the amount of payment up to the maximum maintenance payment.

6-003.02 Payment for Former Ward Completing High School: Payment may be made up to the amount that would be paid in foster care as determined by FCPAY if:

1. The youth had his/her 19th birthday during the last year of high school;
2. The youth will complete high school that school year and plans to continue his/her education;
3. The youth will remain in the foster home while finishing high school;
4. There has been a needs assessment indicating that the higher level of need continues; and
5. The higher payment level is necessary for the youth to complete high school.

The higher payment is allowed only until the youth completes high school.

The protection and safety worker continues oversight and case management to ensure that needed services are being provided.

{Effective 02/23/04}

6-004 Medical Benefits: A former ward who is eligible for a maintenance payment under this program is also eligible for the Nebraska Medical Assistance Program without a separate application. Medical care and treatment will be provided through the NMAP.

Payment for medical benefits may be made from child welfare funds only when a plan for medical or dental treatment was approved before the ward's discharge and the former ward is ineligible for NMAP.

If the former ward becomes ineligible for Extended Assistance for Former Wards and has a medical need, the worker must consider medical eligibility under Children's Medical Assistance Program (see Title 477), and Medically Handicapped Children's Program (see Title 467).

{Effective 8/18/03}

6-004.01 Out-of-State Medical: If an out-of-state provider does not sign an agreement with NMAP and accept the reimbursement rate, the client is liable for any medical bills. Payment may be approved for services provided outside Nebraska in the following situations:

1. When an emergency arises from accident or sudden illness while a former ward is visiting in another state and the former ward's health would be endangered if care is postponed until s/he returned to Nebraska or if s/he traveled to Nebraska;
2. When a former ward customarily obtains service in another state because the service is more accessible; and
3. When the former ward requires a medically necessary service that is not available in Nebraska but is available in another state.

Payment for item 3 must be prior authorized by the Division of Medical Services before the services are provided. The provider must request prior authorization of payment from the appropriate staff of the Division of Medical Services. Prior authorization of item 3 may include economical transportation as a provider payment if needed.

6-004.02 Required Copayments: Former wards are required to pay a copayment for the medical services listed at 479-000-202. Copayment amounts are also listed at 479-000-202.

6-004.02A Covered Persons: With the exceptions listed at 479 NAC 6-004.02B, former wards are subject to the copayment requirement.

The provider must verify the client's copayment status by Accessing the Department's Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln 471-9580); or the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128).

{Effective 7/11/09}

6-004.02B Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes;
5. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Model Waiver for Children with Mental Retardation and Their Families; or the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities;
6. Individuals with a share of cost (over the course of the SOC cycle, both before and after the obligation is met); and
7. Individuals who receive assistance under SDP (program 07).

6-004.02C Covered Services: For covered and excluded services, see 479-000-202.

6-004.02D (Reserved)

6-004.02E Client Rights: If a former ward believes that a provider has charged the former ward incorrectly, the former ward must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.

If the former ward is unable to pay the required copayment, s/he may inform the provider of the inability to pay. While the provider shall not refuse to provide services to the former ward in this situation, the former ward is still liable for the copayment and the provider may attempt to collect it from the former ward.

The former ward has the right to appeal under 465 NAC 2-001.02.

6-004.02F Collection of Copayment: For provider procedures, see 471 NAC 3-008.04.

6-005 Nebraska Health Connection (NHC): Managed care is required for all active Medicaid-eligible individuals except those excluded groups listed at 468-000-347. For more information, see Title 482.

{Effective 02/23/04}

6-005.02 Excluded Clients: The following clients are excluded from the NHC:

1. Clients with Medicare coverage;
2. Clients residing in nursing facilities;
3. Clients residing in intermediate care facilities for the mentally retarded;
4. Clients who are residing out-of-state;
5. Certain children with disabilities who are receiving in-home services under 471 NAC 12-014.04 (also known as the Katie Beckett program);
6. Aliens who are eligible for Medicaid for an emergency condition only;
7. Clients receiving services through the following home and community-based waivers for -
   a. Adults with mental retardation or related conditions (see 480 NAC 2-000);
   b. Aged persons or adults or children with disabilities (see 480 NAC 5-000);
   c. Children with mental retardation and their families (see 480 NAC 6-000);
   d. Infants and toddlers with disabilities (also known as the Early Intervention waiver, see 480 NAC 8-000); and
   e. Any other group for whom the Department has received approval of a 1915(c) waiver;
8. Clients who have excess income (i.e., spenddown, met or unmet);
9. Clients participating in the Subsidized Adoption Program, including those who receive a maintenance subsidy from another state;
10. Clients receiving grant and/or medical assistance through the State Disability Program;
11. Clients eligible during the period of presumptive eligibility; and
12. Clients with private health insurance determined to be primary coverage or whose insurance coverage is pending verification. Primary coverage includes verified standard comprehensive coverage, verified HMO or prepaid plan with specified providers, or verified CHAMPUS (see 482-000-102 for a list of codes).
    Note: Clients with private health insurance will be excluded from the NHC until the coverage is verified; at that time, clients not having primary coverage will be required to participate in the NHC.
    Exception: This exclusion does not apply to the Mental Health/Substance Abuse benefits package.

The Department pays for Medicaid coverage for these clients on a fee-for-service basis. Clients who are excluded from the NHC cannot voluntarily enroll in managed care.

{Effective 7/25/95}

CHAPTER 7-000 SUBSIDIZED GUARDIANSHIP PROGRAM

7-001 Introduction: The Nebraska Department of Health and Human Services subsidized guardianship program provides continued financial assistance to a child after a legal guardian has been appointed and the Department's custody has been terminated.

7-001.01 Purpose: The subsidized guardianship program is designed to ensure that financial barriers or costs associated with a child's needs do not prevent the appointment of a guardian fora child as a preferred alternative to long term foster care.

7-001.02 Legal Basis: State funds may be used for subsidized guardianship payments on behalf of a child who was a Department ward, as provided in Neb. Rev. Stat., section 43-284.02.

7-001.03 Use of Other Resources: The guardian must use all available resources, benefits, and programs, including but not limited to private insurance coverage, care or services available through the education system.

7-002 Child's Eligibility: A child is eligible for the subsidized guardianship program if s/he is a ward of the Department and meets the criteria for guardianship as follows:

1. The child has a documented behavioral, emotional, physical, or mental disability;
2. The child is a member of a sibling group of three or more to be placed together;
3. The child has a strong attachment to the potential guardian and has lived successfully for a minimum of six months in the home of the potential guardian;
4. The child cannot return home despite all efforts to effect reunification;
5. The child cannot be adopted and all attempts to terminate parental rights have failed or the termination is not in the child's best interest;
6. The child is age 12 or older or, if under 12, is part of a sibling group or is attached to the proposed guardian and cannot be freed for adoption; and
7. The prospective guardian and the child can function effectively without Department supervision.

A child's eligibility ends upon the child's 19th birthday, when the child becomes emancipated or self-supporting, or when the guardianship order is terminated.

Notwithstanding any other provision, the eligibility of a child for a kinship guardianship assistance payment under Title IV-E of the Social Security Act shall not be affected by reason of the replacement of a relative guardian with a successor guardian named in a kinship guardianship assistance agreement including any amendment thereto.

7-003 Agreement Prior to Guardianship Order: The agreement for subsidy, specifying type, amount, and duration of subsidy must be completed and approved before the order establishing guardianship is issued.

Any subsidy payments begin after the guardian has been appointed by the court.

7-004 Determining the Guardian's Need for Subsidy: When guardianship becomes the appropriate plan for the child, the child's worker must determine whether the prospective guardian will be able to meet the child's needs without subsidy. The worker must assess the following with the family:

1. Need for Subsidy
    a. The child's present and anticipated future needs; and
    b. The prospective guardian's ability to meet those needs without subsidy. The assessment must consider other programs, benefits, or resources available to meet the child's needs, including but not limited to:
        (1) Public assistance including:
            (a) Maintenance payments. If the ward is eligible for ADC, s/he also receives medical assistance.
            Note: Nebraska guardians are not eligible for ADC payments, although specified relatives who are guardians or conservators are eligible for ADC relative payments if they meet other eligibility criteria;
            (b) Medical assistance only. If the child needs medical assistance, the worker completes Form EA-117. Eligibility for MA is a separate determination from eligibility for subsidy. Eligibility is determined using CMAP guidelines (see Title 477;
        (2) Supplemental Security Income (SSI), Veterans benefits, Social Security benefits, or Railroad Retirement benefits;
        (3) Child support;
        Note: Establishment of a guardianship does not eliminate the potential for child support by a parent. Child support can be ordered by the court to be paid directly to the guardian.
        (4) Medically Handicapped Children's Program; and
        (5) Private insurance coverage by the prospective guardian.

2. Type(s) of subsidy: In some cases, only one or two types of subsidy coverage will be necessary.
3. Amount: If maintenance or other costs incidental to care of the child are being considered:
   (a) The amount must be no more than payment would be if the child had remained in the Department's care;
   (b) Explore other maintenance payments or financial resources. The worker shall explain that any maintenance payments will be deducted from the agreed-to maintenance under subsidy; and
   (c) If the guardian receives an ADC-relative payment, the worker must establish a level of need for the child based on FCPAY and subtract $222 for the maintenance payment. The remainder is the subsidized guardianship payment. If a family provides guardianship for siblings, deduct $222 from the determined payment for the youngest child and $71 for each of the older children.
4. Duration: Discuss how long the guardian anticipates needing assistance.

   Assistance for child care or respite care ends when the child reaches age 13 unless the child has a special need. See 474 NAC 7-006.01 for the definition of special needs for child care.

{Effective }

7-004.01 Subsidy Approval: The worker and supervisor must complete and submit Form DSS-74, "Guardianship Referral Form," to the designated service area adoption staff for signature.

{Effective 9/20/95}

7-005 Types of Subsidy: Subsidized guardianship may include one or more of the following:

1. Maintenance: This includes monthly payments to the guardian to assist in meeting the child's day-to-day needs. The amount must not be greater than what would be paid for the child in foster care.
2. Medical/Surgical: This may include the following:
   a. Payments to a medical practitioner for medical or surgical care. Payment is made by Medicaid at the Nebraska Medicaid rate; or
   b. Payments for Residential Psychiatric Care (see 479 NAC 7-007).
3. Other Costs Incidental to the Care of the Child: This includes payment for a specific service or item related to special needs of the child, including, but not limited to:
   a. Legal fees to obtain the guardianship not to exceed the usual and customary rate for such services within the community;
   b. Expenses for transportation, lodging, and meals for the child and one adult to enable the child to receive medical care. Amounts paid must be no more than those paid for foster care (see 479 NAC 2-004.09B3); or
   c. Expenses related to modifying a home to accommodate a special needs child, such as installation of a ramp, or widening of doors. The maximum to be paid is specified on the subsidy agreement.

