BENEFITS

TABLE OF CONTENTS

Benefits

FOOD AND NUTRITION SERVICES BENEFITS

Food and Nutrition Services (FNS) is a federal food assistance program that helps low-income families buy food. In North Carolina, the Department of Social Services (DSS) runs the program.

Each month, DSS issues the benefits. DSS sends the FNS benefits via Electronic Benefit Transfer (EBT) cards. In the past, the benefits were called "food stamps."

Eligibility for FNS is based on household size and household income.

DSS decides who is eligible for FNS. DSS considers who lives together, who has income and assets, who buys and stores food together, and who has meals together.

► **Who is in the FNS household**. People who live together may or may not be part of a FNS household, or "FNS unit."

Example: A friend or family member lives with you. She buys her own groceries and has meals apart from others in the house. DSS will not consider that person as part of your FNS household. The person's income is not counted when DSS decides if you are eligible for FNS. She might be a separate FNS household, based on her income and assets.

Example: A friend or family member lives with you. She is disqualified for FNS, because she violated a program rule or she is not an eligible alien. DSS will not consider that person as part of your FNS household. That person's income will be counted when DSS decides if you are eligible for FNS.

► **Whose income is counted**. DSS has rules about whose income counts and whose does not. As a result, a person's income may count even if the person is not included in the FNS unit. There are income rules about high school students, other students, non-citizens, foster children, absent wage-earners, children for whom you get guardianship payments, and other individuals.

DSS deducts some essential living expenses from your income.

► **Living expenses**. In deciding about your monthly FNS benefits, DSS considers some of your necessary living expenses.

- Rent or Mortgage Payments. DSS deducts shelter costs and uses a formula for that. The costs may be for a residence or a mobile home lot, taxes, homeowner insurance, condo fees, some home repair costs, homeowner association fees, and other costs
  .

- Utility Payments. DSS deducts costs for water, electricity, gas, oil, and so on.

- Telephone. If you have no utility costs and you have a land line or cellular telephone, DSS deducts some costs for telephone service.

► **Medical costs**. A disabled person or a person age 60 or older may have some medical costs deducted from the household income, when costs are not covered by insurance.

► **Dependent care costs**. DSS deducts some costs that you pay for care for an incapacitated adult or a child if you pay the costs related to your work, training, or school that you attend in order to get a job. The care provider cannot be part of the FNS household.

► **Child support payments**. Child support payments that you make are deducted from the household income if the payments are made due to an administrative or court order, or are included in an enforceable separation agreement.

When you apply for FNS, you must take information with you.

- Proof of identity
- Birth records
- USCIS/Homeland Security and sponsor records
- Social Security cards
- Proof of where you are staying
- Proof of *all* income: Include wages, pensions, public assistance, military benefits, unemployment insurance, child support, annuities, work-study pay, grants, etc.
- Rent or mortgage payment records
- Utility bill receipts
- Telephone bill receipts
- Medical expense records, including costs for transportation to health care places
- Records for child support payments that you make
- Records for dependent care costs

(Rev. 10.17.14)

EMERGENCY ASSISTANCE AND ENERGY ASSISTANCE

The Department of Social Services (DSS) is a good place to start a search for emergency help. There is an office in each county. The staff can tell you about other sources of help in your county. DSS has limited funds for help with some emergency situations. Please call DSS for more information, or see their information at www.ncdhhs.gov.

You do ***not*** have to get Food Stamps, Work First, or Medicaid in order to be eligible for all of these programs.

Crisis Intervention Program. This program helps people who are in a heating-related or cooling-related emergency. While DSS funds last, a household can get up to $600 in assistance from July through the following June of each year. DSS pays the money to the business that provides your electricity, or heating or cooling service.

Requirements: The individual or household must

- include an eligible non-citizen or a US citizen;
- meet an income test; and
- have a cooling or heating related emergency.

Low Income Energy Assistance Program (LIEAP). This program helps people with heating costs. The help is available from December 1st through January 31st. While DSS funds last, DSS will make a one-time payment to the business that provides your heating service.

Requirements: The individual or household must

- be responsible for paying the heating bills;
- include an eligible non-citizen or a US citizen;
- include a person age 60 or older, ***or*** who is a disabled adult who gets help from the Division of Aging and Adult Services;
  meet an income test; and
- have reserves of $2,200 or less.

Work First **Emergency Assistance.** This program helps people who get Work First benefits whose housing is at risk, or whose utility service (gas, water, electric, etc.) is at risk of being cut off. DSS rules for the program vary by county. Funding is very limited.

Requirements: The household must

- have income below 200% of the Federal Poverty Guidelines;
- include an eligible non-citizen or a US citizen;
- include a child below age 17 (or 18, in some situations);
- who lives with a
  - parent (biological or adoptive); or
  - person who has a court order for custody or guardianship; or
  - an alleged father or alleged paternal relative; or
  - a step-parent, or step-brother or step-sister; or

- a blood or half-blood relative or adoptive relative, *limited* to: brother, sister, grandparent, great-grandparent, great-great-grandparent, uncle or aunt, great-uncle or aunt, great-great-uncle or aunt, nephew, niece, first cousin. *Spouses* of these individuals also meet the kinship requirement even if the marriage has been terminated by death or divorce.

Emergency Food Assistance. DSS operates the federal Food and Nutrition Services (FNS) program and helps people with monthly "food stamps." Usually, DSS handles new FNS applications within thirty days.

The *Expedited Service Program* helps people start getting FNS benefits within seven days or less.

Requirements: The individual or household must

- include an eligible non-citizen or a US citizen;
- have less than $150 in gross monthly income (before taxes);
- have less than $100 combined in cash, bank accounts, refunds, rebates, etc.; and
- have monthly rent or mortgage and utility costs that are more than your monthly income and your cash and other funds.

OR The individual or household must include a migrant or seasonal farmworker; and

- have less than $100 combined in cash, bank accounts, refunds, rebates, etc.

Migrant or seasonal farm work includes doing field work that is related to planting or cultivating, or being employed in canning, packing, ginning, seed conditioning or related research, or processing operations, and getting to or from the place of work by means of a day-haul operation.

Other Sources of Help

NC CARE-LINE 800.662.7030
The staff can tell you about state and local programs that might help you, including programs of the NC Department of Health and Human Services.

United Way AIRS 211
The staff can tell you where to find shelter, food pantries, affordable housing, support groups, training, jobs, and more. When calling, use a land line telephone.

NC Coalition Against Domestic Violence 888.997.9124
The staff can tell you how to find emergency shelter and more.

NC Utilities Commission 866.380.9816
The Public Staff may be able to help you work out a payment plan for utility bills.

(Rev. 07.20.14)

ELIGIBILITY FOR MEDICAID HEALTH INSURANCE

- **Mediciaid insurance.** Medicaid is a government health insurance program. It is free, and is available for people who have low incomes and limited assets. You may apply for Medicaid insurance at your county Department of Social Services. You do *not* have to be eligible for public assistance in order to be eligible for Medicaid insurance.

- **Medicaid coverage groups.** Coverage groups include the following.

  - women who are pregnant;
  - women who are at risk for breast cancer or cervical cancer;
  - children under age 18;
  - adults whose children under age 18 live with them;
  - adults who are age 65 or older;
  - adults who are blind; and
  - adults who are disabled

- **Medicaid income and asset rules. T**here are many kinds of Medicaid insurance. The income and asset rules are not the same for each program. For example, the income and asset rules for insurance for children are different from the rules for persons over age 65.

- **Medicaid coverage.** Medicaid helps pay for prescription drugs, care from doctors and dentists, hospital care, nursing home care, and more. Once your claim for Medicaid is approved, your insurance can reach back to cover medical costs up to three months *before* the date of your application.

- **Medicaid and Work First.** Usually, families who are eligible for Work First Family Assistance are also eligible for Medicaid insurance.

- **Medicaid and Medicare.** Some people who have Medicare insurance also have Medicaid assistance. The Medicaid program pays the monthly premium for your Medicare insurance.

- **Medicaid for disabled adults.** In order to get Medicaid insurance, you must be a low- income adult who is *disabled* if you are not over age 65, or blind, or pregnant, or at risk for breast cancer or cervical cancer, or have minor children who live with you.

  Disabled means that you have one or more major health problems that cause you to be *unable to work*. You must have proof of the following about your health.

  The health condition(s) is expected to last for at least 12 months or will result in death, and

  The health condition(s) is so severe that you cannot work at your past job or most other jobs for at least 12 months.

- **Medicaid and Social Security disability rules.** In deciding whether a person is disabled, the Medicaid program uses the Social Security Administration (SSA) disability rules.

> In order to have an active claim for Medicaid disability insurance, you **must** have an active claim for Social Security disability benefits.
>
> If SSA denies your claim, you **must** appeal the SSA denial in order to keep your Medicaid application active.

- **General rules, Medicaid application denials.** The Department of Social Services (DSS) will send you a letter to tell you that your application is approved or denied. DSS may deny an application for many reasons.

If your application is denied, read the letter to see why that happened. DSS might need more information from you.

DSS might have decided that you do not meet the income or asset rules, or they may have decided that you are not eligible for some other reason.

> If you have questions about the denial letter, please call the Medicaid worker at DSS.
>
> The telephone number is stated in the decision letter.

- **Appeals.** You have the right to appeal a denial decision and ask for an appeal hearing. The hearing will be at the DSS office.

  - The DSS decision letter states the deadline for asking for a hearing. You must be sure to meet the deadline. If you miss the deadline, you may make another application for Medicaid.

  - To appeal, you may call or write the Medicaid worker at DSS. We recommend that you do both.

  - If you must leave a message when you call, you should be sure to state your name, your date of birth, your telephone number, and that you are calling to ask for a Medicaid appeal. Be sure to make a written record of your call.

After you appeal, DSS should mail a form to you about your appeal hearing, and should call you to tell you about the hearing date, place and time. If you do not get a call or notice within a week of asking for an appeal, please call the Medicaid worker at DSS.

If you cannot attend the hearing, you may ask for another hearing date. There will be a delay in processing your Medicaid application.

(Rev. 07.20.14)

HOW TO REPRESENT YOURSELF IN AN ADULT *MEDICAID DISABILITY APPEAL* HEARING AT THE DEPARTMENT OF SOCIAL SERVICES

Purpose of the Medicaid Disability appeal hearing. The hearing is your opportunity to explain how you are *disabled* and why you *cannot work at any job* for 12 months or more.

