DEPARTMENT OF HUMAN SERVICES

Income Maintenance (Volume 3)

ADULT FINANCIAL PROGRAMS

9 CCR 2503-5

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

3.500 Adult Financial Programs- Adult Financial Programs consist of the Old Age Pension (OAP) program, Aid to the Needy Disabled (AND) program consisting of AND- State Only (AND-SO) and AND-Colorado Supplement (AND-CS), Home Care Allowance (HCA), Special Populations-Home Care Allowance (SP-HCA), Adult Foster Care (AFC), and Burial Assistance [Eff. 3/2/14]

3.510 DEFINITIONS [Eff. 6/1/15]

“Actual value” means the true value of real property, as reported by the county assessor.

“Anticipated income” means income which can be anticipated with reasonable certainty concerning the amount and month in which it is to be received.

“Applicant” means a person who is applying for benefits.

“Application” means a request on state approved forms for benefits and/or services, which can include the electronic state prescribed form.

“Approval” means assistance is authorized by the county department.

“Authorized representative” means someone acting reasonably for the client with the authority to make decisions on behalf of the client and who has taken responsibility for the case including but not limited to signing documents and speaking with county departments.

“Availability of income or resources” means when actually available and when the client has a legal interest in a sum (includes cash or equity value of a resource) and has the legal ability to make such sum available for support and maintenance.

“Bona fide loan” means a borrower receives money (from relatives, friends or others) which creates a loan if there is an understanding between the parties that the money borrowed is to be repaid and it is recognized as an enforceable contract under State law. The transaction which creates a loan can be in the form of a written or oral agreement if enforceable under State law. Absent a negotiable instrument, a bona fide loan must still be convertible to cash in order to be considered a resource.

“Cash benefits” means a money payment provided to an eligible client, for the purpose of meeting day-to-day ongoing living costs.

“Cash surrender value” means the dollar value at which a resource could be sold or cashed in.

“Claim” means an overpayment of benefits that needs to be researched for validity and, if validated, must be collected from the client by the county department.

“Client” means a current or past applicant or a current or past recipient of benefits.

"Countable income" means income considered to be available to the client, spouse of the client, or sponsor(s) of the client after the application of valid exemptions, disregards, and deductions.

"Countable resource" means resources considered to be available to the client, spouse of the client, or sponsor(s) of the client after the application of valid exemptions, disregards, and deductions.

"County department" means the county department of human/social services.

"Denial" means that the client was not eligible for benefits upon initial application.

"Disability Benefits Guide (Guide)" means a representative appointed to assist an individual to work with the Social Security Administration (SSA). The Guide is responsible for assisting the client with securing a protected filing date for Supplemental Security Income (SSI) within ten (10) days. The Guide must assist the client in completing and submitting a thorough application for SSI. This Guide may be selected by the client and must be:

A. Any attorney licensed in Colorado or licensed to appear in any United States federal court, in good standing who:

   1. Is not disqualified or suspended from acting as a representative in dealings with the SSA; and,

   2. Is not prohibited by any law from acting as a representative; or,

B. Any person who:

   1. Has SSI/SSDI Outreach, Access, and Recovery (SOAR) certification or is employed and endorsed by an organization that has experience in assisting with the SSI application process. Experience is determined by the county worker verifying place and type of employment; and,

   2. Is not disqualified or suspended from acting as a representative in interactions with the SSA or the county department; and,

   3. Is not prohibited by any law from acting as a representative.

C. If the person selected by the client meets these requirements, the county department shall notify the client verbally or in writing that the person has been approved to work with them as the Guide.

D. The county department or the SSA may refuse to recognize the person chosen by the client if the person does not meet the requirements in this section. The county department or the SSA will notify the client and the person disqualified to act as the client's Guide. If disqualified by the county department, the county department must provide written notification within three (3) days of the decision to disqualify. The client shall notify the county department within ten (10) days if he/she has selected a new Guide.

E. If a person is disqualified from acting as the Guide, and he or she wishes to dispute this decision, he or she may request a formal review through the Colorado Department of Human Services, Employment and Benefits Division. The Division will review and make decisions on the dispute.

"Discontinuation" means that the client who is currently receiving benefits is no longer eligible and his/her benefits will be stopped.

"Earned Income" means payment in cash or in-kind received by a client, spouse of a client, or sponsor(s) of the client for services performed as an employee or as a result of the client, spouse of the client, or sponsor(s) of the client being engaged in self-employment.

"Eligibility requirements" means State Department criteria used to determine client eligibility or ineligibility to receive assistance and/or services.

"Eligible client" means a client whose countable resources are below the resource limit, whose countable income is below the grant standard, and who meets all non-financial eligibility criteria.

"Encumbrance" means the valid and legal outstanding payments, loans, or liens on a given resource.

"Equity value of real property" means actual value less encumbrances.

"Exempt income" means any income that is not countable income for the purpose of eligibility.

"Exempt resource" means any property whose value is not a countable resource for the purpose of determining eligibility.

"Face value" means the value predominantly stamped or printed on the resource verification (insurance policy, bonds, stocks, etc.) which represents the future potential worth of the resource, but does not usually represent the true value of the item due to activities that can reduce or increase the value (loans, dividends, etc.).

"Facility" means the residence of a client where the intent is either to care for or provide treatment to the client. Facilities include general medical and surgical hospitals, nursing homes, regional centers, group and host homes, and mental health institutions. Facilities do not include penal institutions, such as federal and state prisons or county, local, and municipal jails.

"Fair Market Value" means the median resale market value of a resource.

"Fleeing felon" means a person fleeing to avoid prosecution or custody or confinement after conviction for a felony.

"Fraud" means the deliberate and conscious violation of rules or law for personal economic gain, including making any falsified claim for payment or benefit issued by the county department on behalf of the State Department by the client or others or receiving financial benefit from the county department on behalf of the State Department by means of willful misrepresentation including intentional concealment of essential fact(s) pertinent to determining eligibility.

"Good cause" means the client is unable to provide verifications, completed redetermination packets, or otherwise complete eligibility requirements timely because of circumstances beyond the control of the client. Good cause includes, but is not limited to, medical emergencies or hospitalization, an individual who has a disability or other medical condition(s) requiring additional time and/or assistance, a delayed appointment with the Social Security Administration beyond the client's control, or other good cause determined reasonable by the county department using prudent person principle.

"Immediate family" means the spouse, parents, and children of the client.

"Income" means any financial gain by means of money payment or in-kind payment.

"In-kind income" means something of value received for the benefit of a client, spouse of a client, or sponsor(s) of a client.

“Intermittent redetermination” means a redetermination that is generated prior to the annual redetermination date due to questionable circumstances surrounding the case, a client moving to a new county, or other reasons.

“Involuntary transfer” means the loss of a resource due to fraud, theft, financial exploitation, or legal action such as judgment, foreclosure, or tax sale, provided that the client can demonstrate that:

A. Every reasonable effort has been made to recover the property through court action or other procedures; or,

B. The client is unable to pursue recovery; or,

C. Pursuit of lost resources or income would constitute a safety issue.

“Life Estate” means a legal estate planning procedure in which the client transfers real property to another individual but retains the right of occupancy and income from the property during the client's lifetime. The life estate's duration is limited to the life of the individual. The life tenant, during his or her life, retains the use and possession of the property, the rights to rents and profits, and the costs of maintaining the property. The life tenant cannot sell or waste the property without the consent of the person(s) to whom the property was transferred.

“Marriage” (for the purpose of these rules) means a marriage as defined in Section 14-2-101, C.R.S., a common law marriage as defined in Section 14-2-101, C.R.S., and a civil union, as defined in Section 14-15-101, C.R.S.

“Non-recipient spouse” means the client's spouse who is not receiving financial benefits.

“Ownership” means lawful title to, legal right of possession of, or legal interest in a property.

“Periodic payments” means payments that are irregular or a one-time payment.

“Personal Needs Allowance” (PNA) means a payment to a client who is currently in a facility to cover additional hygiene costs not usually supplied by the provider.

“Personal property” means all items of ownership that are not considered real property.

“Potential income” means a benefit or payment to which the client, spouse of a client, or sponsor(s) of a client may be entitled and could secure, such as annuities, pensions, retirement or disability benefits, veterans compensation and pensions, workers' compensation, Social Security retirement or disability benefits, SSI benefits, and unemployment compensation.

“Potential resource” means a resource to which the client, spouse of a client, or sponsor(s) of a client has the legal ability to acquire or reacquire rights of ownership.

“Prudent Person Principle” means that, based on experience and knowledge of the program, the county department exercises a degree of discretion, care, judiciousness, and circumspection, as would a reasonable person, in a given case.

"Qualified non-citizen" means an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the United States Citizenship and Immigration Services (USCIS) as an actual or prospective permanent resident or whose physical presence is known and allowed by the USCIS. A qualified non-citizen is defined as follows consistent with the provisions of federal regulations found at 45 CFR 1626.7 as of October 1, 2010, herein incorporated. This rule does not contain any later amendments or editions. Copies of these federal laws are available from the Colorado Department of Human Services, Director of the Employment and Benefits Division, 1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library:

A. A non-citizen lawfully admitted for permanent residence;

B. A non-citizen paroled into the United States under Section 212(d)(5) of the Immigration and Naturalization Act (INA) for a period of at least 1 year;

C. A non-citizen granted conditional entry pursuant to Section 203(a)(7) of the INA prior to April 1, 1980;

D. A refugee under Section 207 of the INA;

E. An asylee under Section 208 of the INA;

F. A non-citizen whose deportation is withheld under Section 243(h) or 241(B)(3) of the INA;

G. A Cuban or Haitian entrant as defined in Section 501(3) of the Refuge Education Assistance Act of 1980;

H. A Victim of Severe Form of Trafficking who has been certified as such by the U.S. Dept. of Health and Human Services (HHS);

I. Iraqis and Afghans granted Special Immigrant Visa status under Section 101(A)(27) of the INA;

J. A non-citizen who has been battered or subjected to extreme cruelty in the U.S. by a family member;

K. A non-citizen admitted to the U.S. as an Amerasian immigrant pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. No. 100-461); or,

L. An individual who was born in Canada and possesses at least fifty percent (50%) American Indian blood or is a member of an Indian tribe as defined in 25 U.S.C. Sec. 450B(E).

"Real property" means houses; land, including land rights such as oil, mineral and water rights; and outbuildings and other objects affixed to land.

"Received" (for the purpose of income and resources) means the date on which the income and/or resource is actually received or legally becomes available for use, whichever occurs first, whether reported timely by the client or not.

"Received" (as it applies to receipt of verification, documentary evidence, and reported changes in circumstances) means the date the verification, documentary evidence, and reported changes were received by the county department.

"Recipient" means a person who is currently receiving or previously received benefits.

"Recovery" means the collection of a valid claim to repay benefits to which a client was not entitled.

"Redetermination" means a case review/determination of necessary information and verifications to determine ongoing eligibility.

"Resources" means real and personal property held as of the first day of a calendar month or as of the date of application if not counted as income for the application month.

"Sponsor" means any person(s) who executed an affidavit of support or similar agreement with the United States Citizenship and Immigration Service (USCIS) on behalf of a non-citizen as a condition of entry into the United States.

"State Department" means the Colorado Department of Human Services.

"Termination" means that the client who is currently receiving Adult Financial program benefits is no longer eligible and his/her benefits will be stopped.

"Transfer Without Fair Consideration (TWFC)" means a property transaction in which the proceeds of the transfer, assignment, or sale are less than the actual value of the resource.

"Unearned income" means any income that is not earned through employment or self-employment.

"Value (for liquid resources such as cash, savings/checking accounts, IRA accounts, etc.)" means the current redemption rate, less encumbrances.

"Value (for real and personal property)" means the actual value of the property less encumbrances.

"Verification" means confirming the accuracy of statements, application information, and other case information by obtaining written, audio, or video evidence or other information that proves such fact or statement to be true.

"Withdrawal" means an application is not processed because the client who submitted the application withdraws his/her request for assistance prior to eligibility determination.

3.520 GENERAL REQUIREMENTS, CASE PROCESSING, AND CASE ACTIONS

3.520.1 GENERAL REQUIREMENTS [Eff. 3/2/14]

A. Information concerning public assistance programs shall be available to all persons in the community. Available information shall include:

1. Benefits and programs available;

2. Eligibility requirements;

3. Related services; and,

4. Rights and responsibilities of clients.

B. The county department shall:

1. Receive applications and assist the client to complete the application and secure documentation when needed;

2. Provide language translation via an interpreter, as needed;

3. Inform the client of his/her responsibility to accurately and fully complete the application and provide documents to substantiate eligibility factors;

4. Inform the client that he/she may use friends, relatives, or other persons to assist in the completion of the application;

5. Inform the client, in writing at the time of application, that the county department shall use the client's Social Security Number (SSN) to obtain information available through the Income and Eligibility Verification System (IEVS) to verify income and that such information may be shared with other assistance programs, other states, the Social Security Administration, the Department of Labor and Employment, and the Child Support Enforcement program;

6. Refer the client to other agencies or services available in the community, such as food banks, Area Agencies on Aging, or the Division of Vocational Rehabilitation;

7. Refer the client to the other benefits for which he/she may be eligible;

8. Inform the client that he/she may terminate the application process at any time;

   A decision by the applicant to “withdraw” shall be treated as a denial by the county department. The applicant shall be notified of the county department's action by the state approved Notice of Action form within ten (10) calendar days of the action.

9. Review applications and determine eligibility for assistance; and,

10. Calculate all claims, initiate recoveries, and prepare for and appear at all appeals.

C. The county department shall require a written application, signed under penalty of perjury, using the State Department's prescribed public assistance application form. The application form shall be used as the primary source of information and shall contain, at a minimum:

   1. The name, date of birth, and residence of the client;

   2. The program(s) requested by the client;

   3. A list of all income and resources available to the client at the time of application;

   4. Any other information required by state and federal law or regulation; and,

   5. The signature of the client, parent, legal guardian, or authorized representative.

      a. A client who may be partially or totally illiterate or cannot write his/her name shall make a mark.

      b. The mark shall be witnessed by the signature and address of at least one witness.

      c. A county department staff member may act as witnesses if he/she is not related to the client; and,

   6. The date of application shall be the first working day the county department receives a signed application form, indicating the client's desire to receive public assistance benefits.

7. Incomplete applications shall be denied.

D. The client shall be required to answer all applicable questions on the application form. If the client does not answer any question(s) in writing on the form, the question(s) shall be asked of the client during the interview and the client must provide an answer at that time.

E. Clients shall be provided the opportunity to register to vote during initial application and at each redetermination.

F. The county department shall adhere to the requirements of the Colorado Address Confidentiality Program (ACP) as defined in Section 24-30-2101, C.R.S. The ACP provides survivors of domestic violence, sexual offenses, and/or stalking with a legal substitute address for creating public records and interacting with all state and local government agencies.

3.520.2 DOCUMENTATION [Eff. 3/2/14]

A. The county department shall create a case record upon initial application and maintain the record while the case is open for assistance. The major purposes of a case record shall be:

1. To assist the county department in reaching a valid decision concerning eligibility and for the amount of payment;

2. To ensure eligibility is based on factual information;

3. To provide for continuity of assistance when a worker is absent, when a case is reopened, and when a case is transferred from one county department to another; and,

4. To provide accountability for the county department's actions.

B. The county department shall document all income, resources, and non-financial eligibility information into the statewide automated system.

1. The county department shall not omit case information from the statewide automated system based on the assumption that the information is unnecessary for eligibility determination.

2. All case information shall be updated at the time of redetermination.

C. The county department shall document all case actions in case comments, to include:

1. All case decisions related to prudent person principle;

2. All decisions related to the disposition of claims;

3. Any atypical interactions with the client;

4. Actions related to a county conference and/or state level hearing;

5. Cause of untimely processing of the application or redetermination; and,

6. Other information that would be critical to document county department actions and/or would be necessary to justify case decisions during a case review, audit, appeal, or lawsuit.

D. Unless otherwise specified in rule, all forms, packets, notices, and applications, shall be state-prescribed.

E. The county department shall be responsible for securely storing paper and/or electronic case records and other confidential material to prevent accidental or intentional disclosure or access by unauthorized persons. If a county department shares building space with other county offices, case materials shall be stored in locked files. Janitors and other maintenance personnel shall be instructed concerning the confidential nature of information.

F. Case records are the property of and shall be restricted to use by the State Department and county department.

G. Case files shall be kept for a minimum of three (3) years beyond the year of the case closure date.

3.520.3 PROGRAM REVIEW AND OVERSIGHT [Eff. 3/2/14]

A. The county department shall be subject to the provisions outlined in Section 26-1-111, C.R.S., requiring the State Department to ensure that the county department complies with requirements provided by statute, State Board of Human Services and Executive Director rules, federal laws and regulations, and contract and grant terms.

B. The county department shall be subject to routine quality control and program monitoring by the State Department, to minimally include:

1. Targeted review of the statewide automated system documentation;

2. Review and analysis of data reports generated from the statewide automated system;

3. Case file review;

4. Targeted program review conducted via phone, email, or survey; and,

5. Onsite program review.

C. The focus of State Department monitoring shall be to identify:

1. Compliance with program statutes and rules;

2. Best practices that can be shared with other county offices; and,

3. Training needs.

D. The county department shall be subject to a performance improvement plan to correct areas of identified non-compliance.

E. The county department shall be subject to corrective action and sanction as outlined in Section1.100, et seq. (9 CCR 2501-1), General Policies and Administration, in case of failure to make improvements required under the performance improvement plan.

F. County department supervisory personnel shall review eligibility determinations (certifications, denials, and/or pending cases) monthly. The supervisor shall:

1. Pull a random sample of a minimum of two determinations per technician;

2. Determine the correctness of eligibility determinations accomplished;

3. Ensure timely correction of any determination errors; and,

4. Maintain a record of the cases reviewed for audit purposes.

3.520.4 APPLICATION PROCESSING [Rev. eff. 1/1/16]

A. The county department shall utilize the following steps to process the application:

1. Date-stamp the application on the date the signed application is received by the county department;

2. Review the application;

3. For AND only, provide the client with a medical disability certification form;

4. Interview the client;

5. Verify statements made by the client on the application and during the interview using the statewide automated system interfaces, documents received from the client, or information gathered from other collateral sources;

6. Approve or deny the application within sixty (60) calendar days for AND and within forty-five (45) calendar days for OAP from the date of receipt of a completed and signed application. Delay in processing the application shall not be allowed for any of the following:

a. When the client has applied for a Social Security number and is awaiting action by the Social Security Administration; or,

b. When the county department is awaiting receipt of information from the State Verification Exchange System (SVES); or,

c. When the county department is awaiting the response for required secondary verification through the Systematic Alien Verification for Entitlements (SAVE).

7. Provide a notice of action to the client by postal or electronic mail or in person using the State Department's prescribed form.

B. A request for benefits following an action to deny an application shall be considered in the following ways:

1. If the client has good cause as outlined in Section 3.510 and notifies the county department that he/she is requesting benefits within thirty (30) calendar days of the denial, the county department shall reschedule the interview and the current application date shall be used.

2. If the client does not have good cause and notifies the county department that he/she is requesting benefits, and the request is made within sixty (60) calendar days of the current application, that application may be used but the date of application shall be the most recent date the client requested benefits.

C. A face-to-face interview, either at the county department office or in the client's home, is mandatory for an initial application for Adult Financial benefits, unless there is good cause.

1. If the client can show good cause, a telephone interview shall be conducted. Good cause includes:

   a. Hospitalization of the client;

   b. Client resides in a long-term facility or has regular contact with a Single Entry Point case manager;

   c. Travel for the client would cause serious medical or physical harm; or,

   d. Other good cause determined by the county department using prudent person principle.

2. If the county department determines good cause prevents a face-to-face interview upon initial application, it shall be documented as to why a telephone interview was conducted and proof of good cause shall be entered into the case record.

D. The interview shall include:

1. An explanation of the various assistance programs available and an opportunity to apply for those additional programs;

2. A brief explanation of the eligibility process and the eligibility requirements;

3. A review of the application with the client to:

   a. Confirm all information on the application;

   b. Answer questions not completed on the application; and,

   c. Provide the client an opportunity to clarify unclear, inconsistent, inaccurate, or questionable statements.

   d. For AND only, provide, explain and obtain necessary signatures on the Authorization for Reimbursement of Interim Assistance form (IM-14).

4. A request for verification of application declarations.

   a. The client has the primary responsibility to provide information necessary to establish eligibility.

   b. If the client is unable to do so, the county department shall assist the client to obtain verification through collateral contacts or a home visit.

   c. If the client returns the verifications within thirty (30) calendar days after denial, the following processing requirements shall be implemented:

      1) If the client has good cause, the denial shall be rescinded and eligibility determined, using the original application date.

      2) If the client does not have good cause, the county department shall use the original application, but the date of the application shall be the date all verifications were received.

d. If the client returns the verification thirty-one (31) or more calendar days after the denial, the county department shall require the client to complete a new application.

5. Discussion of the client's rights and responsibilities, to include:

a. The county department's requirement to inform the client in writing at application and redetermination of the requirement for a client to report any changes in circumstances within thirty (30) calendar days.

b. The client's responsibility to notify the county department in writing within thirty (30) calendar days of any change in resources or income or other change in circumstances which affects eligibility or benefit amount.

c. The county department's responsibility to maintain confidentiality of records and information.

d. The client's right to non-discrimination provisions.

e. The client's right to a county conference or state-level appeal.

f. The client's right to review and copy his/her case file.

6. An explanation provided regarding the process of utilizing the Electronic Benefit Transfer (EBT) card. This explanation shall include:

a. Identification of the following establishments in which clients shall not be allowed to access cash benefits through the Electronic Benefits Transfer service from automated teller machines and point of sale (POS) devices:

1) Licensed gaming establishments;

2) In-state simulcast facilities;

3) Tracks for racing;

4) Commercial bingo facilities;

5) Stores or establishments in which the principal business is the sale of firearms;

6) Retail establishments licensed to sell malt, vinous, or spirituous liquors;

7) Establishments licensed to sell medical marijuana or medical marijuana-infused products, or retail marijuana or retail marijuana products, effective June 30, 2015;

8) Establishments that provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment, effective June 30, 2015.

b. An explanation that the cash portion issued on the EBT card may be suspended with identified misuse.

E. County departments shall require no more than one interview per application.

1. The county department shall review the application for completeness for all programs requested and secure signed copies of the Authorization for Release of Information form and any other forms necessary to determine eligibility.

2. If the client wishes to apply for benefits while already receiving benefits under a different program, such as Food Assistance, the county department may use a redetermination packet if received within sixty (60) calendar days of the request; otherwise a new application will be required. A verbal request to apply for an Adult Financial program shall be documented in the statewide automated system and the date of the request will secure the application date for the client.

F. For clients who have been committed to a facility by order of the district or probate court or who have been made a ward of the court, application for an Adult Financial program shall be completed by the facility's administration or the client's guardian.

G. When the client does not keep a scheduled interview appointment and does not request an alternate time or arrangement the county department shall assume the client is withdrawing his/her request for benefits and shall deny or discontinue the case, as specified in 3.520.4, C.

3.520.5 INTERFACE VERIFICATIONS [Eff. 3/2/14]

A. The Income and Eligibility Verification System (IEVS) provides for the exchange of information on clients with the Social Security Administration (SSA), Internal Revenue Service (IRS) and the Colorado Department of Labor and Employment (DOLE). The county department shall query IEVS, using the client's, client's spouse's, and client's sponsors' Social Security Numbers. Source agency records shall be matched on a regular basis to identify potential earned and unearned income, resources, and assets, including:

1. The following data shall be considered verified upon receipt:

    a. SSA (BENDEX, SDX) Social Security benefits, SSI, pensions, self-employment earnings, federal employee earnings; and,

    b. IRS unearned income information including interest on checking or savings accounts, dividends, royalties, winnings from betting establishments, capital gains, etc.; and,

    c. Unemployment benefits (UIB).

2. DOLE wage data shall not be considered verified upon receipt. However, benefits shall not be delayed pending receipt of verification from a collateral source (e.g., employers).

3. The county department shall, at a minimum, prior to approval of benefits, verify potential earnings or unemployment benefits for the client, client's spouse, and sponsor(s).

4. The county department shall act on all information received through IEVS within forty-five (45) calendar days of receipt.

B. The county department shall query DOLE at initial application and at redetermination. DOLE wage data shall not be considered verified upon receipt. Dole unemployment benefit data shall be considered verified upon receipt. However, benefits shall not be delayed pending receipt of verification from a collateral source.

C. The county department shall query the Public Assistance Reporting Information System (PARIS) at initial application and at redetermination to determine whether the client is receiving benefits in another state, veterans' benefits, or military wages or allotments.

D. The county department shall query the Systematic Alien Verification for Entitlements (SAVE) at initial application and at redetermination to:

1. Determine whether a qualified non-citizen has a sponsor(s); and,

2. Verify the non-citizen registration number provided by the client; and,

3. If the number and name submitted do not match, the county department shall take prompt action to terminate assistance to the client.

4. Determine if there has been a change in the non-citizen's status.

E. The Colorado Department of Revenue, Division of Motor Vehicles (DMV), may be used by the county department to verify lawful presence and identity.

3.520.6 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

3.520.61 Non-Financial Eligibility Requirements [Eff. 3/2/14]

To be eligible for Adult Financial programs, a client shall:

A. Be eighteen (18) through fifty-nine (59) years of age for AND-SO (unless diagnosed with blindness, then age zero (0) through 59 years of age); age zero (0) through 59 years of age for AND-CS; and age sixty (60) years of age or older for OAP and,

B. Be a resident of Colorado, except that inmates of a city, municipal, county, state, or federal correctional institution, and fleeing felons, shall not be eligible for Adult Financial programs; and,

C. Be a citizen of the United States or be a qualified non-citizen or legal immigrant as outlined in Sections 3.520.66 who is lawfully present; and,

D. Have a valid Social Security Number, as outlined in Section 3.520.65; and,

E. For AND only, have a disability, as outlined in Section 3.541; and,

F. Not be currently receiving or eligible for financial assistance from Colorado Works; and,

G. Take reasonable steps to apply for and accept all retirement and public assistance benefits for which they may be eligible; and,

H. Pursue and accept all other income and resources that may be available; and,

I. Meet all other program eligibility requirements, including income and resource limits.

3.520.62 Age Requirements [Eff. 3/2/14]

The county department shall verify the client's age by viewing the statewide automated system interface information or documents, as follows:

A. One of the following valid government issued documents or identification:

1. Birth certificate;
2. Valid Colorado state identification or driver's license;
3. Valid out of state identification or driver's license;
4. Naturalization, immigration, or passport papers;
5. Legal documents from vital statistics; or,
6. Social Security information (SOLQ, SVES, SDX, and BENDEX); or,

B. Two or more of the following documents:

1. School records;
2. Baptismal certificates or other well documented church records;
3. Genealogy records or other well documented family records of birth;
4. Voting records;
5. United States census records.

3.520.63 Marital Status [Eff. 3/2/14]

A. The county department shall determine the client's marital status as one of the following:

1. Single, never married;
2. Married;
3. Widowed; or,
4. Divorced or legally separated.

B. If married, both spouses may apply for and/or receive Adult Financial programs. Each spouse shall have a separate case.