{Effective }

7-005.01 Medical Assistance Provided Out of State: If the child and guardian live in another state, the child is eligible for medical assistance through Nebraska Medicaid as long as the child is receiving a maintenance payment from Nebraska.

If the child does not receive a maintenance payment from Nebraska, the child is no longer eligible for Nebraska Medicaid.

{Effective 9/20/95}

7-006 Initial Application and Agreement: The agreement for subsidy must be completed and approved before the guardianship is finalized. The agreement must include the type, amount, and duration of the subsidy. To obtain a subsidized guardianship, Form PS-74, "Subsidized Guardianship Agreement," is required.

The worker sends the completed form to the designated person in the service area. The designated person approves or disapproves the subsidy and returns the form to the worker. The worker advises the prospective guardian of the decision. If subsidy is approved, the worker continues with the plans for finalizing the guardianship. If subsidy is denied, guardianship may still be pursued without subsidy or the worker may need to consider other permanency options.

{Effective 9/20/95}

7-007 Residential or Inpatient Psychiatric Care

7-007.01 Type of Care: To be covered under subsidized guardianship, inpatient or residential care must be:

1. Provided in a facility licensed or approved by the appropriate agency for therapeutic or psychiatric care; and
2. Psychiatric or mental health treatment.

This care does not include that provided by foster or group homes or child caring agencies.

7-007.02 Length of Care: Residential Psychiatric Care may be provided under subsidized guardianship for a maximum of two years.

7-007.03 Restrictions: The Department will approve payment for residential or inpatient psychiatric care only if:

1. Care is anticipated to result in progress which will enable the child to return to the guardian or community;
2. Less restrictive or acute care alternatives or treatments are not appropriate or available, or have refused to accept the child;
3. The child cannot obtain appropriate care in the guardian's home or community;
4. The child's guardian will continue to remain involved with the child in planning for and making possible the return home;
5. This type of placement is in the child's best interests;
6. Other resources, including those of the child's parent(s), benefits, or programs are not available to cover the care; and
7. Approval for the placement is given by Nebraska Health Connection.

{Effective }

7-007.04 Documentation Required: Department staff must obtain the following documentation:

1. A report from a licensed psychiatrist or licensed clinical psychologist which includes:
   a. The presenting problem to be treated;
   b. Goal of treatment;
   c. Treatment which will be received;
   d. Anticipated results of treatment;
   e. Need for the proposed level of treatment as opposed to less restrictive alternatives; and
   f. Discharge plan, including available treatment resources.

2. A statement from the guardian which includes:
   a. How s/he will remain involved with the child in planning for the return home;
   b. How s/he will participate financially in the treatment and in meeting the child's needs, including the use of private insurance and personal resources;
   c. Plans for treatment and his/her involvement in the child's treatment after discharge;
   d. Commitment to the child returning home.

{Effective 9/20/95}

7-007.05 Approval/Denial Process: When a guardian requests approval for coverage of out-of-state residential treatment, the following process must be used:

1. The worker must:
   a. Discuss with the guardian the requirements and coverage which might be available, including use of other resources and the need for documentation;
   b. If appropriate, contact the child's parent(s) to determine the extent to which they can assist in covering costs;
   c. Assist the guardian in locating and considering less restrictive alternatives or programs, if appropriate;
   d. Assist the guardian in completion of Interstate Compact forms, if potential placement is out-of-state (see 474 NAC 5-024); and
   e. Submit a written recommendation for approval of care and necessary documentation to the approval team. This recommendation must include the worker's and supervisor's opinion whether:
      (1) This placement is the least restrictive alternative available;
      (2) This placement is in the child's best interest;
      (3) The guardian is involved and planning for the child's return home; and
      (4) The request should be approved;
2. Nebraska Health Connection will approve or deny the placement; and
3. The worker must notify the guardian of the decision regarding placement or continued stay.

{Effective }

7-007.06 Adjustment in Maintenance: When the child is approved for residential or inpatient psychiatric treatment, the worker must document with the guardian what, if any, maintenance the guardian will be providing for the child's needs (e.g., clothing or transportation to maintain the relationship with the child), and reduce the maintenance payment as appropriate.

{Effective }

7-007.07 Process After Placement: While the child is in residential or inpatient care, the worker must obtain progress reports from the facility every three months. These reports must show:

1. Progress toward the treatment goal;
2. Continuing need for treatment;
3. Prognosis and estimated length of treatment; and
4. The guardian's involvement in treatment and/or planning for return home.

The worker must review the reports, consult with his/her supervisor, and submit the reports with a recommendation regarding continuation of coverage for care to Nebraska Health Connection.

{Effective }

7-007.08 Payment Termination: The Department will no longer provide payment if:

1. Reasonable progress is not occurring and it is determined that treatment at that facility is no longer appropriate;
2. Treatment is no longer needed;
3. The plan is not to return the child to the guardian's home;
4. The guardian is no longer involved with the child or participating in treatment; or
5. Reports providing the information in 479 NAC 7-007.08 are not provided to the Department.

The worker must send written notice of payment termination to the guardian giving the date on which payment will cease; a minimum of 30 days notice is required. (A copy must be sent to the foster care specialist.)

Note: If the guardian has ceased his/her involvement with the child, the worker must consider whether a child protective services referral is appropriate.

{Effective 9/20/95}

7-008 Deletions or Termination in Subsidy: A subsidy can be terminated, a service deleted, or a maintenance payment decreased because of the following factors:

1. Terms of the agreement have terminated;
2. The Department determines that the guardian is not legally responsible for the support of the child or the child is not receiving any support from the guardian;
3. The child's eighteenth birthday;
4. The guardian fails or refuses to be legally responsible for the support of the child, or to use the maintenance payment to meet the child's needs;
5. The child is no longer residing with the guardian. If the child resides outside of the guardian's home, s/he must:
   a. Be attending college or vocational training; or
   b. Have been placed out-of-home for reasons other than school, and the guardian is cooperating in a plan for the child's return home. In this case, the worker must document with the family what portion of the maintenance is being used for the child's needs and decrease or stop the payment accordingly;
      Note: For a temporary absence, see 479 NAC 7-009.
6. The guardian requests termination of the subsidy;
7. A change in regulations or law makes the child no longer eligible for a subsidy;
8. The guardian refuses to cooperate in the process of renewing the agreement;
9. The child no longer needs the medical care or special services that were specified in the subsidy agreement; or
10. The child dies.

Note: Subsidy benefits cannot be transferred even if the court appoints a new guardian.

{Effective }

7-009 Child's Temporary Absence: Subsidy may continue for a maximum of 90 days if a child is not residing with the guardian for reasons other than those specified in 479 NAC 7-008, if the plan is for the child and the guardian to be reunited.

{Effective 9/20/95}

7-010 (Reserved)

7-011 Closing Department Ward Case: Following receipt of the court order granting the guardianship, the worker must close the Department ward case.

7-012 Annual Review: The worker must review the guardianship subsidy every 12 months to determine the level of continued need and continuing eligibility.

{Effective 9/20/95}

7-013 Right to Appeal: The guardian has the right to a fair hearing if the Department denies the application for subsidy or reduces or terminates the agreement.

7-014 Child Support Enforcement Services: The guardian has the responsibility to apply for non-public assistance child support services.

{Effective 6/8/98}

CHAPTER 8-000 SUBSIDIZED ADOPTION PROGRAM

8-001 Introduction: The Nebraska Department of Health and Human Services' subsidized adoption program provides or continues financial assistance for a child after an adoption is finalized.

8-001.01 Purpose: The subsidized adoption program is designed to ensure that financial barriers or costs associated with a child's special needs do not prevent adoption. The intent is not to provide a financial incentive to families to adopt, but to remove financial barriers to the adoption of children with special needs and enable adoption to occur. Subsidy is for the child, not the parents. It does not diminish parental rights and responsibilities, but is a means of providing assistance to them in meeting their responsibilities.

Adoption subsidy may be provided in the form of ongoing assistance or a one-time reimbursement.

8-001.02 Subsidy to Department Wards

8-001.02A Legal Basis: Subsidized adoption payments may be made to Department wards either:

1. Using state funds as provided by Sections 43-117 and 43-118, Neb. Rev. Stat.; or
2. Through Title IV-E of the Social Security Act, Federal Payments for Foster Care and Adoption Assistance.

8-001.02B Conditions Necessary to Initiate Subsidy: A subsidized adoption is considered based on:

1. The child's eligibility;
2. Efforts to place without subsidy; and
3. The family's needs for subsidy.

{Effective 9/20/95}

8-001.02B1 Child's Eligibility: Eligibility for reimbursement is determined by the needs of the child, not the income and resources of the parent(s). In order for the adoptive parent(s) to receive reimbursement, the child must meet the following special needs criteria.

The child cannot or should not be returned to the legal biological parent(s) and one of the following criteria:

1. Except where it would be against the best interests of the child, a reasonable but unsuccessful effort has been made to place the child without providing adoption assistance;
2. The child is considered to be a child with special needs and cannot be placed without assistance based on the following:
   a. Age (if age is the only special need, children age seven or younger generally are not considered eligible);
   b. Membership in a sibling group of three or more to be placed together;

c. Behavioral, emotional, physical or mental disability; and
d. Membership in a minority race (race by itself is not sufficient to make a child eligible for subsidy);

3. The child must meet all of the following:
   a. Cannot be adopted without subsidy (see 479 NAC 8-001.02B2);
   b. Cannot or should not be returned to the home of the legal/biological parents;
   c. Is a ward of the Nebraska Department of Health and Human Services at the time the adoption petition is filed; and
   d. Is age 18 or younger.

{Effective 9/20/95}

8-001.02B1a Eligibility for State Subsidy: A child who is eligible for state subsidy must:

1. Meet the criteria in 479 NAC 8-001.02B1 and be a ward of the Department at the time the adoption petition is finalized; or
2. Be a child for whom the person adopting has a valid state subsidized guardianship agreement with the Department at the time of finalization of the adoption.

{Effective 8/25/12}

8-001.02B1b Eligibility for Federal Subsidy: A child who is eligible for federal subsidy must meet the criteria in 479 NAC 8-001.02B1 and:

1. Be a ward of the Department at the time the adoption petition is finalized and be eligible for Title IV-E foster care or SSI at the time the adoption petition is filed; and
2. Be a child with special needs who is in foster care placement with his/her minor parent if Title IV-E foster care payment is being made for the care of both.