The Hearing Officer will try hard to make a fair decision. She or he must learn about you, your work history, and your medical evidence. Medical evaluations, tests and records must support your disability claim. However, those alone are rarely enough to prove that a person is disabled. Your own statements are very important. Please see the list of the information that you should take to your hearing.

- **Evaluations, tests and records**. If you do <u>not</u> have all of your medical evaluations, tests and records, you should ask the Medicaid worker or Hearing Officer for help with that.

  If you <u>already</u> have copies of all of your medical evaluations, tests and records, you may mail those to the Hearing Officer in Raleigh. Do ***<u>not</u>*** mail your original records.

- **Witnesses**. You may take someone with you to the hearing. You might ask a relative, friend, partner, or spouse to go with you. The person can help explain how you are *disabled* and unable to work.

- **Get regular medical care.** If a doctor has not seen you recently, make an appointment so that you will have current medical evidence. If you cannot afford to go, please contact your local Health Department about where you might get free medical care. If you cannot get an appointment with a doctor and you feel that you are very sick, you may go to a hospital Emergency Department.

  It can be hard to be unable to work. If you feel anxious or depressed, it may be wise to go to the area mental health department for treatment and support. It will not harm your Medicaid case for you to go to counseling or therapy.

- **Ask for an *<u>evaluation</u>* from your doctors.** Call or visit doctors who have treated you in the last two years. Ask each doctor whether she or he will write a letter about your health problems and treatment, and why you cannot work any more.

  If the doctor agrees to write a letter, then you should ask for the letter in writing. A sample request is attached. The doctor's letter should state that you cannot work <u>at all</u> because of your medical condition(s), that the problem(s) has lasted 12 months or is expected to last 12 months, <u>and</u> state how the doctor <u>tested</u> and <u>evaluated</u> you.

  ► *If the doctor is <u>not</u> willing to write the letter for any reason, ask the doctor to please make no record of your request.* When DSS and SSA review your information, it will not help you if there is a record of a doctor's refusal to write a letter for you.

► The Medicaid disability hearing ◄

- **What to wear to the appeal hearing.** Wear what you might wear to go to the grocery store. You should not wear dressy clothing, shorts, a tee shirt, a hat, or flip-flops.

- **At the Department of Social Services.** Plan to arrive at least 30 minutes before the hearing time. Tell the receptionist that you are there to for a Medicaid hearing. Be sure to sign in. Wait for your name to be called.

- **Make notes for your use at the hearing.** Having notes will help you make sure to remember to say everything that is important to you. See the *Information You Should Write and Take With You*, below. You should give a copy of your information to the Hearing Officer, and keep a copy for your own records.

- **At the hearing**. Usually, the people at the hearing include you, the Medicaid worker, a supervisor, the Hearing Officer, and the person you take with you. The hearing will be tape-recorded. The Medicaid staff will talk about your application and their decision.

  The Hearing Officer will try to make a fair decision. Be respectful to all the DSS staff. Wait your turn to speak, and speak calmly. Speak slowly and clearly, so that the tape recorder will record what you say.

  You will be given time to talk about your health problems and why you cannot work. The Hearing Officer will ask you questions. If you do not understand a question, say so.

  Before **the hearing is over,** you should ask the Hearing Officer if she or he needs more evidence to decide your case.

  If the answer is "yes," ask the Hearing Officer to hold the record open (wait to make a decision). The Hearing Officer may give you time to get more medical records, or go back to the doctor or to the mental health office for evaluation. The Hearing Officer may also schedule an appointment for you to see a different doctor at the state's expense.

- **If the Hearing Officer says that no more information is needed:** If that happens, she or he will review and decide your case.

- **The decision letter**: The Hearing Officer will send you a decision by certified mail.

> If you do not receive a decision after one month,
>
> call the Medicaid Hearing Office at 919.855.3260.
>
> Ask the receptionist when you may expect to receive your decision letter.

► Information you should write and take to your hearing ◄

- Name, Social Security Number, mailing address and the county you live in;
- A **list** of all your physical health and mental health problems;
- A **list** of all the doctors, clinics, and hospitals that you have gone to in the last two years; If you have recent health evaluations or records, take copies with you.

Education

- What grade you finished in school;
- Whether you needed extra help in school or had special education classes;
- Whether you have a high school certificate, diploma, or GED;
- Learning disabilities that you have, if any.

Licenses and Work

- Whether you are licensed to drive;
- A **list** that states where and when you last worked full-time, and all of your jobs in the last 15 years;
- When you last tried to work full-time, and what happened;
- Any special training or license you have had for any job;
- How much lifting, bending, walking, and standing you did *at your last jobs*, and why you can no longer do that work.

Medicines and Medical Aids

- A **list** of your over-the-counter and prescribed medicines. Describe how each one makes you feel. Take the medicines with you to the hearing, in case the Hearing Officer has questions about what you are taking or should be taking.
- A **list** of any things you use, or should use because of a health problem, such as special shoes, a walking cane, a lift chair, leg wraps, wrist brace, truss, and so on.
- If you are *not* taking medicines, or seeing a doctor, or using items that you need because you cannot afford to do so, make sure that you tell the Hearing Officer.

What You Can Do Now

- Tell the Hearing Officer how far you can walk without resting, how much you can lift, what you can carry, how long you can stand at one time, and how long you can sit at one time. Explain *how you feel* if you try to do too much.

Symptoms

- **List** the symptoms you have that keep you from working. For example, if you have pain, or you feel dizzy, sick to your stomach, weak, tired, or worried, *describe* those things.
- When you describe a symptom, state these things: (**a**) how often you have the symptom, (**b**) how long it lasts, (**c**) how much you feel it or how bad it is, (**d**) what it feels like, (**e**) what it keeps you from doing, and (**f**) what, if anything, helps control the symptom.

Your Average Day

- Describe what you now do on an average day.
- **List** things you cannot do or have to do slowly or with help.
- If you have trouble sleeping, eating, sitting, standing, walking, dressing, bathing, cooking, doing laundry, washing dishes, cleaning, driving, shopping, or going to worship or other places, tell the Hearing Officer.

Past Regular Activity

- **List** all of the things you used to do that you no longer can do, or have a hard time doing, and explain what has changed. For example, if you have stopped walking to the mailbox, say so, and describe what has changed.

Help That You Have

- If there are people who are helping you, tell the Hearing Officer who they are and what they do. For example, tell the Hearing Officer if someone helps you with your laundry, meals, going to the store, mowing the grass, bathing, transportation, and so on.

(Rev. 08.01.14)

Date:_____

Dear Health Care Provider:

I have applied for Medicaid disability insurance benefits and Social Security Disability income. In order to receive Medicaid insurance and disability income, I must show the Department of Social Services (DSS) and the Social Security Administration (SSA) medical evaluations and evidence to support a conclusion that I am a *disabled person*.

I must submit complete copies of my evaluations, tests, and medical records to DSS and SSA to show the clinical tests, treatment, and diagnoses I have received over the past two years. I am asking that you provide me with copies of the following records:

- Complete name, title, and contact information for any physician or physician's assistant who treated me;
- Records of my appointments, plans of care, and any admissions, including the date, time, and reason for the visit or admission, and all records created from the start of admission through discharge, including discharge summaries and instructions;
- Copies of all diagnostic tests or evaluations that were used to diagnose or treat my condition(s), such as X-rays, MRIs, pulmonary function tests, pathology reports, laboratory tests, etc.;
- Copies of any physical therapy records;
- A complete list of medications prescribed for me, including over-the-counter drugs;
- A complete list of prescribed medical equipment and supplies;
- All clinical and medical findings by the physician or physician's assistant.

I am respectfully asking that you waive any photocopying or transcription fees because I am a low-income person. I am trying to get Medicaid insurance in order to pay my treatment bills. I must submit copies of the evaluations, tests and records to DSS and SSA so that I may receive benefits as soon as possible. A timely response would be greatly appreciated.

Thank you so much for your kind help,

Sincerely,

_____
Your Patient

My full name: _____
Date of Birth: _____
Medical records #: _____
My Address: _____
_____
Home Phone #: ( )_____
Alternate Phone #: ( )_____

MEDICAID DEDUCTIBLE

- **What is a *deductible*?** A *deductible* is an amount of money that you have to spend before your insurance starts making payments for you.

- **What is a Medicaid deductible or "spend-down" amount?**

A **Medicaid deductible** is the amount of the medical costs that you must owe **or** pay before Medicaid will start paying your medical bills.

Some people have too much income to qualify for Medicaid insurance. Their income amount is called "excess" income. In some situations, people who have excess income may qualify for Medicaid after they meet a deductible.

A Medicaid deductible is also called a "spend-down." You must spend down the excess income. Once you do that, then Medicaid will start paying your medical costs.

Example: Your spend-down amount is $1500. That means that you must have $1500 in medical costs before Medicaid will start paying your medical costs.

NOTE: You must **owe or pay** the medical costs.
You do not have to pay the costs in order for them to count toward your deductible amount.

- **When is the Medicaid spend-down in effect?** Usually, a deductible is in effect every six months. That time is called the "*certification period*."

On the date when Medicaid confirms that your medical costs equal the amount of the spend-down, you will be authorized for full, regular Medicaid insurance. Starting at that time, you will have Medicaid coverage through the end of the six month certification period.

Once the certification period ends, you will have to meet your deductible again before Medicaid will start paying your medical costs again.

- **How does Medicaid decide my deductible amount?** The government sets a "medically needy income limit" for the Medicaid program. If you have a deductible, Medicaid reckons your monthly income, and then subtracts the "medically needy income limit" amount from that. The result is your excess income amount, or the amount of your income that exceeds the income limit. Then, Medicaid multiplies that amount by six.

Example: In year 2013, the medically needy income limit was $317. If your monthly income is $1000, the difference is $683. That is your excess income amount. Multiply that amount by six. The spend-down amount is $4098 for the certification period.
$1000 - $317 = $683. $683 x 6 = $4098.

(Rev. 07.20.14)

- **Whose medical costs count toward the spend-down amount?**

For a married couple, the medical costs of both spouses are counted toward the deductible.

For a child, the medical costs of the parent or parents are counted.