C. If the client is divorced or legally separated, the client shall provide verification in the form of:

1. Legal documents showing divorce or legal separation; or,
2. Written statements by two or more persons who are unrelated to each other and to the spouses, who can establish that they are in a position to know and assert that both physical and financial ties have been dissolved and a complete and permanent separation does, in fact, exist. The county department shall use prudent person principle and weigh the documentation and make a decision regarding marital status.

3.520.64 Residency Requirements [Eff. 3/2/14]

A. To be eligible for Adult Financial programs, a client shall be a resident of Colorado.

B. Residency is established on the first day the client declares him/herself to be a resident of Colorado.

1. A person shall not acquire residence while the person has established his/her permanent place of residence in another state or country.

2. A person receiving assistance from another state shall not be eligible for Adult Financial programs in Colorado during any month in which a payment is made by the other state.

C. The client shall live in the county in which the application is made.

1. A client who resides in a county but who does not reside in a permanent dwelling or have a fixed mailing address shall be considered eligible for assistance, provided all other eligibility requirements are met.

2. Clients who do not have a fixed address may provide a postal box within their county as their mailing address, or may use the county department as their mailing address. It shall be the client's responsibility to go to the postal box or the county department to check for and pick up their mail. Failure to regularly check for and pick up mail shall not be grounds for appealing timely notice.

D. A client who moves out of Colorado or is shown to be a resident of another state shall not be considered a resident of Colorado. A move or residence in another state may be established by actions such as:

1. Purchasing or obtaining a lease of a dwelling unit in another state;

2. Household effects, equipment, and personal belongings being removed to another state;

3. Obtaining a driver's license or state-issued identification card in another state;

4. Registering to vote in another state;

5. Applying for or receiving local, state, or federal assistance in another state;

6. Registering vehicles of any type in another state;

7. Securing a resident hunting or fishing license in another state;

8. Using an address in another state; or,

9. Statements or other positive acts indicating that the client has taken up residence in another state.

E. A client who is out of state temporarily shall be considered a resident, with the following exceptions:

1. A client who leaves the country for a period of thirty (30) or more consecutive days creates a rebuttable presumption (unless the client comes forward with enough information to prove otherwise) that the client shall no longer be considered a resident and shall be ineligible for Adult Financial programs.

2. A client who leaves the state for a period of ninety (90) or more consecutive days creates a rebuttable presumption (unless the client comes forward with enough information to prove otherwise) that the client shall no longer be considered a resident and shall be ineligible for Adult Financial programs. An exception to this is for individuals temporarily out of the state to receive medical treatment.

3. A client who leaves the state for a period of more than six (6) months in any calendar year, even if that time has not been consecutive time away, creates a rebuttable presumption (unless the client comes forward with enough information to prove otherwise) that the client shall no longer be considered a resident and shall be ineligible for Adult Financial programs.

4. A client who leaves the state to care for an immediate family member injured in the line of military duty for a period of one hundred eighty (180) or more consecutive days creates a rebuttable presumption (unless the client comes forward with enough information to prove otherwise) that the client shall no longer be considered a resident and shall be ineligible for Adult Financial programs.

F. When a determination of principal place of residence is difficult to secure due to conflicting documentation, other sources shall be used to gather verification and make a decision, such as addresses obtained from voter registrations, tax returns, Social Security and Medicare, a driver's license, car registrations, or other statements or documents. The county department shall use prudent person principle to weigh the documentation and/or verification and make a decision regarding residency.

G. The burden to prove residency shall be on the client.

3.520.65 Social Security Numbers [Eff. 3/2/14]

A. Each Adult Financial program client shall provide his/her Social Security number (SSN) to the county department.

1. If a client has multiple numbers, all numbers shall be required.

2. If a client is unable to provide their SSN, the client shall be required to apply for an SSN at the local Social Security office and provide the county department with verification of application for an SSN.

3. Refusal or failure to apply for or provide their SSN shall result in denial for Adult Financial programs.

4. Upon proof of application for an SSN, the time required for issuance or to secure verification of the number shall not be used as a basis for delaying action on the Adult Financial program application.

B. The county department shall verify the client's Social Security Number (SSN) with the Social Security Administration (SSA) in accordance with procedures established by the State Department for the State Verification Exchange System (SVES).

1. The county department shall accept as verified a SSN that has been confirmed by the SVES.

2. When the county department receives notification that an SSN cannot be verified or is otherwise discrepant (e.g., name or number do not match SSA records), the county department shall:

a. Conduct a case record review to confirm that the SSN in the case record matches the SSN submitted to the SSA for verification.

1) If an error occurred in the original submittal (e.g., digits transposed, incorrect name submitted) the county department shall correct the error and resubmit the SSN through SVES for verification.

2) If no error is identified, the county department shall advise the client in writing that an SSN could not be verified, and instruct the client to contact the local Social Security office to resolve the discrepancy.

b. Make every effort to assist the client to obtain available documents required by the SSA.

3. If the client is unable to provide his/her valid SSN, the application shall be denied or the case terminated.

3.520.66 Lawful Presence [Eff. 3/2/14]

A. Pursuant to Section 24-76.5-103, C.R.S., Adult Financial program clients are required to produce verification of lawful presence in the United States prior to receiving benefits. For purposes of this section:

1. “Affidavit” means a State prescribed form wherein an applicant attests, subject to the penalties of perjury, that they are lawfully present in the United States. An affidavit need not be notarized.

2. “Produce” means to provide for inspection either: 1) an original, or 2) a true and complete copy of the original document. A document may be produced either in person or by mail.

B. In order to verify his or her lawful presence in the United States, the client shall:

1. Execute an affidavit saying that:

a. He or she is a United States citizen or legal permanent resident; or,

b. He or she is otherwise lawfully present in the United States pursuant to federal law; and,

2. Produce and provide to the county department:

a. A valid Colorado driver's license or a Colorado identification card issued pursuant to Article 2 of Title 42, C.R.S.; or,

b. A United States military card or military dependent's identification card; or,

c. A United States Coast Guard Merchant Mariner Card; or,

d. A Native American tribal document; or,

e. Any other document authorized by rules adopted by the Colorado Department of Revenue (1 CCR 201-17); or,

f. Adult Financial program clients who cannot produce one of the required documents may demonstrate lawful presence by both executing the affidavit and executing a request for waiver. The request for waiver must be provided to the Colorado Department of Revenue in person, by mail, or online, and must be accompanied by all documents the client can produce to prove lawful presence. An approved waiver must be issued by the Colorado Department of Revenue in accordance with 1 CCR 201-17. The county department is responsible for verifying that the applicant is the same individual indicated as being lawfully present through the approved waiver.

3.520.67 Citizenship and Qualified Non-Citizens [Eff. 3/2/14]

A. The following are citizens of the United States and are eligible to apply for Adult Financial programs:

1. Persons born in the United States, Puerto Rico, Guam, Virgin Islands (U.S.), American Samoa, or Swain's Island;

2. Persons who have become citizens through the naturalization process;

3. Persons born to U.S. citizens outside the United States with appropriate documentation.

B. The county department shall verify citizenship when:

1. The claim of citizenship is inconsistent with statements made by the client or with other information on the current or previous applications; or,

2. The claim of citizenship is inconsistent with information received from another source.

C. Citizenship may be verified by a birth certificate, possession of a U.S. passport, a certificate of U.S. citizenship (CIS form N-560 or NH-561), a certificate of naturalization (CIS form N-550 or N-570), a certificate of birth abroad of a citizen of the United States (Department of State forms FS-545 or DS-1350), or Identification Cards for U.S. citizens (CIS-I-179 or CIS-I-197). Documents that are acceptable as verification of citizenship can be found in the Colorado Department of Revenue rules at 1 CCR 201-17, Attachment A.

D. Verification of citizenship by the county department shall not result in discrimination based on race, religion, ethnic background or national origin, and groups such as migrant farm workers or Native Americans shall not be targeted for special verification. The county department shall not rely on a surname, accent, or appearance that seems foreign to find a claim to citizenship questionable. Nor shall the county department rely on a lack of English speaking, reading, or writing ability as grounds to question a claim to citizenship.

E. A qualified non-citizen, considered a legal immigrant by the United States Citizenship and Immigration Services (USCIS), shall provide one of the following verification documents:

1. I-94 Arrival/Departure Record.

2. I-551: Resident Alien Card (I-551).

3. Forms I-688B or I-766 Employment Authorization Document.

4. A letter from CIS indicating a person's status.

5. Letter from the U.S. Dept. of Health and Human Services (HHS) certifying a person's status as a Victim of a Severe Form of Trafficking.

6. Iraqi and Afghan individuals who worked as translators for the U.S. military, or on behalf of the U.S. government, or families of such individuals; and have been admitted under a Special Immigrant Visa (SIV) with specific visa categories of SI1, SI2, SI3, SI6, SI7, SI9, SQ1, SQ2, SQ3, SQ6, SQ7, or SQ9.

7. Any of the documents permitted by the Colorado Department of Revenue rules for evidence of lawful presence (1 CCR 201-17, Attachment B).

F. Qualified non-citizens applying for Adult Financial programs shall present documentation from USCIS showing the client's non-citizen status. All documents shall be verified through SAVE (Systematic Alien Verification for Entitlements) to determine the validity of the document.

G. The following non-citizens and temporary residents shall not be eligible for Adult Financial programs:

1. A non-citizen with no status verification (undocumented) from the U.S. Citizenship and Immigration Service;

2. A non-citizen granted a specific voluntary departure date;

3. A non-citizen applying for a status; or,

4. A citizen of foreign nations residing temporarily in the United States on the basis of a visa issued to permit employment, education, or a visit.

3.520.68 Five Year Bar from Eligibility [Eff. 3/2/14]

A. Qualified non-citizens arriving in the U.S. on or after August 22, 1996, are generally barred from receiving Adult Financial programs for five years beginning on the qualified non-citizen's date of admission into the United States for legal permanent residence, as verified through the Systematic Alien Verification for Entitlements (SAVE) system, unless they meet one of the following exceptions consistent with the provisions of federal regulations found at 45 CFR 286.5 as of February 18, 2000, herein incorporated by reference. This rule does not contain any later amendments or editions. Copies of these federal laws are available from the Colorado Department of Human Services, Director of the Employment and Benefits Division, 1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library:

1. An honorably discharged U.S. veteran or active U.S. military personnel and/or spouse, unmarried children, widow, or widower;

2. A refugee, asylee, deportation withheld, a non-citizen granted status as a Cuban or Haitian entrant, or a certified Victim of a Severe Form of Trafficking (these humanitarian immigrants maintain their original status when adjusting to Legal Permanent Resident (LPR) status and remain exempt from the five year bar);

3. An individual who was born in Canada and possesses at least fifty percent (50%) American Indian blood, or who is a member of an Indian tribe;

4. An individual admitted to the U.S. as an Amerasian immigrant pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988, as amended by Public Law No. 100-461;

5. A lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam War;

6. An Afghan or Iraqi Special Immigrant Visa (SIV) holder;

7. A qualified non-citizen who receives Supplemental Security Income (SSI) benefits.

B. For OAP only, a client that has a documented hardship, as follows, shall not be subject to a five year bar from benefits:

1. Abuse or mistreatment by the sponsor(s). Suspension of five-year bar from benefits is permitted if there is credible evidence that the qualified non-citizen has been physically abused, battered, or subjected to extreme cruelty by his/her sponsor(s) in the United States, and meets the following requirements:

a. The qualified non-citizen subject to such physical abuse, battery, or extreme cruelty does not live in the same household with the individual responsible for the physical abuse, battery, or extreme cruelty; and,

b. There is a substantial connection between the physical abuse, battery, or extreme cruelty and the need for benefits; and,

c. There is documented credible evidence of physical abuse, battery, or extreme cruelty, including, but not limited to:

1) A copy of the protection order issued against the abuser or batterer of the qualified non-citizen claimant; or,

2) A copy of the verdict and the judgment or sentence against the abuser or batterer committing the act of violence against the qualified non-citizen claimant; or,

3) Reports or affidavits from police, judges, or other court officials; or,

4) Written statements from medical/health professionals treating the individual; or,

5) Verification from the U.S. Citizenship and Immigration Services or the Executive Office for Immigration Review (EOIR) that a petition to qualify under this category has been approved.

2. Indigence: Suspension of the five-year bar from benefits is permitted if the qualified non-citizen's income and resources, and income and resources of the qualified non-citizen's sponsor(s) are inadequate. If the qualified non-citizen does not have a sponsor, then their own income and resources would be considered.

a. It is the responsibility of the qualified non-citizen to obtain all required information and documentation from the sponsor(s).

b. The county department shall determine if the total household income available exceeds 125% of the federal poverty guidelines for the household size by dividing the total household income by the number of people in the household.

1) For purposes of this section, the household includes the qualified non-citizen, the qualified non-citizen's spouse, the qualified non-citizen's dependent children, the sponsor(s), the spouse of the sponsor(s), and the sponsor(s)' dependent children, i.e., the children the sponsor(s) claim on his/her income tax.

2) The county department shall total the countable income of the household by adding together income of the non-citizen, and that of his/her spouse, and the sponsor(s).

3) If the total household income available exceeds the monthly amount of 125% of the federal poverty guidelines for the household size, the indigence exception does not apply. If the total household income is less than 125% of the monthly federal poverty guideline for the household size, then,

a) The county department shall determine whether the household resources are above the resource limits, as outlined in Section 3.520.72. If yes, the indigence exception does not apply. If no, then,

b) The indigence exception applies.

c. The county department shall determine if the non-citizen is receiving free room and board from another source, such as a family member, friend, or a non-profit agency. If yes, the indigence exception does not apply.

3. Abandonment by the sponsor(s): suspension of the five-year bar from benefits may be applicable when the qualified non-citizen is abandoned by his/her sponsor(s) and the qualified non-citizen's income and resources are so inadequate that the qualified non-citizen is unable to obtain food and shelter.

a. The county department shall contact the sponsor to confirm the non-citizen's allegations regarding amounts of income and resources the sponsor provides or makes available to the non-citizen. If the non-citizen does not know the sponsor's whereabouts, the county department shall obtain this information if available through SAVE.

b. If the county cannot locate the sponsor of the sponsored non-citizen, a signed allegation (if the allegation is credible and does not conflict with other information in the file) shall be utilized. If the allegations are not credible or conflict with other information in file, the county department shall weigh all information and use prudent person principle to make a decision based on all the information obtained.

c. When a determination of abandonment is made, the county department shall notify the Department of Homeland Security.

C. For OAP only, if approved for a hardship exception to the five year bar, the county department shall process the application or redetermination to determine whether the qualified non-citizen meets the eligibility criteria for OAP. Requirements for the hardship exception shall be reassessed at each redetermination or when circumstances change.

D. For OAP only, the county department shall pursue recovery of OAP benefits from the sponsor(s).

1. The qualified non-citizen shall be notified of the recovery requirement at the time of request for a hardship exception from the five year bar from benefits; and,

2. If granted a hardship, the client shall be notified during the interview of each redetermination of the requirement to recover funds from the sponsor(s).

3.520.69 Sponsorship of Qualified Non-Citizens [Eff. 3/2/14]

This section shall apply to qualified non-citizens who entered the country on or after August 22, 1996.

A. As a condition of eligibility for financial assistance, any legal non-citizen applying for or receiving financial assistance shall agree that, during the time period the client is receiving financial assistance, the client shall not sign an affidavit of support for the purpose of sponsoring a non-citizen seeking permission from USCIS to enter or remain in the United States. A legal non-citizen's eligibility for financial assistance shall not be affected by the fact that the legal non-citizen has signed an affidavit of support for a non-citizen prior to his/her application for benefits.

B. The sponsored qualified non-citizen shall be responsible for the provision of any information and documentation related to the sponsor(s) and shall obtain cooperation from the sponsor(s) necessary to determine:

1. The identity and current address and contact information of the sponsor(s);

2. The relationship of the sponsor(s) to the qualified non-citizen;

3. Income and resources of the sponsor(s), which may be deemed available to the qualified non-citizen or recovered for repayment of benefits paid to or on behalf of the qualified non-citizen.

C. It shall be presumed that an affidavit of support demonstrates the sponsor's ability to make income and resources available to a non-citizen whom he or she sponsors at a minimum of one hundred twenty-five percent (125%) of the federal poverty level. Sponsors are expected to meet their financial commitments to the qualified non-citizen whom they sponsor and for whom they signed an affidavit of support until such time as the:

1. Qualified non-citizen has obtained U.S. citizenship; or,

2. Qualified non-citizen has worked, or can be credited with forty (40) qualifying quarters of coverage under Title II of the federal Social Security Act; or,

3. Qualified non-citizen leaves the United States and gives up lawful permanent resident status; or,

4. Qualified non-citizen dies; or,

5. Sponsor of the qualified non-citizen dies. The death of one sponsor does not terminate the support obligation of a joint sponsor. The sponsor's estate shall be required to repay public benefits.

D. Income and resources of the sponsor(s) shall be deemed to the client, as follows:

1. Deeming shall not apply to qualified non-citizens admitted as refugees or as political asylees.

2. Sponsors who signed sponsorship agreements prior to August 22, 1996, shall not be subject to resource and income deeming.

3. Effective December 19, 1997 through December 31, 2013, sponsor deeming shall apply only to the qualified non-citizen's spouse and/or non-relative sponsor(s) identified in sponsorship agreements signed on or after August 22, 1996.

   a. A relative is defined as any relation by blood, adoption, or marriage.

   b. Kinship relations by marriage continue to exist even if the marriage is terminated by death or divorce.

4. Effective January 1, 2014, sponsor deeming shall apply to all of the qualified non-citizen's sponsors identified in sponsorship agreements signed on or after December 19, 1997, no matter the sponsor's relationship to the client.

5. For OAP only, the hardship exceptions as described in 3.520.68, B-D, shall also be evaluated in relation to sponsor deeming. If it is determined that hardship has been established, sponsor deeming shall not be applied to the non-citizen. Eligibility under one of the hardship exceptions will be reviewed and reassessed at redetermination or when changes in circumstance are reported to determine if hardship still applies. The county department shall pursue recovery of OAP benefits from the sponsor(s).

   a. The qualified non-citizen shall be notified of the recovery requirement at the time of request for a hardship exception from the sponsor deeming; and,

   b. If granted a hardship, the client shall be notified during the interview of each redetermination of the requirement to recover funds from the sponsor(s).

E. If the qualified non-citizen fails to provide information related to the sponsor(s), as outlined in Section 3.520.69, B, assistance shall be denied or discontinued.

If it is determined that the client received Adult Financial program benefits because the client failed to provide necessary information related to the sponsor(s) or the sponsor(s)failed to cooperate with the county department in determining income and resources that are required to be deemed to the client, the county department shall recover such funds from the sponsor(s) and/or the client via the following:

1. Income assignments;

2. State income tax refund offset;

3. State lottery winnings offset; and,

4. Administrative lien and attachment.

F. Income and resources shall be deemed as outlined in Sections 3.534, C, and 3.520.72.

3.520.7 FINANCIAL ELIGIBILITY REQUIREMENTS

3.520.71 Financial Eligibility Requirements [Eff. 6/1/15]

A. To receive Adult Financial program assistance, the client shall meet all financial requirements in addition to all other program eligibility requirements. The client shall:

1. Have countable resources below the resource limit as outlined in Section 3.520.72; and,

2. Have income below the income limit, as outlined in Section 3.520.78; and,

3. Make reasonable attempts to pursue all available income and resources at the client's disposal.

B. The AND-SO client shall apply for Supplemental Security Income (SSI) benefits. If the client has work hours during his/her lifetime, the client shall also apply for Social Security Disability Insurance (SSDI). The client shall appeal all negative decisions regarding their SSI eligibility. Failure to appeal all negative decisions shall result in denial or discontinuation of AND benefits.

   For OAP, the client shall apply for Social Security and/or SSI benefits, as follows:

   1. Clients sixty (60) years of age and older who report a disability may be eligible for SSI or SSDI.

   2. Clients sixty (60) years of age and older may be eligible for Social Security survivor benefits.

   3. Clients sixty-two (62) years of age and older may be eligible for early Social Security retirement benefits; otherwise the client shall provide documentation from the SSA that he/she is ineligible due to insufficient work hours.

   4. Clients sixty-five (65) years of age and older may be eligible for Social Security retirement benefits and/or SSI benefits when the client's income from any source is less than the SSI grant standard plus $20.00.

C. For Adult Financial programs, clients referred to the SSA to apply for any SSA related benefit shall be required to provide verification of application for such benefits within ten (10) calendar days of application for SSA benefits. Benefits shall not be approved prior to receipt of proof of application for SSA benefits, unless he/she is working with a Disability Benefits Guide (Guide) for the AND-SO program. If he/she is working with a Guide, the client will have up to two months of conditional approval from the date of the initial interview with the county department for AND-SO, unless good cause is provided for additional time.

D. For OAP, the client shall apply for SSI or continue to appeal negative decisions unless good cause is provided. Good cause is defined as follows:

   1. The client's and the client's spouse's gross income exceeds the maximum allowed for SSI for an individual or a couple; or,

   2. The client's and the client's spouse's total resources exceed that allowed for SSI for an individual or a couple; or,

   3. The client is not disabled as defined in Section 3.541; or,

   4. As otherwise directed by the SSA.

E. Clients newly approved for SSI benefits who have been charged an in-kind support and maintenance (ISM) deduction by the SSA shall apply to SSA to remove the ISM as soon as the client begins paying his/her fair share for shelter costs. The county department shall deduct an identical ISM amount for Adult Financial programs until the SSA ISM is removed.

F. The client shall apply for TANF/Colorado Works when he/she might be eligible, as follows:

1. An Adult Financial program client with a dependent child is required to apply for and accept, if eligible, TANF/Colorado Works financial benefits.

    a. A grandparent or any other specified caretaker who is not a parent is not required to be a member of the TANF/Colorado Works case when they are not requesting assistance for his/herself.

    b. A TANF/Colorado Works client is not required to apply for an extension to be potentially eligible for Adult Financial program benefits.

    c. The TANF/Colorado Works funds received for the support of a child are not used in determining the specified caretaker's eligibility for Adult Financial program benefits.

2. The client shall be ineligible for Adult Financial program benefits if his/her TANF/Colorado Works case was denied or discontinued:

    a. Due to a sanction or disqualification; or,

    b. Because the client withdrew from the program prior to exhausting all benefits; and,

    c. The ineligibility period shall continue until the sanction or disqualification is removed or until the client rejoins the program and has exhausted all TANF/Colorado Works benefits.

G. The client shall apply for any other retirement income for which the client is eligible.

H. The client shall take reasonable steps to pursue all other income and resources that may be available, to include, but not be limited to, alimony, equitable distribution of resources in a divorce, inheritance income or resources, child support arrears, co-ownership of property, lottery or sweepstakes winnings that are due to the client, lawsuit judgments that are due to the client, or insurance settlements, unless it is demonstrated that good cause exists.

3.520.72 Resources [Eff. 3/2/14]

A. Unless otherwise specified, a resource is countable, and together with all other countable resources of the client, spouse, and sponsor(s) shall be considered against the resource limit. The resource limit is:

1. $2,000 for:

    a. An unmarried client who is a citizen or non-sponsored qualified non-citizen;

    b. An unmarried sponsor; and,

    c. A married sponsor whose spouse is a co-sponsor. Each sponsor shall receive the $2,000 resource limit for a combined resource limit of $4,000.

2. $3,000 for:

    a. A married client who is a citizen or non-sponsored qualified non-citizen; or,

    b. A married sponsor whose spouse is not a co-sponsor.

B. Countable assets include, but are not limited to:

1. Cash on hand or in a savings or checking account.

2. Equity value of real property that is not used as the client's primary home or not exempt as income producing.

3. Proceeds from the sale of the primary home that are in excess of the cost of expenses incurred to purchase or build a replacement home.

4. Personal property or the proceeds from the sale of personal property, such as mobile homes or recreational vehicles not used as the client's primary home and not exempt as income producing.

5. Personal property or the proceeds from the sale of personal property, such as motor vehicles, recreational off road vehicles, boats, trailers, or similar that are not exempt per Section 3.520.77 or exempt as income producing.

6. Stocks, bonds, mutual fund shares, 401Ks, 457Ks, IRAs, Certificates of Deposit (CDs), and other retirement or investment accounts and investment vehicles.

7. Mortgages, promissory notes, and similar properties that can be converted to cash.

8. Cash surrender value of all life insurance policies as outlined in Section 3.520.75.

9. Prepaid revocable funeral or burial expense contracts or trust deposits, as outlined in Section 3.520.77, G.

10. The value of the burial space in excess of that required to meet the burial needs of the immediate family, as outlined in Section 3.520.77, H.

11. Proceeds of fire or casualty insurance payments that were in excess of the expenses incurred to repair or replace the damaged, lost, or stolen property.

12. Proceeds of a loan when those proceeds were not expended to meet the purpose of the loan or proceeds of a loan with no bona fide debt repayment schedule.

13. The estate and all resources identified in the estate inventory for a client adjudicated incapacitated by a court.

C. If it is determined that a married couple is legally or permanently separated as identified in Section 3.520.63, sole ownership of property by the non-recipient spouse does not affect the client's eligibility for assistance.

D. The county department shall obtain verification of all resources and associated values.

1. The county department shall include case notes describing verification documentation in the statewide automated system.

2. Original copies of verification documents shall be returned to the client.

3. The client's authorization shall be obtained to contact a collateral source for valuation information or verification.

4. The client shall disclose the contents of a safety deposit box on request of the county department. The value of the contents is determined by obtaining any necessary valuations for countable items.

E. A sponsor(s)'s resources are only counted toward the non-citizen they sponsor. Determine the total amount of the non-citizen's resources after deeming, and use the SSI individual resource standard to determine resource eligibility for the sponsored non-citizen. To determine the amount of resources deemed to the non-citizen, subtract the resource standard from the amount of the sponsor(s) resources. The difference is the amount of resources that is added to the non-citizen's own resources.

1. When a sponsor is married, but the spouse is not a sponsor to the non-citizen, use the couple resource standard for SSI.

2. When the sponsor is married and the sponsor's spouse is also a sponsor to the non-citizen, the individual resource standard for SSI is applied separately to each spouse.

3.520.73 Liquid Assets [Eff. 3/2/14]

A. Checking and savings accounts:

1. The current amount in a savings or checking account is determined by verifying the balance in the account:

a. From a copy of a current statement of the account; or,

b. With the financial institution online, by phone, or in writing.

2. The balance in a joint account shall be considered available to the client in proportion to the number of persons on the account.

a. If the co-owner of the joint account is the client's legal fiduciary, such as a guardian, conservator, or power of attorney, the account shall be considered to be 100% owned by the client and all funds in the account shall be considered available to the client.

b. If the client establishes clear and convincing evidence that the intent of ownership is other than the client's equal and proportionate share of the account balance, the county department shall apply the prudent person principle to the evidence to determine the amount to be considered available to the client.

c. In cases where it has been shown the client has no interest in the account, the county department shall request a change in the account designation removing the client's name, and submittal of the original and revised account records showing the change was made.

B. A county department may selectively contact one or more financial institutions to establish whether a client has any account at the institution or has an account in addition to one declared. The client's signature on the application provides authorization to make such contacts.