{Effective 02/23/04}

8-001.02B2b(1) Non-Ward Eligibility for Federal Subsidy: The federal government has extended Title IV-E adoption eligibility to the following non-wards:

1. A child who is being adopted privately who is deemed eligible for SSI at the time the adoption petition is filed; or
2. A child who was receiving a Title IV-E subsidy in a previous adoption and that adoption dissolves (parents sign a relinquishment of parental rights or a court of competent jurisdiction terminates their parental rights) or the adoptive parents die is eligible for federal Title IV-E subsidy in a subsequent adoption.

If a child is placed across state lines and is not in the custody of the sending state, the adoptive parents must apply for subsidy in their state of residence. That state is responsible for determining whether the child qualifies for subsidy.

{Effective 02/23/04}

8-001.02B1c Determination of Child's Eligibility: In each case in which a ward is being adopted, the worker must assess the child's eligibility for subsidized adoption, including the child's mental and physical needs. If the child qualifies, the worker must discuss the possibility of subsidized adoption with the adoptive parent(s). To determine a child's eligibility, the worker must:

1. Complete a Determination of Child's Eligibility and attach necessary documentation;
2. If pre-existing medical is to be covered, obtain documentation for each condition to be included consisting of a recent (no older than six months) report from a physician or qualified practitioner which states:
   a. Diagnosis, including severity of condition;
   b. Present and future care or treatment required or likely to be needed; and
   c. If a specific procedure is required, when it likely will be completed and an estimated cost (required for dental or orthodontic work); and
3. Forward form and documentation to the designated staff.

The designated adoption worker must notify the worker of the determination in a timely manner.

{Effective 02/23/04}

8-001.02B2 Efforts to Place Without Subsidy: Federal and state law require that efforts to place without subsidy be made before a child can be adopted with subsidy. Efforts to place without subsidy are not required if the child is placed with a relative who plans to adopt the child. In order to meet this requirement if the Department has done any of the following, the requirement is met:

1. Register the child on an established adoption exchange for at least three months;
2. Feature the child in the media to recruit a family;
3. Determine that the potential family is best able to meet the child's needs after consideration of other families; or
4. Determine that the potential family is the only one to consider because the child attached to the foster family and it would not be in the child's best interest to move her/him to another family that might be able to adopt without subsidy.

{Effective 02/23/04}

8-001.02B3 Family's Need for Subsidy: During the placement process or the post-placement period, the child's worker and supervisor shall determine whether the potential for subsidized adoption should be discussed with the family. If the child is eligible and it appears that subsidy will be needed, the worker shall assess the need for subsidy and negotiate the type and amount with the family.

A determination of the child's present and anticipated future needs and the family's ability to meet those needs without assistance must be made after considering the needs of the child and the circumstances of the family. The payment that is agreed upon in combination with the parent(s)' resources should cover the ordinary and special needs of the child projected over an extended period of time and should cover anticipated needs.

{Effective 02/23/04}

8-001.02B3a Resources Available for the Child: Subsidy is intended to be used only if other resources are not available, including those through other programs or in the community.

8-001.02B4 Approval of Family for Adoption of a Child With Subsidy: Families adopting with subsidy must meet the same criteria established for any other adoptive family, with the major factor being ability to meet the child's needs on a permanent basis. If all other criteria contained in the Home Study (see the Adoption Services Guidebook) are met and finances are the only barrier, subsidy may be considered, if the child is eligible.

8-001.02B5 Approval Before Adoption Decree: The application and agreement for subsidy, specifying type, amount, purpose, and duration of subsidy must be completed and approved before the date of adoption finalization. Any pre-existing medical condition to be covered must be specified on the initial agreement. Conditions cannot be added after finalization but can be changed if the original diagnosis was incorrect. (See 479 NAC 8-001.02F1b.)

8-001.02C Types of Subsidy

8-001.02C1 Federal Subsidy: This type of subsidy is also known as Adoption Assistance or Title IV-E subsidy. The funding source is federal, with state match. A federal subsidy, if available, is the first choice of the Department. All federal subsidies must include:

1. Full medical coverage (i.e., the child continues to be eligible for Medicaid, including HEALTH CHECK within the resident state's guidelines, regulations, and rates); and
2. Services defined by policy to be available to the child through the Social Services block grant.

Federal subsidy may also include maintenance coverage -- monthly payment to the adoptive parent to assist in meeting the child's day-to-day needs. The amount must be less than the payment would be if the child had remained in foster care through the Department.

When a child whose subsidy includes child care is approaching the age of 13, the worker must discuss with the family the ongoing need for payment for this service. If the adoptive parent agrees, in writing, to end this service, the worker must end the child care authorization. (The worker cannot end the authorization without written agreement of the adoptive parent, even if the subsidy agreement stated that child care would cease at a specific time.)

When a child who had been receiving federal subsidy reaches the age of 18 years and does not qualify as disabled, either by SSI eligibility or determination by the Department's Medical Review Team, the child can be transferred to a state maintenance and medical subsidy.

{Effective 02/23/04}

8-001.02C2 State Subsidy: The funding source for this assistance is state general fund appropriation. It may include one or more of the following:

1. Maintenance: Monthly payment to adoptive parent to assist in meeting the child's day-to-day needs. It is not intended to finance long-term plans (e.g., college). The amount must be less than the payment would be if the child had remained in foster care through the Department;
2. Medicaid and Payment for Pre-existing Medical: The child may receive Medicaid if s/he:
   a. Has a documented pre-existing medical need which is a barrier to adoption; and
   b. Was receiving or was eligible to receive Medicaid before execution of the adoption agreement.

When a child whose subsidy includes child care is approaching the age of 13, the worker must discuss with the family the ongoing need for payment for this service. If there is no special need, as defined in 392 NAC 1-003, or if the subsidy agreement states that child care payments will end upon the 13th birthday, the worker must end the child care authorization.

Payment for care for a pre-existing medical condition is paid from non-Medicaid funds only if the care is not covered under the Medicaid program or no Medicaid provider is available in the community.

Payment is made to providers for medical or mental health care or treatment related to pre-existing medical or mental health needs which were identified and documented on the subsidy agreement before the decree. This care may include psychiatric, psychological, and mental health services, inpatient hospitalization, and care needed to teach basic life skills, sustain life, or maintain a physical/medical condition, as well as medications and prostheses. It does not include vocational training.

The care or treatment must be medically necessary and provided:

a. By a medical practitioner or qualified mental health professional and/or prescribed by a physician; and
b. In the least restrictive, most family-like setting appropriate to meet the child's needs, as determined by the Department.

3. Special Service: Special services are payments made for a specific service or item related to the child's need(s) and for a specified time period. They can be one-time only in nature. Special services may be covered only if other resources or programs are not available to provide them. These services may include, but are not limited to -
   a. Legal fees for the adoption (may include services of an attorney to terminate parental rights, if this is occurring as a part of the adoption proceeding). The maximum amount to be paid must be specified on the subsidy agreement.
   b. Costs of integrating the child into the adoptive family, including items such as furniture for three or more siblings placed together or where specially designed furniture is required because of a child's disability, or training for adoptive parents in parenting a special-needs child. The maximum amount to be paid must be specified on the subsidy agreement;
   c. Expenses related to modifying a home to accommodate a special-needs child, such as a ramp or widening of doors. The maximum amount to be paid must be specified on the subsidy agreement; or
   d. Expenses for transportation, lodging, and meals for the child and one parent for the child to receive medical care/treatment for a pre-existing condition. Amounts paid will be no more than those used for child welfare foster care. (See 479 NAC 2-002.11.) The condition must have been documented before finalization, but the medical care/treatment itself need not be included for coverage.

{Effective 02/23/04}

8-001.02C3 Federal With State Supplement: When a Department ward who is receiving a federal subsidy has needs which cannot be met through federal subsidy, preexisting medical or special service components may be provided from state subsidy.

8-001.02D Initial Subsidy Application

8-001.02D1 Need for Subsidy: The worker must determine the child's present and anticipated future needs and the family's ability to meet those needs without assistance, considering the following:

1. Family circumstances. The family is expected to make budgetary adjustments to absorb as much of the child's cost as possible without significantly altering their standard of living, as they would if a child were born to the family;
2. Other programs, benefits, or resources available to the family to meet the child's needs; and
3. Adequacy of the family's insurance to cover medical needs. (The worker must obtain documentation from the family showing what insurance will cover.)

{Effective 02/23/04}

8-001.02D2 Type of Subsidy: In some cases, the only assistance needed will be medical or special service without maintenance.

8-001.02D3 Amount: If maintenance is being considered the amount must be less than the payment would be if the child had remained in agency care and the coverage must be no greater than would have been provided if the child had remained a ward. Payment may be as little as $10. (In foster parent adoptions, a larger maintenance amount will be a more frequent occurrence.)

The worker must explain that other maintenance payments which they might receive for the child (e.g., Social Security benefits, SSI, Veteran's benefits, ADC)will be deducted from the agreed-to maintenance payment under subsidy (see 479 NAC 8-001.02B3a).

Exception for Federal IV-E Subsidy: Payment cannot be reduced without the written agreement of the adoptive parent for any reason, including an increase in other resources such as SSI, SSA, or VA benefits.

{Effective 02/23/04}

8-001.02D4 Duration: The worker must consider the length of time the family anticipates needing assistance. This determination might include the family's financial situation (e.g., a parent completing school) or correction of the child's medical problem.

8-001.02D5 Application Process: (Note: Application may be made only after the child's eligibility has been approved, see 479 NAC 8-001.02B1). An initial application for subsidy is processed.

8-001.02E Review: No review of the subsidy is required. A revised agreement may be done upon the request of the family, Department receipt of information regarding a change in family circumstances, or when a change in law or regulation indicates the need for a revision.

{Effective 02/23/04}

8-001.02E1 Increase in Subsidy: The Department cannot arbitrarily reject a request for an increase in the subsidy. The worker must consider an increase requested by the adoptive parent(s). The amount of the subsidy increase must not exceed the amount the child would have received in foster care at the time of the request. It can be based on the child's special needs or on the life choices by the adoptive parent(s), such as resigning one's job to stay at home with the adopted child or to return to school. The family must complete and sign a Subsidized Adoption Renewal or Change Request. The worker and supervisor must approve or deny the request. If the request is approved, the worker and supervisor must sign the Subsidized Adoption Renewal or Change Request. The worker sends the original to the family, forwards a copy to State Ward Medical, and retains a copy for the case record.

If the request is not approved, the worker must send a Notice of Finding with a copy of the Subsidized Adoption Renewal or Change Request to the family with the reason for the denial of the requested changes.

{Effective 02/23/04}

8-001.02E2 Reduction in Subsidy: If the family no longer needs the amount of maintenance they have been receiving, the worker should make all reasonable efforts to obtain the family's agreement to reduce the amount of the payment. For example, if the child no longer received child care, that amount would be reduced from the payment.

The worker must consider reduction when a child is placed out of the adoptive home or if the worker determines that the child is receiving maintenance from another source not previously computed in determining maintenance.