- **What medical costs count toward a Medicaid deductible?**

Current Medical Costs. Current costs may be paid or unpaid. Medicaid *only* counts the part of the cost that *you* are responsible for paying.

For example, if you have other health insurance or Medicare coverage, the Medicaid program does not count the part of the cost that is paid by your other insurance.

Current medical expenses can include the following:

- Over-the-counter drugs such as aspirin, Tylenol, cold medicine
- Medical supplies such as gauze, bandages, rubbing alcohol
- Medical equipment such as dentures, eyeglasses, or a cane
- Vitamins or supplements, if prescribed by your doctor
- Cost or mileage for transportation to the doctor or hospital
- Premiums for private health insurance
- A bank loan or credit card money used to pay medial costs
- Hospital charges for in-patient or out-patient care
- Clinic and laboratory charges
- Prescription drugs

Unpaid Medical Costs. If Medicaid can confirm some information, then you can use some medical costs that you owe but have not paid. The costs must be owed before the current certification period. You can use an unpaid bill to meet the spend-down one time only.

The Medicaid caseworker must confirm that

- The unpaid bill is less than 2 years old, or, if over 2 years old, that you have made a payment on the bill in the last 2 years;
- The health care provider is still billing you; and
- If you had any kind of health insurance at the time when the bill was first owed, that a claim was filed with your insurance company and was either paid or denied.

Once you meet the deductible amount, Medicaid will pay for medical cost that you have after that. Medicaid will **not** go back and pay the costs that you used to meet your spend-down.

MEDICAID AND TRANSFERS OF ASSETS

- **Eligibility for Medicaid health insurance**

Medicaid is free health insurance for low-income people. There are Medicaid insurance programs for women, children, families, older adults, and disabled individuals.

Generally, eligibility is based on a person's age, household, income, and "resources."

- **A *resource* is income or an asset.**

A resource is something that you own. For example, a resource is a pension, savings account, land, home, tractor, money that someone owes to you, a certificate of deposit, and so on.

- ***Why* does the Medicaid program review transfers and sales of resources?**

The government does not want people to sell or change ownership of property just in order to become eligible for Medicaid insurance

- **Does the Medicaid program always review transfers and sales of resources?**

No. The Medicaid program reviews transfers and sales of resources when a person applies for

- **long-term care** in a rest home, nursing facility, intermediate care facility for the mentally retarded, or swing bed or inappropriate level of care bed, or

- **in-home supplies and services** that include the Community Assistance Program (**CAP**) and the Program of All-inclusive Care for the Elderly (**PACE**)

TIP: Medicaid does ***not*** review transfers or sales of resources when a person gets Personal Care Services (PCS) or when a person gets acute care in a hospital, regardless of how long the person is in the hospital.

- **When is there a problem with a transfer or sale of a resource?**

There may be a problem if you do not get the *current fair market value* for a resource that you sell or transfer.

Example: You have an insurance annuity that pays $8,000 per year. You transfer the annuity to your niece. Your niece pays you $1.00. That transfer is not for current fair market value.

Example: You have a truck that is worth $8,000. You sell it for $2,000. That sale price is not the current fair market value.

- **Is there *always* a problem with a resource transfer or sale?**

No. There should be no problem if you have proof that you made a transfer or sale for a purpose that is *not* related to Medicaid eligibility.

Example: You own land that is worth $5,000. You have not paid the property taxes for the last three years. You sell the land for $4,000, and pay the back taxes. You can use your tax bills and receipt to prove that you made the sale for a purpose that is not related to Medicaid eligibility.

There are hardship exceptions to the Medicaid rules. There are also special protections if you transfer ownership of your home to following people.

- your spouse who remains in the primary home
- your dependent relative
- your biological, adopted, or step child under age 21
- your disabled or blind child of any age
- your sister or brother who co-owns your home and has lived there for at least a year
- your biological, adopted or step child over age 21, in some situations

- **Can a person dispute that a sale or transfer was for less than fair market value?**

Yes. You may dispute ("rebut") that in various ways. For example, you may have proof that

- you tried to sell the resource for market value at least twice, or
- Medicaid did not value the resource correctly, or
- you got back all or most of the resource.

If you cannot show that a sale or transfer was for a reason that Medicaid allows, you will not be eligible for Medicaid for a time. The time when you are not eligible is called a "*sanction period*" or "*penalty period*."

- **How long is the sanction period?**

Generally, the length of a sanction period depends on the value of the resource that you sold or transferred. If the transfer or sale happened on or after 11.01.07, Medicaid divides the value of the resource by the monthly cost for long-term care. For the year 2014, the cost is about $6300.

- **How far back does Medicaid look at transfers and sales of resources?**

It depends on when you first apply for any type of Medicaid insurance. If you first apply for Medicaid on or after 11.01.12, then the Medicaid program will review your sales and transfers for the past sixty months.

If you applied for any type of Medicaid before 11.01.12, please see the Look Back Page.

Medicaid *Look Back*

If you applied for any type of Medicaid insurance before 11.01.12, the following general rules are used to decide whether you will have a sanction period. There are exceptions to these general rules.

Medicaid has a *starting point* and a *look-back period*.

The *starting point* is the date when you first applied for any type of Medicaid insurance.

The *look-back period* is the amount of time that Medicaid will *look back* to see if you sold or transferred a resource for less than fair market value.

If you made a transfer or sale for less than fair market value during the look-back period, you will have a sanction.

Starting point

► Start at the date of first application	Applied *between* 02.01.03 and 10.31.07
► Start at the earliest of these: □ the person asks for CAP or PACE or goes to long-term care, and □ the person applies for Medicaid	Applied *before* 02.01.03 or *after* 11.01.07

Look-back period

► When the starting point is before 11.01.10	look back 36 months, or 60 months for resources transferred to trusts or annuities
► When the starting point is between 11.01.10 and 10.31.12	look back to 11.01.07, or 60 months for assets transferred to trusts
► When the starting point is on or after 11.01.12	look back 60 months

(Rev. 09.29.14)

HOW TO APPEAL A DENIAL OF MEDICAID COVERAGE

If you get a notice about denial of Medicaid coverage, that means that Medicaid has decided not to pay, or keep paying for equipment or services for you. **You have the right to appeal**.

► **Who sent the notice.** The notice might come from the NC Division of Medical Assistance (DMA) or from an agency that works with Medicaid. Agencies include ACS, The Carolinas Center for Medical Excellence, Crossroads Behavioral Healthcare, The Durham Center, Eastpoint LME, HP Enterprise Services, MedSolutions, Murdoch Center, Pathways LME, Piedmont Behavioral Healthcare, and ValueOptions.

► **Appeal deadlines.** Everyone must make an appeal within 30 days. The deadline starts on the date that is on the notice itself.

• 10 Day appeal deadline. If you already have Medicaid services, then in order to *keep* your current level of services, you must appeal within ten calendar days. If you do not appeal within the 10 days but you appeal before 30 days, you may have a break in your services for a short time until your appeal is received.

► **Appeal instructions and form.** Along with the notice, you will get appeal instructions and a *Medicaid Services Recipient Hearing Request Form.* A sample is attached to these materials.

► **How to appeal.** Fill out the hearing request form. Use only the pre-printed form that has your information on it. If you lose the form or need another, call the DMA Appeals Unit at 919.855.4260 to ask for a form. Use ink when you fill out the form. Print clearly. Make a photocopy of the form that you send. Keep it for your records.

Send the form by regular US mail and fax the form to two places. Those are Office of Administrative Hearings (OAH) and NC Department of Health and Human Services (DHHS). These offices must receive your appeal request within the 10 days or 30 days.

You must fill out the form on your own. Your doctor or health care provider, or the staff at the Department of Social Services cannot fill out the form for you. They might send a fax for you.

● Office of Administrative Hearings (OAH)
Attention: Clerk of Court
6714 Mail Service Center
Raleigh, NC 27699-6714
Office 919.431.3000 *Fax* 919.431.3100

● NC Department of Health and Human Services (DHHS)
Medicaid Recipient Appeals Section
2501 Mail Service Center
Raleigh, NC 27699-6714
Office 800.662.7030 *Fax* 919.733.2796

► **Three steps in the appeal process.** The State must complete the entire appeal process within 90 days from the date OAH receives your appeal hearing request. You should be sure to check your mail for notices about your appeal. There are three steps in the process.

1. **Mediation (voluntary)** — Mediation must be completed within 25 days of the date that OAH receives your hearing request.

2. **OAH Proceeding** — The hearing before OAH must be completed within 55 days of the date that OAH receives your hearing request.

3. **Final Agency Decision** — You must receive notice of the final agency decision within 20 days of the agency's receipt of your case from OAH.

► **Mediation** is a free, informal process. It is a good way to try to reach an agreement in your case. You do not have to participate in mediation. It is voluntary. Mediation may help you resolve your case fairly quickly. You do not have to accept any offer made during mediation.

Usually, mediation is by telephone. You may offer new evidence that has not been seen or heard by the Medicaid agency before. If you have new evidence, the Medicaid representatives will be allowed to review and respond to your new information.

If mediation resolves your case, the appeal will end. You will get the Medicaid services that you agreed to in the mediation. If mediation does not resolve your case, or you do not accept an offer made at mediation, you may still have a hearing. OAH will schedule your case for a hearing.

► **The appeal hearing.** The hearing will be held by an administrative law judge (ALJ).

● *Hearing by telephone*. The hearing will be held by telephone unless you specifically ask in writing for an in-person hearing or a videoconference hearing.

● *Representation*. You may represent yourself or ask someone to speak for you. The person who you ask to speak for you is called a *personal representative*. That person may be a relative, friend, or other person, including a case manager or a health care provider. You may hire a lawyer, or work with a Legal Aid staff member or volunteer. A lawyer is a *legal representative*.

● *Changing the hearing date*. You may ask for a later hearing date (a *continuance*) if you have a good reason for doing that. You must ask for that in writing, and well in advance of the hearing date. A continuance will not be granted on the day of the hearing except for good cause. The ALJ decides what serves as good cause.

● *Missing the hearing*. If you got proper notice of the hearing and you are not present, the hearing will be **immediately dismissed**. That will happen unless you have proof of good cause as to why you were not at the hearing. You must submit your proof of good cause within three business days of the date of the dismissal.