3.520.74 Real Property and Personal Property [Eff. 3/2/14]

3.520.741 Real Property [Eff. 3/2/14]

A. In order for real property to be considered a resource to the client, the following shall be determined:

1. The actual value less encumbrances of the client's ownership interest:

a. Actual value of real property may be obtained by using the actual value reported by a county assessor or from the most recent property assessment notice.

b. The assessed value shall be verified from a copy of the most recent property assessment notice or with the county assessor's office on the Internet, by phone, personal contact, or in writing.

c. Encumbrances include mortgages, liens, judgments, delinquent taxes, loan agreements, and other forms of indebtedness. Encumbrances shall be verified. Only direct and documented encumbrances against a specific item or property shall be considered in determining its equity value. Verbal agreements of indebtedness shall not be accepted.

2. The negotiability of the ownership interest (that is, there are no legal restrictions from selling the client's property interest); and,

3. The ability to sell the property interest (that is, that the ownership interest can, in fact, be sold on the open market at any price).

B. The degree of the client's ownership interest is determined by the type of ownership. Generally, the types of ownership are:

1. Sole ownership, in which the client is the only owner. If the client has the right to dispose of the property, the actual value less encumbrances of the property is determined and counted as a resource;

2. Shared ownership, in which the property is owned by the client and one or more individuals. The actual value less encumbrances is determined and charged in proportion to the client's share of ownership. There are two kinds of shared ownership:

a. Joint ownership or ownership in common, in which the property's actual value less encumbrances is divided equally among the owners; and,

b. Tenancy in common, in which the property's actual value less encumbrances is divided by the number of owners in proportion to their stated interest (which may not necessarily be equal).

C. Negotiability and, if applicable, the client's ability to sell the property interest at a reasonable price must be determined. Negotiability refers to the client's legal right to dispose of an ownership interest; ability to sell refers to a legal ability to sell. Reasonable price is determined to be two-thirds of the actual value.

1. Negotiability - there may be legal reasons why a client may not be able to sell the client's property interest, such as when the estate is in probate or there is a lawsuit pending against the property. The refusal of co-owners to consent to the sale of a property interest is not a legal restriction of the client's right to sell.

2. If the co-owner of the property uses the property as the principal place of residence and sale of the property would cause undue hardship, the client's equity in the property shall be exempted. Undue hardship for this purpose is defined as:

    a. The co-owner uses the property as his/her primary residence; and,

    b. The co-owner would have to move as a result of the sale of the property; and,

    c. The co-owner has no other available housing, including relatives or income to rent at fair market value; and,

    d. The co-owner documents, in writing, his/her undue hardship allegations; and,

    e. Using prudent person principle, the county department determines the undue hardship allegations to be reasonable.

3. If the client cannot sell the property for two-thirds of the actual value, the property shall be exempted provided that the client continues reasonable efforts to sell the property such as listing the property with an agency or by advertising in the local media.

    a. The county department shall verify on a quarterly basis that a reasonable effort is being made to sell the property.

    b. The property shall not be exempted if the county department, using prudent person principle, determines the client is not making a reasonable effort to sell.

    c. If the client rejects an offer to purchase the property that is at least two-thirds the actual value of the property, the entire equity value of the property shall be considered a countable resource.

4. If the property interest cannot be disposed of because of legal technicalities, the client's equity value is not a countable resource. The county department shall verify any limitations that prevent the disposition of the property and document those limitations in the statewide automated system case comments.

3.520.742 Personal Property [Eff. 3/2/14]

A. The actual value of any personal property which is assessed for taxation, such as a mobile home, house trailer, or property used in a trade or business, is determined by using the actual value reported by a county assessor or by obtaining a copy of the most recent property assessment notice. If the actual value is not on the assessment notice, the value may be determined by:

    1. Verifying the actual valuation from a copy of the most recent property assessment notice or with the county assessor's office on the Internet, by phone, other personal contact, or in writing; or,

    2. When personal property valuation is necessary, and the usual means of valuation is not possible, the county department shall use available local resources or the classified ad section of the local or other state newspaper or Internet to determine and verify the actual value.

    3. To determine the equity value of personal property, first determine the actual value; then subtract encumbrances.

B. The actual value of any personal property which is not assessed for taxation is determined by obtaining the appraised value less liabilities, i.e., farm equipment and livestock or inventories of merchandise and materials, such as art, jewelry or valuable collections, as appraised by a verifiable, industry recognized source.

1. The actual value of automobiles and trucks is determined by using the trade-in fair condition value as provided by an auto valuation company, such as Kelly Blue Book or NADA guides. A greater or lesser value shall be used if verified by a statement from a reliable source, such as a car dealer, collector car expert, or scrap yard professional.

2. For personal property which has not been assessed for taxation and vehicles which are not listed by an auto valuation company, the client shall submit verification of the appraised value based on written statements received from the following:

a. Assessment standards obtained from the state or county motor vehicle office or county assessor's office; or,

b. Valuation obtained from a local merchant, dealer, Internet or other reliable source.

C. The fair market value of stocks, mutual fund shares, municipal, corporate or government bonds, and other securities is based on the price as of the opening of the market on the date their value is determined by the county department. The market price is obtained from the published quotations on the Internet or by contacting a local securities firm.

1. The value of stocks traded over-the-counter is expressed on a “bid” and “asked” basis. In such cases, the bid price is used to determine the market value.

2. When stocks or other securities have no locally determinable value, the market value is requested from the issuing company. The Office of the Secretary of State in each state will supply the address of the issuing company and information as to whether the stock is still on the market.

D. The current cash value of U.S. Savings Bonds, Treasury Notes, and similar investment vehicles is determined from the value tables appearing on the bonds themselves or by contacting a financial institution.

E. Personal property may be exempted if the client has made an attempt to sell and has been unable to do so.

1. Failure to sell personal property at the asking price or for a reasonable value the resource shall not be exempt. Under such circumstances, the county department shall determine whether the property could be sold for two-thirds of the actual value.

2. If the client receives an offer for at least two-thirds of the actual value and refuses to sell the property, the property shall not be exempted.

3. If the client cannot sell the property for two-thirds of the actual value, the property shall be exempted provided that the client continues reasonable efforts to sell the property such as, by listing the property with an agency or by advertising in the local media.

a. The county department shall verify on a quarterly basis that a reasonable effort is being made to sell the property.

b. The property shall not be exempted if the county department, using prudent person principle, determines the client is not making a reasonable effort to sell.

c. If the client rejects an offer to purchase the property that is at least two-thirds the actual value of the property, the entire equity value of the property shall be considered a countable resource.

F. The equity value of mining claims and oil, mineral or water rights, if assessed separately from land, is determined by using the equity value established by the current market value.

G. The client shall have the right to submit evidence establishing a lesser property value. Such value may be established to be zero. The county department shall evaluate the evidence and determine the property value.

3.520.75 Life Insurance [Eff. 3/2/14]

A. Life insurance policies owned by the client that have a cash surrender value available to the client must be evaluated for original face value at the time of purchase and for current cash surrender value.

B. Term life insurance policies should be reviewed to determine if a cash surrender value exists.

C. The county department shall obtain the most recent documentation related to the policy, to include active status, liens or encumbrances, and current cash surrender value.

D. If the total face value of all life insurance policies owned by a client is equal to $1,500 or less, the full cash surrender value of all policies is exempt.

E. For OAP only, if the total face value of all life insurance policies owned by a client is equal to more than $1,500 and the cash surrender value of all policies combined is $100,000 or less, then the following applies:

1. If all policies were purchased more than forty-eight (48) months prior to the eligibility determination date, and no further contributions or payments to the policies have been made in the past 48 months, all cash surrender value is exempt.

2. If the client has contributed additional monies or made payments to any of the policies within 48 months of eligibility determination date, those additional monies contributed are counted toward the resource limit; the original cash value amount prior to the 48 month period remains exempt.

3. If any of the policies were purchased within the 48 months prior to eligibility determination date, the total cash surrender value is a countable resource.

F. For OAP only, if the total face value of all life insurance policies owned by a client is equal to more than $1,500 and cash surrender value of all policies combined is more than $100,000, then the following applies:

1. If all policies were purchased more than 48 months prior to eligibility determination date, and no further contributions or payments to the policies have been made in the past 48 months, the cash surrender value over $100,000 is countable; the first $100,000 is exempt.

2. If the client has contributed additional monies or made payments to any of the policies within 48 months of eligibility determination date, those additional monies contributed are counted toward the resource limit and the cash surrender value over $100,000 is countable; the original cash value amount prior to the 48 month period remains exempt.

3. If any of the policies were purchased within the 48 months prior to eligibility determination date, the total cash surrender value is a countable resource.

G. The original face value of a policy may be increased because of dividends and reinvestment of dividends. This increased face value shall not be used to determine eligibility. The original face value of the policy shall be used to determine whether the cash surrender value of the policy is exempt.

3.520.76 Transfers Without Fair Consideration (TWFC) [Eff. 3/2/14]

A. A Transfer Without Fair Consideration (TWFC) is a transfer of any resource to another person at a price that is below fair market value. A transfer of a resource shall be considered a TWFC if the transfer was:

1. Voluntary; and,

2. Without fair and valuable consideration; and,

3. Made within thirty-six (36) months prior to the application date; and,

4. For the purpose of rendering the client eligible for assistance; or,

5. Made while receiving Adult Financial program benefits.

    a. The county department shall make a rebuttable presumption that the transaction was made for the purpose of becoming or remaining eligible for Adult Financial program benefits when the transfer was made any time during the thirty-six (36) month period immediately prior to the filing of application for assistance or during such time that assistance was being received.

    b. A client shall be given the opportunity to disprove the presumption. The presumption shall be nullified if the client can demonstrate to the county department that the transfer was for another purpose.

        1) The client's primary purpose cannot be to acquire money or profit from the transaction; and,

        2) The client shall provide written documentation of any agreement made in relation to the transfer of property, that was created at the time of the agreement to transfer property; and,

        3) The county department shall weigh the evidence and use prudent person principle to determine whether there is sufficient evidence to disprove the presumption.

B. Circumstances at the time of the transaction may indicate a reasonable rationale for a client's willingness to accept a sum which is less than a fair consideration based on a hardship just prior to the transaction. Hardships include:

1. A period of unemployment resulting in an inability to meet monthly bills, and costs of subsistence; or,

2. An accident or severe illness resulting in a need of funds to meet large expenditures for medical care and services; or,

3. Other hardship deemed reasonable by the county department using prudent person principle.

C. A documented involuntary transfer of a resource shall not affect eligibility. Transfers that would be considered involuntary are:

1. Loss of property through fraud, provided that the client can demonstrate that every reasonable effort has been made to recover the property by court action or other procedures as indicated; or,

2. Loss of property through legal action such as judgment, foreclosure, delinquent tax sale; or,

3. Other involuntary transfer identified and determined reasonable by the county department using prudent person principle.

D. Transfers of up to a fifty percent (50%) share of the equity value of a resource between the client and the client's spouse, while legally married, shall not be a transfer without fair consideration.

E. The county department shall determine the eligibility penalty as a result of a TWFC as follows:

1. Determine the actual value of the resource less encumbrances and subtract the amount the client received for the resource from the determined actual value. This is the uncompensated value.

2. Determine the current Adult Financial program grant standard and add to the Adult Financial program grant standard any monthly medical costs, including health insurance premiums, for which the client is responsible to pay. This is the TWFC monthly penalty value.

3. Divide the uncompensated value by the TWFC monthly penalty value and round down to the nearest whole number.

4. This equals the number of months of ineligibility for Adult Financial program benefits.

F. Upon the request of the client, the county department shall re-calculate the penalty when there is a subsequent increase in the Adult Financial program grant standard or in the client's monthly medical care costs. The county shall notify the client of any change in the period of ineligibility.

G. A life estate established on the residence by the client and/or the client's spouse within thirty-six (36) months from the date of application or while receiving Adult Financial program benefits shall be a TWFC.

H. The amount to be considered as a TWFC on a life estate shall be calculated by using equity value of the property and applying it to the life estate table pursuant to the “Social Security Program Operations Manual System (POMS)”, 26 CFR 20.2031-7, 49 Federal Register Vol. 49 No. 93/5-11-84, herein incorporated by reference. This rule does not contain any later amendments or editions. Copies of these federal laws are available from the Colorado Department of Human Services, Director of the Employment and Benefits Division, 1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library contained in these rules as follows:

1. Determine the equity value of the property at the time the life estate was established. The equity value of the residential property shall be determined by obtaining the actual value and subtracting encumbrances.

2. Multiply the equity value of the property by the “Remainder” factor from the life estate table that corresponds to the client's age at the time the life estate was established. The result is the amount to be considered as a transfer of assets without fair consideration and is the uncompensated value.

    a. When a life estate is established on the residence held by spouses in joint tenancy, the age of the younger spouse shall be used.

    b. Once the uncompensated value is calculated, the penalty period is determined by using the steps outlined in Section 3.520.76, E, 2-4.

3.520.77 Exempt Resources [Eff. 3/2/14]

Resources that shall be exempt and not counted toward the resource limit for an individual or married couple include:

A. One vehicle regardless of its value, if it is used for the transportation of the client or a member of the household.

B. Household goods and personal effects such as furnishings, appliances, and clothing.

C. A home in which a client and his/her spouse have an ownership interest and that serves as the client's principal place of residence. This property includes the shelter in which the client resides, the land on which the residence is located, and related outbuildings.

1. The home is not a countable resource regardless of its value. However, when there is an income producing property located on or adjacent to the home property, the income producing resource shall not qualify under the home exemption unless assessed collectively with the principal home.

2. When a client or his/her spouse requires long-term medical care that is outside the client's county of residence, the home continues to be exempt so long as there is intent for the client and/or spouse to return to the home at the conclusion of medical treatment.

3. When a client requires care in a long-term care facility, the home continues to be exempt so long as there is intent for the client to return to the home.

    a. This intent to return home applies to the home in which the client or spouse was living prior to being admitted to the facility or to the replacement home. Such intent is documented by the following:

1) A written statement from the client indicating the intent to return home for any reason; or,

2) A written statement from the client's spouse, legal fiduciary, doctor, or authorized representative indicating the client's intent to return home.

b. An arrangement by the client for occupancy of the home by another person, either on a rental basis, rent free, or in exchange for home maintenance, during a period of temporary absence shall not affect the home property exemption.

4. The home of an OAP-C client shall be exempt as a resource during the period of commitment.

5. If a client's home can no longer be excluded due to a change in his/her principal place of residence, the equity value of the property shall count as a resource.

D. Part or all of the value of property may be exempt if it is essential to the self-support of the client. To determine whether property is producing income or being used in a trade or business, the county department shall obtain a copy of the most recent tax returns from the client. If a return has not yet been filed, obtain a current estimate of income and a copy of the previous year's return. Property used for self-support activities include:

1. Property used in self-employment.

a. To be considered a valid trade or business as self-employment, the activity shall be:

1) Currently ongoing rather than in the stage of preparation or inactivity; and,

2) Intended to make a profit.

b. The liquid resources (e.g., cash, funds in a checking account) considered necessary for use in the trade or business shall not exceed three times the average monthly cash expenditure for operating the business, unless there is good cause, as determined and documented by the county department using the prudent person principle.

c. If property has been but is not currently in use, the exemption for such property shall continue for twelve (12) months if there is a reasonable expectation that the use of the property will resume within that time. The exemption is for twenty-four (24) months where non-use is due to a disabling condition.

2. Property owned by the client that is necessary to perform a job for wages, such as tools, safety equipment, or uniforms. If property has been but is not currently in use the exemption for such property shall continue for twelve (12) months if there is a reasonable expectation that the use of the property will resume within that time. The exemption is for twenty-four (24) months where non-use is due to a disabling condition.

3. Non-business property used to produce goods necessary for the client's daily activities.

a. A maximum of six thousand dollars ($6,000) of the equity value of such property shall be exempt as a resource. Any equity value in excess of $6,000 shall be a countable resource.

b. Examples of this type of property include land which is used to produce vegetables or livestock only for personal consumption in the client's household, and personal property necessary to perform that function (e.g., a garden tractor), but do not include motor vehicles, boats, or other special vehicles.

c. If property has been but is not currently in use, the exemption for such property shall continue for twelve (12) months if there is a reasonable expectation that the use of the property will resume within that time. The exemption period shall be twenty-four (24) months where nonuse is due to a disabling condition.

4. Non-business, income-producing property shall be exempt, but the income shall be countable.

a. If a client owns non-business, income-producing property, a maximum of six thousand dollars ($6,000) of the equity value of such property is an exempt resource, as long as the property produces a net annual income of at least six percent (6%) of the excluded equity. If the equity value of such income-producing, non-business property exceeds $6,000, only the equity value above $6,000 will be counted as a resource. If there is more than one potentially exempt property, the rate-of-return requirement applies individually to each. However, the total combined exemption for all such properties shall not exceed $6,000.

b. “Non-business” means that the property is not used in a trade or business as defined in Section 3.520.76. Non-business, income-producing property may include but is not limited to houses or apartments for rent and land other than home property.

c. If non-business, income-producing property is not producing net income of at least six percent (6%) of the excluded equity, the entire equity value is counted as a resource. However, the exemption for up to $6,000 of the property's equity may continue if the property is earning less than 6% due to circumstances beyond the client's control (e.g., crop failure, illness, etc.), and there is a reasonable expectation that, within twenty-four (24) months, the property will again produce a 6% return.

5. A permit, license, or other similar authority granted by a governmental agency to engage in an income-producing activity is not a countable resource.

E. Proceeds from fire or casualty insurance shall be considered exempt to the extent that they are used to restore or replace an exempt resource. This exemption shall be allowed for up to three (3) months for restoration or replacement of exempt personal property and six (6) months for restoration or replacement of exempt real property from the date the client receives such sums.

1. Establishing eligibility for the duration of the replacement exemption requires:

a. Obtaining appropriate documentation to verify the amount of proceeds and date they were received; and,

b. Obtaining the client's signed statement verifying that the proceeds will be used for restoration or replacement of exempt property.

2. The client must be contacted upon the expiration of the allowable time period to verify that restoration or replacement has occurred. Restoration or replacement shall be considered to occur when payment for such is made or contracted in writing to be made.

3. When the allowable time period ends, proceeds in excess of payments made or contracted to be made must be counted as a resource in the month following the month in which the time period expired, unless good cause for an extension is determined by the county department using the prudent person principle.

F. Proceeds from sale of the home property, relocation payments, or condemnation awards from a governmental agency shall be considered exempt to the extent that they are used to purchase or build a replacement home. This exemption is allowed for up to six (6) months from the date the client receives such sums. Proceeds of a home sale are the net payments received by the seller after satisfaction of all actual encumbrances and sales expenses.

1. Establishing eligibility for and the duration of the replacement exemption requires:

a. Obtaining appropriate documentation to verify the amount of proceeds and date they were received; and,

b. Obtaining the client's signed statement verifying that the proceeds will be used for restoration or replacement of exempt property.

2. The client must be contacted upon the expiration of the allowable time period to verify that restoration or replacement has occurred. Restoration or replacement shall be considered to occur when payment for such is made or contracted in writing to be made.

3. When the allowable time period ends, proceeds in excess of payments made or contracted to be made must be counted as a resource in the month following the month in which the time period expired, unless good cause for an extension is determined by the county department using the prudent person principle.

G. An irrevocable trust or prepaid contract for burial expense. Irrevocable means that the contract cannot be terminated, sold, or transferred.

H. A revocable trust if the following conditions are met:

1. Revocable means that the contract can be terminated, sold, or transferred.

2. The burial prepaid contract is exempt if it is revocable and does not exceed one thousand five hundred dollars ($1,500).

a. To evaluate a prepaid revocable burial contract, the following shall apply:

1) Only the paid-up amount of the contract, not the face value, is taken into consideration;

2) The interest on the exempt $1,500 is also exempt;

b. To evaluate a trust deposit for burial expense, the $1,500 exemption applies only when the trust:

1) Is made with a federally insured bank or savings and loan association, or with a trust company under supervision of the State Banking Commissioner;

2) Is revocable during the lifetime of the client and is to be paid by the trustee only upon death of the client for the purpose of burial expense; and,

3) Provides for payment of the trust funds without limitation as to place of burial or provider of related services unless the trust was established prior to November 1966. In any case, however, the client is not precluded from indicating a preference as to place of burial or provider of related services.

I. The value of burial spaces required to meet the burial needs of the immediate family, even if not living in the home. The immediate family includes the client's spouse, minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those persons.

J. Any retroactive SSI or Social Security retirement or disability benefits still remaining after the month of receipt shall be exempt as a resource for nine months following the month they are received.

K. An income tax refund shall be exempt in the month received. Any remaining balance shall be counted as a resource after twelve (12) months.

L. Monies from a bona fide loan are exempt in the month received. Any remaining balance shall be counted as a resource in the following month(s).

3.520.78 Types of Income [Eff. 3/2/14]

3.520.781 Income [Eff. 3/2/14]

A. If a client's income equals or exceeds the Adult Financial program grant standard, the client shall not be eligible for that specific Adult Financial program.

B. Income eligibility determination utilizes four types of income:

1. Earned income;

2. In-kind earned income;

3. Unearned income; and,

4. In-kind unearned income.

C. Certain income shall be exempt and shall not be considered as countable income, in part or in whole, as outlined in Section 3.520.786.

D. Certain income shall have deductions, herein termed as income “disregards,” applied before determining final countable income as outlined in Section 3.533.

E. The income of a spouse who is not receiving public assistance benefits, SSI benefits or Medicaid assistance, and the income of the sponsor(s) shall be countable, herein termed as “deemed,” to the client as outlined in Section 3.534.

F. The total countable income of the client shall be deducted from the AND or OAP grant standard to determine the payment amount.

G. All income shall be countable in the month it is actually received or legally becomes available, whichever comes first, with the following exceptions:

1. Income that can be anticipated with reasonable certainty concerning the amount and the month it is expected to be received shall be counted in the month anticipated.

2. The anticipated monthly income shall be based on the income received in the previous month, except when the previous month does not provide an accurate indication of anticipated income, or under other circumstances as specified below:

   a. For new or changed income, a period shorter than a month may be used to project a monthly amount;

   b. For contract employment, such as in some school systems, where the employees derive their annual income in a period shorter than a year, the income shall be prorated over the term of the contract, provided that the income from the contract is not earned on an hourly or piecework basis;

   c. For regularly received self-employment income, net earnings will usually be prorated and counted as received in a three (3) month period, except for farm income. For further information see Section 3.520.783.

   d. For all other cases where receipt of income is reasonably certain but the monthly amount is expected to fluctuate, a period of twelve (12) months shall be used to arrive at an average monthly amount;

   e. Income from rental property shall be considered self-employment income provided the client actively manages the property at least an average of twenty (20) hours per week.

      1) Income from rental property shall be considered unearned income if the client is not actively managing the property an average of at least 20 hours per week.

      2) Rental income, as self-employment or as unearned income, shall be averaged over a twelve month period to determine monthly income.

      3) Income from jointly owned property must be considered as a percentage at least equal to the percentage of ownership or, if receiving more than percentage of ownership, the actual amount received.

   f. For cases where a change in the monthly income amount can be anticipated with reasonable certainty, such as with Social Security cost of living adjustments (COLA), or other similar benefit increases, the expected amount shall be considered in determining a countable monthly income for the month received.

3.520.782 Earned Income [Eff. 3/2/14]

A. Earned income is monetary wages received by the client for services performed as an employee or as profit from self-employment.

B. In-kind earned income is non-monetary benefits received by the client for services performed as an employee or as self-employment profit, such as shelter as payment for building maintenance or babysitting or other barter goods in exchange for services.

   1. In-kind income received in exchange for employment is employment income and shall have the appropriate earned income disregards applied to the total value of the income.

2. The amount considered as earned income when the client is paid in-kind shall be the value of the item supplied. The current market value of the item is used if the value of the item is not provided.

3.520.783 Self-Employment Income [Eff. 3/2/14]

A. An individual involved in a profit making activity shall be classified as self-employed.

B. To determine the net profit of a self-employed client, deduct the cost of doing business from the gross income.

1. Cost of doing business expenses include, but are not limited to, the rent of business premises, wholesale cost of merchandise, utilities, interest, taxes, labor, and upkeep of necessary equipment.

2. Depreciation of equipment shall not be considered as a business expense.

3. The cost of and payments on the principal of loans for capital assets or durable goods shall not be considered as a business expense.

4. Personal expenses such as personal income tax payments, meals, and transportation to and from work are not business expenses.

C. Some types of self-employment income shall be calculated using a method specific to the type of self-employment, as follows:

1. Farm income shall be considered on a yearly basis. Net income for the prior year shall be determined and averaged for the succeeding year and counted as earned income. When a client ceases to farm, the income is no longer deducted from the grant standard.

2. Rental income shall be considered as follows:

a. When the client actively manages a self-owned rental property at least twenty (20) hours a week, treat rental income as self-employment income. Average the rental income over a twelve (12) month period to determine monthly earned income.

b. Board (to provide a person with regular meals only) payments to the client shall be considered earned income in the month received. For each boarder, calculate documentable expenses directly related to provision of board. Subtract the result from the board payment to determine the countable earned income.

c. Room (to provide a person with lodging only) payments to the client shall be considered earned income in the month received. For each boarder calculate the documentable expenses directly related to the provision of the room. Subtract the result from the room payment to determine the countable earned income.

d. Room and board (to provide a person regular meals and lodging) payments shall be considered earned income in the month received. For each boarder, calculate the documentable expenses directly related to the provision of room and board. Subtract the result from the room and board payment to determine the countable earned income.

3. Appropriate allowances for cost of doing business for clients who are licensed child care providers are:

a. For the first child for whom day care is provided, deduct $55; and,

b. For each additional child deduct $22.

c. Subtract the total allowances from the documented expenses to determine the earned income.

d. If the client can document a cost of doing business that is greater than the amounts above, the procedure, described in Section 3.520.783, B, shall be used to calculate earned income.

D. The net profit amount, secured after the appropriate deductions, is earned income.

3.520.784 Donated Work Hours and Volunteerism [Eff. 3/2/14]

A. Work hours or personal services, for which monetary compensation is not realized, provided to a business, to a person who is self-employed, or to any other person or business in need of a regular, temporary, or non-traditional employee, such as a seasonal worker, shall be considered countable earned income when the work:

1. Is regular and scheduled; and,

2. Is a necessary service; and,

3. If not performed by the client someone would have to be hired to perform the work; and,

4. Is greater than five (5) hours per week.

B. If donated work hours or personal services meet these requirements, the value of these hours is determined by:

1. The going rate in the community for similar work; or,

2. The current minimum wage standard, whichever is greater.

C. Volunteerism for the betterment of the community less than an average of thirty (30) hours per week shall not be considered income. Volunteerism for the betterment of the community includes but is not limited to:

1. Visiting persons in nursing homes, hospitals, etc.;

2. Delivering meals to homebound persons;

3. Providing limited transportation to medical appointments for disabled or aging persons; or,

4. Other opportunities deemed volunteerism for the betterment of the community by the county department using the prudent person principle.

3.520.785 Unearned Income [Eff. 3/2/14]

A. Unearned income is monetary benefits not earned through employment or self-employment, such as Social Security or other retirement benefits, interest, or investment income.