The family must complete and sign a Subsidized Adoption Renewal or Change Request. The worker and supervisor sign the Subsidized Adoption Renewal or Change Request. The worker sends the original to the family and retains a copy for the case record.

{Effective 02/23/04}

8-001.02E2a Change in Federal IV-E Subsidy: Payment cannot be reduced without the written agreement of the adoptive parent for any reason, including an increase in other resources such as SSI, SSA, or VA benefits.

{Effective 02/23/04}

8-001.02F Change in Subsidy

8-001.02F1 Change in Medical Subsidy

8-001.02F1a Change in Medical Coverage: In order to be covered under subsidy, each medical condition must be specified on the initial agreement.

The parents must inform the Department of changes in the child's or family's circumstances such as change in address, change in child's living arrangement, change in the child's needs. A change in coverage under a state subsidy is possible as a result.

A parent may request a change in medical coverage because of an incorrect medical diagnosis on the initial subsidy application. The parent must submit a report no more than six months old from a qualified medical practitioner or mental health professional stating:

1. The new diagnosis and substantiating evidence; and
2. That the former diagnosis was inaccurate and, if possible, why that diagnosis occurred; for example, the child was too young before the decree to diagnose fully.

The family must be notified in writing of the decision. If approval was given, the family must complete a new subsidy agreement.

{Effective 02/23/04}

8-001.02G Determination of Maintenance and Medical

8-001.02G1 Maintenance: Any maintenance payments received for the child (e.g., Social Security benefits, SSI, VA, ADC) will be deducted from the agreed-to maintenance payment under state subsidy.

For federal subsidy, a written agreement must be obtained in order to reduce for any reason.

{Effective 02/23/04}

8-001.02G2 Medical

8-001.02G2a Payment/Coverage for Pre-existing Medical Care/Treatment Rate: Payment will be made directly to the provider at Nebraska Medicaid rate within applicable Medicaid guidelines, or at the rate established for child welfare medical payments within child welfare medical guidelines. If no rate has been established, the rate will be determined by Medical Services staff, using "usual and customary" as a general guideline. When a Department staff questions whether a particular service is coverable under the specified pre-existing condition, staff shall ask the provider to submit a statement regarding if/how it is related, and/or the adoption specialist shall request an opinion from Medical Services staff.

8-001.02G2b Payment for Medical from Non-Medicaid Funds: Payment for pre-existing medical will be paid only if the care is not covered under the Medicaid program or no Medicaid provider is available in the community. If a Medicaid provider is available but a family chooses not to use him/her, payment will not be made under state subsidy.

8-001.02H Family's Responsibilities: The family must meet its responsibilities to as great an extent possible without subsidy, and is responsible for exploring and using other resources or funding sources which reasonably can be considered available and appropriate before using subsidy coverage. (See 479 NAC 8-001.02D1 for further clarification.) The family is also responsible for supplying needed documentation to continue the coverage and for notifying the Department of changes in the family's or child's circumstances which would affect the subsidy.

8-001.02H1 Medical: Before requesting payment under subsidy either through Medicaid or pre-existing medical/mental health, the family must use other available resources, benefits, and programs, including but not limited to private insurance coverage and care or treatment available through the education system. The family is expected to make a self-determination regarding ability to cover medical costs from its private resources before requesting that a provider submit the bill for subsidy coverage.

8-001.02J Residence Provisions: A child's eligibility for subsidy is not affected by the state of residence of the adoptive parent(s). Specified coverage is provided regardless of the state of residence.

8-001.02J1 Federal Subsidies: Medicaid coverage of children is provided by the state of residence within that state's regulations and at that state's rate.

{Effective 02/23/04}

8-001.02J2 State Option Subsidies: Medicaid coverage for children who are living out of state can be provided by the state of residence provided that state allows Medicaid coverage for state-funded children. If the resident state disallows medical coverage, the child's medical coverage continues to be provided by Nebraska.

{Effective 02/23/04}

8-001.02K Reinstatement of Subsidy: In some circumstances it is possible to reopen an original subsidy after the subsidized adoption case has been closed. The worker must submit these requests to the designated adoption staff who will consider them on an individual basis. The designated adoption staff must make a final determination based on the original intent of subsidy (i.e., making possible adoption and a permanent family for the child). Reinstatement is not possible if the parents are no longer the legal parents of the child.

{Effective 9/20/95}

8-001.02L Transfer of Subsidy: It is not possible to transfer a subsidy agreement to new adoptive parents, unless the person is a stepparent who has adopted the child while married to an original adoptive parent. When a request of this type is received, the worker must assist the parent(s) to complete a Recertification/Change Request and submit it to the designated staff for approval.

{Effective 9/20/95}

8-001.02M Inpatient Psychiatric Care: The purpose of inpatient psychiatric care is to provide treatment when the child cannot benefit from less restrictive care.

8-001.02M1 Type of Care: To be covered under subsidy, inpatient psychiatric treatment must:

1. Be provided in a facility licensed or approved by the appropriate agency/department (e.g., Nebraska Department of Health) for therapeutic, psychiatric care or JCAH accredited;
2. Be psychiatric or mental health treatment related to or resulting from a covered pre-existing condition; and
3. Follow admission procedures as outlined in 471 NAC 20-000 ff.

For children covered under subsidized adoption but residing in another state, that state's Medicaid procedures for inpatient admission must be followed.

Care provided by foster or group homes or child caring agencies is not considered inpatient psychiatric care.

8-001.02N Out of State Residential Care

8-001.02N1 Length of Care: Residential Psychiatric Care can be provided under subsidy for up to 18 months only. Payment for treatment in an inpatient setting will be an exception and must be approved by the adoption specialist, Central Office.

8-001.02N2 Restrictions: Payment for residential psychiatric care will be approved only if:

1. It is related to or results from a pre-existing condition covered on the subsidy agreement;
2. It is anticipated to result in progress which will enable the child to return to the family or community;
3. Less restrictive or acute care alternatives/treatments are not appropriate or available, or have refused to accept the child;
4. The child cannot obtain appropriate care in his/her own home or community;
5. The child's family will continue to remain involved with the child in planning for and making possible return home;
6. This type of placement is in the child's best interests; and
7. Other resources, benefits, or programs are not available to cover the care. (This includes the use of private insurance and reasonable use of private/family resources).

{Effective 9/20/95}

8-001.02N3 Approval/Denial Process: When a family requests approval for coverage of out-of-state residential or inpatient psychiatric treatment, the following process must be used:

1. The worker must:
   a. Discuss with the family the requirements and coverage which might be available, including use of other resources and the need for documentation;
   b. Assist the family in locating and considering less restrictive alternatives/programs, if appropriate;
   c. Request the family to provide necessary reports or a release of information so that the worker can obtain them. If the family refuses, the worker shall deny the request based on lack of information; and
   d. Submit a written recommendation for approval of care and necessary documentation to the designated district adoption staff. This recommendation must include the worker's and supervisor's opinion whether or not:
      (1) This placement is the least restrictive alternative available;
      (2) This placement is in the child's best interest;
      (3) The family is involved and planning for the child's return home; and
      (4) The request should be approved.
2. The placement must be approved or denied by:
   a. The Peer Review Organization for a Medicaid-eligible child in a Medicaid-enrolled facility; or
   b. A team including adoption staff and the Central Office adoption specialist for a facility that is not enrolled in Medicaid or a child who is not Medicaid-eligible.
3. The worker must notify the family of the decision regarding placement or continued stay;
4. The family will be involved in the child's treatment as recommended by the facility; and
5. If the placement is approved and is to be outside of Nebraska, the worker must assist the family in completion of Interstate Compact forms.

{Effective 9/20/95}

8-001.02N4 Documentation Required: The documentation needed from the facility is as follows:

1. A report from a licensed psychiatrist or licensed clinical psychologist which includes:
   a. A complete diagnosis and its relationship to a pre-existing condition covered under the subsidy agreement;
   b. Goal of treatment, including involvement of family;
   c. Treatment which will be received;
   d. Anticipated results of treatment;
   e. Need for the level of treatment as opposed to less restrictive alternatives; and
   f. A discharge plan, including available treatment resources.

2. A statement from the parent(s) which includes:
   a. How they will remain involved with the child in planning for the return home;
   b. How they will participate financially in the treatment and in meeting the child's needs, including the use of private insurance and personal resources;
   c. Plans for treatment and their involvement in the child's treatment after discharge; and
   d. Their commitment to the child returning home.

{Effective 9/20/95}

8-001.02N5 Process After Placement: While the child is in psychiatric residential inpatient treatment, the worker shall obtain progress reports from the facility every three months. These reports must show:

1. Progress toward the treatment goal;
2. Continuing need for treatment and at the present level of care;
3. Prognosis and estimated length of treatment that will be needed; and
4. The family's involvement in treatment and/or planning for return home.

The worker shall review the reports, consult with his/her supervisor, and submit the reports with a recommendation regarding continuation of coverage for care to the designated district adoption staff. The designated district adoption staff must consult with the Central Office adoption specialist and/or Medical Services, as appropriate, to determine if the Department will continue to pay for treatment/hospitalization, based on 479 NAC 8-001.02M, and must notify the worker of the determination. The worker must send written notice of the decision to the family. If payment will terminate, the notice must include the date on which payment will cease; a minimum of 30 days notice is required.

{Effective 9/20/95}

8-001.02N5a Payment Termination: The Department will no longer provide payment if:

1. Reports are not provided;
2. Progress is not occurring and it is determined that treatment at that facility is no longer appropriate;
3. Treatment is no longer needed;
4. The plan is not to return the child home; or
5. The family is no longer involved with the child.

Note: If the family has refused contact with the child, or involvement in planning for the child, the worker must consider whether a child protective services referral is appropriate.

8-001.02P Right to Appeal: The adoptive family has the right to a fair hearing if the Department:

1. Denies the application for subsidy;
2. Reduces or terminates the subsidy agreement; or
3. Refuses to pay for psychiatric residential or inpatient psychiatric treatment if psychiatric care is covered in the agreement.

The appeal must be filed in writing within 90 days of the action or inaction. (See PAF 4-4 for completion of Form DA-6.) No change in coverage will occur while the appeal is pending.

{Effective 02/23/04}

8-001.02P1 Right to Appeal Federal Title IV-E Subsidy: The adoptive family has the right to request and be granted a fair hearing if the adoptive parents allege they were denied subsidy due to:

1. Facts about the child's special needs were not presented to the parents prior to finalization of the adoption;
2. Subsidy was denied based on a means test of the adoptive parents' income;
3. Adoptive parents disagree with the determination that the child is ineligible for subsidy;
4. The adoptive parents were not informed of subsidy available to the child in the Department's custody;
5. The agency decreased the amount of subsidy without the concurrence of the adoptive parents; or
6. The agency denied the parents' request for an increase in subsidy due to a change in the adoptive parents' circumstances.