● *Burden of Proof, first request for services.* You have the burden of proving that you are entitled to the requested services.

● *Burden of Proof, change in services.* Medicaid has burden of proof when they make a decision to cut, end, or suspend services you have been getting.

● *Evidence*. You may give new evidence at the hearing. New evidence might be medical records, written reports, testimony from family and friends, and testimony from doctors and other health care people who can say why you need the services or equipment. People who testify must be at the hearing.

● *Your Medicaid file*. You have the right to see all of the documents in Medicaid's file about your case. You have the right to do that before the hearing date.

● *ALJ recommended decision*. After your hearing, the ALJ will make a decision within 20 days of the date the hearing ends. The ALJ will send the decision to you and to the Medicaid agency.

● *Final agency decision*. The Medicaid agency will make the final agency decision within 20 days of their receipt of the ALJ's recommended decision.

► **Repayment to Medicaid.** If you lose your appeal, Medicaid has the right to seek repayment from you for services or equipment you got during the appeal.

► **Further appeals.** If you disagree with the final agency decision, you may appeal to the Superior Court within 30 days of the date of the final agency decision.

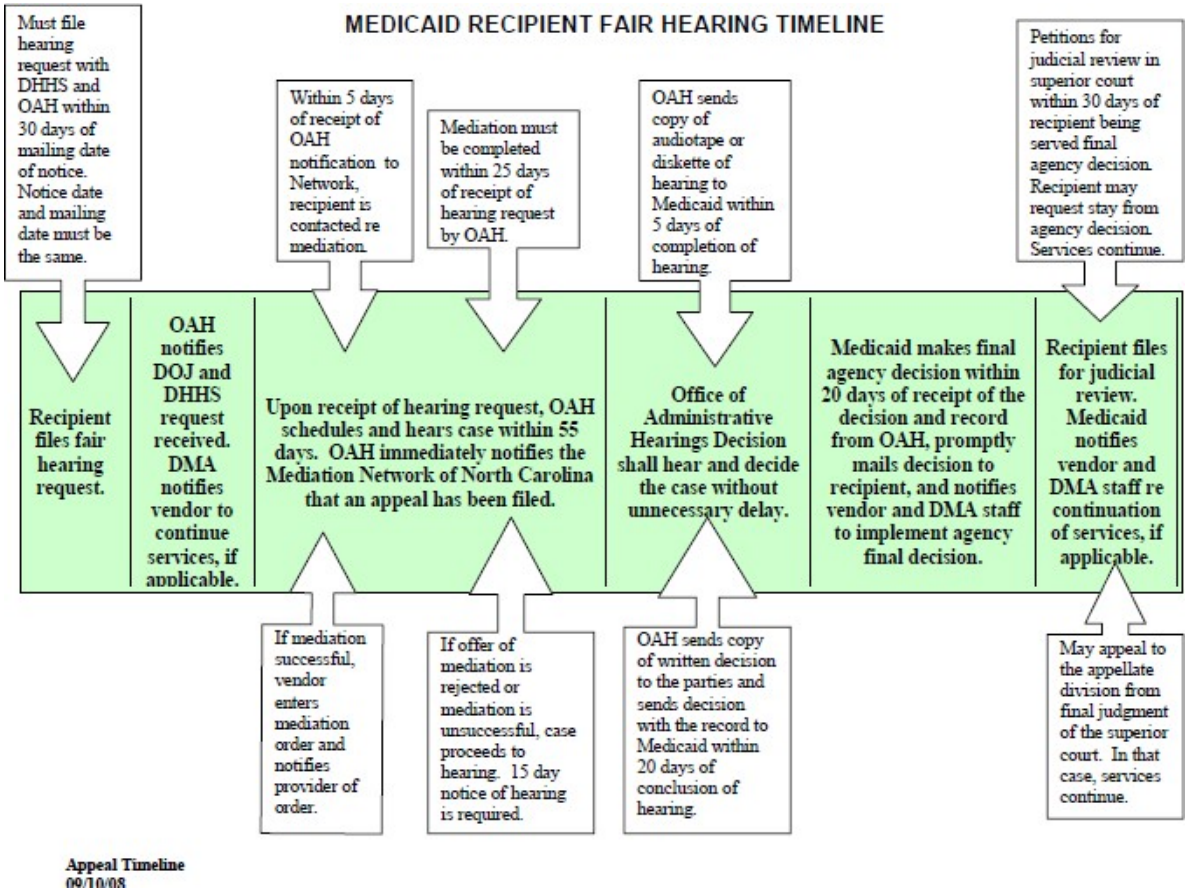
You may do that by filing a *Petition for Judicial Review* with Clerk of Superior Court in Wake County or in the county where you live.

You will need legal help to file the *Petition*. There are no forms for the public for a Petition for Judicial Review. A personal representative who is not an attorney cannot file an appeal for you in Superior Court.

If a Legal Aid of North Carolina staff lawyer or volunteer did not represent you at the hearing, you will need to contact a lawyer in private practice for help with the Petition.

The North Carolina Lawyer Referral Service can help you find a lawyer in private practice. You may call 800.662.7660 to find legal help. There is a fee of up to $50 for a brief consultation. You do not have to hire the attorney, and the attorney does not have to help you further.

(Rev. 11.30.14)



Appeal Timeline
09/10/08

(Rev. 11.30.14)

SAMPLE* MEDICAID SERVICES RECIPIENT HEARING REQUEST FORM *SAMPLE

COMPLETE AND SEND THIS FORM IF YOU WANT TO APPEAL MEDICAID'S DECISION

Date:_____[insert date of notice (must be date notice mailed)]
Decision made by:
____DMA____ACS____CCME____EDS____MedSolutions____Murdoch____PBH____VO

Type of Request:_____Initial/No Service in Place____Continuing/Reauthorization

Type of Notice Issued:_____2001____2001A____2001E_____2002____2002A____2002E

[Insert name of Medicaid recipient] (MID #) [insert MID # in ()]
Address [insert street address of Medicaid recipient]
City, State Zip code [insert city, state, and zip code]

DIRECTIONS: Please complete this form. Send the completed form by mail or fax to OAH at the address or fax number in the above box. The hearing request form must be **received** by OAH within **30 days of the date this notice was mailed to me**.

I would like to appeal the [denial] of my request for OR change in my] [insert service requested]. I have the right to a hearing conducted telephonically, by video technology, or in-person. The hearing will be conducted by telephone unless I request an in-person or video hearing. If I request an in-person hearing, I understand it will be held at the Office of Administrative Hearings in Wake County (Raleigh) unless I can show good cause why I cannot come to Wake County. I am requesting a hearing **(please check one)**:

_ by telephone _ by videoconference _ in-person in Raleigh _ in-person in my county of residence because_____.
I may represent myself during the appeal process, hire an attorney or use a legal aid attorney, or ask a relative, friend, my case manager, or another spokesperson to represent me. By signing this form, I authorize any person listed below to represent me during the appeal, to discuss my case, and to have access to my Medicaid file, including medical records and other confidential information about my case. I understand that I can file this appeal form now and still ask a representative to help me at a later time. I will **(please check one)**:

_ Represent myself. _ Be represented by someone else. If yes, complete box below.
Name of Representative_____Relationship to Recipient _____
Address_____Telephone Number ( )_____-_____

I understand if I am appealing a CHANGE notice and I submit a request for hearing within **30 days of the date this notice was mailed and** as long as I remain otherwise Medicaid eligible, unless I give up this right, I will continue to receive services until my appeal is decided. Should I have been receiving services and appeal within **10 days of the date this notice was mailed** as long as my provider submitted the service request before the last authorization expired, my services will continue without interruption. If I appeal within **30 days of the date this notice was mailed** to me and services were stopped or reduced, services will be reinstated. Services will be provided at the same level I was receiving the day before the decision or the level requested by my provider, whichever is less. **I will continue to be authorized to receive my current service(s) even if I change providers.** If I lose my appeal, I understand that I (the recipient) may be required to pay for the services that continue because of the appeal.
____***SAMPLE***_____***SAMPLE***_____
Signature of Medicaid Recipient/Applicant or Legal Guardian Date Telephone Number

TRANSITIONAL MEDICAID INSURANCE

Even if you are no longer eligible for Medicaid, your insurance might continue for a few months. This type of Medicaid is called *transitional* Medicaid.

You may get *transitional* Medicaid and have insurance for up to 12 more months when

- You had Medicaid for Families with Children (M-FC) and it ended, *or*
- You got Work First Family Assistance (also called TANF), and it ended

and

- You live in North Carolina
- A child under age 21 lives with you for the entire 12 months
- Your benefits ended because your household income increased
- You got Work First or M-FC for 3 of the 6 months just before you lost eligibility.

During the 12 months, your eligibility may end if your income goes up too much, if you move out of North Carolina, if the child moves out, or if you stop working.

You may get *transitional* Medicaid and have insurance for up to 4 more months when

- You lose eligibility because you begin to get child support, *or*
- You lose eligibility because you get more child support

and

- You live in North Carolina
- A child under age 21 lives with you for the entire 12 months
- You got Work First or M-FC for 3 of the 6 months just before you lost eligibility.

You will *not* be eligible for transitional Medicaid if your Work First or M-FC ended for a reason *other than* increased income or increased child support.

► When the transitional Medicaid ends, you may apply for Medicaid again. You and your children may be eligible for Medicaid again.