B. Countable unearned income includes the following and any other payments that could be construed to be a gain or benefit to the client and which are not earned income.

1. Benefits issued by the Social Security Administration, such as Social Security retirement, Social Security Disability Insurance (SSDI), or Supplemental Security Income (SSI).

    a. Lump sum payments shall be counted as income in the month received. Any unspent amount will be treated as a resource after nine (9) months.

    b. A recovery of Adult Financial program benefits shall be established if the lump sum payment is received too late in the month to adjust the Adult Financial program grant paid to the client.

    c. If the Social Security Administration (SSA) is recovering any portion of the SSI payment from the client due to an overpayment of benefits, Adult Financial program shall be calculated based on the gross SSI payment, not the received amount.

2. Pension or retirement payments made by a former employer or from any insurance or other public or private fund. If a lump sum payment for the value of the pension or retirement is an option, the client shall pursue the lump sum payment.

3. Disability or survivor's benefits made by an employer or from any insurance or other public or private fund.

4. Veteran compensation and pension based on service in the armed forces. Such payments may be made by the U.S. Veterans Administration (VA), another country, a state or local government, or other organization. Any portion of a VA pension paid to a veteran for support of a dependent shall be considered countable unearned income to the dependent rather than to the veteran.

5. Railroad retirement payments, such as sick pay, annuities, pensions, and unemployment insurance benefits, which are paid by the Railroad Retirement Board (RRB) to a client who is or was a railroad worker, or to such worker's dependents or survivors.

6. Unemployment Compensation.

7. Union strike benefits.

8. Amounts withheld from unearned income because of a garnishment.

9. Workers' Compensation payments awarded under federal and state law to an injured employee. Payments for medical, legal, or related expenses incurred by the client in connection with such claim are deducted prior to determining the amount of countable unearned income.

10. Dividends and interest received on financial accounts, savings bonds, leases, etc.

11. Annuity payments. If a lump sum payment for the value of the annuity is an option, the client shall pursue the lump sum payment.

12. Inheritance.

13. Gifts and prizes.

14. Proceeds of a life insurance policy to the extent that they exceed the amount expended by the beneficiary for the purpose of the insured recipient's last illness and burial which are not covered by other benefits.

15. Proceeds of a health insurance policy or personal injury lawsuit to the extent that they exceed the amount to be expended or are required to be expended for medical care.

16. VA educational assistance (G.I. Bill) payments or other military or veterans benefits, which are conditional upon school attendance, are income to the extent that they exceed expenses necessary for school attendance.

17. Income from jointly owned property in a percentage at least equal to the percentage of ownership or, if receiving more than percentage of ownership, the actual amount received.

18. Lease bonuses (oil or mineral) received by the lessor as an inducement to lease land for exploration are income in the month received.

19. Oil or mineral royalties verified through tax documents such as the 1099 from the prior year shall be considered averagable income.

20. Income from rental property is considered as unearned income when the client is not actively managing the property on an average of at least twenty (20) hours a week. Rental income is countable to the extent it exceeds allowable expenses. Allowable expenses are maintenance, taxes, management fees, interest on mortgage, and utilities paid, and do not include the purchase of the rental property and payments on the principal of loans for the rental property.

21. Income derived from monies (or other property acquired with such monies) received pursuant to the “Civil Liberties Act of 1988” (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts), P.L. 100-383, herein incorporated by reference. This rule does not contain any later amendments or editions. Copies of these federal laws are available from the Colorado Department of Human Services, Director of the Employment and Benefits Division, 1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library.

22. Trusts.

3.520.786 Exempt Income [Eff. 3/2/14]

Earned and unearned income that is not countable to the client, in whole or in part is exempt, including:

A. Income tax refunds in the month received. Any remaining funds shall be a countable resource after twelve (12) months.

B. The value of any third-party payment for medical care paid on behalf of the client. This exemption also applies to room and board furnished during medical confinement and paid for by a third party.

C. Home energy assistance granted to the client by a private non-profit organization or home energy supplier, whether in-kind or by voucher or vendor payment.

D. Emergency or general assistance, other than home energy assistance, received on a one time basis in-cash or in-kind from the county department or other agencies.

E. Personal care or home care allowance grants paid to the client from a federal, state or local government program to purchase in-home supportive services shall be exempt as income. However, if the non-recipient spouse is the provider and receives the payment from the client for in-home services it shall be classified as employment income and is subject to deeming.

F. VA Aid and Attendance is exempt income to the client if used for medical supplies and medical or attendant care not covered by Medicare, Medicaid, or other health insurance programs. The remainder is countable and deducted from the assistance grant.

G. Educational loans and grants.

H. Work study income that exceeds the need-based grant shall be earned income in the month received.

I. Wages received by persons fifty-five (55) years of age and older under the Senior Community Service Employment Program (SCSEP) under Title V of the Older Americans Act;

J. Income and resources set aside as part of a Plan to Achieve Self Support (PASS) approved by the Social Security Administration.

K. Compensation received by the client pursuant to the Colorado Crime Victims Compensation Act; and,

L. Certain unearned income as defined in the Social Security Program Operations Manual System (POMS), Section SI 00830.099 Guide to Unearned Income Exclusions.

M. Reverse mortgage loan payments.

3.520.79 In-Kind Support and Maintenance (ISM) FOR OAP and AND-CS Only [Eff. 3/2/14]

A. For certain clients who are not paying their fair share of housing costs, an In-kind Support and Maintenance (ISM) amount shall be determined and counted as unearned income.

B. The ISM calculation does not apply to a client:

1. Residing in and owning his/her primary residence;

2. Residing in subsidized housing;

3. Who is homeless;

4. Who is paying his/her fair share of shelter when shelter costs are market value or greater, even if the fair share is less than the current ISM amount.

   a. Fair share is calculated by totaling rent and utility costs and dividing by the number of people living in the household.

   b. Market value is the amount a landlord or property manager would charge if the dwelling were rented on the open market. Rent may include heating fuel, gas, electricity, water, sewage and garbage collection; or,

5. Who is paying shelter costs in an amount equal to or greater than the current maximum ISM amount established for the shelter component, whether or not the costs are the client's fair share or market value.

C. If the client's monthly shelter costs are less than the current maximum ISM amount established for the shelter component and the client is not paying his/her fair share, the county department shall determine the ISM amount to be applied, as follows:

1. If the client's shelter costs are less than the current market value, then the amount the client is actually paying is subtracted from the current maximum ISM amount. The result is counted as in-kind unearned income to the client.

2. If the shelter costs are market value but the client is paying less than his/her fair share, then the amount the client is actually paying is subtracted from the client's fair share amount or the current maximum ISM amount, whichever is less. The result is counted as in-kind unearned income to the client.

3. If the client is paying no shelter costs, and all shelter costs are supplied in full, then the current maximum ISM amount is counted as in-kind unearned income to the client.

D. A client receiving SSI and being charged an ISM by the Social Security Administration (SSA) shall be charged a matching ISM for Adult Financial programs.

1. The client shall be instructed to work with the SSA to remove or reduce the ISM once the client is paying a fair share of his/her shelter costs.

2. Once the SSA removes or reduces the ISM, the county department shall remove or reduce the Adult Financial programs ISM.

E. If the client has an established life estate and client's shelter is being provided in full, the shelter component shall be deducted from the Adult Financial programs grant.

F. A client may purchase occupancy in a non-profit congregate home for the aged or in an individual private owner home. If all or part of the client's shelter is being provided in such an arrangement, an ISM shall be calculated.

G. If the client receives an educational grant or loan that provides for the client's shelter in full, an ISM deduction shall be applied.

H. The Adult Financial programs maximum shelter in-kind support and maintenance (ISM) shall be determined as follows:

1. The ISM includes shelter and utilities.

2. The ISM is calculated by multiplying the current SSI grant standard by 33.33%, then adding a $20.00 disregard and rounding to the nearest whole dollar.

3.530 OLD AGE PENSION (OAP) PROGRAM [Em. eff. 1/1/15; Rev. eff. 3/20/15]

The Old Age Pension (OAP) program provides financial assistance and may provide health care benefits for low-income Colorado residents who are sixty (60) years of age or older who meet basic eligibility requirements.

A. The total monthly OAP grant standard, as set by the State Board of Human Services, is $771.00, effective January 1, 2015.

B. Effective January 1, 2015, the maximum monthly In-Kind Support and Maintenance (ISM) deduction amount for shelter, including utilities, is $264.00.

3.530.1 DEFINITIONS [Eff. 3/2/14]

"OAP A" is a program for a client sixty-five (65) years of age or older.

"OAP B" is a program for a client sixty to sixty-four (60-64) years of age.

"OAP C" is a program for a client age sixty (60) or older who has been committed to the Colorado Mental Health Institute or to a Regional Center by order of the district or probate court.

3.531 DETERMINATION [Eff. 3/2/14]

A. The county department shall enter all client, resource, and income information into the statewide automated system.

1. The county department shall determine eligibility.

2. If the client is missing any verification, the county department shall request additional and/or required verifications from the client. The request shall include:

a. A specific list of verifications necessary to determine eligibility;

b. The due date for when the verifications must be returned, which shall be ten (10) calendar days from the date the verification was requested in writing; and,

c. Notification that if the client fails to return the verifications by the due date, the county department shall process the application without those verifications, which may lead to a denial of benefits.

B. The client shall be advised that a collateral contact or home visit may be used to confirm questionable evidence, to investigate potential fraud, or when documentary evidence is insufficient to make a determination of eligibility or benefit level or cannot otherwise be obtained.

1. A collateral contact is a verbal or written confirmation of a client's circumstances by a person outside of the household. The county department shall:

a. Request the name of an appropriate collateral contact from the client; or,

b. Independently determine an appropriate collateral contact; or,

c. Substitute a home visit when an appropriate collateral contact cannot be identified.

2. An application may be denied if a collateral contact refuses to provide documentation of essential verifications and the applicant is unwilling to cooperate in obtaining such information personally.

a. Authorization of the release of such information alone does not constitute cooperation if the county department requests further assistance from the applicant. Documentation of lack of cooperation must be entered in the case record.

b. However, if the applicant is willing to cooperate but unable to obtain the information, no denial or delayed action shall be taken. The county shall assist the participant in gaining the information required to make a determination of eligibility.

3. Client confidentiality shall be maintained to the greatest extent possible when using a collateral contact for verification.

C. Each verification document shall be date-stamped with the date it was received in the county department office.

D. Upon timely receipt of the required verifications, the county department shall enter verifications into the statewide automated system. When all verifications have been entered, the county department shall review the results, verify accuracy, and determine eligibility. If a client fails to return verifications, the case will be denied.

E. If a client returns the required verifications late, the county department shall enter verifications into the statewide automated system. When all verifications have been entered, the county department shall review the results, verify accuracy, determine if good cause exists, and determine eligibility. If the client does not have good cause and informs the county department that he/she is requesting benefits, the client shall be required to reapply for benefits.

F. If a client believes that the value used for income or resource calculation was incorrect, the client shall provide supporting documentation. If such documentation confirms an incorrect calculation, the county department shall correct the case.

G. The county department shall send the client a notice explaining the eligibility determination results and the client's appeal rights as outlined ins Section 3.850, et seq. (9 CCR 2503-8).

H. The client shall have the right to decide how to spend his/her OAP benefit.

I. The county department shall promptly act to make changes in food assistance eligibility and other public assistance benefits as necessary in all instances where a client or mass change in OAP eligibility or payment occurs.

3.532 GRANT DETERMINATION [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. OAP grants shall be calculated on an individual basis, with just one client per case.

B. When a client has been found eligible based upon eligibility rules as outlined in Sections 3.520.6 and 3.520.71, the amount of the client's authorized OAP benefit shall be determined by deducting the client's total countable income from the OAP grant standard.

1. If determined eligible on the first of the month, the client shall receive his/her authorized benefit in the initial and subsequent months.

2. If determined eligible on any other day of the month, the client's first month benefit shall be prorated according to the number of days remaining in the month; the client shall receive their authorized benefit in subsequent months.

3. If a client is receiving services in another Adult Financial (AF) program in the month he/she turns sixty (60) years of age and is otherwise eligible for OAP, the client shall transition from the other AF program to OAP effective the first day of the client's birth month, and receive his/her authorized benefits for the birthday month and subsequent months.

C. If found eligible, the client's eligibility date shall be determined as follows:

1. If the client returns all verifications within the forty-five (45) day processing time frame, the eligibility date shall be the application date.

2. If the client returns all verifications after the forty-five (45) day processing time frame, but within sixty (60) calendar days of the original application date, the eligibility date shall be the date the verifications were returned.

3. If the client returns all verifications after sixty (60) days from the original application date, the client shall be required to re-apply for benefits.

D. If a client is actively attempting to sell, liquidate, or legally acquire a resource or secure available income, the county department shall not delay action on an application.

1. OAP shall be continued without adjustment until the resource or income is available. The county department is urged to monitor the attempts to access the resource or income.

2. If the client refuses or fails to make a reasonable effort to secure a potential resource or income, such resource or income shall be considered as if available, and timely and adequate notice shall be given regarding a proposed action to deny, reduce, or terminate assistance.

3. If the client secures the potential resource or income prior to the effective action date identified in the notice, the proposed action to deny, reduce, or terminate assistance shall be withdrawn by the county, and the case shall be corrected. Benefits may still be denied, reduced, or discontinued due to a change in income or resources.

E. The OAP benefit shall be made directly to the client or to a legally designated person, such as a representative payee, fiduciary, or conservator.

For OAP-C clients, the financial officer of the facility or the client's guardian shall establish a reserve for the client in the amount of the current Personal Needs Allowance (PNA) grant standard for the client's personal needs.

F. The client shall be eligible only for a monthly personal needs allowance when program requirements are met and the client is a resident of a facility at least thirty (30) consecutive days, as follows:

1. In a general medical and surgical hospital.

2. In a nursing home, assisted living residence, or, intermediate care facility, group home, host home, or other long-term care facility.

3. In a psychiatric facility when sixty-five (65) years of age or older.

G. The following persons are not eligible for a personal needs allowance or OAP benefit:

1. Inmates in a penal institution; or,

2. Residents in an unlicensed private or uncertified public facility.

H. For every full calendar month that the client is a resident in an approved facility, the OAP personal needs allowance maximum shall be seventy seven dollars ($77), effective January 1, 2015.

3.533 INCOME DISREGARDS [Eff. 3/2/14]

Disregards shall not be applied if a client's total income equals or exceeds the OAP grant standard.

A. If the client's gross earnings are less than the OAP grant standard, apply the following income disregards:

1. To determine countable earned income:

a. Deduct $65 from the gross earned income; and,

b. Divide the remainder by two (2).

c. The result is the countable earned income.

2. To determine countable unearned income:

a. A client who receives SSI only, and does not receive any other unearned income, does not receive an unearned income disregard.

b. An OAP client living in an Adult Foster Care facility is not eligible to receive an unearned income disregard.

c. To determine countable unearned income of a client who does not receive SSI or who receives SSI and has other unearned income:

1) Deduct $20 from the gross unearned income;

2) The result is the countable unearned income.

3) If the client's unearned income is less than $20, the difference between the gross unearned income and the $20 deduction shall be applied to the earned income calculation if applicable.

d. Only one $20 unearned income disregard is allowed per couple and is divided equally between the two spouses.

B. Subtract the countable earned and countable unearned income from the OAP grant standard to determine the benefit amount.

3.534 DEEMING INCOME [Eff. 3/2/14]

A. To determine the amount of income to deem from a non-recipient spouse to a recipient spouse calculate the countable earned income of the non-recipient spouse as follows:

1. Deduct $65 from the non-recipient spouse's gross earned income; and,

2. Divide the remainder by two (2); and,

3. The remainder is the amount of earned income deemed to the client.

4. The deemed earned income shall be considered income to the client and shall be deducted, together with any other income, from the grant of the client.

5. Wages being garnished by the court are countable earned income.

B. To determine the amount of unearned income to deem from a non-recipient spouse to a recipient spouse, calculate the countable unearned income of the non-recipient spouse as follows:

1. Calculate the total amount of unearned income of the non-recipient spouse;

2. Deduct the OAP grant standard from the total unearned income of the non-recipient spouse;

3. Deduct an amount to meet the needs of each dependent child of the non-recipient spouse equal to half the maximum SSI grant standard less the dependent child's own income;

4. Deduct any medical care payments by the non-recipient spouse for his/her dependents who are not covered by Medicare, Medicaid, or other health programs;

5. Deduct any amount of obligation of the non-recipient spouse due to orders of judgment or for support by a court, unless there is a garnishment. Income being garnished by the court is countable as unearned income.

6. The remainder is the amount of unearned income deemed to the client.

7. The deemed unearned income shall be considered income to the client and shall be deducted, together with any other income, from the grant of the client.

C. A sponsor's income can only be deemed towards the non-citizen they sponsor. To determine the amount of earned and unearned income to deem from a sponsor(s) to a client, calculate, as follows:

1. The total earned and unearned income of the sponsor are added together.

2. The following deductions are subtracted from the total income of the sponsor:

   a. A deduction for the sponsor equal to the current SSI benefit standard for an individual for the month in which eligibility is being determined; plus

   b. A deduction for the sponsor's spouse living in the same household with the sponsor, equal to one-half the current SSI benefit standard for an individual; or a deduction for the sponsor's spouse, who is also a co-sponsor of the non-citizen, equal to the current SSI benefit standard for an individual; plus,

   c. A deduction equal to one-half the SSI benefit standard for an individual for each person who is a dependent of the sponsor (other than the non-citizen and the non-citizen's spouse).

3. The difference between the total income and the total deductions is deemed as unearned income to the non-citizen. This deemed income is added to the non-citizen's own income to determine the total countable income.

4. Compare the non-citizen's countable income to the income standard of the Adult Financial program for which the non-citizen is applying to determine eligibility and/or the benefit amount.

5. If more than one non-citizen has the same sponsor, deem all of the sponsor's income to each non-citizen. Do not divide the sponsor's income among the non-citizens.

3.540 AID TO THE NEEDY DISABLED (AND) PROGRAM [Em. eff. 1/1/15; Rev. eff. 3/20/15]

The Aid to the Needy Disabled State Only (AND-SO) program provides interim assistance to clients age eighteen (18) through fifty-nine (59) years of age (unless diagnosed with blindness, then age zero (0) through 59 years of age); who are disabled or blind but have not been approved for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). The AND-Colorado Supplement (AND-CS) program provides a supplemental payment for client's age zero (0) to 59 who are receiving SSI due to a disability or blindness, but are not receiving the full SSI grant standard.

A. The total AND-SO grant standard is $189.00, effective August 6, 2014.

B. The total AND-CS grant standard is $733.00, effective January 1, 2015.

C. The grant standards for AND-SO and AND-CS shall be adjusted as needed to remain within available appropriations. Appeals shall not be allowed for grant standard adjustments necessary to stay within available appropriations.

D. In addition to the regular monthly AND-CS grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

E. Effective January 1, 2015, the maximum ISM amount for shelter, including utilities, is $264.00.

3.540.1 DEFINITIONS [Eff. 3/2/14]

“Administrative error” means the county department incorrectly applied the disability certification, as documented on the medical certification form, and/or incorrectly applied the social factors used to determine the client's residual functional capacity.

“Aid to the Needy Disabled (AND)” includes the Aid to the Needy Disabled-State Only (AND-SO) , which include persons disabled due to blindness, and the Aid to the Needy Disabled-Colorado Supplement (AND-CS) programs.

“Blind or blindness” means central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

“Disability” means a physical or mental impairment that is disabling and combined with other factors impacting the client's residual functional capacity substantially precludes the client from engaging in a useful occupation in any employment in the community for which he/she has competence as a wage earner or through self-employment. Disability also means blindness, as defined in this Section.

“Disability determination error” means the prior determination of disability was incorrect, based on documented evidence.

“Employment which exists in the community” means there are jobs for which the client has competence located within an area where the client might reasonably be expected to commute (see definition of “reasonable commute”). It does not mean that there are actual job vacancies that the client could fill or that the client would be hired to fill a job vacancy.

"Improvement" related to the client's medical condition means that in comparison to the most recent medical certification, the physical or mental impairment(s) which prevented the client from engaging in a useful occupation has decreased to the point that the client is able to engage in a useful occupation or the client's residual functional capacity has increased to the point that the client is able to engage in a useful occupation.

"Medical provider" means a Colorado licensed physician, psychiatrist, physician's assistant, advanced practice nurse, or registered nurse. The physician may be a general practitioner or a specialist. A medical provider determining blindness shall be an ophthalmologist licensed in Colorado. A medical provider may be licensed in a bordering state when the nearest Colorado provider is more than one hour from the client's home and the provider in the bordering state is closer.

"Reasonable commute" means a commute no further than one hour one way.

"Residual functional capacity" means the client's remaining ability to perform work of any type despite some disabling limitations.

"Self-supporting" means a job or self-employment that provides wages or income in an amount greater than the AND-SO grant standard.

"Semi-skilled work" means sufficient knowledge and ability is required to complete a job. The job tasks are not so specialized as to be labeled "skilled" work, but some specialized training is required. A semi-skilled employee can work with a moderate level of supervision.

"Skilled work" means special knowledge, expertise, or ability is required to complete the job. This may be learned in higher education or in a technical school. The skill could also be learned via on-the-job or other vocational education. A skilled employee is capable of working independently and accurately.

"Unskilled work" means a job that requires little or no special training or experience and involves performing simple duties. Little or no independent judgment is required to be made by the employee and a moderate to heavy level of supervision in the job is required.

"Useful occupation" means any occupation which can be considered as self-supporting. Protected employment, such as a sheltered workshop or enclave, shall not be considered a useful occupation.

3.541 DISABILITY REQUIREMENTS [Eff. 3/2/14]

A. To meet the disability eligibility requirement for AND-CS, the client must be approved for Supplemental Security Income (SSI) due to a disability or blindness. The county department shall verify SSI eligibility through SVES and document in the statewide automated system case comments.

B. To meet the disability requirement for AND-SO, the client shall be certified by a medical professional as defined by Section 3.541.1, under one of the following categories:

    1. Disabled due to substance abuse, as outlined in Section 3.541.3; or,

    2. Totally disabled, as outlined in Section 3.541, C; or,

    3. With a medical disability that prevents the client from working in his/her usual occupation and when the disability is combined with additional functional deficits related to certain social factors, the client's residual functional capacity to work in any type of employment is severely disabling, as outlined in Section 3.541, D-G.

C. To be determined totally disabled the client shall meet the criteria below or have other disabling conditions identified by the Social Security Administration (SSA):

1. Be blind or have a physical or mental impairment that is severely disabling. These conditions are generally permanent, fully debilitating, and may be expected to result in death. These impairments include:

    a. Respiratory disorders, such as cystic fibrosis, chronic persistent lung infections, or chronic pulmonary insufficiency;

    b. Cardiovascular disorders, such as chronic heart failure despite medication, congenital heart disease, or recurrent arrhythmias not related to a reversible cause;

    c. Digestive disorders, such as liver dysfunction or gastrointestinal hemorrhage;

    d. Genitourinary disorders, such as chronic renal failure resulting in chronic hemodialysis;

    e. Hematological disorders, such as sickle-cell disease, hemophilia, or aplastic anemia;

    f. Congenital disorders, such as fragile X syndrome or phenylketonuria (PKU);

    g. Neurological disorders, such as multiple sclerosis, muscular dystrophy, head trauma, or cerebral palsy;

    h. Disorders of speech or other senses, such as blindness, tinnitus in combination with progressive hearing loss, or loss of speech;

    i. Musculoskeletal disorders, such as a gross anatomical deformity, spinal stenosis or other spinal disorder resulting in nerve root compression, or amputation of both hands;

    j. Mental or cognitive disorders, such as schizophrenia, affective disorders, personality disorders, developmental disabilities, or substance abuse to the extent that the disorder results in at least two of the following activities:

        1) Marked restriction of activities of daily living; or,

        2) Marked difficulties in maintaining social functioning; or,

        3) Marked difficulties in maintaining concentration, persistence, or pace; or,

        4) Repeated episodes of decompensation, each of extended duration.

2. Have an impairment or blindness that is expected to last twelve (12) months or more; and,

3. Must be completely unable to participate in a substantial gainful activity. Substantial gainful activity (SGA) means a level of work activity and earnings that is both substantial and gainful. The activity involves performance of significant physical or mental activities, or a combination of both. For a work activity to be considered substantial it does not need to equal full time. If impairment is anything other than blindness, earnings averaging over the current AND grant standard a month generally demonstrates a SGA. Gainful work activity is:

   a. Work performed for pay or profit; or,

   b. Work generally performed for pay or profit; or,

   c. Work intended for profit, whether or not a profit is realized.

D. The client shall be considered disabled due to a lack of residual functional capacity when the client has a medical disability that is moderately to severely disabling and when combined with additional functional deficits due to certain social factors, severely limits the client's residual functional capacity if he/she:

1. Is blind or has a physical or mental impairment that is disabling; and,

2. Has an impairment or blindness that is expected to last six (6) months or longer, as documented on the medical certification form; and,

3. Has additional functional deficits related to certain social factors that create a barrier to employment to the extent that the client is unable to work or learn skills necessary to work as a wage earner in any type of employment that exists in the community.

E. To determine if the client's residual functional capacity would preclude him/her from employment, or from learning skills necessary for employment, the county department shall document other medical data and functional strengths and deficits, as follows:

1. Review other medical records from licensed medical personnel; and,

2. Review other disability assessments performed by other disability specialists; and,

3. Review other records, documentation, and other information and/or observations related to the client's functional strengths and deficits received from or observed by the client, family, friends, other professionals, community members, or the county department; and,

4. Determine whether the client has education, training, or experience that could qualify him/her for any work in the community and whether the client has the ability to learn new skills if training is available; and,

5. Determine whether employment exists in the community within a reasonable commute of the client's home; and,

6. Determine if the client has other training opportunities available in the community, such as Vocational Rehabilitation, Workforce Center, or the Senior Community Services Employment Program (SCSEP).

F. The county department shall review all documentation collected to determine if certain social factors combined with a medical disability reasonably prevent the client from working or from learning new skills, such as:

1. The client has significant limitations in understanding, remembering, or carrying out instructions; or,

2. The client lacks the ability to use judgment, concentrate, or respond appropriately to supervisors, co-workers, or the pressures of a regular work environment; or,

3. The client has significant communication barriers; or,

4. The client's vocational experience and capabilities do not permit him/her to learn new skills.

G. The county department shall utilize the following process to score all medical and functional assessment documentation, information, and observations to determine whether the client's residual functional capacity would preclude him/her from work or from learning new skills:

1. The county department shall weigh more heavily:

   a. A medical certification form completed by the client's usual doctor than a form completed by a doctor who has had no previous history with the client, unless the doctor with no known history is a specialist in the field of medicine pertaining to the client's disability.

   b. A disability determination completed through a Medicaid disability determination process than a medical certification form completed by a medical provider.