No change in coverage will occur while the appeal is pending. (See Adoption Guidebook, Section XXIII.)

{Effective 02/23/04}

8-001.02Q Deletions or Termination in Subsidy:

8-001.02Q1 Deletion or Termination of State Subsidy: A subsidy can be terminated, a service deleted, or a maintenance payment decreased because of the following factors:

1. Terms of the agreement have terminated;
2. The Department determines the parents are not legally responsible for the support of the child or if the child is not receiving any support from the parents;
3. The child is beyond the age of eligibility: A state subsidy is terminated on the child's 19th birthday.

{Effective 02/23/04}

8-001.02Q2 Deletion or Termination of Federal IV-E Subsidy: Termination or deletion of federal IV-E subsidies are made because of the following factors:

1. The terms of the agreement have terminated;
2. The child is beyond the age of eligibility. A federal subsidy is terminated:
   (1) On the child's 19th birthday if the child is disabled, as documented by SSI determination or determination of the Department's Medical Review Team. A determination made after finalization can be submitted by the worker for the purpose of continuation between the child's 18th and 19th birthdays; or
   (2) On the child's 18th birthday if the child is not determined disabled by SSI determination or determination of the Department's Medical Review Team. In this case, if the need for subsidy continues between the child's 18th and 19th birthdays, the child can be transferred to the state maintenance program.
3. The parents requested termination of the subsidy;
4. The child dies;
5. The child re-enters foster care and the Department determines that the parents are:
   a. No longer legally responsible for support of the child; or
   Note: A parent is considered no longer legally responsible for support of the child when parental rights have been terminated or relinquished, or when the child becomes an emancipated minor, marries, or enlists in the military.
   b. No longer providing any support to the child.
   Note: Any support is defined as various forms of financial support, such as:
      (1) Child support payments;
      (2) Clothing purchases;
      (3) Incidental items;
      (4) Transportation, meals, and lodging for visits with the child and/or to participate in family therapy;
      (5) Expenses for long distance phone calls.

      Maintenance of the home for the child is not included as support.

      If the family is providing any of these forms of support but the amount of money spent on them appears to be less than the subsidy amount, the worker must discuss with the family the possibility of reducing the maintenance payment. However, it cannot be reduced without the family's written agreement.

      Note: If a and b are not present, the subsidy cannot be reduced without written consent of the adoptive parent.

8-001.02R Subsidized Adoption Case Record: For organization of the case record, see 479-000-318.

8-001.02R1 Case Closure: Closed records are sent to the vault for storage.

8-001.02R2 Retroactive Approval of Subsidy: Subsidy may be approved retroactively using state funds as provided by Neb. Rev. Stat., section 43-117.

Retroactive approval of subsidy for a child who has already been adopted must be approved only if all the following conditions are met:

1. The child who was adopted was a ward of the Department at the time the adoption was finalized;
2. The adoptive family contacted the Department and made a written request for subsidy within three years after the date the adoption was finalized;
3. The child is diagnosed with a physical or mental illness or condition that was present prior to the adoption finalization;
4. The Department did not inform the adoptive parents of this condition(s) prior to the adoption even if the Department did not have the information prior to the adoption;
5. The condition requires medical, psychological, or psychiatric treatment. Documentation from a medical professional stating that the condition was pre-existing (prior to the adoption finalization) must be provided by the family; and
6. Treatment is more intensive than the ordinary childhood illness. This factor must be documented by a professional.

{Effective 02/23/04}

8-001.02R2a Documentation: The child's special needs and pre-existing conditions must be documented by a medical professional specifically addressing:

1. The child's diagnosis;
2. Documentation that the child's condition is more intensive than an ordinary childhood illness;
3. The progress and length of anticipated treatment;
4. Length of time that the child has had the condition and that it was pre-existing to the time of the finalization of the adoption.

{Effective 02/23/04}

8-001.02R2b Approval: Approval for retroactive subsidy must be made by a team comprised of service area staff and staff from Central Office, Office of Protection and Safety. (See guidebook for processing of approval.)

{Effective 02/23/04}

8-001.02R2c Subsidy Provided Retroactively: If the subsidy is approved retroactively, a Medicaid card will be issued for the child. The adoptive family must be informed about the Medicaid Program including:

1. The family's health insurance will be billed before using Medicaid funds;
2. Payment will only be made to Medicaid providers at Medicaid rates and Medicaid guidelines;
3. Payment for bills during this retroactive period not falling under the Medicaid Program will be the family's financial responsibility;
4. Coverage under the subsidy will be made retroactive to either the date that the family made a written request, or the date that Medicaid coverage became effective, whichever is earlier.

Payment will be made for medical bills associated with the special needs back to the date of application or the beginning of Medicaid coverage, whichever is earlier. These bills will only be paid if Medicaid would have covered them, to a Medicaid provider, and at Nebraska Medicaid rates.

{Effective 02/23/04}

8-001.02R2d Items Not Covered Under Subsidy Approved Retroactively: Subsidy approved retroactively is limited to payments related to medical treatment. Payment which cannot be covered includes but is not limited to:

1. Maintenance payments;
2. Legal fees to finalize the adoption as a part of the process to request and set up the retroactive subsidy;
3. Expenses such as:
   a. Respite care;
   b. Child care;
   c. Repairs to the home;
4. Payments made directly to the family as reimbursement for medical/psychiatric/psychological care that the family had already paid. (Payment must be made only to the provider).

8-001.03 Adoption Subsidies for Wards of Private Nonprofit Agencies: The Nebraska Department of Health and Human Services may provide financial assistance for a ward of a private nonprofit agency after the adoption of the ward is finalized.

8-001.03A Legal Basis: Title IV-E of the Social Security Act, "Federal Payments for Foster Care and Adoption Assistance," allows the payment of adoption subsidies for wards of private agencies.

8-001.03B Conditions Necessary to Initiate Subsidy:

8-001.03B1 Child's Eligibility: To be eligible for adoption subsidy, a child must meet the following criteria:

1. The child must meet all of the following:
   a. Cannot be adopted without subsidy (see 479 NAC 8-001.03B2);
   b. Cannot or should not be returned to the home of the legal or biological parents;
   c. Is age 18 or younger;
   d. Is a ward of a private nonprofit agency that is licensed in Nebraska to place children for the purpose of adoption at the time the adoption is finalized;
   e. At the time the adoption petition is filed, the child is eligible for Title IV-E adoption assistance under any of the following circumstances:
      (1) The child was receiving an ADC grant or was eligible to receive an ADC grant when the child was first removed from the biological family. State regulations that were in place on July, 1996, must be used (see 479 NAC 2-009.01A);
      (2) The child is ADC-eligible and is placed in foster care following a court determination that continuation in the home would be contrary to the welfare of the child (see 479 NAC 2-009.01B1 #1). Regarding current regulations, if an ADC-eligible child is placed through a voluntary placement agreement or a relinquishment without court jurisdiction, there must be a judicial determination within six months of removal of the child from the home of a relative~~)~~ that continuation in the home would be contrary to the welfare of the child; or
      Note: A determination of reasonable efforts is not required.
      (3) The child meets the eligibility requirements for the SSI program at the time the adoption petition is filed and at finalization of the adoption;

2. There must be documentation of at least one of the following special needs:
   a. Age (if age is the only special need, children age seven or younger generally are not considered eligible);
   b. Membership in a sibling group of three or more to be placed together;

c. Strong attachment to foster/adoptive parent(s) so that breaking the attachment would be harmful to the child; or
d. Behavioral, emotional, physical, or mental disability; and

Note: Being a member of a minority race also is considered a special need. If applicable, it should be noted. However, race by itself is not sufficient to make a child eligible for subsidy.

3. If a child is eligible for SSI, no court order is necessary.

{Effective 02/23/04}

8-001.03B1a Determination of Child's Eligibility: To determine a child's eligibility, the private agency worker must :

1. Complete Determination of Child's Eligibility for Subsidized Adoption - Private Agency Wards and attach necessary documentation. Form DSS-551 may be submitted with the Determination of Child's Eligibility for Subsidized Adoption - Private Agency Wards;
2. Complete the Family Financial Information, Initial Eligibility and Review; and
   Note: If the child is receiving SSI or was receiving ADC in a specified relative's home at the time the adoption petition was filed, the Family Financial Information, Initial Eligibility and Review is not necessary.
3. Forward the forms, documentation, and a copy of the court order (if appropriate), to the adoption specialist, Human Services Division, Nebraska Department of Health and Human Services.

The adoption specialist must review the Determination of Child's Eligibility for Subsidized Adoption - Private Agency Wards to determine if the child meets eligibility as a special needs child. The adoption specialist must notify the private agency worker if additional information is needed. If the adoption specialist determines that this is a special needs child, s/he must send a copy of the Family Financial Information, Initial Eligibility and Review and the Determination of Child's Eligibility for Subsidized Adoption - Private Agency Wards along with a copy of the court order, if appropriate, and the birth certificate to the appropriate local office worker for IV-E eligibility determination. The worker must forward a Notice of Action to the adoption specialist with notification of IV-E eligibility within 30 days.

The adoption specialist must notify the private agency worker of the eligibility determination within 45 days.

8-001.03B2 Efforts Toward Placement Without Subsidy: Federal laws require that efforts to place without subsidy be made before a child may be adopted with subsidy. Efforts to place without subsidy are not required if the child is placed with a relative who plans to adopt the child. The private agency must ensure that this occurs and document the efforts taken. The following may be used to document efforts to place without subsidy:

1. Registration on an established adoption exchange(s) for at least three months with no appropriate responses. For Native American children, this must include listing on the exchange for the appropriate tribe;
2. Featuring the child in media to recruit a family (television shows, newspaper articles, or magazines);
3. Documentation that this family is best able to meet the child's needs after consideration of all appropriate families approved by the agency submitting the request or available on the Nebraska Department of Health and Human Service's adoption exchanges. (This documentation must include a listing of the other families and why they were not able to meet the child's needs); and/or
4. This particular placement was the only one considered, because of best interests of the child (that is, in cases where attachment to foster parents exists, it would not be in the best interests of a child to move him or her to another family which might be able to adopt without subsidy. (This documentation by itself is adequate);

{Effective 02/23/04}

8-001.03B3 Family's Need for Subsidy: A determination of the child's present and anticipated future needs and the family's ability to meet those needs without assistance must be made after considering the needs of the child and the circumstances of the family. The payment that is agreed upon, in combination with the parent(s)' resources should cover the ordinary and special needs of the child projected over an extended period of time, and should cover anticipated needs.