(Rev. 10.17.14)

NC Division of Medical Assistance Medicaid and Health Choice
Orthodontic Services Clinical Coverage Policy No.: 48
Revised Date: March 12, 2012
06.27.2012 4

3.2 Specific Criteria
3.2.1 Medicaid Specific Criteria

The following criteria for functionally impairing occlusal conditions apply when cases are reviewed for Medicaid orthodontic approval. The probability for approval is increased when two or more of the following criteria exist:
a. Severe skeletal condition that may require a combination of orthodontic treatment and orthognathic surgery to correct (recipient's age and the direction of growth are also considered).
b. Severe anterior-posterior occlusal discrepancy (Class II or Class III dental malocclusion).
c. Posterior transverse discrepancies that involve several posterior teeth in crossbite, one of which must be a molar (crossbite must demonstrate functional shift).
d. Anterior crossbite that involves more than two teeth.
e. True anterior openbite (excessive 4 mm or greater and does not include one or two teeth slightly out of occlusion or where the incisors have not fully erupted and not correctable by habit therapy).
f. Significant posterior openbite (not involving partially erupted teeth or one or two teeth slightly out of occlusion).
g. Overbite must be deep, complete, and traumatic (a majority of the lower incisors must be causing palatal tissue trauma).
h. Overjet (excessive protrusion 6 mm or greater).
i. Crowding greater than 6 mm in either arch that must be moderate to severe and functionally intolerable over a long period of time (such as occlusal disharmony or gingival recession secondary to severe crowding).
j. Impactions with a good prognosis of being brought into occlusion.
k. Excessive anterior spacing of 8 mm or greater from mesial of cuspid to mesial of cuspid.
l. Occlusal condition that exhibits a profound impact from a congenital or developmental disorder or severe, traumatic incident.
m. Psychological and emotional factors causing psychosocial inhibition to the normal pursuits of life (requires supporting documentation of pre-existing condition from a licensed mental health professional specializing in child psychology or child psychiatry).
n. Potential that all problems will worsen.

MEDICARE PART D: PRESCRIPTION DRUG PLANS

Generally, Medicare is health insurance for people who are age 65 or older.

Medicare Part D is insurance for prescription drug costs. There are two ways to get Medicare Part D insurance.

One way is through buying a Medicare Advantage Plan, or *MAP*. Another way is to buy Medicare Part D insurance from a private insurance company.

The *Low Income Subsidy* (LIS) program gives low-income people extra help with Medicare Part D costs and prescription drug costs

► **Medicare and Medicaid.** Some people have both Medicare and Medicaid insurance. Medicaid is free health insurance for eligible low-income people. If you have *full* Medicaid insurance, you should have a *blue* Medicaid ID card.

Medicare-aid is a Medicaid program that pays some of your Medicare insurance costs. It is also called MQB or MWD. It is not full Medicaid insurance. You should have a *gray* or *buff* insurance card.

►**Eligibility for Low Income Subsidy**.

- **Full subsidy**. If you get **SSI or** you have full **Medicaid** insurance, you are eligible for a full Medicare Part D subsidy. You do not have to apply for LIS. Enrollment is automatic. If you have Medicare and full Medicaid, you are "*dual eligible*" because you are someone who is eligible for both programs. If you do not have LIS, please see your Medicaid caseworker.

  You will pay no premium for Medicare Part D. Depending on your income, your co-pay will be from $1.20 to $6.35 for prescription drugs that are covered by your Part D insurance plan. There is no co-pay after you pay $4500.

- **Full or partial subsidy**. If you do not get SSI or have full Medicaid insurance, you may be eligible for a *full* or a *partial* Medicare Part D subsidy. Please see the Low Income Subsidy chart on the following page.

► **Enrollment, if you have Medicare insurance only.** If you only have Medicare insurance and you do *not* have Medicaid insurance, you should shop for a prescription drug insurance plan. Call the NC Senior Health Insurance Information Program for help in choosing a MAP or Medicare D insurance plan. You may call 919.807.6900 or toll-free at 800.443.9354.

Applications are available at the offices of the Social Security Administration and the Department of Social Services. Applications are also available from many MAP and Medicare Part D insurance companies.

LIS Eligibility Chart

2015 Full Subsidy

Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Co-pay or Co-insurance, formulary drugs
People with Medicare & full Medicaid who **live in LTC facilities**	Meet state Medicaid financial elig rules	Meet state Medicaid financial elig rules	No. Get LIS automatically	No	No	None
Other people with Medicare & full Medicaid, incl. those with MSP	Meet state Medicaid financial elig	Meet state Medicaid financial elig	No. Get LIS automatically	No	No	Co-pay for medications until $4700 limit is reached
Non-duals with income ≤ 135% FPL	$1,325/mo if single, or $1,793 /mo if married	$8,780 or less if single, or $13,930 or less if married	No, **if** on SSI Otherwise Yes	No	No	Co-pay for medications until $4700 limit is reached

2015 Partial Subsidy

Non-duals with income ≤ 135% FPL AND assets limits apply	$1,325/mo if single, or $1,793/mo if married	Between $8,780 and 13, 640 if single; Btn $13,930 and $27,250 if married	Yes	No	$66	co-insurance 15% up to $4700 limit then co-pays
Non-duals with income between 135% and 150% FPL	≤ $1471.25/mo if single, or ≤ $1991.25/mo if married	$13,640 or less if single, or $27,250 or less if married	Yes	Sliding Scale	$66	co-insurance 15% up to $4700 limit then co-pays

*All asset eligibility limits include $1,500 per person burial allowance.

Guidelines are effective 04.01.15.

(**Rev. 04.27.15)**

CHILD CARE FINANCIAL ASSISTANCE

You might be eligible for Child Care Financial Assistance if you have a low income and meet other eligibility rules. The main rules are the Household Situation rules and Income rules.

In North Carolina, the funding for the program is different from county to county. All counties have waiting lists, and all have separate waiting lists for children with special needs. Some counties have rules about who gets priority on waiting lists.

► ***Where to apply*****.** Contact the county Department of Social Services (DSS) for information. Applications may be taken at DSS or at an authorized local agency.

► ***The child or children*****.** Assistance is available for children from birth to age 17.

► ***The location*****.** You have the right to choose the location. Child care may be in a child's home, a caregiver's home, or a facility. The location must meet Division of Child Development rules.

► ***The assistance payments and period*****.** The child care provider gets the payments. The standard assistance period is 12 months. A shorter time may be possible. For example, you might need child care while you look for work, or because of a school vacation.

► ***The responsible adult or parent*****.** The person who gets the assistance voucher must be a child's parent or foster parent or the person who provides a home for a child and is responsible for the child's care and welfare.

► ***The situation rules*****.** You may be eligible if one or more of the following is true.

You are	or	Your child
□ in a job training program		□ has developmental needs
□ working		□ needs child care because your family has a crisis due to illness, violence, etc.
□ looking for work		□ gets child protective services **
□ in school		□ needs care to support child welfare services **
		□ is in DSS custody, getting foster care services, and placed in a licensed home or with an adult who is not a parent **

** *No* income limit

FEES
Most people must pay a part of the child care cost and pay that directly to the child care provider.

It is called the "parental fee."

► ***Income and parental fees*****.** You are financially eligible for assistance if you get Food and Nutrition Services ("food stamps") benefits or if your income is at or below the following limits.

Family Size	Maximum Gross Monthly Income	Parental Fee Percentage
1	$2,177	10%
2	$2,847	
3	$3,517	
4	$4,187	9%
5	$4,856	
6	$5,526	8%
7	$5,652	
8	$5,777	
9	$5,903	
10	$6,029	
11	$6,154	
12	$6,280	

The parental fee that you pay is a percentage of your gross (before taxes) monthly income. You pay the fee directly to the child care provider. Example: A household of three with a gross income of $3600 would pay the child care provider a monthly fee of $360.

► ***Reporting*****.** Within five days of any of the following changes, you must report the change to your child care social worker in writing.

□ Change of address
□ Change in household size
□ Separation (informal or formal)
□ Change of job
□ Change in work hours or days
□ Income increase from any source
◘ Change of telephone number
◘ Marriage
◘ Divorce
◘ Change in work shift
◘ Change in child support amount
◘ Income decrease from any source

►***Appeals*****.** You do not have the legal right to appeal a denial or termination of a specific child care provider. You do have the legal right to appeal and have a hearing if you disagree with a decision about the financial assistance.

You may appeal the following.
● sanctions related to fraud.

● denial of service ● termination of service ● change in fees

You must appeal and ask for a hearing within 60 days of the effective date of the action taken by the program. The 60 days starts on the day after the effective date.

To appeal, you must contact your child care social worker. You may do that by telephone or in writing. It is best to do both, and to keep a photocopy of your written appeal request. The appeal hearing will be at DSS or the authorized local agency. **(Rev. 09.02.14)**

APPEAL HEARINGS AT THE DEPARTMENT OF SOCIAL SERVICES

In most situations, you have the right to an appeal hearing about Medicaid, Work First Family Assistance, or Food and Nutrition Services when the Department of Social Services (DSS) does the following.

- *will not let you apply* or discourages you from applying;
- *denies* your application;
- *ends* your benefits; or
- *changes* your benefits.

If you believe that the DSS decision was wrong, you may ask for a hearing. A "*fair hearing*" or "*local hearing*" is the first formal step in the DSS appeal process for most benefits programs. The next step is *State* appeal hearing. The hearings are at the county DSS offices.

► **How to appeal.** You may appeal and ask for a hearing by calling DSS, or by mail. It is best to do both.

► Appeal *by telephone*. You may call the DSS worker whose name and telephone number are on the DSS notice. You may talk with the person, or leave a message and say that you want to appeal the decision and have a hearing. You should be sure to state your name and date of birth.

► Appeal *by mail*. Photocopy the DSS notice that you got. On the back, state that you appeal and request a hearing. You should briefly state why you think the DSS decision is wrong. Print clearly, and use black ink. Send your appeal request by Certified Mail.

► **Appeal deadlines.** You must appeal and ask for a hearing as follows.

Work First Family Assistance (WFFA, or TANF)	within **60 calendar days** of the date the decision was mailed.
Food and Nutrition Services (FNS, or "food stamps")	within **90 calendar days** of the date the decision was mailed.
Medicaid	within **60 days.** The deadline is stated on the notice.

► DSS conferences. If you appeal an FNS benefits decision, the DSS staff may ask you to have a *conference* with them before a hearing takes place. A conference can be a good way to get answers to your questions, and quickly resolve problems. You should go to the conference.

► Missed deadlines. If you miss your deadline, you may still appeal and ask for a hearing. You must show DSS that there is a *good reason* that you missed the deadline. Good reasons include serious illness; hospitalization; death or serious illness in your immediate family; problems in getting records in time for the hearing; loss of records due to fire or other accident; and a misunderstanding of the appeal requirements.

► Application denial. If DSS denied your application, you *cannot* get benefits until after the conference or appeal hearing takes place.

►Benefits change or end. If DSS changed or ended your benefits, in most situations you can get *continued assistance* if you ask for that right away, in writing, and within 10 days of when you got the DSS notice.