2. The county department shall use the Residual Functional Capacity Scoring Matrix (RFCSM) to determine whether the client's residual functional capacity would preclude the client from performing any type of work or from learning new skills. The RFCSM shall only be utilized for individuals as defined in 3.541, B, 3.

   a. A client shall not be considered disabled under the AND-SO program if his/her total score is zero (0) to 13. The county department shall deny or discontinue AND-SO benefits.

   b. A client shall be considered disabled under the AND-SO program if his/her total score is 14 to 21.

   c. A client shall not be considered disabled under the AND-SO program if his/her disability, as shown on the medical certification form, is expected to last less than six (6) months, no matter the score on the Residual Functional Capacity Scoring Matrix.

   d. The county department shall use the following guidelines for scoring social factors impacting residual functional capacity:

      1) None: the client is able to adequately meet all essential components of the social factor.

      2) Mild: the client has some difficulty in meeting at least one of the essential components of the social factor. The client would require occasional or intermittent supervision in meeting components of the job-related activity. Occasional or intermittent means the client does not need assistance daily, but may need assistance a few times a week or up to two (2) times per day.

3) Moderate: the client is unable to perform two (2) or more of the essential components of the social factor even with supervision. The client requires hands-on and/or frequent assistance to accomplish the activity. Frequent means the client needs assistance at least three (3) times per day and up to hourly.

4) Severe: the client is totally unable to perform any of the essential components of the social factor and requires someone to perform the task, or the client requires constant supervision for the task.

RESIDUAL FUNCTIONAL CAPACITY SCORING MATRIX					
	Score Zero (0) Points	**Score One (1) Point**	**Score Two (2) Points**	**Score Three (3) Points**	**Points**
Age (in years)	18-30	31-49	50-54	55-59	
Education	GED, high school diploma, or higher	7th through 11th grade	6th grade or less	Illiterate	
Communication Barriers	None	Mild	Moderate	Severe or Non-English Speaking	
Previous Work History	Skilled	Semi-Skilled	Unskilled	None	
Limitations Related to the Ability to: ● **Understand,** ● **Remember,** ● **Carry Out Instructions**	None	Mild	Moderate	Severe	
Limitations related to the Ability to: ● **Use Judgment,** ● **Concentrate, or** ● **Respond Appropriately in a Work Environment**	None	Mild	Moderate	Severe	

Medical disability results as reported on medical certification form, a Medicaid disability determination, or other medical evidence obtained by the county department	Disabled less than six (6) months. The client is ineligible for AND-SO.	Disabled six (6) months or longer but able to work in some type of employment. Physical exertion limited to sedentary, light, or moderate.	Disabled six (6) months or longer but able to work in some type of employment. Physical exertion limited to light or sedentary.	Disabled twelve (12) months or longer but able to work in some type of employment. Physical exertion limited to light or sedentary.	
				TOTAL RESIDUAL FUNCTIONAL CAPACITY SCORE (maximum points possible = 21)	

3.541.1 MEDICAL CERTIFICATION FORM [Eff. 3/2/14]

A. Medical certification shall be completed on the State Department's prescribed medical report form.

1. The county department shall provide the form to the client or the medical provider at the time of application or interview and at each re-examination date. The client shall arrange for the medical exam with an appropriate medical provider of his/her choosing.

a. It is the county department's responsibility to provide the medical form to the client or the client's provider of choice within ten (10) calendar days of application.

b. If the client fails to make arrangement for or submit to the required medical examination within forty-five (45) calendar days following date of application, the client has failed to comply with the requirements for eligibility and the program will be denied or discontinued. The county department shall provide a notice of adverse action to the client.

c. If the client requests a second opinion, the subsequent medical examination shall be at the client's expense. The county department shall not be obligated to pay for more than one medical exam per client per application o r medical certification period.

d. If the county department requests a second opinion, the subsequent medical examination shall be at the county department's expense.

e. The county department shall review the medical certification form for completeness and to determine whether the information submitted is in conflict with other medical data, records, documentation, and information and/or observations received from the client, family, friends, professionals, community members, or the county department. The county department shall:

1) Ensure any incomplete forms are returned to the provider to be completed; and,

2) Consult and verify with the provider any questionable or contradictory information.

2. The medical certification shall be completed and signed by a Colorado licensed physician, psychiatrist, physician's assistant, an advanced practice nurse, or a registered nurse. The physician may be a general practitioner or a specialist. Medical certification for blindness shall be completed only by an ophthalmologist licensed in Colorado.

    a. The client shall be allowed to choose a medical provider licensed in a bordering state when the nearest Colorado provider is more than one hour from the client's home.

    b. No other health care or counseling professionals shall be allowed to complete the medical form.

3. The medical certification form shall contain the disability limitations, including the length and scope of the disability, if any; and,

4. The medical re-examination date shall be based upon the date of the initial exam and the length of the disability, as documented by the medical provider, but shall not exceed twelve (12) months. However, if the client has been determined disabled by the State disability review contractor, the medical re-examination date shall be established by the review contractor.

B. The county department shall authorize payment for examinations for AND-SO medical certification examinations.

1. Fees and costs shall be reimbursed to the county department using the 80% state share, 20% county share reimbursement methodology.

2. The county department shall set the provider fee and shall make such payments in a timely manner.

3. Providers shall accept fees for services as negotiated as payment in full. No client shall be assessed any additional or supplementary fee.

4. Providers may be excluded from completing medical certification examinations if there is adequate documentation that the provider:

    a. Is not completing a thorough examination on which to base his/her decision; or,

    b. Falsified a medical certification form.

C. A determination of medical eligibility shall be completed by each medical re-examination date. The county department shall be allowed to request the client submit a medical re-examination at the time of financial redetermination or when the county has information that the client's medical condition may have changed.

1. At the time of medical re-examination the county department shall obtain a release of information from the client and send the prior medical certification forms to the client or the medical provider.

2. The provider shall be required to indicate on the form whether there has been any improvement in the client's medical condition since the last medical certification.

3. If the client fails to make arrangement for or submit the required medical re-examination within ten (10) calendar days of the request, the county department shall terminate assistance and provide notice of adverse action to the client.

3.541.2 DENIAL AND DISCONTINUATION RELATED TO DISABILITY [Eff. 3/2/14]

A. The county department shall deny or discontinue AND assistance when:

1. There was an administrative or disability determination error in the prior disability determination. The county department shall gather more information on the discrepancies before taking a negative action on the case.; or,

2. There has been improvement in the client's medical condition and the client is no longer disabled, as outlined in Section 3.541. Improvement may be demonstrated by:

    a. Observations, symptoms, or other findings which demonstrate positive changes in the client's medical condition; or,

    b. Observations, symptoms, or other findings which demonstrate that the effect of the medical impairment(s) on the client has decreased.

    c. New medical evidence which shows that while the client's underlying condition may not have changed, advances in medical therapy or technology have reduced or eliminated the adverse effect of the condition on the client; or,

    d. New or improved diagnostic techniques or other medical evaluations show that the client's previously determined medical condition is not as serious as previously indicated; or,

    e. There has been a change in prognosis; or,

    f. The client has compensated or adjusted to the medical condition which now enables the client to engage in a useful occupation; or,

    g. The client's medical condition is correctable and the client refuses, without good cause, to obtain prescribed medical treatment to correct the condition. Good cause may include, but is not limited to:

        1) Treatment is contrary to the established teachings of the client's religion, provided the client can establish he observes his/her religion; or,

        2) Surgery has previously been performed with unsuccessful results and the same surgery is again being recommended for the same impairment; or,

        3) The treatment because of its magnitude (e.g., open heart surgery or organ transplant that has less than a 50% chance of improving the client's condition) or unusual nature (e.g., experimental procedures) is very risky; or,

        4) The cost of treatment is prohibitive or cannot be obtained; or,

3. There has been improvement in the client's residual functional capacity and the client is not disabled, as outlined in Section 3.541. Improvement may be demonstrated by:

    a. Observations, symptoms, or other findings which demonstrate positive changes in the client's residual functional capacity; or,

b. Observations, symptoms, or other findings which demonstrate that the effect of the social factors impacting residual functional capacity on the client has decreased; or,

c. New evidence shows that while the client's underlying condition may not have changed, the client's vocational abilities and/or residual functional capacity has so improved that the client is able to engage in a useful occupation; or,

d. Vocational opportunities for which the client has competence have become available in the community; or,

e. The client has compensated or adjusted to the social factors impacting residual functional capacity and the client is able to engage in a useful occupation; or,

f. Residual functional capacity is not a barrier to employment in some type of employment that exists in the community.

B. If the county department has documented evidence that a client is working more than five (5) hours per week as an employee, engaged in self-employment with earnings exceeding the grant standard, or donating services or work hours without pay as defined in Section 3.520.784, the county department shall deny or discontinue the client from benefits.

3.541.3 DISABILITY DUE TO SUBSTANCE ABUSE [Eff. 3/2/14]

For the purpose of AND-SO, when the client's primary diagnosis is alcoholism or controlled substance addiction, the following criteria shall apply:

A. The client shall only be eligible for twelve (12) cumulative months in a lifetime when substance abuse is identified on the medical certification form.

B. The client shall agree to treatment for addiction to be eligible for AND-SO. Upon consent, the county department shall refer the client to a designated assessment/treatment agency of the CDHS Office of Behavioral Health.

C. The client shall agree to a defined treatment program by the designated agency.

D. If the client fails to comply with treatment, the following steps shall be followed:

1. The treatment center shall contact the county department within twenty-four (24) hours of the client's termination from treatment; and,

2. The county department shall discontinue the client's State AND-SO assistance immediately upon termination from treatment.

E. The client shall submit to random testing to ensure the client remains free of alcohol/controlled substance(s).

F. Any time a client tests positive for alcohol or controlled substance(s), the client shall be warned by the treatment center in writing. Written warnings shall have a copy placed in the client's file and noted as either mailed or hand delivered. If a client tests positive for alcohol or controlled substance(s) twice in any three-month period, the county department shall be notified and the client shall be terminated from AND-SO using the five (5) day notice for non-compliance.

G. The initial partial month is not counted toward the twelve-month maximum allowed. However, if a client is discontinued and subsequently reapplies and is approved, partial months after re-approval will count as a full month toward the twelve-month maximum allowed.

3.542 DETERMINATION [Rev. eff. 6/1/15]

A. The county department shall enter all client, resource, and income information into the statewide automated system.

1. The county department shall determine eligibility.

2. If the client is missing any verification, the statewide automated system or the county department shall send a check list of required verifications to the client. The verification check list shall include:

a. A specific list of verifications necessary to determine eligibility;

b. The due date for when the verifications must be returned, which shall be ten (10) calendar days from the date of the verification checklist; and,

c. Notification that if the client fails to return the verifications by the due date, the county department shall process the application without those verifications, which may lead to a denial of benefits.

B. The client shall be advised that a collateral contact or home visit may be used to confirm questionable evidence, to investigate potential fraud, or when documentary evidence is insufficient to make a determination of eligibility or benefit level or cannot otherwise be obtained.

1. A collateral contact is a verbal or written confirmation of a client's circumstances by a person outside of the household. The county department shall:

a. Request the name of an appropriate collateral contact from the client; or,

b. Independently determine an appropriate collateral contact; or,

c. Substitute a home visit when an appropriate collateral contact cannot be identified.

2. An application may be denied if a collateral contact refuses to provide documentation of essential verifications and the applicant is unwilling to cooperate in obtaining such information personally.

a. Authorization of the release of such information alone does not constitute cooperation if the county department requests further assistance from the applicant. Documentation of lack of cooperation must be entered in the case record.

b. However, if the applicant is willing to cooperate but unable to obtain the information, no denial or delayed action shall be taken. The county shall assist the participant in gaining the information required to make a determination of eligibility.

3. Client confidentiality shall be maintained to the greatest extent possible when using a collateral contact for verification.

C. Each verification document shall be date-stamped with the date it was received in the county department office.

D. Upon timely receipt of the required verifications, the county department shall enter verifications into the statewide automated system. When all verifications have been entered, the county department shall review the results, verify accuracy, and determine eligibility. If a client fails to return verifications, the case will be denied.

E. If a client returns the required verifications late, the county department shall enter verifications into the statewide automated system. When all verifications have been entered, the county department shall review the results, verify accuracy, determine if good cause exists, and determine eligibility. If the client does not have good cause and informs the county department that he/she is requesting benefits, the client shall be required to reapply for benefits.

F. If a client believes that an income or resource has been attributed incorrectly, the client shall provide documentation that the value used for the computation was incorrect. If such documentation confirms an incorrect computation has been made, the county department shall correct the case.

G. The county department shall send the client a notice explaining the eligibility determination results and the client's appeal rights as outlined in Section 3.850, et seq. (9 CCR 2503-8).

H. The client shall have the right to decide how to spend his/her AND benefit.

I. The county department shall promptly act to make changes in food assistance eligibility and other public assistance benefits as necessary in all instances where a client or mass change in AND eligibility or payment occurs.

J. Eligibility shall begin with the date of application or the date the client meets all eligibility requirements, whichever is later. In the case of AND-SO, if the client is delayed in completing the paperwork and appointment process for SSI and/or the medical exam through no fault of their own or if he/she is working with a Disability Benefits Guide, the date of application shall be used as the date of eligibility.

K. If a client is terminated from SSI, the client shall lose eligibility for the AND-CS program. The client may apply for AND-SO.

3.543 GRANT DETERMINATION [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. AND grants shall be calculated on an individual basis with just one client per case.

B. When a client has been found eligible based upon eligibility rules as outlined in Sections 3.520.6 and 3.520.71, 3.520.72, and 3.520.73, the amount of the client's authorized AND benefit shall be determined by deducting the client's total countable income from the AND grant standard.

   1. If determined eligible on the first of the month, the client shall receive his/her authorized benefit in the initial and subsequent months.

   2. If determined eligible on any other day of the month, the client's first month benefit shall be prorated according to the number of days remaining in the month; the client shall receive their authorized benefit in subsequent months.

C. If found eligible, the client's eligibility date shall be determined as follows:

1. If the client returns all verifications within the sixty (60) day processing time frame, the eligibility date shall be the application date.

2. If the client returns all verifications after the sixty (60) day processing time frame, but within 90 days of the original application date, the eligibility date shall be the date the verifications were returned.

3. If the client returns all verifications after ninety (90) days from the original application date, the client shall be required to re-apply for benefits.

D. If a client is actively attempting to sell, liquidate, or legally acquire a resource or secure available income, the county department shall not delay action on an application.

1. AND shall be continued without adjustment until the resource or income is available. The county department is urged to monitor the attempts to access the resource or income.

2. If the client refuses or fails to make a reasonable effort to secure a potential resource or income, such resource or income shall be considered as if available, unless the client can show good cause. Timely and adequate notice shall be given regarding a proposed action to deny, reduce, or terminate assistance.

3. If upon receipt of the prior notice, the client secures the potential resource or income prior to the effective action date, the proposed action to deny, reduce, or terminate assistance shall be withdrawn, and the case shall be corrected. Benefits may still be denied, reduced, or discontinued due to a change in income or resources.

E. Except as specified below, the AND benefit shall be made directly to the client.

F. When the client lives in a facility or has a payee, legal fiduciary, or authorized representative, the payment shall be made to the payee, fiduciary, authorized representative, or facility on behalf of the client.

G. The client shall be eligible only for a monthly personal needs allowance when program requirements are met and the client is a resident of a facility at least thirty (30) consecutive days, as follows:

1. In a general medical and surgical hospital;

2. In a nursing home, assisted living residence, or, intermediate care facility, group home, host home, or other long-term care facility.

H. The following persons are not eligible for a personal needs allowance or AND benefit:

1. Inmates in a penal institution; or,

2. Residents in an unlicensed private or uncertified public facility.

I. For every full calendar month that the client is a resident in an approved facility, the AND personal needs allowance maximum shall be seventy seven dollars ($77) effective January 1, 2015.

J. If the Social Security Administration (SSA) is recovering any portion of the client's SSI payment due to an overpayment of benefits, AND-CS shall be calculated based on the gross SSI payment and not the received amount.

3.544 AND-SO INCOME DISREGARDS AND DEEMED INCOME [Eff. 3/2/14]

A. The earned and unearned income for an AND-SO client shall be counted dollar for dollar, with no disregards.

B. A portion of the earned income of the AND-SO client's spouse shall be deemed to the client, as follows:

1. Determine the spouse's monthly gross earnings.

2. Deduct $20.00.

3. From the remainder, deduct fifty percent (50%) but no more than $30.00.

4. From the remainder, subtract federal and state income tax, Medicare withholdings, and Social Security withholdings.

5. From the remainder, deduct $30.00 or the actual documented expenses of employment as allowed under Internal Revenue Services (IRS) deductions, whichever is greater.

6. The remainder is the amount of income deemed to the client.

C. A portion of the unearned income of the AND-SO client's spouse shall be deemed to the client, as follows:

1. Determine the spouse's unearned monthly gross income.

2. Deduct $20.00.

3. The remainder is deemed to the client.

3.545 AND-CS INCOME DISREGARDS AND DEEMED INCOME [Eff. 3/2/14]

A. A portion of the earned income of an AND-CS client's spouse shall be deemed to the client, as follows:

1. Determine the spouse's monthly gross income.

2. Deduct $65.00.

3. Divide the remainder in half.

4. The result is the amount deemed to the client.

B. A portion of the unearned income for an AND-CS client who receives SSI and other unearned income shall be disregarded and shall not be countable income, as follows:

1. Determine the client's unearned income from all sources except SSI.

2. Deduct $20.00. If the client is married, the $20.00 disregard shall be split between the client and the spouse so that no more than a $20.00 disregard is applied.

3. The remainder is countable unearned income.

4. If the client's unearned income is less than $20, the difference between the gross unearned income and the $20 deduction shall be applied to the earned income calculation, if applicable.

C. A portion of the unearned income for AND-CS client's spouse shall be deemed to the client, as follows:

1. Determine the spouse's monthly gross unearned income.

2. Deduct any remaining unearned income disregard remaining from the client or $20.00, whichever is less. A couple shall be allowed a combined $20.00 disregard, which is split between the client and the spouse.

3. The remainder is countable unearned income and is deemed to the client.

D. An AND-CS client who does not receive another source of unearned income other than SSI such as an Adult Foster Care allowance does not receive the $20.00 unearned income disregard.

E. When the AND-CS client is an unemancipated child under eighteen (18) years of age, the earned and unearned income of the child and the child's parents shall be subject to disregards and deeming, as outlined above. The parents' income shall be deemed using the same calculations as a spouse.

F. If a spouse or parent is receiving assistance under another category of public assistance, SSI benefits, or medical assistance, the income from those benefits shall not be considered as available to the client.

G. A sponsor's income can only be deemed towards the non-citizen they sponsor. To determine the amount of earned and unearned income to deem from a sponsor(s) to a client, calculate, as follows:

1. The total earned and unearned income of the sponsor are added together.

2. The following deductions are subtracted from the total income of the sponsor:

a. A deduction for the sponsor equal to the current SSI benefit standard for an individual for the month in which eligibility is being determined; plus

b. A deduction for the sponsor's spouse living in the same household with the sponsor, equal to one-half the current SSI benefit standard for an individual; or a deduction for the sponsor's spouse, who is also a co-sponsor of the non-citizen, equal to the current SSI benefit standard for an individual; plus

c. A deduction equal to one-half the SSI benefit standard for an individual for each person who is a dependent of the sponsor (other than the non-citizen and the non-citizen's spouse).

3. The difference between the total income and the total deductions is deemed as unearned income to the non-citizen. This deemed income is added to the non-citizen's own income to determine the total countable income.

4. Compare the non-citizen's countable income to the income standard of the Adult Financial program for which the non-citizen is applying to determine eligibility and/or the benefit amount.

5. If more than one non-citizen has the same sponsor, deem all of the sponsor's income to each non-citizen. Do not divide the sponsor's income among the non-citizens.

H. The county department shall determine all countable earned and unearned income available from the client, the spouse, and the sponsor(s). The total shall be deducted from the AND grant to determine the client's benefit amount.

3.546 INTERIM ASSISTANCE REIMBURSEMENT (IAR) [Eff. 3/2/14]

A. AND-SO payments made while an SSI claim is pending, in suspense, terminated, or in appeal shall be classified as interim assistance. At the time of application, the SSI payment procedure shall be explained to the client.

1. All AND-SO payments made to the client are recoverable upon approval for SSI benefits.

2. As a condition of eligibility for AND-SO the client shall be required to sign the “Authorization for Reimbursement of Interim Assistance” (IM-14) annually allowing recovery of the funds from the first retroactive SSI payment.

3. The client shall be required to give signed authorization for recovery directly from the client in the event that the first retroactive SSI payment is sent to the client rather than to the county department.

4. The authorization shall be effective for a maximum of one (1) year from the date it was signed by the client. The county department shall ensure that a new “Authorization for Reimbursement of Interim Assistance” (IM-14) is signed prior to the expiration of the previous IM-14 form.

B. Within ten (10) working days of receipt of the initial SSI retroactive payment, the county department shall complete and send to the client the apportionment notice to include the amount of the interim assistance payments made, by month, for all counties that provided AND-SO payments to the client.

C. The accounting of payments made shall be entered in the federal SSA eIAR data system. SSA shall process the information and make a payment to the county department. SSA distributes the remainder, if any, to the client. Recoveries directly from a retroactive SSI payment can only be made from the first such payment.

D. When the SSI payment is received by the client, the county department shall consider the payment as income in the month received.

E. In the event that a client receives the initial retroactive SSI payment directly, the county department shall establish a recovery from the client.

1. The county department may agree to recover interim payments by periodic payments or through a lump sum recovery.

2. Any such recovery(ies) made shall be coded as Interim Assistance Reimbursement (IAR) Recovery(ies).

3. Any amount recovered in the same month as the month in which the retroactive payment was received shall not be counted as income.

F. The county department shall not pay any portion of its share of the federal SSI lump sum payment to the client or to any third party for legal, professional, or other fees incurred by the client in securing SSI benefits. All of the IAR payment shall be used to reimburse the AND-SO program for benefits paid to the client as interim assistance in accordance with the agreement between the Colorado Department of Human Services and the Social Security Administration. The client is not required to obtain legal or other third party representation in order to apply for and/or obtain SSI benefits, and the client is solely responsible for any fees incurred in this process.

G. If an SSI client's SSI payment is suspended or terminated, the client may apply for AND-SO and complete the “Authorization for Reimbursement of Interim Assistance” (IM-14).

H. The county department that filed the original “Authorization for Reimbursement of Interim Assistance” (IM-14) for an AND-SO client shall be the County of Record. The County of Record acting as an agent of the state shall:

1. Collect and apportion all AND-SO payments for all county departments that may have provided AND-SO benefits; and,

2. Account for all AND-SO payments to the Social Security Administration (SSA) timely; and,

3. Make an accounting in the statewide automated system for any reimbursement received. Non-system determined claims (NSDC) shall not be entered for IARs without State Department approval.

3.550 FINANCIAL REDETERMINATION [Eff. 3/2/14]

A. A redetermination of eligibility shall mean a case review/determination of necessary information and verifications to determine ongoing eligibility every twelve (12) to twenty-four (24) months for OAP and every twelve (12) months for AND. The eligibility period for OAP shall be determined by the statewide automated system based on the following factors:

1. OAP cases shall be redetermined, at a minimum, every twenty-four (24) months when:

a. There is no earned income; and,

b. The value of the client's countable resources are at least two hundred dollars ($200) under the client's resource limit, as defined in Section 3.520.72, A.

2. All other OAP cases shall be redetermined every twelve (12) months, at a minimum.

B. Clients shall file their redetermination with the county by the fifteenth (15th) of the month as specified in the redetermination packet.

1. A client's failure to file a RRR timely may delay the determination of benefits.

2. Complete forms received timely must be acted upon by the county department by the last day of the month.

3. Complete forms received between the 16th and the last day of the month the redetermination is due must be approved or denied as soon as possible but no later than the tenth (10th) calendar day in the following month.

C. The county department shall schedule an interview with the client at each redetermination.

1. The interview shall be an in-person interview if the county department has not had an in-person interview with the client within three (3) years of the RRR due date.

    a. Exception to this rule is allowed if there is good cause, as outlined in Section 3.520.4, C; or,

    b. If the client resides in a long-term care facility and the county department is able to verify information through the facility administration; or,

    c. Has regular monitoring (to include face-to-face visits) by a Single Entry Point case manager.

2. The interview may be a phone interview if the county department has had an in-person interview with the client within the past three years.

3. When a redetermination interview is scheduled, the client shall be notified at least ten (10) calendar days in advance, in writing, of:

    a. The date and time for the interview;

    b. Any documentation that may be needed including, but not limited to:

        1) Non-financial eligibility requirements, as outlined in Section 3.520.6; and,

        2) Resources, as outlined in Section 3.520.72; and,

        3) Income, as outlined in Section 3.520.78.

    c. The opportunity to reschedule the appointment or make other arrangements in the event of good cause.

4. When the client does not keep the appointment and does not request an alternate time or arrangement, benefits will be discontinued.

D. To redetermine eligibility a case review must be conducted and necessary verification must be received to determine ongoing eligibility.

1. If the client is approved and is receiving SSI benefits and has no other earned or unearned income, the income and resources received through the federal State Data Exchange (SDX) interface shall be considered verified upon receipt.

    a. The county department shall verify non-financial eligibility; and,

    b. If the county department has obtained or received information related to income, resources, or non-financial eligibility requirements that is contrary to the SDX interface, the county department shall independently verify the information; and,

    c. The county department shall forward such contrary information to the local Social Security Administration office.

2. During the redetermination process, the county worker shall:

    a. Conduct an interview;

b. Explain the purpose of the interview and the use of the information supplied by the client on the redetermination form and any additional required forms;

c. Inform the client in writing that Social Security Numbers will be used to request and exchange information with other agencies as part of the eligibility process, including the Department of Labor and Employment (state wage and unemployment data), Social Security Administration, and Internal Revenue Service;

d. Have the client complete the forms or complete the form on behalf of the client;

e. Explain the appeal rights to the client as outlined in Section 3.850, et seq. (9 CCR 2503-8);

f. Witness the signature of the client and sign as a person who helped complete the forms, when applicable;

g. Review documents, verifications, and any other information supplied by the client with the client in order to obtain clarification if needed.

h. Request updated verifications for all income, resources, and non-financial eligibility requirements, to include, but not limited to:

1) Newly declared, such as a new vehicle;

2) Previously declared, such as a change in marital status;

3) Changes from the previous RRR, such as closure of a bank account; and,

4) Changes in value, such as an increase in the cash surrender value of life insurance policies.

E. Any time while receiving Adult Financial program benefits, if there is questionable information regarding the circumstances of a household, the county worker can request a redetermination. The county department shall generate an intermittent redetermination when:

1. It receives information that would contradict eligibility or that is questionable; or,

2. It suspects possible fraud; or,

3. It receives direction to do so from the State Department; or,

4. Otherwise reasonable under the prudent person principle.

F. Forms that the client is required to complete shall be mailed to the client at least thirty (30) calendar days prior to the first of the month in which the eligibility redetermination is due. This is considered the prior notice period. A review of the case record will indicate the forms required based on individual case circumstances. The following procedures relate to mail-out redeterminations:

1. A redetermination form shall be mailed to the client;

2. Forms shall be completed, signed by the client, and returned to the county department no later than redetermination due date; and,

3. When the client is unable to complete the forms due to physical, mental, or emotional disabilities, and has no one to help, the county department shall assist the client to complete the forms, unless there is another available legal or other resource that is willing and able to assist the client.