{Effective 02/23/04}

8-001.03B4 Approval of Family for Adoption of a Child With Subsidy: Families adopting with subsidy must meet the same criteria established for any other adoptive family, with the major consideration being ability to meet the child's needs on a permanent basis. If all other criteria set by the private agency are met and finances are the only barrier, subsidy may be considered, if the child is eligible.

8-001.03B5 Approval Before Adoption Decree: The application and agreement for subsidy, specifying type, amount, purpose, and duration of subsidy must be completed and approved before the date of adoption finalization.

8-001.03C Assistance Provided by Subsidy: Federal adoption assistance or Title IV-E subsidy is funded by federal funds with state match. All federal subsidies must include:

1. Medicaid coverage (i.e., the child is eligible for Medicaid, including HEALTH CHECK, within the resident state's guidelines, regulations, and rates), and
2. Social Services block grant for which the family is eligible.

Federal subsidy may also include maintenance payment to adoptive parents to assist in meeting the child's day-to-day needs. The amount must be less than the private agency would expend for the child if the child were their ward.

If additional payment for adoption expenses is required, see 390 NAC 6-003.03G for Reimbursement of Non-Recurring Adoption Expenses.

{Effective 02/23/04}

8-001.03D Residence: A child's eligibility for subsidy is not affected by the state of residence of the adoptive parent(s). Specified coverage is provided regardless of the state of residence. Nebraska must continue to pay the maintenance subsidy if the child moves out of state; however, Medicaid coverage is no longer provided by Nebraska. The state of residence must provide Medicaid, within that state's regulations and at that state's rate (see 479-000-304).

Social Services Block Grant services are provided by the state of residence based on the family's eligibility.

8-001.03E Initial Subsidy Application

8-001.03E1 Need for Subsidy: The agency worker must determine the child's present and anticipated needs and the family's ability to meet those needs without assistance, considering the following:

1. Family circumstances. The family is expected to make budgetary adjustments to absorb as much of the child's cost as possible without significantly altering their standard of living, as they would if a child were born to the family;
2. Other programs, benefits, or resources available to the family to meet the child's needs; and
3. Adequacy of the family's insurance to cover medical needs. (The private agency worker shall obtain documentation from the family showing what insurance will not cover.)

8-001.03E2 Type of Subsidy: In some cases, the only assistance needed will be medical. Maintenance will be included only if necessary.

8-001.03E3 Amount: If maintenance is being considered, the amount must be less than the payment would be if a foster care payment were being made by the private agency. Payment may be as little as $10. (In foster parent adoptions, a larger maintenance amount will be a more frequent occurrence, as the foster care payment was included by the family in its budgeting.

The agency worker must explain that other maintenance payments which they might receive for the child (e.g., Social Security benefits, SSI, Veteran's benefits, ADC) cannot be reduced without the written agreement of the adoptive parent for any reason, including an increase in resources such as SSI, SSA, or VA benefits.

{Effective 02/23/04}

8-001.03E4 Application Process: Application can be made only after the child's eligibility has been approved, see 479 NAC 8-001.03B1. To process an initial application for subsidy:

1. The private agency worker must:
   a. Complete assessment and negotiation process with the family (see 479 NAC 8-001.03B3);
   b. Complete a Determination of Child's Eligibility for Subsidized Adoption - Private Agency Ward;
   c. Complete or assist the family to complete Application for Subsidized Adoption - Private Agency Wards with appropriate signatures;

d. Complete Insurance Information (see PAF 1-6);
e. Complete Third Party Agreement for Medical Care (see PAF 9-45); and
f. Forward the Determination of Child's Eligibility for Subsidized Adoption - Private Agency Ward and Application for Subsidized Adoption - Private Agency Wards to the adoption specialist, Office of Protection and Safety, HHSS, in a timely manner.

2. The adoption specialist must review the Application for Subsidized Adoption - Private Agency Wards and return it to the private agency worker in a timely manner with approval, denial or further questions;
3. Upon receipt, the private agency worker must notify the family of approval/denial or make arrangements to renegotiate or clarify the request;
4. Within 21 days of approval of the application, the worker must:
   a. Prepare Subsidized Adoption Agreement - Private Agency Wards;
   b. Obtain necessary signatures;
   c. Forward to the adoption specialist, Office of Protection and Safety, HHSS;
5. The private agency worker must send the adoption specialist, Office of Protection and Safety, HHSS, a copy of the adoption petition and decree in a timely manner after the adoption is finalized; and
6. The adoption specialist sends a copy of all forms to the eligibility worker when the adoption is finalized.

{Effective 02/23/04}

8-001.03F Review: No review of the subsidy is required.

A revised agreement may be done upon the request of the family, the Department's or private agency's receipt of information regarding a change in family circumstances or when a change in law or regulation indicates the need for a revision.

Note: IV-E eligibility does not need to be redetermined

{Effective 02/23/04}

8-001.03F1 Family Request for Change: If the family requests a change on Form DSS-553 accompanied by a letter from the family explaining the reasons, the private agency worker makes an in-person contact with the family to discuss the requested changes in the agreement and/or to explore requests for other post-legal adoption services. If the worker feels that the request is inappropriate, s/he must deny it. If the request is appropriate, the worker must forward the appropriately signed Form DSS-553 and a letter from the family explaining their reasons for requesting a change to the adoption specialist, HHSS, Office of Protection and Safety, for approval with a copy to the eligibility worker.

The adoption specialist must approve or deny the request in a timely manner and return it to the private agency worker with a copy to the IM worker or send a request for further information. If the adoption specialist approves the change, the private agency worker must prepare and sign a new Subsidized Adoption Agreement - Private Agency Wards.

The private agency sends the original to the family and two copies to the adoption specialist, and retains one for the case record. The adoption specialist sends a copy to the eligibility worker. If the child resides outside of Nebraska, the adoption specialist sends a copy of the completed and signed Subsidized Adoption Agreement - Private Agency Wards and DSS-553 to the eligibility worker in the resident state.

If the adoption specialist requests more information, the adoption specialist negotiates the changed agreement with the private agency and notifies the eligibility worker of the new agreement.

If the adoption specialist does not approve the change, the adoption specialist returns Form DSS-553 to the private agency with a copy to the eligibility worker.

{Effective 02/23/04}

8-001.03G Change in Subsidy

8-001.03G1 Increase: The private agency worker must consider the family's request for an increase in maintenance subsidy. The amount of the subsidy increase must not exceed the amount the child would have received in foster care at the time of the request. It can be based on the child's special needs or on the life choices by the adoptive parent(s), such as resigning one's job to stay at home with the adopted child or returning to school. The private agency worker must forward a letter from the family explaining their reasons for requesting an increase along with the Subsidized Adoption Review or Change Request. The worker's request to the adoption specialist must describe the amount of the requested increase and reason for the request.

{Effective 02/23/04}

8-001.03H Family's Responsibilities: The family is responsible for supplying the private agency worker with information about changes in the family's or child's circumstances that could affect the subsidy.

{Effective 02/23/04}

8-001.03J Reinstatement of Subsidy: In some circumstances it is possible to reopen an original subsidy after the subsidized adoption case has been closed. The private agency worker must submit these requests to the adoption specialist who will consider them on an individual basis. S/he must make a final determination based on the original intent of subsidy (i.e., making possible adoption and a permanent family for the child). Reinstatement is not possible if the parents are no longer the legal parents of the child.

8-001.03K Transfer of Subsidy: It is not possible to transfer a subsidy agreement to new adoptive parents, unless the person is a stepparent who has adopted the child while married to an original adoptive parent. When a request of this type is received, the private agency parent must assist the parent(s) to complete Form DSS-553 and submit it to the adoption specialist for approval (see 479 NAC 8-001.03F2a).

8-001.03L Right to Appeal: The adoptive family has the right to request and be granted a fair hearing if the parents allege they were denied subsidy due to:

1. Facts about the child's special needs were not presented to the parents prior to finalization of the adoption;
2. Subsidy was denied based on a means test of the adoptive parents' income;
3. The adoptive parents disagree with the determination that the child is ineligible for subsidy;
4. The adoptive parents were not informed of subsidy available to the child in the Department's custody;
5. The agency decreased the amount of subsidy without the concurrence of the adoptive parents; or
6. The agency denied the parents' request for an increase in subsidy due to a change in the adoptive parents' circumstances.

No change in coverage will occur while the appeal is pending. (See Adoption Guidebook, Section XXIII.) The appeal must be filed in writing within 90 days of the action or inaction. No change in coverage will occur while the appeal is pending.

{Effective 02/23/04}

8-001.03M Deletions or Termination in Subsidy: Termination or deletion of federal IV-E subsidies are made because of the following factors:

1. Terms of the agreement have terminated;
2. The child is beyond the age of eligibility. Subsidy is terminated:
   a. On the child's 19th birthday if the child is disabled, as documented by SSI determination or determination of the Department's Medical Review Team. A determination made after finalization can be submitted by the worker for the purpose of continuation between the child's 18th and 19th birthdays; or
   b. On the child's 18th birthday if the child is not determined disabled by SSI determination or determination of the Department's Medical Review Team. In this case, if the need for subsidy continues between the child's 18th and 19th birthdays, the child can be transferred to the state maintenance program.
3. The parent(s) requested termination of the subsidy;
4. The child dies;
5. The child re-enters foster care and the Department determines that the parents are:
   a. No longer legally responsible for support of the child; or
      Note: A parent is considered no longer legally responsible for support of the child when parental rights have been terminated or relinquished, or when the child becomes an emancipated minor, moves, or enlists in the military.
   b. No longer providing any support to the child;
      Note: Any support is defined as various forms of financial support such as:

(1) Child support payments;
(2) Clothing purchases;
(3) Incidental items;
(4) Transportation, meals, and lodging for visits with the child and/or to participate in family therapy; or
(5) Expenses for long distance phone calls.

Maintenance of the home for the child is not included as support.

If the family is providing any of these forms of support but the amount of money spent on them appears to be less than the subsidy amount, the worker must discuss with the family the possibility of reducing the maintenance payment. However, it cannot be reduced without the family's written agreement.

Note: If a and b are not present, the subsidy cannot be reduced without written consent of the adoptive parents.

{Effective 02/23/04}

8-001.03N Retention of Closed Records: Closed records are sent to the vault for storage.

{Effective 9/20/95}

8-002 MEDICAID for CHILDREN LIVING in NEBRASKA with STATE FUNDED ADOPTION ASSISTANCE from ANOTHER STATE: Nebraska is a COBRA-Reciprocity state. Therefore, Nebraska will provide Medicaid coverage for child/ren living in Nebraska who has a state funded adoption assistance agreement from another state. Additionally the other state:

1. Is a member of the Interstate Compact on Adoption and Medical Assistance; and
2. Reciprocates by extending Medicaid to Nebraska children who have Nebraska state funded adoption assistance living in the state.