► Scheduling information and communication. If you do not have a telephone, you should give DSS a telephone number where DSS can reach a friend or family member during business hours. Generally, DSS must schedule hearings very promptly and cannot postpone hearings unless there is a *good reason* to do so. You should tell DSS in writing if you know that you will be unavailable within the next 30 days due to hospitalization, travel, or for another good reason.

► Notice of scheduled hearing. In most situations, DSS will call to tell you that a local hearing is scheduled. When there is a State appeal hearing, DSS will mail a notice to you. You should get that at least 10 days before the hearing. If you know that you cannot be at a hearing, you should *call DSS right away* and ask for a different hearing time or date.

► At the hearing. A Hearing Officer will run the hearing. She or he will be someone who was not involved in making decisions about your application or benefits. As a first step, the DSS staff will review your file with you and the Hearing Officer. You must be allowed to do the following.

- look at your file and the records that DSS used to make its decision in your case;
- question any witnesses presented by DSS; and
- offer your own documents and witnesses to show that the DSS decision is wrong.

The Hearing Officer will make a new decision. The decision will be mailed to you.

► Notice of the hearing decision**.** After a local hearing, DSS mails a decision within a week. After a State hearing, DSS mails a decision within thirty days or more.

► Appeals. Every local and State hearing decision includes information about how to appeal, and the deadline for an appeal.

► After a State appeal hearing. Once the State hearing decision becomes final**,** you must take the case to the civil courts in order to appeal. You must file a *Petition for Judicial Review* in superior court within **30 days** of your receipt of the decision. You will need the help of a lawyer.

In a Medicaid or FNS appeal case, within **10 days** of getting a State hearing decision, you may contact DSS and ask to make oral or written legal arguments. If you do not, the decision will be final.

(Rev. 09.29.14)

BENEFITS OVERPAYMENT ~ DSS

► What is an overpayment? If you get benefits and you are not eligible, you have gotten an "overpayment." A person might get an overpayment of Medicaid, Work First, or Food and Nutrition Services benefits from the Department of Social Services (DSS).

► What does DSS do when there is an overpayment? DSS will write to let you know that you were overpaid, and tell you to pay back the assistance. By federal law, DSS must take steps to get back the benefits payments *even if* you were not at fault for the overpayment. If you do not agree to pay back the assistance, DSS can take a case to civil court, to criminal court, can garnish wages, take income tax refunds, and more.

► How does an overpayment happen? Overpayment may be due to the following.

Agency Error	DSS made an error and overpaid you.
Household Error	You gave incorrect information *by mistake*.
Fraud	You gave false information or concealed information *on purpose.*

► Who is responsible for paying back an overpayment? All adult members of the overpaid household are responsible for paying back the benefits.

► **Fraud**: What can I do if DSS claims that I was overpaid due to fraud?

- Appeal. You may ask DSS for an appeal hearing in writing and by telephone. Be sure to do that by the deadline that is stated in the DSS overpayment letter.

- Get legal help *right away*. Public assistance fraud is a crime. You should talk with a lawyer right away. You should not meet with DSS or sign anything until you have gotten independent legal advice.

  DSS takes fraud cases to the criminal courts. If you are convicted of benefits fraud, you risk having your wages garnished, being fined, and going to jail or prison. You will not be eligible for benefits for a year or more.

► **Mistake**: What can I do if I was overpaid and it was not my fault? If the overpayment was due to an agency error or a mistake on your part, you have the following options.

- Appeal. You may appeal an overpayment decision. You should ask DSS for an appeal hearing in writing and by telephone. Be sure to **appeal by the deadline**. The deadline is stated in the DSS letter about the overpayment.

- Continued assistance. In most situations, you can choose to keep getting benefits until DSS makes an appeal hearing decision. You must ask in writing to keep getting benefits. There is a risk to getting continued assistance.

If the appeal decision is not in your favor, you will have to pay back the benefits that continued while your appeal was pending.

- Decline to pay back the benefits. If you decide not to pay back the benefits, DSS can sue you in civil court. A court can give DSS the right to garnish your wages, take ("intercept") your income tax refunds, and take NC Educational Lottery winnings. If you are sued, you may apply for help from Legal Aid of North Carolina. To apply, please visit www.legalaidnc.org/apply.

- Agree to pay back the benefits. You may ask DSS to "compromise," or lower the amount of the overpayment. DSS is ***not*** required to compromise.

  □ If you agree to pay back the benefits, you may do so all at once in a lump sum.

  □ You might pay back the money through wage withholding.

  □ If you are still eligible for *Work First* or *Food and Nutrition Services* (FNS) benefits, you might be able pay back the overpayment by lowering your monthly benefit amount until the money is paid back.

  □ If you are still eligible for *Medicaid*, you might be able to pay back the overpayment by having a deductible, or a change in your deductible.

TIP: If you were overpaid Medicaid Family & Children benefits due to an *agency error*, DSS might not seek repayment from you.

  □ If you pay back the benefits in cash installments, it is likely that DSS will ask you to make a down payment and then pay the rest within 12 months. It is important to make a repayment plan that you are sure you can afford.

  Repayment Agreement. DSS may ask you to sign a repayment agreement. If you do not make the payments as agreed, DSS can sue you for the overpaid benefits.

  If a court finds that you owe the money, then DSS will have more ways to collect payment from you. A court decision ("judgment") will allow DSS to garnish wages, and DSS will have a lien on your real and personal property.

  Confession of Judgment. DSS might ask you to sign a *Confession of Judgment*. Signing such a document is a serious matter. Information about that is enclosed.

  If you sign a Confession of Judgment, DSS will not have to sue you if you do not pay as agreed. Instead, DSS can file the document with the court.

  Once DSS files the *Confession of Judgment* at court, the document **is** a judgment against you. DSS will have a lien on your real and personal property, can garnish wages, and will have other collection options. **(Rev. 09.29.14)**

Date:_____

Dear Health Care Provider,

I have applied for Medicaid disability insurance benefits, and /or Social Security Disability income. In order to receive benefits, I must show the Department of Social Services (DSS) and the Social Security Administration (SSA) medical evidence to support a conclusion that I am a disabled person.

It is necessary that I submit complete copies of my medical records to the DSS and SSA showing the diagnosis and treatment I have received over the past two years. I am requesting that you provide me with copies of the following records:

- Records of my appointments and/or admissions listing the date, time, and reason for the visit.
- Complete name, title, and contact information for any physician or physician's assistant that treated me.
- Copies of any diagnostic tests that were used to diagnose and/or treat my condition, such as X-rays, MRIs, laboratory tests, etc.
- Copies of any physical therapy records
- A complete list of medications prescribed (including over-the-counter drugs)
- All clinical and medical findings by the physician

I am respectfully requesting that you waive any photocopying or transcription fees because I am low income. I am attempting to obtain Medicaid in order to pay my treatment bills. I need to submit these medical records to the Department of Social Services and the Social Security Administration so that I can start receiving benefits as soon as possible. A timely response would be greatly appreciated.

Thank you so much for your kind help,

Sincerely,

_____
Your Patient

My full name: _____
Date of Birth: _____
Medical records #: _____
My Address: _____
_____
Home Phone #: ( )_____
Alternate Phone #: ( )_____

OFFICE FOR CIVIL RIGHTS

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Get It.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.

You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file. In most cases, the file should be updated within 60 days.

Know Who Has Seen It.

By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- **Learn how your health information is used and shared by your doctor or health insurer.** Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got new health insurance, but you can ask for another copy anytime.
- **Let your providers or health insurance companies know if there is information you do not want to share.** You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider or pharmacy does not need to get paid by your insurance company.

- **Ask to be reached somewhere other than home.** You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

To learn more, visit **www.hhs.gov/ocr/privacy/**.

SOCIAL SECURITY DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME

The Social Security Administration has two disability benefits programs. One is the program that most people call "disability benefits." The other program is called SSI. Some people get both types of benefits.

Social Security Disability Insurance (**SSDI**) benefits are paid to someone who has worked for at least 5 years in the last 10 years before becoming disabled. The benefits are based on the individual's work and wage records.

Supplemental Security Income (**SSI**) benefits are paid to someone from age 1 to 64 who is disabled and has limited income and assets, or has no income and assets. These benefits are government support for disabled low-income people who have not worked, or who worked and earned very little.

What is "disabled?" The SSA has rules ("listings") that define a disability. A disability is a serious physical or mental impairment that causes a person to be unable to do substantial work. Your physical or mental conditions must be so severe that you cannot work and earn more than $1070 per month, or $1,800 per month if you are blind.

SSA may decide that you are disabled if :

- you have one or more severe health conditions that will last 12 months or more, or will result in death;
- you cannot do the work that you did before;
- you cannot adjust to doing any other substantial work, because of your health

How to apply. There are four ways to apply.

- **In person:** Call SSA at 1.800.772.1213 to get an appointment at a local SSA office. You do not have to have an appointment, but the waiting time may be shorter if you do.
- **By mail:** Call SSA at 1.800.772.1213 and ask for the forms to be mailed to you, or visit the SSA office and ask for the forms. The staff at the local office can help you with the forms.
- **By internet:** Go to http://www.ssa.gov/onlineservices/
- **By telephone:** Call SSA at 1.800.772.1213 from 7 AM to 7 PM Monday - Friday.

Medical information that you will need. On the application, you must list every health problem that keeps you from working, all of the places where you have been seen or treated for each condition, the number of visits you have had, the most recent visit, and the address and telephone number of each office, clinic, or hospital. To gather your information, use your medical bills, discharge records, and medical records.

If you have gotten medical care under more than one name, be sure to tell SSA.

SSA application processing. SSA sends the application to the North Carolina Disability Determination Services (**DDS**) Office in Raleigh. The DDS staff will decide whether you are disabled according to the SSA rules.

A worker at DDS will order your medical records, review them and make a decision. If DDS needs more information, they will let you know. DDS may ask you to give them more information about your job history, or your education, or about your daily activities.

DDS may direct you to see one or more medical professionals for evaluation. SSA will pay for that. Be sure to go to the appointments. Call DDS as soon as possible if there is a good reason why you cannot go to an appointment and must ask for a different date or time.

SSA will review the information from DDS, and write and let you know their decision. If SSA approves your application, their *Notice of Decision* letter will state the monthly benefit amount that you will get, and when the checks will start.

If SSA denies your application, their letter will state that. Do not give up. You have the right to appeal.