4. When the client is unable to complete the redetermination packet in a timely manner due to good cause, the county department shall extend the due date up to thirty (30) calendar days. The assistance or referral action of the county department shall be recorded in the case record.

G. When the county department receives the completed RRR packet, it shall:

1. Date stamp the redetermination forms and corresponding verification.

2. Thoroughly review the RRR packet for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility and payment.

   a. If the client failed to sign the RRR, the RRR packet shall be returned to the client for signature with instructions to return the signed packet before the end of the client's eligibility period.

   b. If the RRR is incomplete, the county department shall ask for all necessary verification.

3. Review the RRR packet for changes to:

   a. Non-financial eligibility requirements, as outlined in Section 3.520.6; and,

   b. Resources, as outlined in Section 3.520.72; and,

   c. Income, as outlined in Section 3.520.78.

4. Document verifications in the case file. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

   a. Due to incomplete forms or lack of verification, a notice shall be mailed to the client. The notice shall specify the items that are required for a redetermination to be completed in order to determine eligibility and/or payment;

   b. Due to inaccurate or inconsistent data, the client may be contacted by telephone or be requested to make an office visit, to secure the proper information.

   c. Complete forms must be acted upon promptly by the county.

H. If the redetermination form is received by the first filing deadline, but it is incomplete, a correction notice shall be sent to the client advising the client that the redetermination form is incomplete and must be corrected by the correction deadline to avoid termination and/or the county department shall work with the client to complete the form.

I. When the information provided on the redetermination form, or otherwise provided by the client, is the basis for reduction in the amount of assistance or in termination of assistance, such actions shall be taken after adequate notice is given.

3.551 LATE REDETERMINATIONS [Eff. 3/2/14]

When a client fails to return his/her redetermination packet prior to the last day of the month of the expiring eligibility period, the client's case shall be discontinued.

A. If the client returns the redetermination packet within thirty (30) calendar days after discontinuation, the following processing requirements shall be implemented:

1. If the client has good cause, the client's benefits shall be reinstated. There shall be no break in the client's benefit.

2. If the client does not have good cause, the county department shall use the redetermination packet as a new application. The date of the new application shall be the date the county department received the redetermination packet. There shall be a break in the client's benefit.

B. If the client returns the redetermination packet thirty-one (31) or more days after the discontinuation, the county department shall require the client to complete a new application. This will result in a break in the client's benefit.

3.560 CASE TRANSFERS [Eff. 3/2/14]

A. If the client's eligibility has been discontinued and he/she reports a change of address after the discontinuation, the client shall be required to complete a new application for benefits in the new county department of residence. This will result in a break in the client's benefits.

B. If the client notifies a county department of a change in address while the client's case is approved, the following steps shall be completed:

1. The case transfer shall be completed within three (3) working days if no additional verification is needed.

2. Prior to transferring an ongoing case to the new county department, the originating county department shall update the case to address any unresolved IEVS, discrepancies, claims, and any unworked case changes.

3. The new county department may choose to pull a case from the originating county department.

   a. If the new county department chooses to pull the case, it is responsible for addressing any unresolved IEVS, notifying the originating county department that the case has been transferred, and requesting from the originating county department any unworked changes so the new county department can process the changes.

   b. The originating county department shall be responsible for researching and documenting any discrepancies and claims.

C. If the client notifies the county department of a change of address during his/her RRR certification period, the following apply:

1. The county department receiving the change of address notice shall:

   a. Notify the client of the RRR due date and the affected benefit month; and,

b. Determine whether the client has received the RRR packet.

1) If yes, the client shall be instructed to complete and return the RRR packet to the new county department.

2) If no, the new county department shall mail an RRR packet to the client's new address, ask the client to come to the office to complete an RRR, or ask the client to complete the RRR through the online application process.

2. If a client submits their RRR packet to the originating county department prior to the end of the eligibility period and subsequently submits a new application in the client's new county department of residence before the RRR is processed, the date of the RRR shall be the date of application. The new county department may process the RRR at the same time the new application is processed.

3. When the client's RRR packet has been mailed and then the client reports a change in address, the following shall apply:

a. If the client reports the change of address and returns the RRR packet to the originating county department, the originating county department shall process the RRR and then transfer the case to the new county department.

b. If the client reports the change of address to the new county department prior to returning his/her RRR packet to the originating county department, the originating county department shall instruct the client to return their RRR to the new county department for processing.

c. If the client reports the change of address to the new county department after returning his/her RRR packet to the original county department, the RRR shall be processed by the original county department and then transferred to the new county department.

4. When the client's RRR packet has not been mailed and the client reports the change in address during the recertification timeframe, the county department receiving the change of address shall:

a. Update the client's address in the statewide automated system to ensure the RRR is mailed to the client's new address when it is generated by the statewide automated system;

b. Inform the client that his/her case shall be transferred to the new county department; and,

c. Provide the client with the name and address of the new county department office; and,

d. The originating county department shall transfer the case.

D. For AND-SO cases, if the medical certification form is expiring within thirty (30) calendar days of the reported change of address, the originating county department is strongly encouraged to send the medical certification form to the client immediately.

1. If the form is returned to the originating county department, the originating county department shall process the medical RRR.

2. If the form is returned to the new county department, the new county department shall process the medical RRR.

3. If the form was not provided to the client at the time of the reported change of address, the new county department shall provide the client with the form and process the medical RRR.

3.570 HOME CARE ALLOWANCE, SPECIAL POPULATIONS HOME CARE ALLOWANCE, ADULT FOSTER CARE, AND BURIAL

3.570.1 HOME CARE ALLOWANCE [Eff. 3/2/14]

3.570.11 Purpose of Program [Eff. 3/2/14]

A. Home Care Allowance (HCA) is a special cash payment made to a client for the purpose of securing in-home, personal care services.

1. HCA is a non-entitlement program; and,

2. Cannot be received while receiving Home and Community Based Services or Adult Foster Care; and,

3. HCA is designed to serve clients with the lowest functional abilities and the greatest need for paid care.

B. Effective January 1, 2014, the HCA grant standard maximums are as follows:

1. Tier 1 - $200.00

2. Tier 2 - $342.00

3. Tier 3 - $475.00

C. The tier grant standard maximums shall be lower for certain clients who have income greater than program limits, as defined in Section 3.570.13, B, or for clients with special circumstances, as defined in Section 3.570.13, D.

D. The HCA grant is not taxable income to the client. The payment made to the care provider using the HCA grant received by the client is income to the care provider and subject to taxation under State and Federal laws.

E. The HCA grant standards shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

F. In addition to the regular monthly HCA grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

3.570.12 Definitions [Eff. 3/2/14]

“Activities of daily living” means physical transfers, bladder care, bowel care, mobility, dressing, bathing, hygiene, and eating.

“Authorized representative” means an individual designated by the client, or by the parent or guardian of the client, if appropriate, to assist in acquiring or utilizing Home Care Allowance (HCA). The extent of the authorized representative's involvement shall be determined upon designation.

“BUS” means the Benefits Utilization System, the data system used to document case management activities for Home Care Allowance (HCA) clients.

“Care planning” means identifying client goals and choices for the care needed, services needed, appropriate service providers, and knowledge of the client and of community resources. The care plan shall be documented on the State Department prescribed care plan tool.

“Case management” means the assessment of a client's long-term care needs, development and implementation of a care plan, coordination and monitoring of the long-term care service delivery, evaluation of service effectiveness, and periodic reassessment of client needs.

“Client” means a current or past applicant or a current or past recipient of benefits under the HCA program.

“County department” means the county department of human/social services.

“Functional assessment” means the comprehensive evaluation of the client's ability to manage his/her activities of daily living and to determine the level of assistance the client requires to complete his/her activities of daily living.

“Home” means a non-facility residence.

“Intake/screening/referral” means the initial contact with clients by the Single Entry Point (SEP) and shall include, but not be limited to, a preliminary screening of: the client's need for long term care services, the client's need for referral to other programs or services, eligibility for financial and program assistance, and the need for a comprehensive assessment.

“Medical leave” means the absence of the client from their home for more than twenty-four (24) hours due to admittance to a hospital or other facility, upon physician's order with the presumption on the part of the physician that the client will be returning to their home. Medical leave may be planned or unplanned.

“Non-medical leave” means the absence of the client from their home for more than twenty-four (24) hours for non-medical reasons that are not part of a client's care plan. Non-medical leave may be planned or unplanned.

“Ongoing case management” means the evaluation of the effectiveness and appropriateness of services, on an ongoing basis, through contacts with the client, appropriate collaterals, and service providers.

“Reassessment” means a comprehensive re-evaluation by the case manager with the client and appropriate collaterals (such as family members, friends and/or caregivers) to determine the client's level of functioning, service needs, available resources, potential funding resources, and necessity for paid care. The reassessment of functional need shall be documented on the State Department prescribed assessment tool.

“Single Entry Point (“SEP”) agency” means the agency selected by the Colorado Department of Health Care Policy and Financing to provide case management functions for persons in need of long term care services within specific demographic areas, pursuant to Section 25.5-6-106, C.R.S.

"Skilled personal care" means some exceptions to personal care for activities of daily living that, because of the severe or complex nature of the client's need, requires a person with specialized training and skill to complete the task. Skilled personal care is not a paid service of the Home Care Allowance (HCA) program. See Section 8.489.30 (10 CCR 2505-10) of the Colorado Department of Health Care Policy and Financing's rules for the definitions of personal care and the skilled exceptions to personal care.

"State Department" means the Colorado Department of Human Services.

3.570.13 Eligibility [Eff. 3/2/14]

A. Eligibility for HCA shall be based on both financial need and the client's functional needs. The client shall meet eligibility for both financial and functional requirements to be approved for an HCA payment.

B. To be financially eligible, the client shall:

1. Be approved for Supplemental Security Income (SSI) benefits and be receiving at least one dollar ($1) SSI payment; or,

2. Meet all eligibility criteria required for Aid to the Needy Disabled – State Only (AND-SO) program; or,

3. Have been receiving both Old Age Pension (OAP) benefits and HCA as of December 31, 2013 and remain continuously eligible for both benefits.

C. To be functionally eligible, the client shall have an HCA eligible functional assessment score. The functional assessment score is calculated by determining the client's functional capacity score and need for paid care score, as follows:

1. Functional Capacity: determined by assessing the client's ability to complete all activities of daily living (ADLs) and applying a score to his/her ability to complete the ADLs using the functional impairment scale; and,

2. Need for Paid Care: determined by identifying the unmet need for paid care and applying a score to the unmet need using the need for paid care scale, as outlined in Section 3.570.14; and,

3. Combining the functional capacity score and the need for paid care score to determine whether the client meets the minimum scores for eligibility and, if eligible, the tier of benefits to be approved, as follows:

TIER	CAPACITY SCORE	NEED FOR PAID CARE SCORE
1	21 or Higher	1 to 23
2	21 or Higher	24 to 37
3	21 or Higher	38 to 51

D. The SEP shall not approve the maximum authorized HCA amount for the tier if:

1. The client's needs can be fully or partially met through other paid or unpaid sources (excluding family and friends); or,

2. The HCA provider is able to provide the authorized services for less than the maximum authorized amount; or,

3. The client is unwilling or unable to use the maximum authorized amount.

E. Each client who meets the minimum functional assessment scoring requirements for the HCA program shall be functionally eligible for an HCA grant.

1. The authorization by the SEP shall be forwarded to the county department to determine financial eligibility.

2. Clients shall not be approved for HCA if financially ineligible, even if the client is functionally eligible.

3. Clients shall not be approved for HCA if functionally ineligible, even if the client is financially eligible.

F. If financially and functionally eligible for HCA, payment of the HCA authorized grant shall begin on the first day of the month following the month in which the HCA is approved. There shall be no retroactive HCA payments.

3.570.14 Functional Assessment Scoring [Eff. 3/2/14]

A. The need for skilled personal care shall not be included in the scoring of the need for paid care.

B. In order to be eligible for the Home Care Allowance program, each client shall score a minimum of twenty one (21) points when assessed for the ability to complete the activities of daily living (ADLs) using the following functional impairment scale:

1. Independent: score zero (0) if the client is physically able to perform all essential components of the ADL, with or without an assistive device.

2. Low: score one (1) if the client is able to perform all essential components of the function, but impairment of function exists even with an assistive device. The client requires occasional or intermittent supervision or physical assistance in a limited number of the components of the activity.

   a. Occasional or intermittent means the client does not need assistance daily, but may need assistance a few times a month or up to two (2) times per week.

   b. Supervision or assistance means verbal prompting, cueing, and reminders, and means stand-by assistance or monitoring to help the client if he/she needs physical assistance up to two (2) times per week.

3. Moderate: score two (2) if the client is unable to perform the majority of the essential components of the function even with an assistive device, and the client requires hands-on and frequent assistance to accomplish the activity.

   a. Frequent means the client needs assistance at least three (3) times per week and up to daily.

   b. Hands-on assistance means the care provider must physically assist the client in completing the task.

4. Severe: score three (3) if the client is totally unable to perform the function and requires someone to perform the task, or the client requires constant supervision for the task.

C. The need for paid care score shall be based on the frequency of the client's unmet need for paid care and shall be modified by the following factors:

1. Need for paid care shall be scored as zero (0) when those services are provided through another program, agency, or individual.

2. For clients living with others, the need for paid care shall be scored only on the client's needs that are greater than and differentiated from typical household routine and the typical expectation of assistance by family members living in the home.

D. For children age zero (0) through eighteen (18) years, functional capacity and need for paid care shall be scored according to age appropriate criteria.

E. The need for paid care scale is as follows:

SCORE	FREQUENCY	DEFINITION OF FREQUENCY
0	None	Client's needs are met. No need for paid care.
1	Weekly	Client needs paid care up to and including once a week.
2	Daily	Client needs paid care more than once a week and up to once a day, seven days a week.
3	Twice Daily	Client needs paid care two or more times per day at least five days per week.

F. The functional assessment shall be scored on the State Department prescribed form, which shall list each activity of daily living, the functional capacity score and the need for paid care score for each ADL.

3.570.15 Activities of Daily Living [Eff. 3/2/14]

A. Activities of daily living (ADLs) shall be scored using the functional capacity impairment scale and the need for paid care scale.

B. The activities of daily living are:

1. Critical ADLs

a. Transfers: the ability to move between surfaces, such as getting in and out of bed; transferring from a bed to a chair, wheelchair, or walker; moving from a chair or wheelchair to a walker or to a standing position; and the ability to use assistive devices, including prosthetics. A child age 0 to 48 months shall not be scored for any transfers, including positioning. A child age 0 to 60 months shall not be scored for car seat, highchair, or crib transfers.

b. Bladder care: the extent to which the client has control of his/her bladder functions and the ability of the client to accomplish the tasks of toileting, including catheterizing, getting on and off the toilet, changing incontinence products, and cleaning him/herself. A child age 0 to 36 months shall not be scored for bladder incontinence or care.

c. Bowel care: the extent to which the client has control of his/her bowel functions and the ability of the client to accomplish the tasks of toileting, including getting on and off the toilet, changing incontinence products, and cleaning him/herself. A child age 0 to 36 months shall not be scored for bowel incontinence or care.

2. Basic ADLs

a. Mobility: the ability of the client to ambulate around the home and around essential places outside the home, with or without assistive devices. A child age 0 to 36 months shall not be scored for mobility.

b. Dressing: the ability of the client to accomplish all phases of the activities of dressing and undressing, including getting, putting on, fastening, and taking off all items of clothing, braces, and artificial limbs. A child age 0 to 60 months shall not be scored for dressing.

c. Bathing: the ability of the client to safely accomplish the task of washing body parts including getting into bathing waters, with or without assistive devices or whether the client requires stand by or hands-on assistance from another person. A child age 0 to 60 months shall not be scored for bathing.

d. Hygiene: the ability of the client to maintain personal hygiene other than bathing, including combing hair, brushing teeth, and clipping nails. A child age 0 to 60 months shall not be scored for hygiene.

e. Eating: the ability to cut food into manageable size pieces, chew, and swallow food, with or without assistive devices. A child age 0 to 48 months shall not be scored for eating.

3. Instrumental ADLs

a. Meals: the ability to safely prepare food to meet the basic nutritional requirements of the client, including cutting food, transferring food to cooking vessels and/or dishes, utilizing utensils, using a stove or microwave, and implementing special dietary needs. A child age 0 to 14 years shall not be scored for meals.

b. Housekeeping: the ability to maintain the interior of the client's residence for the purpose of health and safety, such as wiping surfaces, cleaning floors, making a bed, and cleaning dishes. A child age 0 to 12 years shall not be scored for housekeeping.

c. Laundry: the ability to gather and wash soiled clothing and linens; use washing machines and dryers; hang, fold, and put away clean clothing and linens. A child age 0 to 12 years shall not be scored for laundry.

d. Shopping: the ability to purchase goods that are necessary for health and safety. Activities include the ability to make needs known, to make a list, reach for the needed items at the store, ability to estimate or determine the cost of the item, and to move items into the home and put them away. A child age 0 to 15 years shall not be scored for shopping.

4. Supportive ADLs

a. Medicine: the ability to manage medications, including knowing the name of the medication, knowing the amount, frequency, and how to take the medicine, understanding the reason for taking it, and understanding possible side effects. A child age 0 to 14 years shall not be scored for medicine.

b. Appointment: the ability to schedule or make an appointment for essential activities, such as doctor visits, meetings with caseworkers, and transportation. A child age 0 to 16 years shall not be scored for appointments.

c. Money: the ability to manage money, such as balancing a check book, writing checks or paying a bill electronically, and ability to understand financial decisions. A child age 0 to 16 years shall not be scored for money.

d. Access: the ability to access resources or services in the community, such as locating the resource/service and completing the process necessary to receive the resource or service. A child age 0 to 16 years shall not be scored for access.

e. Telephone: the ability to use the telephone to communicate essential needs, such as answering the phone in a reasonable time, speaking clearly and loudly enough to be understood, dialing the phone, initiating a conversation, hearing the caller, and placing a call in an emergency. A child age 0 to 12 years shall not be scored for telephone.

3.570.16 Care Planning and Case Management [Eff. 3/2/14]

A. Home Care Allowance may be used to purchase:

1. Non-skilled assistance with activities of daily living, as defined in Section 3.570.15; and;

2. Electronic monitoring, such as an emergency alert button; and,

3. One-time deep cleaning if a referral is initiated by Adult Protective Services and determined necessary by the SEP.

B. The SEP shall develop a care plan on the State Department prescribed form within ten (10) working days after program eligibility has been determined and prior to the arrangement for services.

1. The care plan shall be:

a. Signed by the client, SEP, and the service provider;

b. Reviewed and updated at least once every twelve months; and,

c. Reviewed sooner if there is a change in the client's needs; and,

d. Provided to all parties.

2. Care planning shall include, but not be limited to, the following tasks:

a. Identify and document care plan goals and client choices.

b. Identify and document services, including type, duration and frequency.

c. Arrange for services through a service provider, family member, or other provider of the client's choosing.

1) Providers shall be at least eighteen (18) years of age or older and have the ability to provide appropriate services. The SEP shall assist the client in finding an appropriate service provider, if needed.

2) The SEP shall negotiate with the client and care provider to arrive at the total number of paid care hours to be provided monthly.

3) The HCA payments shall be made directly to the client or authorized representative who shall pay the provider the agreed upon, authorized amount monthly.

4) No portion of the authorized HCA amount shall be withheld by the client for personal use. The entire HCA authorized amount shall be spent for HCA allowable services.

d. Coordinate service delivery, negotiate with the service provider and the client regarding service provision, and formalize the provider agreement.

e. Complete program requirements for the authorization of services.

f. Refer the client to community resources, as needed, and attempt to develop resources for the client if a resource is not available within the client's community.

g. Explain the complaint procedures to the client, as listed on the care plan document.

h. Explain the client's right to appeal any decision.

3. The SEP shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

a. When services are available to the client at no cost from family, friends, volunteers, or others, these services shall be utilized before the purchase of services, providing these services adequately meet the client's needs.

b. When public dollars must be used to purchase services, the SEP shall encourage the client to select the lowest cost provider of service when quality of service is comparable.

c. The SEP shall assure there is no duplication in services provided by any other public or privately funded services.

C. The SEP shall provide ongoing case management, as follows:

1. Monitor the quality of care provided to clients.

2. Contact service providers concerning service coordination, effectiveness, and appropriateness.

3. Review the client's assessment, care plan, and service agreements to include changes in client functioning, service effectiveness, appropriateness, and cost-effectiveness that may require a reassessment or a change in the care plan.

4. Make changes in care plans as appropriate to client needs and/or refer the client to community resources, if appropriate.

5. Provide conflict resolution and/or crisis intervention, as needed.

6. Identify, contact appropriate individuals, and resolve any problems or complaints raised by the client or others regarding service delivery.

7. Notify the appropriate law enforcement and/or Adult Protective Services agency of suspected abuse, neglect or exploitation, as required by 18-6.5-101 and 26-3.1-102, C.R.S.

D. The SEP shall complete a review of the client's current assessment or reassessment and the care plan with the client six months following the assessment or reassessment.

1. The review shall be conducted by telephone, at the client's place of residence, at the place of service, or other appropriate setting as determined by the client's needs.

2. A face-to-face home visit shall be completed when significant changes in the client's condition are identified.

E. The SEP shall complete a face-to-face functional reassessment within twelve (12) months of the initial functional assessment and every twelve months thereafter. A reassessment shall be completed sooner if the client's condition changes.

F. Reassessment shall include the following tasks:

1. Review the care plan, service agreement, and provider contract or agreement.

2. Evaluate service effectiveness, quality of care, and appropriateness of services.

3. Verify continuing financial and program eligibility.

4. Annually, or more often if indicated, complete a new care plan and service agreement.

5. Refer the client to community resources, as needed.

6. Determine continued appropriateness of placement.

G. The SEP shall update the information provided at the previous assessment or reassessment, utilizing the State Department prescribed functional assessment tool and the Benefits Utilization System. When a new functional assessment is completed a copy shall be sent to the county department within ten (10) working days of the reassessment.

3.570.17 Denials, Discontinuations, and Case Transfers [Eff. 3/2/14]

A. The responsibility of the SEP is to determine the functional eligibility of the client. The SEP shall deny or discontinue the client from the HCA program if he/she is determined functionally ineligible.

1. The client shall be informed of his/her appeal rights in accordance with rules under Section 3.850, et seq.

2. The client shall be provided appropriate referrals to other community resources within one (1) working day of discontinuation or denial.

3. The SEP shall notify all providers on the care plan within one (1) working day of discontinuation.

4. The SEP shall notify the county department within one (1) working day of discontinuation.

5. The SEP shall prepare for and defend at the hearing any appeal related to functional denial or discontinuation. The SEP may request assistance and/or testimony from the county department.

B. The responsibility of the county department is to determine the financial eligibility of the client. The county department shall deny or discontinue the client from the HCA program if he/she is determined financially ineligible.

1. The client shall be informed of his/her appeal rights in accordance with rules under Section 3.850, et seq.

2. The client shall be provided appropriate referrals to other community resources within one (1) working day of discontinuation or denial.

3. The county department shall notify all providers on the care plan within one (1) working day of discontinuation.

4. The county department shall notify the SEP within one (1) working day of discontinuation.

5. The county department shall prepare for and defend at the hearing any appeal related to financial denial or discontinuation. The county department may request assistance and/or testimony from the SEP.

C. Denial and/or discontinuation from the HCA program shall occur for the following reasons:

1. Financial and Functional Eligibility: The SEP or county department shall deny or discontinue a client if the client is not financially eligible and/or is not functionally eligible for HCA.

2. Level of Care: The SEP shall deny or discontinue when the client:

a. Does not meet functional capacity score minimum requirements; or,

b. Does not meet need for paid care score criteria.

3. Receipt of Services: The SEP or county department shall deny or discontinue when the client:

a. Has not received services for one month;

b. Has twice refused to schedule an appointment for an initial assessment, six (6)-month review, or reassessment within a thirty (30) day consecutive period;

c. Has failed to keep three (3) scheduled appointments within a thirty (30) consecutive day period;

d. Has refused to schedule an appointment for a required visit after the client's case has been transferred to a new SEP or county department;

e. Refuses to use the HCA payment to pay for services or uses the payment for services not identified in the service agreement; or,

f. Refuses to sign the intake form, care plan, or other documents and forms required to receive services.

4. Facility Status: The SEP or county department shall deny or discontinue when the client:

    a. Is a resident of a nursing facility, hospital, or any other long-term care facility; or,

    b. Enters a hospital or other long-term care facility for treatment, hospitalization, or rehabilitation that continues for thirty (30) days or more.

5. Service Limitations Related to Safety: The SEP or county department shall deny or discontinue when the client cannot be safely served given the type and/or amount of services available. Evidence of safety concerns include, but are not limited to:

    a. The results of an Adult Protective Services assessment that substantiates ongoing risk.

    b. A statement from the client's physician attesting to diminished cognitive capacity, debilitating mental health concerns, or ongoing risk.

    c. Lack of available and/or appropriate service providers.

    d. A functional assessment score indicating a level of need for services in excess of those available under the HCA program.

    e. Other available information or evidence that will support the determination that the client's safety is at risk.

6. Service Limitations Related to Cost Effectiveness: The SEP or county department shall deny or discontinue when other more cost effective alternatives are available to meet the client's needs.

7. Living Arrangements: The SEP or county department shall deny or discontinue when the client is residing anywhere other than his/her home.

    a. The SEP may continue to authorize services while a resident is on medical or non-medical leave.

    b. Combined leave shall not exceed a total of forty-two (42) days in a twelve (12) month period beginning with the date the client was approved for the HCA program.

8. Move Out of State: The SEP or county department shall deny or discontinue when the client has moved out of state.

    a. Discontinuation shall be effective the day after the date of the move.

    b. Clients who leave the state on a temporary basis with the intent to return to Colorado within thirty (30) calendar days shall not be discontinued. If the client fails to return to Colorado the client shall be discontinued on day thirty one (31).

9. Voluntary Withdrawal from the Program: The SEP or county shall deny or discontinue when the client requests withdrawal from the HCA program.

10. Death: The SEP or county shall discontinue the HCA program effective the day after the client's date of death. No notice of discontinuation shall be sent.

D. The SEP shall complete the following procedures to transfer an HCA client to a new county department:

1. Notify the county department of the client's plans to relocate to another county and the date of transfer.

2. If the client's current service providers do not provide services in the area where the client is relocating make arrangements, in consultation with the client, for new service providers.

E. The SEP shall complete the following procedures to transfer an HCA client to a new SEP:

1. The transferring SEP shall contact the receiving SEP by telephone or email to give notification that the client is planning to transfer, to negotiate a transfer date, and to provide information.

2. The transferring SEP shall forward copies of the client's case records, including forms required for the HCA program, to the receiving SEP prior to the relocation, if possible, but in no case later than five (5) working days after the client's relocation.

3. The receiving SEP shall complete a face-to-face meeting with the client and an assessment and case summary update within ten (10) working days after notification of the client's relocation.

4. The receiving SEP shall review the care plan and the assessment tool, revise as necessary, and coordinate services and providers.