CHAPTER 9-000 EMERGENCY ASSISTANCE (EA) TO NEEDY FAMILIES WITH CHILDREN

9-001 Legal Basis: The Emergency Assistance to Needy Families with Children Program (EA) was established by Title IV-A of the Social Security Act, 45 CFR 233.120, and Section 68-28, Nebraska Revised Statutes.

EA must be provided in accordance with the following regulations. Assistance may be authorized only once per client under the Title IV-A/EA program in any 12 month period.

9-002 Purpose: The purpose of Emergency Assistance is to provide money and/or services to or on behalf of a needy child(ren) and any other members of the household to meet needs that have been caused by an emergency situation when the needs cannot be met because of destitution. The program provides a means to deal with financial situations that are threatening the health or well being of an eligible child and family. Emergency assistance benefits must be used to help return the family to a stable environment that they will be able to maintain.

EA services can be provided to alleviate five kinds of emergencies:

1. Abuse, neglect, or abandonment of children, or family violence.
2. Children who are in emergency situations where continued presence in the home is not in the best interests of the child.
3. Removal and/or risk of removal and/or continued need for out-of-home placement of a child due to an allegation of abuse or neglect; abandonment; or judicial determination of dependency, delinquency or status offense.
4. Risk of return of an adopted child or a child in a subsidized guardianship situation to foster care due to behavioral, medical, or special needs of the child.
5. Loss of housing or potential loss of housing and/or other essential services.

9-003 Definitions: For use within EA, the following definition of terms will apply unless the context in which the term is used denotes otherwise:

Applicant: Person on whose behalf application is being made.

Authorization Period: The 30-day period following application for EA.

Catastrophic Illness: An illness in which inpatient hospitalization is required, excluding childbirth, optional surgery, diagnostic work-ups, and services not included in Title XIX coverage.

Child Welfare Crisis: A circumstance, or combination of circumstances, which result in the need for protective services by NDSS or out-of-home placement in custody of NDSS or another state agency that has an interagency agreement with NDSS related to EA. The crisis must be the result of one of the following:

- Abuse, neglect, or abandonment of children, or family violence.
- Children who are in emergency situations where continued presence in the home is not in the best interests of the child.

- Removal and/or risk of removal and/or continued need for out-of-home placement of a child due to an allegation of abuse or neglect; abandonment; or judicial determination of dependency, delinquency or status offense.
- Risk of return of an adopted child or a child in a subsidized guardianship situation to foster care due to behavioral, medical, or special needs of the child.

Destitution: Lack of the necessities of life including but not limited to food, shelter, and medical care resulting from an emergency situation.

Domestic Abuse Crisis: A circumstance, or combination of circumstances, which result in physical or emotional mistreatment or the fear or continued fear of physical or emotional mistreatment of a family member.

Domestic Violence Project Personnel: Staff employed by Domestic Violence Projects under contract to the Nebraska Department of Social Services.

Emergency: A sudden and urgent situation requiring immediate action.

Financially Responsible Adult: The following are considered financially responsible adults:

1. A spouse; or
2. The parent or stepparent of a child age 18 or younger.

Gross Monthly Income: The earned and unearned income determined to be available to an applicant. Earned income includes gross (before taxes, FICA, or other potential withholdings from earnings) wages, tips, salary, self-employment income, etc.. Unearned income includes but is not limited to -

1. Retirement, Survivors, and Disability Insurance (RSDI);
2. Railroad Retirement;
3. Supplemental Security Income (SSI);
4. Aid to Dependent Children (ADC);
5. Assistance to the Aged, Blind, or Disabled;
6. Veteran's or military service benefits;
7. Unemployment Compensation or disability insurance benefits;
8. Disability benefits paid by the employer;
9. Child or spousal support; and
10. Contributions

    Note: If a self-supporting member of the household is paying the entire expense for shelter the worker uses the figure from 479-000-321. If the client states that the self-supporting individual is paying a share of the shelter expenses, it is not counted as income to the client.

Presumptive Eligibility: A situation where it is "presumed" that a child is eligible for Title IV-A/EA services because s/he requires immediate services to begin the alleviation of a child welfare and/or a domestic violence emergency.

Specified Relative: A relative with which a child must be living or have been living within six months prior to the month in which EA is requested. A child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, second cousin, nephew or niece. These relatives may be half blood, related by adoption, or from a preceding generation as denoted by prefixes of grand, great, great-great, or great-great-great. A child may also live with the spouse of any persons previously named even after the marriage has been terminated by death or divorce.

Unit: Person or persons who will be eligible to receive EA services under the same application. A unit must include at least one child.

9-004 Application Processing

9-004.01 Application: An application for EA may be made by the client, his/her parent, guardian or conservator, a relative, caretaker, other interested party, or in the case of a child age 18 or younger, the Department acting on the child's behalf.

9-004.02 Approval/Authorization: Approval/authorization of the EA application and related services will be done in accordance with procedures at 479-000-321. Services related to an approved EA application must be authorized within 30 days of the application date in order to be reimbursable under Title IV-A/EA.

9-005 Case Management Responsibilities: The case manager shall -

1. Ensure completion of an EA application including completion of the application document(s) for child welfare cases;
2. Determine presumptive eligibility for EA services related to child welfare;
3. Authorize services necessary to begin remediation of a child welfare emergency situation;
4. Explore and assist the applicant/individual in obtaining any other sources of aid available to alleviate the applicant's destitution or other crisis situation, including assisting the applicant in setting up payment plans with creditors;
5. Assist the applicant in developing a plan to alleviate and avoid a recurrence of the emergency situation;
6. Inform the applicant of his/her right to appeal to the Director of the Nebraska Department of Social Services for the purpose of having the Director review any action or inaction; and
7. Take all reasonable steps to act as promptly as possible on the application.

It is permissible for Program and Income Maintenance responsibilities to be carried out by the same NDSS employee where the employee normally performs duties of both positions. In domestic violence situations, program responsibilities may be performed by DVP personnel.

9-006 Income Maintenance Responsibilities: The Income Maintenance Worker shall -

1. Receive EA application forms from Program Workers and complete authorization sections as appropriate;
2. Determine eligibility for EA services;
3. Authorize necessary EA services for Domestic Violence services and for housing and other essential services;
4. Complete notice of finding when the application has been signed by the applicant. A notice is not required for applications made by Department staff in behalf of a child; and
5. File and maintain client case file.

It is permissible for Program and Income Maintenance responsibilities to be carried out by the same NDSS employee where the employee normally performs duties of both positions. In cases of domestic violence situations, income maintenance responsibilities must be performed by the DVP coordinator.

9-007 Client Responsibilities: The client shall -

1. Cooperate with the Program Worker in exploring all other sources of available aid, including setting up payment plans with creditors;
2. Accept any aid available to alleviate the emergency situation; and
3. Develop, with the Program Worker, a plan to alleviate and prevent a recurrence of the emergency situation.

9-008 Client Rights: The client has the right to -

1. Apply. Anyone who wishes to request and/or apply for EA must be given the opportunity to do so;
2. Reasonably prompt action on his/her application for EA;
3. Appeal any action or inaction with regard to an application, the amount of the benefit, or failure to act with reasonable promptness;
4. Adequate notice of any action affecting his/her EA case;
5. Have his/her information treated confidentially;
6. Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, handicap, religion, or political belief;
7. Have the program requirements and benefits fully explained;
8. Be represented and/or assisted in the application process by the person(s) of his/her choice; and
9. Referral to other social or private agencies.

9-009 Scope: The program has the following guidelines.

1. A case that is eligible under one of the ongoing programs may qualify for EA. For example, an emergency need may arise while an applicant is awaiting determination of eligibility for another program or while receiving other assistance.

2. This program includes migrant workers and transients statewide if they are otherwise eligible. There is no durational residence requirement.
3. EA should be used to pay for Foster Care only where the Foster Care cannot be claimed as a IV-E expense, unless specifically determined otherwise.

9-009.01 Time Period For Services: Payment can be made for services to meet needs which arose up to two months prior to, and which extend beyond, the application date.

To be included, the prior and subsequent needs must be directly related to the emergency need for which the application was made and must be such that, if they are met, the current emergency will be resolved. The maximum period for which payment for services can be authorized under an application for EA is 12 months. If the emergency continues beyond 12 months for child welfare/domestic violence-related needs, services may be reauthorized (see 479-000-321 for procedures).

Authorization for all benefits/services which are to be provided under a IV-A/EA application must be made within a period of 30 consecutive days beginning with the application date. This 30-day period is the authorization period.

Payment under Title IV-A/EA will be made only for services/benefits authorized during the 30-day authorization period and should be made as soon as possible in order to alleviate the emergency. Actual payment of services authorized as part of the EA application may extend beyond the 30-day authorization period but must not extend beyond 12 months following the date of initial authorization of services as previously defined.

Because services can only be authorized during one 30-day period in each 12 months, the worker should authorize all the types of EA services related to the emergency situation that are likely to be needed by the applicant during the 12-month period. For example, a family may need both payment of a rent arrearage and family support services to address an emergency so the worker would authorize both assistance related to housing and other essential services and child welfare services.
Note: See 479-000-321 for the maximum EA payment that can be authorized during any 12-month period for the services specified in 479 NAC 9-009.02.

If the Medically Handicapped Children's Program (MHCP), an insurance company, or other third party liability (TPL) is involved, approval for assistance may be made before the receipt of a decision by the third party.

If the availability of TPL cannot be resolved prior to payment being made using EA funds, the local office shall notify the third party of the Department's rights of subrogation according to 479 NAC 9-011.

9-009.02 EA Benefits Relating To Housing and Other Essential Services: Payment may be made for the following items if applicable eligibility requirements are met.

9-009.02A Shelter: Payment may be made for a mortgage payment, rent, and/or a rental deposit if the Program Worker verifies that payment will alleviate the emergency situation. If the applicant has received an eviction notice (or if an eviction notice is planned or threatened), payment may be made only if it will forestall the eviction. Shelter payment may also be made if the applicant was forced to move with no other shelter arrangements.

9-009.02B Utility Bills: If the applicant has received a shut-off notice, the worker may authorize payment for electricity, gas, and/or water. Payment may also be made for delivery of bulk fuel. EA may be used for payment of heating and cooling bills only if the applicant is not eligible for the Nebraska Low Income Energy Assistance Program (see Title 476). The applicant and Program Worker shall develop a plan to avoid a recurrence of the shut-off or depletion of fuel.

Payment may be made if the utilities are in a name other than the applicant's if the Program Worker can establish that -

1. The applicant is the sole beneficiary of the service; and
2. The utilities are not included in the rent payment.

9-009.02C Home Furnishings: Payment may be made for the purchase or repair of only those home furnishings that are essential for health and safety.