You must appeal within 60 days of receiving the denial letter.
See the information in How to Appeal a Disability Claim Denial.

Tips for disability benefits claims

- **Make sure that SSA knows about ALL of your serious health problems**. When you apply for disability benefits, be very sure to tell SSA about all the medical reasons why you cannot work. On the application, include all of your physical and mental conditions that make you unable to work.

- **Get the name of your DDS worker.** You can find out who you're DDS worker is by calling 1.800.443.9360. You can ask your worker to make sure that DDS has all of your records. If the worker asks you for information, you should respond as promptly as you can.

- **Make sure the DDS worker gets ALL your medical records from ALL sources for EACH of your health problems**. Ask the person who took your SSA disability application to give you a *copy* of all the medical information you gave to SSA. You can use the information to make sure that your DDS worker gets all the medical records from all your health care sources.

- **Personal representative**. You can choose someone to help you as you work with SSA and DDS. The individual can be a friend, relative, counselor, or anyone who you trust, and who is willing to help you. You can name, or "appoint" the person as your Representative.

In order to appoint someone, you must complete a form SSA-1696 *Appointment of Representative*. Deliver or mail the form to SSA. You should keep a copy of the form for your records. You can change your Representative at any time.

Once SSA has the form, then SSA and DDS will have your formal permission to talk with your Representative about your disability claim. SSA will send the Representative a copy of all the mail that SSA sends to you.

TIP: If you appoint a Representative, SSA can share your information with that person. That does not mean that the person will get your benefits.

As you may know, SSA sends some people's checks to a *Representative Payee*. A Representative Payee is not the same as an appointed Representative.

❖ **Vocational Rehabilitation.** The NC Division of Vocational Rehabilitation Services (DVRS) helps disabled people live independently, get training for work, and get helpful tools and technology for work. The program is called **VR** and has offices throughout the state. For more information about how VR can help you learn new skills and get back to work, call 800.225.7227.

Becoming a VR client is a way to support your SSA disability claim. Being a VR client shows SSA that even though you have health problems, you are *willing* to work. If the VR experts can help you return to work, you will benefit. If they cannot, then your VR records can be good evidence to show SSA that there is no work that you can do.

❖ **Legal representative**. If SSA denies your disability application, you should seriously consider getting the help of an experienced advocate or lawyer. Many lawyers and advocates charge no fee unless and until SSA approves your application.

❖ **Mail from SSA.** If you are homeless, or if you do not live at your mailing address, be sure to tell SSA. Give SSA a reliable mailing address. Check your mail often.

Also, be sure to tell SSA where you are staying. If DDS directs you to have an evaluation, they will try to make your appointments at places that are near you.

You may ask a local shelter about whether the shelter will accept mail for you. If you stay with someone who gets housing assistance and you are not listed on that person's housing lease or voucher, do not use the person's address.

SSA may send mail to you from an office in another state. Do not expect the local SSA staff to know about what SSA has mailed to you.

HOW TO APPEAL A DISABILITY CLAIM DENIAL BY THE SOCIAL SECURITY ADMINISTRATION

If your claim for Social Security Disability Insurance (**SSDI**) or Supplemental Security Income (**SSI**) is denied, it is important that you appeal. **You must appeal within 60 days from the date of the denial decision.**

There are four stages in the appeal process. The first appeal is Reconsideration. The second is a hearing at SSA. An Administrative Law Judge holds the hearing. The third stage is a review by the Appeals Council. The last is a hearing in federal district court.

NOTICE about DEADLINES. It is important that you **appeal** any SSA decision **on time**. If you do not, you will have to start the entire process over again and may lose benefits.

STEP ONE. To start the appeal process, visit the local Social Security Administration (SSA) office or call 1.800.772.1213 and ask for help in asking for Reconsideration, the first stage appeal. Do that right away.

STEP TWO. You must complete the following forms and mail or take the forms to SSA right away. SSA forms are available at the local SSA office and on the internet at www.ssa.gov. You may ask a worker at the local SSA office for help with the forms.

- ❑ SSA-561 *Request for Reconsideration*
- ❑ SSA-827 *Authorization to Disclose Information*
- ❑ SSA-3441 *Disability Report - Appeal*

In order to complete the forms, you will need the following information.

- Your name, address, and contact telephone number, and Social Security Number.
- Your denial letter, the *Notice of Decision*.
- If you have a representative, your representative's name, addresses, and telephone number.
- The name, address, and telephone number of a friend or relative who knows about your medical condition.
- List of prescribed and over-the-counter medicines that you are currently taking, who prescribed or directed you to take the medicines, and any side effects the medicines cause

  Medical information that is *new*, since you made your application:
  Description of any changes and new medical conditions
- Clinics, doctors, hospitals: The name, address, telephone number and (a) type of treatment and (b) visit dates
- List of all medical tests, with the (a) test name, (b) test site address (c) date, and (d) the name of the person who directed you to be tested.

STEP THREE. Once you have given SSA your three completed forms, SSA will send your appeal documents to Disability Determination Services (**DDS**) in Raleigh, North Carolina. DDS will review your disability claim again and decide if that should be approved or denied. You can call 1.800.443.9360 to check on the status of the Reconsideration.

STEP FOUR. If SSA denies your claim after Reconsideration, you must appeal again and **ask for an appeal hearing. You must appeal within 60 days from the date of the denial decision.**

To ask for a hearing, you must complete the following three forms, and take or mail the forms to SSA. You may ask a worker at the local SSA office for help with the forms.

- HA-501 *Request for Hearing by Administrative Law Judge.*
- SSA-827 *Authorization to Disclose Information*
- SSA-3441 *Disability Report - Appeal*

An Administrative Law Judge (**ALJ**) hears the appeal. If possible, the hearing will be at an SSA office that is not more than 75 miles from where you live, it may be by videoconference, or by telephone. Usually, a hearing is scheduled about 16 to 20 months after SSA gets the hearing request forms. You should contact a lawyer in private practice for help with the hearing. You and your representative will get a notice about the hearing date, time and place at least 20 days in advance.

Before the hearing, SSA may direct you to be evaluated by a medical doctor or other medical professional. You should go to the evaluation. If you do not, it is very likely that SSA will deny your disability claim. SSA will pay for the evaluation visit. The visit is for an assessment and is not for treatment of your health problems.

At least ten days before the hearing date, you and your representative should give SSA the following information.

Medical information that is *new*, since you asked for Reconsideration:
Description of any changes and new medical conditions

- Clinics, doctors, hospitals: The name, address, telephone number and (a) type of treatment and (b) visit dates
- List of all medical tests, with the (a) test name, (b) test site address (c) date, and (d) the name of the person who directed you to be tested.

STEPS FIVE and SIX: There are further appeals to the SSA Appeals Council and to a federal district court. You should contact an attorney in private practice for help with those appeals.

NOTICE about MEDICAID

If you have Medicaid insurance because you are disabled, you must **appeal every denial** in your SSA disability case. If you do not, *you will lose your Medicaid insurance*.

(Rev. 08.09.14)

IF YOU MISSED THE APPEAL DEADLINE WITH THE SOCIAL SECURITY ADMINISTRATION

You have the right to appeal when the Social Security Administration denies your claim for disability benefits. You should not make an appeal by telephone. In order to appeal, you should

- use the official Social Security appeal forms.

  The forms are available at the local Social Security Administration (SSA) office and on the internet at www.ssa.gov/forms/

- make sure that you meet the appeal deadline.

  The appeal deadline is stated in the denial decision. Generally, the appeal time ends **sixty days** after the date of the decision.

If you miss a deadline, that could cause SSA to close your disability claim.

You will have to start the entire process all over again.

If you miss an appeal deadline, you should do **two** things.

- apply again. Make a new claim, **and**
- appeal, and explain why you missed the deadline

SSA will decide whether you had **good cause** to miss the deadline. If SSA finds that you had good cause to miss the deadline, SSA might allow your appeal to be late.

Some examples of good cause include the following.

- You did not get the denial decision.
- A situation *outside your control* kept you from meeting the deadline. For example, there may have been a death or serious illness in your immediate family, or you might have been seriously ill or in the hospital and unable to contact SSA through a friend or relative.
- Important records were destroyed or damaged by a fire, flood, or other accident.
- You did not understand the requirement to appeal by the deadline because of your limited English

(Rev. 08.13.14)

HOW TO ASK FOR A WAIVER OF AN OVERPAYMENT FROM THE SOCIAL SECURITY ADMINISTRATION

The Social Security Administration may send you a letter to tell you that you got more benefits than you should have gotten. If you get too much money, that is called an "overpayment" of benefits. If that happens, you can do three things.

(1) You can appeal. If you do not agree that you were overpaid, or you do not agree about the amount of the overpayment, you can appeal. The appeal is called *Reconsideration*.

► **Deadline**. You must ask for Reconsideration within 60 days of when you got the letter that said you were overpaid. The form used to ask for Reconsideration is SSA-561. Call or visit the Social Security Administration (SSA) if you need help with the form.

TIP: If you appeal within 10 days of when you got the letter that said you were overpaid, you can keep getting your regular monthly checks while SSA decides about your appeal. However, if SSA denies your appeal, you may have to pay back even more money.

(2) You can ask SSA whether you may **pay back the money in small installments each month,** while you keep getting your monthly checks. That arrangement is called *Reduction of Recovery*. *Recovery* means repayment. The form used to ask for Reduction of Recovery is SSA-632. You can ask for reduction of recovery at any time.

TIP for SSI overpayments: Usually, SSA recovers an SSI overpayment by keeping ten percent of a person's monthly benefits. You can ask SSA to take less than ten percent each month.

(3) YOU CAN ASK FOR A WAIVER. When a waiver is granted, someone gives up a right. You may ask SSA to waive the right to recover the benefits overpayment. You can ask for a waiver at any time, even if SSA has recovered or collected money from you.

- To get a waiver, you must show that you were **not at fault** when you got the money that resulted in the overpayment ***and*** that it would be a **hardship** or very difficult for you to pay the money back to SSA.

- There is no legal right to a waiver. SSA decides about waivers on a case-by-case basis.

► If SSA grants your request for a waiver, then you will not have to pay back the money. SSA should also refund any money that was collected from you.

► If SSA does not grant your waiver request, you can appeal that decision. **Deadline**: You must appeal within 60 days of when you got the letter that said your waiver request was denied.