3.570.18 County Department and Single Entry Point (SEP) Requirements and Responsibilities [Eff. 3/2/14]

A. The county department shall:

1. Ensure all requirements of the county department are implemented, as appropriate for the HCA program, related to:

   a. General county requirements, as outlined in Section 3.520; and,

   b. Documentation, as outlined in Section 3.520.2; and,

   c. Program review and oversight, as outlined in Section 3.520.3; and,

   d. Application processing, as outlined in Section 3.520.4.

2. The county department shall determine financial eligibility for HCA in the statewide automated system and update any changes in the case record.

3. The county department shall notify the SEP in writing:

   a. Within five (5) working days of determining HCA eligibility.

   b. Within five (5) working days after the eligibility worker determines that the client is no longer financially eligible for HCA.

   c. Within one (1) working day when the client has filed a written appeal with the county department.

d. Within one (1) working day when the client has withdrawn the appeal or a final agency decision has been entered.

4. The county department shall respond to requests for information from the SEP within ten (10) working days.

B. The SEP shall:

1. Provide intake, screening, and referral activities, as follows:

a. Determine of the appropriateness of a referral for a client assessment.

1) If appropriate, complete intake activities within two (2) working days of the referral.

2) Obtain the client's or client's authorized representative's signature on the intake form.

3) Complete the HCA functional assessment within thirty (30) calendar days of referral.

b. Provide the client information and referral to other agencies, as needed.

2. The SEP shall identify potential payment source(s), including the availability of private funding:

a. Refer the client to the county department to complete an application; or,

b. Refer the client to another community resource that can assist in completing the application; or,

c. Verify the client's ability to private pay for services.

3. The SEP shall complete a functional assessment when the county department provides written notification that the client has requested HCA and is receiving or has submitted an application for Old Age Pension (OAP), Aid to the Needy Disabled Colorado Supplement (AND-CS), Aid to the Needy Disabled State Only (AND-SO), or the client is receiving Supplemental Security Income (SSI).

a. If the client is being discharged from a hospital or nursing facility, the SEP shall complete the functional assessment regardless of whether the Medicaid application date has been provided by the county department.

b. The SEP shall complete the functional assessment within two (2) working days after notification when a client is being transferred from a hospital to the HCA program.

c. The SEP shall complete the functional assessment within five (5) working days after notification when a client who is being transferred from a nursing facility to the HCA program.

d. The SEP shall complete the functional assessment within ten (10) working days after notification for all other clients. However, the SEP shall have a procedure for prioritizing urgent referrals.

4. The SEP shall document all case information.

   a. Documentation of contacts and case management activities shall be entered into the Benefits Utilization System (BUS) within five (5) working days of the contact or activity.

   b. All information related to intake, assessment, and care planning shall be thoroughly documented within ten (10) working days of the intake, assessment or care planning using State Department prescribed forms and the BUS.

   c. Additional documentation that cannot be entered into the BUS shall be maintained in the case file.

5. The SEP shall notify clients of their program status using the State Department prescribed form at the time of initial eligibility, when there is a significant change in the client's payment or services, when an adverse action is taken, or at the time of discontinuation.

6. The SEP shall notify the county department in writing:

   a. Within five (5) working days of determining HCA functional eligibility.

   b. Within five (5) working days after the SEP determines that the client is no longer functionally eligible for HCA.

   c. Within one (1) working day when the client has filed a written appeal with the SEP.

   d. Within one (1) working day when the client has withdrawn the appeal or a final agency decision has been entered.

7. The SEP shall respond to requests for information from the county department within ten (10) working days.

8. The SEP shall notify the client, at the time of his or her application and at the time of reassessment or discontinuation of the right to request a fair hearing before an Administrative Law Judge in accordance with Section 3.850 (9 CCR 2503-8), and to appeal adverse actions of the SEP or county department.

9. The SEP shall inform the client's Adult Protective Services caseworker, if applicable, of the client's status. The case manager shall participate in mutual staffing of the client's case.

10. The SEP shall report to the Colorado Department of Public Health and Environment any congregate facility, with three (3) or more residents, that is not licensed.

11. The SEP shall immediately report to the county department any information that indicates an overpayment, incorrect payment, or misuse of any HCA benefit, and shall cooperate with the county department in any subsequent recovery process.

12. The SEP shall be subject to routine quality control, program monitoring, and contract management to minimally include:

    a. Targeted review of the BUS documentation;

b. Case file review;

c. Targeted program review conducted via phone, email, or survey;

d. Onsite program review;

e. A performance improvement plan to correct areas of identified non-compliance; and,

f. Contract sanctions when the SEP fails to implement a performance improvement plan.

3.570.2 SPECIAL POPULATIONS HOME CARE ALLOWANCE (SP-HCA) [Eff. 3/2/14]

3.570.21 Purpose of Program [Eff. 3/2/14]

A. Special Populations Home Care Allowance (SP-HCA) is a special cash payment made to a client for the purpose of securing in-home, personal care services.

1. SP-HCA is a non-entitlement program; and,

2. Cannot be received while receiving benefits from a Home and Community Based Services waiver other than Supportive Living Services (HCBS-SLS) or Children's Extensive Supports (HCBS-CES); and,

3. Is for clients that received Home Care Allowance (HCA) and HCBS-SLS or HCBS-CES services for at least one month between September 2011 and December 2011.

B. Effective January 1, 2014, the SP-HCA grant standard maximums are as follows:

1. Tier 1 - $200.00

2. Tier 2 - $342.00

3. Tier 3 - $475.00

C. The SP-HCA grant is not taxable income to the client. The payment made to the care provider using the SP-HCA grant received by the client is income to the care provider and subject to taxation under State and Federal laws.

D. The SP-HCA grant standards shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

E. In addition to the regular monthly SP-HCA grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

3.570.22 Definitions [Eff. 3/2/14]

“Activities of daily living” means physical transfers, bladder care, bowel care, mobility, dressing, bathing, hygiene, and eating.

“Authorized representative” means an individual designated by the client, or by the parent or guardian of the client, if appropriate, to assist in acquiring or utilizing Special Populations Home Care Allowance (SP-HCA). The extent of the authorized representative's involvement shall be determined upon designation.

“BUS” means the Benefits Utilization System, the data system used to document case management activities for Special Populations Home Care Allowance (SP-HCA) clients.

“Care planning” means identifying client goals and choices for the care needed, services needed, appropriate service providers, and knowledge of the client and of community resources. The care plan shall be documented on the State prescribed care plan tool.

“Case management” means the assessment of a client's long-term care needs, development and implementation of a care plan, coordination and monitoring of the long-term care service delivery, evaluation of service effectiveness, and periodic reassessment of client needs.

“Client” means any person identified by the State Department as meeting the minimal eligibility criteria to apply for a Special Populations Home Care Allowance (SP-HCA) program grant as outlined at Section 3.570.23, or any person approved for a SP-HCA program grant.

“Functional Assessment” means a comprehensive evaluation by the case manager with the client and appropriate collaterals (such as family members, friends and/or caregivers) to determine the client's level of functioning, service needs, available resources, and necessity for paid care.

“Home” means a non-facility residence.

“Medical leave” means the absence of the client from their home for more than twenty-four (24) hours due to admittance to a hospital or other facility, upon physician's order with the presumption on the part of the physician that the client will be returning to their home. Medical leave may be planned or unplanned.

“Non-medical leave” means the absence of the client from their home for more than twenty-four (24) hours for non-medical reasons that are not part of a client's care plan. Non-medical leave may be planned or unplanned.

“Ongoing case management” means the evaluation of the effectiveness and appropriateness of services, on an ongoing basis, through contacts with the client, appropriate collaterals, and service providers.

“Reassessment” means a comprehensive re-evaluation by the case manager with the client and appropriate collaterals (such as family members, friends and/or caregivers) to determine the client's level of functioning, service needs, available resources, potential funding resources, and necessity for paid care. The reassessment of functional needs shall be documented on the State prescribed assessment tool.

“Service Plan Authorization Limit” (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Purchase of services not subject to the SPAL are in accordance with the Colorado Department of Health Care Policy and Financing rules in Section 8.500.102, B (10 CCR 2505-10). A specific limit is assigned to each of the six (6) support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of clients in each level, and projected utilization.

“Spending Limitation” means an annual maximum limit of funds available to purchase services to meet the client's needs under the Home and Community Based Services Children's Extensive Support (HCBS-CES) waiver.

"Single Entry Point ("SEP") agency" means the agency selected by the Colorado Department of Health Care Policy and Financing to provide case management functions for persons in need of long term care services within specific demographic areas, pursuant to Section 25.5-6-106, C.R.S.

"Skilled personal care" means some exceptions to personal care for activities of daily living that, because of the severe or complex nature of the client's need, requires a person with specialized training and skill to complete the task. Skilled personal care is not a paid service of the Special Populations Home Care Allowance (SP-HCA) program. See the Colorado Department of Health Care Policy and Financing rules in Section 8.489.30 (10 CCR 2505-10) for the definitions of personal care and the skilled exceptions to personal care.

"State Department" means the Colorado Department of Human Services (CDHS).

3.570.23 Application Process and Eligibility Determination [Eff. 3/2/14]

A. Eligibility for SP-HCA shall be based on financial need, the client's functional needs, and SP-HCA special eligibility criteria. The client shall meet eligibility for financial, functional, and special requirements to be approved for an SP-HCA payment.

B. The State Department shall identify persons eligible to apply for SP-HCA as potential clients through a review of the statewide automated system for eligibility determination, the data system for the Division for Developmental Disabilities, and review of the Single Entry Point (SEP) case file. Persons identified as potential clients for a SP-HCA grant minimally shall have been:

1. Approved for Supplemental Security Income (SSI) benefits and been receiving at least a one dollar ($1.00) SSI payment at least one month between September 2011 and December 2011; or,

2. Eligible for a Home Care Allowance (HCA) grant under criteria for the Old Age Pension (OAP) or Aid to the Needy Disabled/Aid to the Blind – State Only (AND/AB-SO) programs as outlined in Sections 3.500 (9 CCR 2503-5), et seq., at least one month between September 2011 and December 2011; and,

3. Receiving a Home Care Allowance (HCA) grant at least one month between September 2011 and December 2011; and,

4. Receiving Home and Community Based Services Supported Living Services (HCBS-SLS) or Home and Community Based Services Children's Extensive Support (HCBS-CES) services at least one month between September 2011 and December 2011; and,

5. One thousand dollars ($1,000) or less from the maximum Service Plan Authorization Limit (SPAL) or Spending Limitation for his/her functional level of need within the HCBS-SLS or HCBS-CES waiver between September 2011 and December 2011.

C. Persons identified by the State Department in March 2012 as potential clients as outlined in Section 3.570.23, B, shall be provided a one-time-only opportunity to apply for SP-HCA.

1. The application process to determine eligibility for the SP-HCA grant shall be initiated no later than March 23, 2012.

2. An application packet for SP-HCA shall be sent to the identified clients. The application packet shall include:

    a. A cover letter outlining the SP-HCA grant, the application process, and other necessary information; and,

b. The application; and,

c. Any other forms or documents deemed necessary by the State Department to determine eligibility and process grant payments.

3. No additional persons shall be identified as potential clients after March 2012. Appeals shall not be granted to persons wishing to apply for SP-HCA who were not identified as potential clients at the inception of the SP-HCA program in March 2012.

D. Persons identified by the State Department as potential clients who wish to apply for an SP-HCA grant shall return the application packet and all supporting documentation so it arrives in the State Department office no later than June 1, 2012.

1. Applications may be returned via email, fax, or mail service.

2. Clients whose application is received in the State Department office after June 1, 2012 shall be determined permanently ineligible for SP-HCA. An appeal of this decision must be filed no later than thirty (30) calendar days after the denial.

E. Each application that was returned timely shall be reviewed within forty five (45) calendar days of receipt of the application to determine eligibility and grant award, to include:

1. Completeness of the application.

a. Incomplete and/or unsigned applications shall be returned to the client immediately.

b. If an incomplete application is received between April 15 and June 1, 2012, the State Department may grant a waiver, at its discretion, for the client to return the completed application after the June 1, 2012 program deadline for application.

2. Financial eligibility determination.

a. A client receiving at least one dollar ($1.00) in SSI benefits shall be determined financially eligible.

b. A client not receiving at least $1.00 in SSI benefits shall meet eligibility under either the Old Age Pension (OAP) or Aid to the Needy Disabled-State Only (AND-SO) program requirements, as outlined in Sections 3.530 and 3.540 to be determined financially eligible.

1) A secondary application to collect income and resource information shall be sent to the client immediately.

2) The client shall return the completed secondary application along with all verifications of income and resources within twenty (20) working days.

3) A phone interview shall be scheduled with the client or authorized representative to review the secondary application and verifications.

4) If the client or authorized representative refuses to consent to the interview, fails to return the secondary application, or fails to provide required verification the client shall be permanently ineligible for the SP-HCA program. An appeal of this decision must be filed no later than thirty (30) calendar days after the denial.

3. Functional eligibility determination.

   a. If the client's most recent functional assessment (FA), care plan (CP), and provider agreement (PA) were completed ten (10) or more months prior to the application date, the State Department shall refer the client to the appropriate SEP for a new FA, CP, and PA prior to determining eligibility.

      1) The SEP shall complete the FA, CP, and PA no later than fifteen (15) working days from the date of referral by the State Department.

      2) The SEP shall email the State Department with the completed FA, CP, and PA within one (1) working day of completion.

   b. If the client's most recent FA, CP, and PA were completed less than ten (10) months prior to the application date, the State Department shall review for functional eligibility.

   c. To be functionally eligible, the client shall have an SP-HCA eligible functional assessment score as outlined in Section 3.570.24. The functional assessment score is calculated by determining the client's functional capacity score and need for paid care score, as follows:

      1) Functional Capacity: determined by assessing the client's ability to complete all activities of daily living (ADLs) and applying a score to their ability to complete the ADLs using the functional impairment scale, as outlined in Section 3.570.24; and,

      2) Need for Paid Care: determined by identifying the unmet need for paid care and applying a score to the unmet need using the need for paid care scale as outlined in Section 3.570.24; and,

      3) Combining the functional capacity score and the need for paid care score to determine whether the client meets the minimum scores for eligibility and, if eligible, the tier of benefits to be approved, as follows:

TIER	CAPACITY SCORE	NEED FOR PAID CARE SCORE
1	21 or Higher	1 to 23
2	21 or Higher	24 to 37
3	21 or Higher	38 to 51

   d. The SEP shall not approve the maximum authorized SP-HCA amount for the tier if:

      1) The client's needs can be fully or partially met through other paid or unpaid sources (excluding family and friends); or,

      2) The SP-HCA provider is able to provide the authorized services for less than the maximum authorized amount, or,

      3) The client is unwilling or unable to use the maximum authorized amount.

   e. Each client who meets the minimum functional assessment scoring requirements for the SP-HCA program shall be functionally eligible for an SP-HCA grant.

1) The authorization by the SEP shall be forwarded to the State Department to determine financial eligibility and SP-HCA special eligibility, as outlined in Sections 3.570.23, E, 2 and 3.570.23, E, 4.

2) Clients shall not be approved for SP-HCA if financially ineligible and/or do not meet SP-HCA special eligibility criteria, even if the client is functionally eligible.

3) Clients shall not be approved for SP-HCA if functionally ineligible, even if the client is financially eligible and/or meets SP-HCA special eligibility criteria.

4. SP-HCA special eligibility criteria.

a. A client must have received a Home Care Allowance (HCA) program payment at least one month between September 2011 and December 2011.

b. A client must have received HCBS-SLS or HCBS-CES waiver services at least one month between September 2011 and December 2011.

c. A client must have been $1,000 or less from his/her SPAL in HCBS-SLS or Spending Limitation in HCBS-CES at least one month between September 2011 and December 2011.

d. All applications will be reviewed for eligibility retroactive to January 2012, provided the client was still a resident of Colorado on January 1, 2012.

F. All eligible clients shall be approved for an SP-HCA program grant.

1. The SP-HCA program approval shall be retroactive to January 2012 for all months that the client is eligible.

2. The client's grant amount shall be based on the SP-HCA tier of payment as determined by the functional assessment conducted by the SEP.

3. Grants shall be for one full month and shall not be prorated based on a partial month of services.

G. Notice shall be provided to the client of approval for or denial of an SP-HCA grant no later than ten (10) working days after completing the eligibility determination.

1. The notice shall contain the eligibility result and appropriate rule citations; and,

2. The date when the grant will be effective, if approved; or,

3. The date and reason for denial and the appeal process, if denied.

H. Monthly payments shall be processed on the 20th of the month.

1. The client or authorized representative shall report any changes related to income, resources, functional assessment, HCBS waiver status, or any other change that might affect eligibility to the State Department or SEP within five (5) working days of the change.

2. Failure to report a change shall be grounds for discontinuation from the program and any payments made after the change shall be subject to recovery and/or fraud investigation and possible prosecution, as outlined in Section 3.800, et seq. (9 CCR 2503-8).

I. Ongoing review of the client's eligibility beginning February 2012 and thereafter shall be conducted in coordination with the SEP, Division for Developmental Disabilities, and State Department. To remain eligible for a SP-HCA grant, the client shall continually:

1. Be approved for Supplemental Security Income (SSI) benefits and be receiving at least a one dollar ($1.00) SSI monthly payment; or, meet all eligibility criteria for the Aid to the Needy Disabled – State Only (AND-SO) programs; or, were receiving both Old Age Pension (OAP) benefits and SP-HCA as of December 31, 2013 and remain continuously eligible for both benefits; and,

2. Be receiving HCBS-SLS or HCBS-CES services and SP-HCA; and,

3. Remain one thousand dollars ($1,000) or less from the maximum SPAL or Spending Limitation for his/her functional level of need within the HCBS-SLS or HCBS-CES waiver; and,

4. Meet the SP-HCA eligible functional capacity score and need for paid care score as outlined in Section 3.570.24.

J. Annual reassessment and redetermination shall be conducted.

1. A new functional assessment shall be conducted by the SEP.

2. A new financial and SP-HCA eligibility determination shall be conducted.

3. The client or authorized representative shall compete and timely return the redetermination application and any other required documentation required to process the redetermination.

4. Notice of continued eligibility and grant amount shall be provided, if the client is determined eligible for SP-HCA.

K. If during ongoing review or at the time of annual redetermination the client is no longer eligible for SP-HCA, notice of discontinuation and appeal rights, as outlined in Section 3.850, et seq. (9 CCR 2503-8) shall be provided within ten (10) working days.

1. The notice shall include the reason for the discontinuation, the appropriate rule citations, and information on the appeal process.

2. The appeal process shall be as outlined in Section 3.850, with the following exceptions:

a. Requirements of the county department shall be changed to requirements of the State Department and/or SEP and requests for a county level conference shall be a State Department level conference.

b. Appeals shall be granted for specific SP-HCA requirements only within thirty (30) days of denial or discontinuation.

L. No hardship exceptions shall apply to SP-HCA grants.

3.570.24 Functional Assessment and Need for Paid Care Score [Eff. 3/2/14]

A. The need for skilled personal care shall not be included in the scoring of the need for paid care.

B. The Single Entry Point (SEP) agency shall complete a functional assessment for each client as follows:

1. Upon referral by the State Department to determine initial eligibility for the SP-HCA program; or,

2. Immediately whenever the SEP, during ordinary case management services and in his/her professional opinion, identifies a significant change in the client's ability to perform activities of daily living; or,

3. Immediately whenever the client or authorized representative reports a significant change in the client's ability to perform activities of daily living; or,

4. Annually, at a minimum. The annual functional assessment shall be completed no earlier than forty-five (45) calendar days prior to and no later than the client's reassessment due date. The assessment shall include, but may not be limited to:

   a. A new functional assessment during a face-to-face visit at the client's place of residence;

   b. Evaluation of the appropriateness of services, service effectiveness, and quality of care over the past year; and,

   c. Completion of an updated care plan and provider agreement.

C. In order to be eligible for the SP-HCA program, each client shall score a minimum of twenty-one (21) points when assessed for the ability to complete the activities of daily living (ADL) using the following functional impairment scale:

1. Independent: score zero (0) if the client is physically able to perform all essential components of the ADL, with or without an assistive device.

2. Low: score one (1) if the client is able to perform all essential components of the function, but impairment of function exists even with an assistive device, or the client requires occasional or intermittent supervision or physical assistance in a limited number of the components of the activity.

   a. Occasional or intermittent means the client does not need assistance daily, but may need assistance a few times a month or up to two (2) times per week.

   b. Supervision or assistance means verbal prompting, cueing, and reminders, and means stand-by assistance or monitoring to help the client if he/she needs physical assistance up to two (2) times per week.

3. Moderate: score two (2) if the client is unable to perform the majority of the essential components of the function even with an assistive device, and the client requires hands-on and frequent assistance to accomplish the activity.

   a. Frequent means the client needs assistance at least three (3) times per week and up to daily.

b. Hands-on assistance means the care provider must physically assist the client in completing the task.

4. Severe: score three (3) if the client is totally unable to perform the function and requires someone to perform the task, or the client requires constant supervision for the task.

D. The need for paid care score shall be based on the frequency of the client's unmet need for paid care and shall be modified by the following factors:

1. Need for paid care shall be scored as zero (0) when those services are provided through another program, agency, or individual.

2. For clients living with others, the need for paid care shall be scored only on the client's needs that are greater than and differentiated from typical household routine and the typical expectation of assistance by family members living in the home.

3. Need for paid care shall be scored only on the client's needs that are greater than and differentiated from services received through the Medicaid Home and Community Based Services Supportive Living Services (HCBS-SLS) or Children's Extensive Support (HCBS-CES) waiver.

E. For children age zero (0) through eighteen (18) years, functional capacity and need for paid care shall be scored according to age appropriate criteria.

F. The need for paid care scale is as follows:

SCORE	FREQUENCY	DEFINITION OF FREQUENCY
0	None	Client's needs are met. No need for paid care.
1	Weekly	Client needs paid care up to and including once a week.
2	Daily	Client needs paid care more than once a week and up to once a day, seven days a week.
3	Twice Daily	Client needs paid care two or more times per day at least five days per week.

G. The functional assessment shall be scored on the State Department prescribed form, which shall list each activity of daily living, the functional capacity score, and the need for paid care score for each ADL.

3.570.25 Activities of Daily Living [Eff. 3/2/14]

A. Activities of daily living (ADLs) shall be scored using the functional capacity impairment scale and the need for paid care scale outlined in Section 3.570.24.

B. The activities of daily living are:

1. Critical ADLs

a. Transfers: the ability to move between surfaces, such as getting in and out of bed; transferring from a bed to a chair, wheelchair, or walker; moving from a chair or wheelchair to a walker or to a standing position; and the ability to use assistive devices, including prosthetics. A child age 0 to 48 months shall not be scored for any transfers, including positioning. A child age 0 to 60 months shall not be scored for car seat, highchair, or crib transfers.

b. Bladder care: the extent to which the client has control of his/her bladder functions and the ability of the client to accomplish the tasks of toileting, including catheterizing, getting on and off the toilet, changing incontinence products, and cleaning him/herself. A child age 0 to 36 months shall not be scored for bladder incontinence or care.

c. Bowel care: the extent to which the client has control of his/her bowel functions and the ability of the client to accomplish the tasks of toileting, including getting on and off the toilet, changing incontinence products, and cleaning him/herself. A child age 0 to 36 months shall not be scored for bowel incontinence or care.

2. Basic ADLs

a. Mobility: the ability of the client to ambulate around the home and around essential places outside the home, with or without assistive devices. A child age 0 to 36 months shall not be scored for mobility.

b. Dressing: the ability of the client to accomplish all phases of the activities of dressing and undressing, including getting, putting on, fastening, and taking off all items of clothing, braces, and artificial limbs. A child age 0 to 60 months shall not be scored for dressing.

c. Bathing: the ability of the client to safely accomplish the task of washing body parts including getting into bathing waters, with or without assistive devices or whether the client requires stand by or hands-on assistance from another person. A child age 0 to 60 months shall not be scored for bathing.

d. Hygiene: the ability of the client to maintain personal hygiene other than bathing, including combing hair, brushing teeth, and clipping nails. A child age 0 to 60 months shall not be scored for hygiene.

e. Eating: the ability to cut food into manageable size pieces, chew, and swallow food, with or without assistive devices. A child age 0 to 48 months shall not be scored for eating.

3. Instrumental ADLs

a. Meals: the ability to safely prepare food to meet the basic nutritional requirements of the individual, including cutting food, transferring food to cooking vessels and/or dishes, utilizing utensils, using a stove or microwave, and implementing special dietary needs. A child age 0 to 14 years shall not be scored for meals.

b. Housekeeping: the ability to maintain the interior of the client's residence for the purpose of health and safety, such as wiping surfaces, cleaning floors, making a bed, and cleaning dishes. A child age 0 to 12 years shall not be scored for housekeeping.

c. Laundry: the ability to gather and wash soiled clothing and linens; use washing machines and dryers; hang, fold, and put away clean clothing and linens. A child age 0 to 12 years shall not be scored for laundry.

d. Shopping: the ability to purchase goods that are necessary for health and safety. Activities include ability to make needs known, to make a list, reach for the needed items at the store, ability to estimate or determine the cost of the item, and to move items into the home and put them away. A child age 0 to 15 years shall not be scored for shopping.

4. Supportive ADLs

a. Medicine: the ability to manage medications, including knowing the name of the medication, knowing the amount, frequency, and how to take the medicine, understanding the reason for taking it, and understanding possible side effects. A child age 0 to 14 years shall not be scored for medicine.

b. Appointment: the ability to schedule or make an appointment for essential activities, such as doctor visits, meetings with caseworkers, and transportation. A child age 0 to 16 years shall not be scored for appointments.

c. Money: the ability to manage money, such as balancing a check book, writing checks or paying a bill electronically, and ability to understand financial decisions. A child age 0 to 16 years shall not be scored for money.

d. Access: the ability to access resources or services in the community, such as locating the resource/service and completing the process necessary to receive the resource or service. A child age 0 to 16 years shall not be scored for access.

e. Telephone: the ability to use the telephone to communicate essential needs, such as answering the phone in a reasonable time, speaking clearly and loudly enough to be understood, dialing the phone, initiating a conversation, hearing the caller, and placing a call in an emergency. A child age 0 to 12 years shall not be scored for telephone.

3.570.26 Care Planning And Case Management [Eff. 3/2/14]

A. Special Populations Home Care Allowance may be used to purchase:

1. Non-skilled assistance with activities of daily living, as defined in Section 3.570.25; and;

2. Electronic monitoring, such as an emergency alert button; and,

3. One-time deep cleaning if a referral is initiated by Adult Protective Services and determined necessary by the SEP.

B. The SEP shall develop a care plan on the State Department prescribed form within ten (10) working days after program eligibility has been determined and prior to the arrangement for services.

1. The care plan shall be:

a. Signed by the client, SEP, and the service provider.

b. Reviewed and updated at least once every twelve (12) months; and,

c. Reviewed sooner if there is a change in the client's needs; and,

d. Provided to all parties.

2. Care planning shall include, but not be limited to, the following tasks:

    a. Identify and document care plan goals and client choices.

    b. Identify and document services, including type, duration and frequency.

    c. Arrange for services through a service provider, family member, or other provider of the client's choosing.