9-009.02D Emergency Non-Food Items: Emergency non-food items such as toilet paper and cleaning supplies may be purchased.

9-009.02E Emergency Food: If food stamps cannot be used to meet the emergency, the Program Worker may authorize the purchase of food up to the amount of food stamps a family of that size would receive. If the family has already received its total food stamps and an emergency occurs, the Program Worker may supplement the food stamp allotment.

9-009.02F Emergency Clothing: Emergency clothing may be purchased if it is essential for health and safety.

9-009.02G Moving Costs: Moving costs may be paid if it is necessary for the applicant to move to lower cost housing or from substandard to adequate housing, or to accept a bona fide job offer. The moving cost must be by the least expensive means available consistent with the applicant's age and physical condition. EA must not be used if the applicant is moving from one job to another. The Program Worker shall give prior approval to the moving plan.

9-009.02H Transportation: Transportation may be paid for a family which was traveling through the county or the state when the emergency occurred. Transportation may also be paid to obtain emergency medical treatment.

9-009.02J Emergency Special Diets: Payment may be made for emergency special diets for members of families receiving Aid to Dependent Children. The case record must contain a copy of the diet and a written statement by a physician that the diet is necessary. EA funds may be used only if the diet is more expensive than a normal diet.

9-009.02K Medical Payments: Medical payments may be made to alleviate current needs of a family which is in a crisis situation because of a catastrophic illness. The illness must require hospitalization (see 479 NAC 9-003). Any member of the family may have the illness. Medical services related to the illness (such as physician's fees and ambulance charges) are included. Funeral expenses are not covered.

Before authorizing EA, the Income Maintenance worker shall determine that the family is not eligible for categorical medical assistance.

9-009.02L Emergency Telephone Installation: Payment may be made for emergency telephone installation when a phone is necessary because of medical needs.

9-009.03 EA Benefits Relating To Domestic Violence: Emergency Assistance benefits are available for crisis intervention activities intended to lessen the trauma of an event that is perceived as physically or emotionally threatening and to assist a person so that a more adaptive outcome will result, including the ability to better cope with a future crisis. Payment may be made for the following services if applicable eligibility requirements are met.

1. Crisis Counseling: Supportive listening; providing information on dynamics of domestic violence, impact of violence on self and children; and identification of needs and resources to meet needs;
2. Transportation: Transportation for victims and their dependents to and from community facilities and resources;
3. Safe Living Environment: Safe living environments which provide a supportive, non-threatening shelter to victims, their families, and household members including -
   a. Residential facilities that provide an in-house program of individual and group counseling. The formula for reimbursement of shelter costs must be approved by the Central Office of the Nebraska Department of Social Services;
   b. Motels and hotels (with support services provided by domestic violence project personnel, as needed);
   c. Private homes (with support services provided by domestic violence project personnel and/or hosts);
4. Food: Food, if food is billed separately from shelter costs; and
5. Emergency Telephone: Emergency telephone installation when a phone is necessary because of safety needs.

9-009.04 EA Benefits Relating To Child Welfare Services: Emergency assistance benefits are available to clients of NDSS and other state agencies that have interagency agreements with NDSS related to EA for crisis intervention activities. These activities must be intended to lessen the trauma of an event that is perceived as physically or emotionally threatening to a child age 18 or younger and to assist the child and family so that a more adaptive outcome will result, including the ability to better cope with a future crisis. Payment may be made for the following items if applicable eligibility requirements are met.

9.009.04A Out of Home Care: Out of home care, including but not limited to shelter care, foster family care, group/residential care (including any out of home care, treatment and/or shelter necessary to meet special needs) for children separated from their parents, unless the child receives such assistance under Title IV-E, and needed medical care, unless the child is eligible for such care under Title XIX. Assistance will be provided at established Nebraska Department of Social Services rates.

9-009.04B Social Services: Case management, counseling, therapy, in-home intensive family services, and any other social services provided to alleviate the emergency condition, as determined appropriate and necessary by the local Department of Social Services agency.

Parenting education and training including household management training, family support, and development services provided to alleviate the emergency condition as determined appropriate and necessary by the local Nebraska Department of Social Services agency. Child care and respite care to alleviate the emergency condition and/or prevent out-of-home placement of the child at risk as determined appropriate and necessary by the local office.

9-010 General Eligibility Requirements: EA may be provided to a needy child and any other member of the household in which the child is living only if -

1. The child is age 18 or younger (a pregnant woman with no other children may be eligible);
2. The child is currently living with one or both parents, or, within six months prior to the month in which assistance is required, was living with a "specified relative" in a place of residence maintained as his or their own home.
3. The household is without income and resources immediately accessible to meet the needs that are caused by the emergency situation;
4. The child meets requirements of citizenship or permanent resident alien status (see 468 NAC 2-002);
5. The relevant income eligibility requirements, as set forth in sections 479 NAC 9-010.01, 9-010.02, and 9-010.03, are met; and
6. The destitution or need did not arise because the child (if age 16 or older and not in school) or the relative responsible for support and care refused without good cause to accept employment or training for employment or quit a job without good cause. However, if the child or family member refused without good cause to accept employment or training for employment or quit a job without good cause, but the emergency was not caused by this action, the family is still eligible for EA.

Note: EA is not limited to families eligible for or receiving ADC. Although the family must meet the eligibility requirements previously stated, it is not necessary that the child(ren) be deprived of parental support or care.

Nebraska's definition of Emergency covers three basic situations: (1) financial emergencies faced by families and children who need help to meet their basic living needs, (2) removal of a child into publicly funded care or supervision, or risk of same, and (3) parent with minor child in need of protection and services of a domestic violence/sexual assault project. Each situation has a financial needs restriction with a more severe limit for emergency #1 due to the very nature of the emergency - financial need - whereas there is a less severe income limit for emergencies #2 and #3 due to the fact that the nature of these emergencies is very different from that in #1. This reflects the state's desire to recognize and serve families with those specified emergency conditions if they do not have income sufficient to meet those emergent needs.

9-010.01 Income Eligibility Requirements For EA/Housing and Other Essential Service Benefits: The family's gross monthly income must not exceed 185 percent of the ADC standard for the family size (see chart at 479-000-321).

The client's statement of available income is accepted without further verification unless a prudent person would question the information.

9-010.02 Income Eligibility Requirements For EA/Domestic Violence Service Benefits: The applicant must be eligible for ADC, SSI, Food Stamps, or Medicaid or be without sufficient income immediately accessible to meet the unit's needs.

An applicant is considered to be without sufficient income immediately accessible to meet the unit's needs if the gross monthly income does not exceed 800 percent of the Federal Poverty Level (FPL) for their family size (see 479-000-321 for FPL chart).

In making a determination of an applicant's gross monthly income for the purposes of EA/Domestic Violence Service Benefits, a Program Worker considers only income that is available to the applicant. To determine if income of a financially responsible adult is available, the Worker shall explore the applicant's living situation. If the applicant states that s/he and the child(ren) included in the application are not living in the home, this is considered a separation and income of the financially responsible adult is not considered available to the applicant. If the applicant continues to reside with the financially responsible adult, the financially responsible adult's income is considered available.

If the applicant resides with an adult who is not financially responsible and the individual is paying the entire shelter and/or utility expense, the amount is counted as unearned income. If the individual gives cash to the applicant, the contribution is counted as unearned income.

The client's statement of available income is accepted without further verification unless a prudent person would question the information.

9-010.03 Income Eligibility Requirements For EA/Child Welfare Service Benefits: The applicant must be eligible for ADC, SSI, Food Stamps, or Medicaid or be without sufficient income immediately accessible to meet his/her needs.

An applicant is considered to be without sufficient income immediately accessible to meet his/her needs if his/her gross monthly income does not exceed 800 percent of the Federal Poverty Level (FPL) for the family size,(see 479-000-321 for FPL chart).

In determining the unit's gross monthly income, a Program Worker considers only income that is available to the unit. When a child applicant is placed in out-of-home care or when the parents of a child cannot be located or refuse to cooperate in supporting the child or applying for EA, and when the EA is necessary to avoid destitution of the child or to provide out of home living arrangements in a home or child care facility, the child's income alone is considered in determining eligibility. The client's statement of available income is accepted without further verification unless a prudent person would question the information.

9-011 General EA Payment Provisions: Payment for all approved EA is made by warrant directly to the provider or to the designated member of the family when appropriate. Payment may be made for all or a portion of the bills related to the family's crisis.

If insurance or third party liability is involved, every effort must be made to resolve issues of liability before EA payment is made. If it is impossible to resolve liability issues within 60 days from the EA application date, EA payment may be made but the insurance company must be notified of the Department's right of subrogation.

9-011.01 Payment Provisions Specific To EA/Housing and Other Essential Service Benefits: With the exception of catastrophic illness payments, total payments for the benefit period of 12 months of EA/Housing and Other Essential Service Benefits must not exceed one month's ADC standard of need for the applicant's family size (see chart at 479-000-321).

All payments for medical care must be made at rates no higher than those paid by the Nebraska Medical Assistance Program.

9-011.02 Payment Provisions Specific To EA/Domestic Violence Service Benefits: Payment for all authorized EA/Domestic Violence Service Benefits is made by Domestic Violence Personnel (DVP). There is no maximum on the amount of EA/Domestic Violence Service Benefits that may be authorized for an applicant within the 30-day authorization period.

9-011.03 Payment Provisions Specific To EA/Child Welfare Service Benefits: Payment for all authorized EA/Child Welfare Service Benefits is made at established NDSS rates. There is no maximum on the amount of EA/Child Welfare Service Benefits that may be authorized for an applicant within the 30-day authorization period.

9-012 Claims For Reimbursement: Claims for reimbursement under Title IV-A/EA will be paid only for services authorized within the 30-day authorization period.

9-013 Case Records: A separate case record or identifiable documents/documentation within the case record must be maintained for each EA case. The record must contain all the prescribed forms and documentation (see 479-000-321).

Case records on EA cases are required to be maintained for four years and are subject to state and federal audit.

9-014 Appeal Process: Every applicant for or recipient of EA has a right to appeal to the Director of the Nebraska Department of Social Services for a hearing on any action or inaction of any Department employee or official in regard to the EA Program. The appeal must be filed in writing within 90 days of the action or inaction. It is the responsibility of both the local office and the Central Office to inform the client of his/her right to appeal to the Department Director for the purpose of having the Director review any action or inaction.

9-014.01 Expedited Appeal: All EA hearings must be handled quickly. The following time limits govern an expedited appeal:

1. The appeal must be conducted within -
   a. Ten days of receipt of a Notice of Appeal from the Omaha or Lincoln Offices; or
   b. Twenty days of receipt of a Notice of Appeal from all other local offices; and

2. A determination must be made on the appeal within seven days of the hearing date.