Waiver denial, SSI. You may appeal by asking for Reconsideration. If your Reconsideration request is denied, then you may ask for a hearing before an Administrative Law Judge. The form for asking for a hearing is HA-501.

Waiver denial, Social Security Disability Insurance. You may appeal by asking for a hearing before an Administrative Law Judge. The form for asking for a hearing is HA-501.

► Instructions for Waiver Request Form ◄

To ask for waiver, you must fill out form SSA-632. Print your answers.

Mail or take your completed form to SSA, and *keep a photocopy* for your own records. If you have questions about the form, call or visit SSA.

- **Question 1A and B.** Print your name and your Social Security Number.
- **Question 2**. Check box A. On the form, print the following. *I request that all overpayments on my record be waived, even the amounts you have already collected.*
- **Questions 3** and **4**. Skip these unless you are asking for waiver for someone else.
- **Question 5**. Print the following. *To my knowledge, I have not been overpaid.*
- **Question 6**. Print the following. *To my knowledge, I have not been overpaid.* Then state why you think that you are **not at fault** for an overpayment that might have happened.

Here are some ***examples*** of reasons why an overpayment may not have been your fault:

"I reported my work and wages to you as soon as I started working. I was told by the Social Security office in_____(town) that I could keep getting my check even though I was working."

or

"I do not understand the Social Security rules. I only finished the (_____) grade. I have trouble reading and understanding. I get confused and forgetful because of my disability."

- **On pages 3 through 7 of the form:** You must print information about your income, assets, and living expenses. Print an answer for every question and do not leave any blank spaces. If the answer to a question is zero, write the number zero.

  Your answers should be honest and show that you cannot afford to repay SSA. You may attach photocopies of your records to the form. You are *not* required to do that.

- **Answer Questions 9 through 12.**
- **Question 12.** If you currently get SSI benefits, answer "yes." If you get *other* assistance, such as Work First benefits, heating assistance, Link-Up/Lifeline, Food and Nutrition Services benefits, or if your rent is based on your income, print the information on the form. If you need more space, print your information at the bottom of page 7.

If you get SSI benefits, STOP and go to page 8.

You do not have to answer questions on pages 4, 5, 6, or 7.

- If you do not get SSI benefits, print your answers to the questions on pages 4 through 7.

  You must show SSA that you need all of your income to pay your *necessary* living expenses. Bear in mind that SSA might not consider some costs as necessary, such as costs for internet or cable service, or costs for more than one telephone.

- **Question 21**. If your monthly expenses are *more than* your income, you must tell SSA how you are paying your bills. On the form at Question 21, and at the bottom of page 7, you should tell SSA about the following things.

  ► your bills that are past due
  ► things you have sold so that you could pay bills
  ► loans you have gotten so that you could pay bills
  ► court cases against you for unpaid bills
  ► free food or clothing that you have gotten from an agency, group, or other source.
  ► help with utilities, medication, or rent that you have gotten from an agency, group, or other community source. Tell SSA even if you only got the help one time.

- **Sign the form on page 8 and date it**. Make sure to put your address and phone number on page 8. If you do not have a telephone, tell SSA and write a contact number and the name of the person who has the telephone.

  Example*: I do not have a telephone. You may leave messages for me with Ms. Blevins, my sister, at (910) 222-2222. Please call after 1:00 pm. Thank you.*

After SSA receives your waiver request form, SSA should immediately stop collecting the overpayment from your monthly check.

SSA should not collect any more money from you until the waiver request has been processed and SSA has made a decision about it. If SSA keeps taking money from your monthly check, please call SSA.

Form SSA 632-BK is available at all local SSA offices and is on the internet at http://www.socialsecurity.gov/forms/ssa-632.pdf

(Rev. 08.08.14)

SOCIAL SECURITY DISABILITY: TRIAL WORK

The following information does not apply to people who get SSI (Supplemental Security Income) benefits. The SSI program has different rules.

The Social Security Administration (SSA) rules are on the internet at www.ssa.gov.

If you get **Social Security Disability Insurance** (SSDI) benefits, you may try to work for a time and still be considered "disabled" according to the SSA rules.

You must report all work and wages to SSA. Your reports must be written, dated, and signed. You should keep a photocopy of everything that you report to SSA.

The time when you try to work is called a **Trial Work Period** (TWP). A disabled person may try to work for **9 months** in any **60 month period**.

The 9 months do not have to be all at once. The 60 month period is a "rolling" period, which means that it is any 60 months while you get SSDI.

The general rule is that a disabled person has the right to one TWP during the time that she or he is considered to be disabled. There are some exceptions to the rule.

During the TWP, a disabled person can get SSDI benefits,
regardless of how much she or he earns,
so long as the work is reported to SSA.

In any 60 month period, the TWP continues until the disabled person has 9 "**service months**."

A service month is a month when your gross pay is more than the amount set by SSA for the year. SSA sets the amount for a service month every year.

During a TWP, SSA will consider whether your condition has improved and whether you are still disabled.

When SSA checks to see if a TWP has ended, only service months are considered. In 2014, a service month is any month in which wages are more than $770 per month.

In 2014, a TWP will end if a disabled person has worked for 9 months in a 60 month period and has earned $770 per month.

After the TWP ends, an **Extended Period of Eligibility** starts.

SOCIAL SECURITY DISABILITY: EXTENDED PERIOD OF ELIGIBILITY

The following information does not apply to people who get SSI (Supplemental Security Income) benefits. The SSI program has different rules.

The Social Security Administration (SSA) rules are on the internet at www.ssa.gov.

The **Extended Period of Eligibility** (EDE) is a period of 36 consecutive months that follows the end of a TWP. It applies whether or not you are working.

Generally, SSDI benefits stop after any month when your earnings suggest that you can work. The EPE allows you to try to work and keep your SSDI eligibility.

During the EPE, you are eligible for SSDI if you are still disabled. You must very carefully record and report your wages to SSA. Your reports should be written, dated, and signed. You should keep a photocopy of everything that you report to SSA.

You can get SSDI benefits for any month in which your wages are below the amount set by SSA.

The amount set by SSA is called the "**substantial gainful activity**" amount, or SGA. In year 2014, the monthly SGA amount is $1070 ($1800 for blind individuals).

NOTICE: You are not eligible for SSDI for months in which your wages are more than the SGA amount.

During any EPE, the first time that you earn more than the SGA amount, SSA will reckon that your disability has ended ("ceased").

You will get SSDI benefits for that month and two more months. If your wages drop back below the SGA amount, you can get SSDI again and do not have to make a new application for disability benefits.

During any EPE, the disabled person continues to receive SSDI benefits until:

- there is evidence of medical improvement and the person is presumed to be able to work, or
- the person works and the earnings are more than the SGA amount.

(Rev. 07.08.14)

SOCIAL SECURITY DISABILITY STANDARDS FOR CHILDREN

The Social Security Administration (SSA) evaluates children for disability benefits eligibility by looking at how children perform in different areas. SSA considers a "child" to be someone who is under age 18, or under age 22 if the person is a student who regularly attends school.

First, SSA considers these three things.

- Is the child working? If yes, the claim is denied.
- Does the child have a severe medical condition? If not, the claim is denied.
- Does the severe medical or mental condition meet the *Listing of Impairments* or result in functional limitations that equal the listings? If yes, the child is disabled.

► **Listing of Impairments.** The *Listing* is a list of different medical conditions. To meet a listing, a child must have a doctor's opinion and medical tests and findings. If a child meets a listing, then SSA finds that the child is disabled.

► **Functional equivalent.** If a child's condition does not meet a listing, SSA might still find that the child is disabled. That is possible if the child's condition is practically the same, or *functionally equivalent* to a listing.

► **Limitations.** In deciding whether a child's condition is functionally equivalent to a listing, SSA considers whether the child has marked limitations in two of the following, or an extreme limitation in one of the following.

Acquiring and Using Information	How well does the child learn?
Attending and Completing Tasks	How well does the child start, follow through, and finish a task?
Interacting and Relating with Others	How well does a child respond to others, respond to criticism, and cooperate with others?
Moving About and Manipulating Objects	How developed are the child's fine and gross motor skills? How does the child move her body, and use things?
Caring for One's Self	How well does the child take care of her or his own body, and possessions, and the living areas?
Health and Physical Well-Being	The total effect of mental and physical conditions, treatment and therapies on the child's functioning.

► **Evidence and evaluations of functional capacity.** A doctor or other qualified professional must decide what health conditions that the child has, and then evaluate the child's ability to function.

In order to develop evidence of a child's functional limitations, evaluations are needed as follows.

Mental retardation, learning disabilities, and borderline intellectual function: Evaluation is needed by a licensed or certified psychologist.

Speech and language problems: Evaluation is needed from a speech and language pathologist.

Severity of medical or mental conditions: Doctors, teachers, counselors, and lay (non-professional) sources such as friends and family members

Records: School records, including attendance records, special education programs, IEPs, Section 504 plans

How a child functions at school is very important to show that a child is disabled. You should give SSA all the information that you have to show that a child's medical conditions limit attendance and participation in school activities.

► **SSA review of a child's needs.** SSA must consider the amount of help that a child requires. SSA looks at the following factors.

Extra help. SSA considers any extra help that a child requires to do activities that are appropriate for her or his age. SSA will determine how the child would function without the help.

Structured or supportive settings. Children with serious impairments may spend some or all their time in a structured setting.

Unusual settings. Children may behave differently in unusual settings. A child's behavior alone is not considered when SSA determines to the severity of limitations.

Effects of medications. Even if medications help to reduce or control a child's limitations, SSA will consider whether side effects cause or contribute to the limitations.

Treatment. SSA will consider the frequency of mental and physical therapy. SSA will consider whether therapy interferes with activities that are normal for children of the same age who do not have limitations.

WANT SOME EXTRA MONEY EVERY MONTH?

Benefits

Are you a low-income Medicare recipient who needs a little extra money for life's necessities? You might qualify for additional benefits and not know it.

BENEFITS ENROLLMENT CENTER
1-877-579-7562 (toll-free)
Monday - Friday: 9AM - 5PM
Press 3 at the beginning
of the recorded greeting

Call our Benefits Enrollment Center today! Our trained staff can see if you are eligible for additional benefits and guide you through the application process.
All our help is completely free!