        1) Providers shall be at least eighteen (18) years of age or older and have the ability to provide appropriate services. The SEP shall assist the client in finding an appropriate service provider, if needed.

        2) The SEP shall negotiate with the client and care provider to arrive at the total number of paid care hours to be provided monthly.

        3) The SP-HCA payments shall be made directly to the client or authorized representative who shall pay the provider the agreed upon, authorized amount monthly.

        4) No portion of the authorized SP-HCA amount shall be withheld by the client for personal use. The entire SP-HCA authorized amount shall be spent for SP-HCA allowable services.

    d. Coordinate service delivery, negotiate with the service provider and the client regarding service provision, and formalize the provider agreement.

    e. Complete program requirements for the authorization of services.

    f. Refer the client to community resources, as needed, and attempt to develop resources for a client if a resource is not available within the client's community.

    g. Explain the complaint procedures to the client, as listed on the care plan document.

    h. Explain the client's right to appeal any decision.

3. The SEP shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

    a. When services are available to the client at no cost from family, friends, volunteers, or others, these services shall be utilized before the purchase of services, providing these services adequately meet the client's needs.

    b. When public dollars must be used to purchase services, the SEP shall encourage the client to select the lowest cost provider of service when quality of service is comparable.

    c. The SEP shall assure there is no duplication in services provided by any other public or privately funded services.

4. The SEP shall notify the client in writing of the outcome of the functional assessment no later than ten (10) working days from the date of the functional assessment. The notice shall contain:

a. The functional eligibility result and appropriate rule citations.

b. The authorized grant amount, if the functional assessment determines the client has a functional need for paid care:

1) The authorized grant amount shall be the tier grant standard based on the client's overall functional capacity and need for paid care score; or,

2) An amount less than the tier grant standard based on the client's overall functional capacity score if the care provider has agreed to provide all services outlined in the care plan for the lesser amount.

c. The reason for denial and the appeal process, if denied.

C. The SEP shall provide ongoing case management, as follows:

1. Monitor the quality of care provided to clients.

a. Contact service providers concerning service coordination, effectiveness and appropriateness.

b. Review the client's assessment, care plan, and service agreements to include changes in client functioning, service effectiveness, appropriateness, and cost-effectiveness that may require a reassessment or a change in the care plan.

c. Make changes in service plans as appropriate to client needs and/or refer the client to community resources, if appropriate.

d. Provide conflict resolution and/or crisis intervention, as needed.

e. Identify and contact appropriate individuals, and resolve any problems or complaints raised by the client or others regarding service delivery.

f. Notify the appropriate law enforcement and/or Adult Protective Services agency of suspected abuse, neglect, or exploitation, as required by Sections 18-6.5-101 and 26-3.1-102, C.R.S.

D. The SEP shall complete a review of the client's current assessment or reassessment and the care plan with the client six (6) months following the assessment or reassessment.

1. The review shall be conducted by telephone, at the client's place of residence, at the place of service, or in another appropriate setting as determined by the client's needs.

2. A face-to-face home visit shall be completed when significant changes in the client's condition are identified.

E. The SEP shall complete a face-to-face functional reassessment within twelve (12) months of the initial functional assessment and every 12 months thereafter. A reassessment shall be completed sooner if the client's condition changes.

F. Reassessment shall include the following tasks:

1. Review the care plan, service agreement, and provider contract or agreement.

2. Evaluate service effectiveness, quality of care, and appropriateness of services.

3. Verify continuing functional and program eligibility.

4. Annually, or more often if indicated, complete a new care plan and service agreement.

5. Refer the client to community resources, as needed.

G. The SEP shall update the information provided at the previous assessment or reassessment, utilizing the State Department prescribed functional assessment tool and the BUS. When a new functional assessment is completed a copy shall be sent to the State Department within ten (10) working days of the reassessment.

3.570.27 Denials, Discontinuations, and Case Transfers [Eff. 3/2/14]

A. A client shall meet all eligibility requirements outlined in Sections 3.570.23 and 3.570.24 each month to continue to be eligible for the SP-HCA program.

B. Clients shall be denied or discontinued from the SP-HCA program if he/she is determined ineligible. The client shall be informed of the adverse action and appeal rights in accordance with rules under Sections 3.570.23, K, and 3.850.

C. Clients that are denied and/or are discontinued from the SP-HCA program are permanently disqualified from the program and shall not be eligible to apply for or be approved for benefits in subsequent months or years.

1. To ease the eligibility process for the SP-HCA program, the following provisions shall apply:

a. Clients originally approved for the SP-HCA program and then subsequently discontinued from SP-HCA on or before June 30, 2013, may reapply for reinstatement of benefits.

b. Application must be received no later than July 12, 2013, for reinstatement of benefits.

c. The application shall be reviewed to determine if between January 1, 2012 and June 30, 2013, the client again met SP-HCA eligibility criteria following the most recent discontinuation.

d. If the client is determined to meet SP-HCA eligibility criteria again following the most recent discontinuation, but still on or before June 30, 2013, benefits shall be retroactive to the new eligibility date.

2. Clients originally approved for the SP-HCA program and then subsequently discontinued from SP-HCA on or after July 1, 2013, shall be permanently discontinued from receiving SP-HCA benefits.

D. The SEP and/or CCB shall notify the State Department when the agency has knowledge that any of the following occurs. The State Department shall notify the client of discontinuation from SP-HCA when it has information from the SEP, CCB, program data systems, or any other source that any of the following has occurred:

1. The client no longer receives services under the HCBS-SLS or HCBS-CES waiver.

2. The client's needs changed and his/her level of service need is no longer within one thousand dollars ($1,000) of the SPAL or Spending Limitation for HCBS-SLS or HCBS-CES.

3. The client no longer meets financial eligibility criteria.

4. The client no longer meets the functional capacity and need for paid care scores necessary to be approved for SP-HCA.

5. The client has not received services for thirty (30) or more consecutive days.

6. The client or authorized representative has refused to schedule an appointment with the SEP, CCB, or State Department or refuses to allow for a home visit, an initial assessment, six (6)-month review, reassessment, or other review.

7. The client or authorized representative has failed to keep two (2) scheduled appointments.

8. The client or authorized representative refuses to sign the application, the care plan, or other documents and forms required to receive services or in any other way refuses to cooperate with the requirements of the SP-HCA program.

9. The client or authorized representative refuses to use the SP-HCA grant to pay for services, uses the grant for services not identified in the care plan and provider agreement, or uses the grant to purchase household expenses including, but not limited to, shelter costs, utilities, food, toiletries, clothing, home furnishings or other items not authorized by the SP-HCA care plan.

10. The client is a resident of a nursing facility, hospital, alternative care facility, group home, licensed or unlicensed long-term care facility.

11. The client enters a hospital or other long-term care facility for treatment or rehabilitation that continues for thirty (30) or more consecutive days.

    a. SP-HCA benefits shall be temporarily discontinued while the client remains in the hospital or long-term care facility for treatment or rehabilitation.

    b. SP-HCA benefits shall be permanently discontinued if the client remains in the hospital or long-term care facility for treatment or rehabilitation for one hundred eighty (180) or more consecutive days.

12. The client cannot be safely served given the type and/or amount of services available. To support a denial or discontinuation for safety reasons related to service limitations, the SEP shall document the limitations and evidence of safety concerns, when available, including, but not limited to:

    a. The results of an adult protective services assessment;

    b. A statement from the client's physician attesting to diminished cognitive capacity, debilitating mental health concerns, or increased medical or physical care needs;

    c. Lack of available services and/or providers;

    d. An assessment score indicating a level of need for services in excess of those available under the SP-HCA program; and/or,

e. Other available information or evidence that will support the determination that the client's safety is at risk.

13. The level of service need is not cost effective under the SP-HCA program. To support a denial or discontinuation due to cost effectiveness the SEP shall document the level of service need and more cost effective alternatives.

14. The client has moved out of the state or country or has or been out of the state or country for more than thirty (30) consecutive days. Discontinuation shall be effective the day after the date of the move or on day thirty-one (31) of the absence from the state or country.

15. The client or authorized representative requests withdrawal from the program.

16. The client or authorized representative has failed to report a change in circumstances that potentially affects eligibility for SP-HCA.

17. The client has died. Discontinuation shall be effective the day after the client's death. No notice of discontinuation shall be sent.

E. The notice of adverse action shall include the reason for denial or discontinuation, the appropriate rule cite, and appeal rights as outlined in Section 3.850, et seq. (9 CCR 2503-8).

F. In the event of denial or discontinuation, the SEP shall:

1. Provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.

2. Notify all providers on the care plan within one (1) working day of discontinuation.

3. Notify the State Department within one (1) working day of discontinuation.

4. Attend the appeal hearing to defend the denial or discontinuation.

3.570.28 State Department and SEP Requirements and Responsibilities [Eff. 3/2/14]

A. The State Department shall:

1. Determine eligibility for SP-HCA and update any changes in the case record.

2. Notify the SEP in writing:

a. Within five (5) working days of determining SP-HCA eligibility.

b. Within five (5) working days after the State Department determines that the client is no longer financially eligible for SP-HCA.

c. Within one (1) working day when the client has filed a written appeal with the State Department.

d. Within one (1) working day when the client has withdrawn the appeal or a final agency decision has been entered.

3. Respond to requests for information from the SEP within ten (10) working days.

B. The SEP shall:

1. Provide intake, screening, and referral activities, as follows:

    a. Complete intake activities within two (2) working days of the referral.

    b. Obtain the client's or client's authorized representative's signature on the intake form.

    c. Complete the SP-HCA functional assessment within thirty (30) calendar days of referral.

    d. Provide the client information and referral to other agencies, as needed.

2. Complete a functional assessment when the State Department provides written notification that the client has requested SP-HCA and is receiving or has submitted an application for Old Age Pension (OAP), Aid to the Needy Disabled State Only (AND-SO), or the client is receiving Supplemental Security Income (SSI).

    a. If the client is being discharged from a hospital or nursing facility, the SEP shall complete the functional assessment regardless of whether the Medicaid application date has been provided by the county department.

    b. The SEP shall complete the functional assessment within two (2) working days after notification when a client is being transferred from a hospital to the SP-HCA program.

    c. The SEP shall complete the functional assessment within five (5) working days after notification when a client who is being transferred from a nursing facility to the SP-HCA program.

    d. The SEP shall complete the functional assessment within ten (10) working days after notification for all other clients. However, the SEP shall have a procedure for prioritizing urgent referrals.

3. Document all case information.

    a. Documentation of contacts and case management activities shall be entered into the BUS within five (5) working days of the contact or activity.

    b. All information related to intake, assessment, and care planning shall be thoroughly documented within ten (10) working days of the intake, assessment or care planning using forms and the BUS.

    c. Additional documentation that cannot be entered into the BUS shall be maintained in the case file.

4. Notify clients of their program status using the State Department prescribed form at the time of initial eligibility, when there is a significant change in the client's payment or services, when an adverse action is taken, or at the time of discontinuation.

5. Notify the State Department in writing:

    a. Within five (5) working days of determining SP-HCA functional eligibility.

    b. Within five (5) working days after the SEP determines that the client is no longer functionally eligible for SP-HCA.

c. Within one (1) working day when the client has filed a written appeal with the SEP.

d. Within one (1) working day when the client has withdrawn the appeal or a final agency decision has been entered.

6. Respond to requests for information from the State Department within ten (10) working days.

7. Notify the client, at the time of his or her application and at the time of reassessment or discontinuation of the right to request a fair hearing before an Administrative Law Judge in accordance with Section 3.850, and to appeal adverse actions of the SEP or State Department.

8. Inform the client's Adult Protective Services caseworker, if applicable, of the client's status. The case manager shall participate in mutual staffing of the client's case.

9. Report to the Colorado Department of Public Health and Environment any congregate facility, with three (3) or more residents that is not licensed.

10. Report immediately to the State Department any information that indicates an overpayment, incorrect payment, or misuse of any SP-HCA benefit, and shall cooperate with the county department in any subsequent recovery process.

11. Be subject to routine quality control, program monitoring, and contract management to minimally include:

a. Targeted review of the BUS documentation; and,

b. Case file review; and,

c. Targeted program review conducted via phone, email, or survey; and,

d. Onsite program review; and,

e. A performance improvement plan to correct areas of identified non-compliance; and,

f. Contract sanctions when the SEP fails to implement a performance improvement plan.

3.580 ADULT FOSTER CARE (AFC)

3.581 PURPOSE OF PROGRAM [Em. eff. 1/1/15; Rev. eff. 3/20/15]

A. The AFC program provides twenty-four (24) hour care and supervision for frail elderly or physically or emotionally disabled adults, age eighteen (18) or older, who do not require twenty-four (24) hour medical care but who cannot return to their home and need twenty-four (24) hour non-medical supervision.

B. Effective January 1, 2015, the maximum AFC grant standard is $1,365.00, determined as follows:

1. Deduct the client's income, from the AFC grant standard; and,

2. Deduct the client's OAP or AND-CS grant and any Supplemental Security Income (SSI) benefits; and,

3. The remainder is the AFC benefit.

C. The AFC maximum grant standard shall be adjusted to stay within available appropriations. Appeals shall not be granted for these adjustments.

D. The AFC grant is not taxable income to the client.

E. In addition to the regular monthly AFC grant payments, supplemental payments necessary to comply with the federal Maintenance of Effort (MOE) requirements may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

3.582 DEFINITIONS [Eff. 3/2/14]

“Adult Foster Care (AFC) Facility” means a Colorado Department of Public Health and Environment (CDPHE) licensed assisted living residence (ALR) that shall provide:

A. Twenty-four hour residential care for no more than sixteen (16) residents;

B. An environment that is sanitary and safe from physical harm;

C. Adequate sleeping and living areas; and,

D. Appropriate AFC services.

“Adult Foster Care (AFC) Services” means services provided for each AFC client including, but not limited to:

A. Availability of three (3) balanced meals per day with provision for special diets when those diets have been prescribed as part of a medical plan;

B. Assistance with transportation;

C. Protective oversight;

D. Assistance with basic personal tasks, such as bathing, hair care, and dressing;

E. Supervision of self-administration of medications;

F. Housekeeping services such as changing of bed linen, cleaning of living areas, and rearrangement of furniture as needed to promote freer mobility;

G. Laundering of resident's clothing and bedding; and,

H. Opportunities for structured recreational activities and socializing.

“Appropriateness of placement” means the determination of whether a client would be appropriate for an AFC facility and/or the AFC program.

“BUS” means the Benefits Utilization System used to document case management services conducted by the Single Entry Point agencies.

“Client” means a current or past applicant or a current or past recipient of benefits under the AFC program.

“County department” means the county department of human/social services.

“Medical leave” means the absence of the client from the Adult Foster Care (AFC) facility for more than twenty-four (24) hours due to admittance to a hospital or other facility, upon physician's order with the presumption on the part of the physician that the client will be returning to the AFC facility. Medical leave may be planned or unplanned.

“Non-medical leave” means the absence of the client from the Adult Foster Care (AFC) facility for more than twenty-four (24) hours for non-medical reasons that are not part of a client's care plan. Non-medical leave may be planned or unplanned.

“Operator” means any person who owns an Adult Foster Care (AFC) facility or an individual with authority delegated by the owner who manages, controls, or performs the day-to-day tasks for operating an AFC facility.

“Protective Oversight” means guidance of an Adult Foster Care (AFC) client, as required by the needs of the client or as reasonably requested by the client, including the following:

A. Knowing the client's general whereabouts, although the client may travel independently in the community;

B. Monitoring the activities of the client while on the premises to ensure the health, safety, and well-being of the client, including monitoring of prescribed medications;

C. Reminding the client to carry out activities of daily living; and,

D. Reminding the client of any important activities, including appointments.

“Single Entry Point (“SEP”) agency” means the agency selected by the Colorado Department of Health Care Policy and Financing (HCPF) to provide case management services for persons in need of long term care services within specific demographic areas, pursuant to Section 25.5-6-106, C.R.S.

“Staff” means a paid employee of the Adult Foster Care (AFC) facility.

“Substance Abuse” means the use of alcohol or drugs or any other mind or mood altering material in a manner that deviates from standard medical practice in the community, which acts to the detriment of the individual clients or the public.

“Universal Precautions” refers to a system of infection control, which assumes that every direct contact with body fluids is potentially infectious including skin, eye, mucous membrane, blood, blood-tinged body fluids, or other potentially infectious materials.

3.583 ELIGIBILITY [Em. eff. 1/22/15; Rev. eff. 4/1/15]

A. The AFC program provides twenty-four (24) hour care and supervision for clients who are:

1. Frail elderly or physically or emotionally disabled adults age eighteen (18) or older who do not require twenty-four (24) hour medical care but who cannot return to their home and need twenty-four (24) hour non-medical supervision; and,

2. Living in a non-medical facility of no more than sixteen (16) clients that is licensed by the Colorado Department of Public Health And Environment (CDPHE); and,

3. Receiving or eligible to receive Old Age Pension (OAP), Aid to the Needy Disabled-Colorado Supplement (AND-CS), or Supplemental Security Income (SSI).

B. AFC shall not be available to persons:

1. Receiving home care allowance; or,

2. With a developmental disability, as defined in 27-10.5-102, C.R.S.; or,

3. Receiving or eligible to receive behavioral or mental health services pursuant to any provision in Title 27, C.R.S.

C. Eligibility for the Adult Foster Care program shall be based on:

1. Financial eligibility; and,

2. Functional eligibility that includes the client's functional assessment, the client's need for twenty-four (24) hour supervision and assistance, and the client's appropriateness for the AFC program.

D. The county department shall determine financial eligibility for AFC.

1. The client's application shall be processed to determine eligibility for OAP or AND-CS, or the county department shall determine whether the client is receiving SSI benefits.

2. If approved for OAP or AND-CS or the client is receiving SSI, deduct the client's income and the OAP or AND-CS grant standard from the AFC maximum grant standard to determine the client's AFC benefit.

3. If a client is receiving or eligible to receive Home Care Allowance (HCA) or a Home and Community Based Services (HCBS) waiver that provides services for any person receiving or eligible to receive services pursuant to any provision in Title 27, C.R.S., eligibility for AFC cannot begin until the first day of the month following the discontinuation of HCA OR HCBS.

4. The AFC benefit shall be paid to the client. The client shall:

a. Keep $77.00 of the payment for personal needs; and,

b. Use the remainder of the AFC payment to pay a portion of the fee charged by the AFC provider; and,

c. Pay the remainder of the AFC charges using his/her income from OAP, AND/CS, or SSI.

5. AFC facilities shall charge a standard rate of payment for all AFC clients.

a. The AFC rate charged by the AFC facility shall be no greater than the current maximum AFC grant standard less seventy seven dollars ($77), effective January 1, 2015, for the client's personal needs.

b. AFC facilities shall charge private pay clients an amount at least equal to that charged to clients receiving an AFC benefit.

E. The Single Entry Point (SEP) shall determine functional eligibility.

To be functionally eligible, the client shall have an AFC eligible functional assessment score as outlined in Section 3.584. The functional assessment score is calculated by determining the client's functional capacity score and need for paid care score, as follows:

1. Functional Capacity: determined by assessing the client's ability to complete all activities of daily living (ADLs) and applying a score to his/her ability to complete the ADLs using the functional impairment scale; and,

2. Determining the client's appropriateness of placement in an AFC facility.

F. When the client is determined functionally eligible for the AFC program, the Single Entry Point (SEP) shall notify the county department. The county department shall notify the SEP when the client has been determined financially eligible for the AFC program.

G. The AFC payment effective date shall be the date that the client was admitted to the AFC facility or the date he/she is determined to be financially eligible, whichever is later. If the client is receiving or eligible to receive Home and Community Based Services (HCBS) pursuant to any provision in Title 27, C.R.S, the effective date is the first day of the month following the discontinuation of HCBS.

3.584 FUNCTIONAL ASSESSMENT SCORING [Eff. 3/2/14]

A. The need for skilled personal care shall not be included in the scoring of the functional capacity or need for paid care. Skilled personal care is not a paid service of the AFC program.

B. In order to be eligible for the AFC, each client shall score a minimum of ten (10) points when assessed for the ability to complete the activities of daily living (ADL) using the following functional capacity impairment scale:

1. Independent: score zero (0) if the client is physically able to perform all essential components of the ADL, with or without an assistive device.

2. Low: score one (1) if the client is able to perform all essential components of the function, but impairment of function exists even with an assistive device. The client requires occasional or intermittent supervision or physical assistance in a limited number of the components of the activity.

   a. Occasional or intermittent means the client does not need assistance daily, but may need assistance a few times a month or up to two (2) times per week.

   b. Supervision or assistance means verbal prompting, cueing, and reminders, and means stand-by assistance or monitoring to help the client if he/she needs physical assistance up to two (2) times per week.

3. Moderate: score two (2) if the client is unable to perform the majority of the essential components of the function even with an assistive device, and the client requires hands-on and frequent assistance to accomplish the activity.

   a. Frequent means the client needs assistance at least three (3) times per week and up to daily.

   b. Hands-on assistance means the care provider must physically assist the client in completing the task.

4. Severe: score three (3) if the client is totally unable to perform the function and requires someone to perform the task, or the client requires constant supervision for the task.

C. The functional assessment shall be scored on the State Department prescribed form, which shall list each activity of daily living and the functional capacity score for each ADL.

3.585 ACTIVITIES OF DAILY LIVING [Eff. 3/2/14]

A. Activities of daily living (ADLs) shall be scored using the functional capacity impairment scale.

B. The activities of daily living are:

1. Critical ADLs

    a. Transfers: the ability to move between surfaces, such as getting in and out of bed; transferring from a bed to a chair, wheelchair, or walker; moving from a chair or wheelchair to a walker or to a standing position; and the ability to use assistive devices, including prosthetics.

    b. Bladder care: the extent to which the client has control of his/her bladder functions and the ability of the client to accomplish the tasks of toileting, including catheterizing, getting on and off the toilet, changing incontinence products, and cleaning him/herself.

    c. Bowel care: the extent to which the client has control of his/her bowel functions and the ability of the client to accomplish the tasks of toileting, including getting on and off the toilet, changing incontinence products, and cleaning him/herself.

2. Basic ADLs

    a. Mobility: the ability of the client to ambulate around the home and around essential places outside the home, with or without assistive devices.

    b. Dressing: the ability of the client to accomplish all phases of the activities of dressing and undressing, including getting, putting on, fastening, and taking off all items of clothing, braces, and artificial limbs.

    c. Bathing: the ability of the client to safely accomplish the task of washing body parts including getting into bathing waters, with or without assistive devices or whether the client requires stand by or hands-on assistance from another person.

    d. Hygiene: the ability of the client to maintain personal hygiene other than bathing, including combing hair, brushing teeth, clipping nails, and shaving.

    e. Eating: the ability to cut food into manageable size pieces, chew, and swallow food, with or without assistive devices.

3. Instrumental ADLs

    a. Meals: the ability to safely prepare food to meet the basic nutritional requirements of the individual, including cutting food, transferring food to cooking vessels and/or dishes, utilizing utensils, using a stove or microwave, and implementing special dietary needs.

b. Housekeeping: the ability to maintain the interior of the client's residence for the purpose of health and safety, such as wiping surfaces, cleaning floors, making a bed, and cleaning dishes.

c. Laundry: the ability to gather and wash soiled clothing and linens; use washing machines and dryers; hang, fold, and put away clean clothing and linens.

d. Shopping: the ability to purchase goods that are necessary for health and safety. Activities include ability to make needs known, to make a list, reach for the needed items at the store, ability to estimate or determine the cost of the item, and to move items into the home and put them away.

4. Supportive ADLs

a. Medicine: the ability to manage medications, including knowing the name of the medication, knowing the amount, frequency, and how to take the medicine, understanding the reason for taking it, and understanding possible side effects.

b. Appointment: the ability to schedule or make an appointment for essential activities, such as doctor visits, meetings with caseworkers, and transportation.

c. Money: the ability to manage money, such as balancing a checkbook, writing checks or paying a bill electronically, and ability to understand financial decisions.

d. Access: the ability to access resources or services in the community, such as locating the resource/service and completing the process necessary to receive the resource or service.

e. Telephone: the ability to use the telephone to communicate essential needs, such as answering the phone in a reasonable time, speaking clearly and loudly enough to be understood, dialing the phone, initiating a conversation, hearing the caller, and placing a call in an emergency.

3.586 APPROPRIATENESS OF PLACEMENT [Eff. 3/2/14]

A. The appropriateness of placement shall be determined.

1. The appropriateness of placement shall be documented on the state prescribed form.

2. An AFC facility shall not admit or keep any client requiring a level of care or type of service that the facility does not provide or is unable to provide.

B. If a client meets one or more of the following disqualifying criteria for appropriateness of placement, he/she shall be ineligible for the AFC program, regardless of the functional assessment score or the client's financial eligibility. The client shall be ineligible for AFC when he/she:

1. Needs skilled care services more frequently than once per week. If skilled care services are provided, the services must be provided by a skilled care provider; or,

2. Is unable or unwilling to meet his/her own personal hygiene needs under supervision; or,

3. Has an acute physical illness which cannot be managed through medications or prescribed therapy; or,

4. Has a substance abuse problem, unless the substance abuse is no longer acute and a physician determines it to be manageable; or,

5. Has ambulation limitations, unless compensated for by an assistive device with minimal assistance from staff; or,

6. Has a reportable communicable or infectious disease, unless the transmittal of the disease can be managed through the use of universal precautions and appropriate medical and/or drug treatment; or,

7. Is consistently disoriented to time, person, and place to such a degree that he/she poses a danger to self or others; or,

8. Has a seizure disorder which is not adequately controlled by medications; or,

9. Exhibits behavior that poses a physical threat to self or others. Such behavior includes, but is not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation; or,

10. Requires intravenous or tube feeding; or,

11. Is consistently unwilling to take medications prescribed by a physician or psychiatrist; or,

12. Is incapable of self-administration of medications. The client is not disqualified if the AFC facility has a staff member trained in medication administration, in accordance with Section 25-1.5-302, C.R.S., et seq., or who possesses all necessary licenses to administer medication; or,

13. Is a person whose physical safety cannot be assured in an AFC; or,

14. Is consistently, uncontrollably incontinent of bowel or bladder and it cannot be managed by the client with assistance from staff; or,

15. Needs restraints of any kind. “Restraint” for the purpose of this section means any physical or chemical device, application of force, or medication that is designed or used for the purpose of modifying, altering, or controlling behavior for the convenience of the facility and excludes medication prescribed by a physician as part of an on-going treatment plan or pursuant to a diagnosis; or,

16. Has a primary diagnosis of mental illness and is unwilling to comply with medications prescribed by the physician or psychiatrist; or,

17. Is receiving or is eligible to receive behavioral or mental health services, as defined in Title 27, C.R.S; or,

18. Has a developmental disability, as defined in Title 27, Article 10.5-102, C.R.S.

3.587 CARE PLANNING, PLACEMENT, AND CASE MANAGEMENT [Eff. 3/2/14]

A. When the client is determined eligible for the AFC program, the Single Entry Point (SEP) shall review available AFC facilities to determine if the client's needs can be met by any of the facilities. The review:

1. May require contact with AFC facilities outside of the client's county of residence.

2. Shall include a discussion of the client's needs with the AFC facility staff.

B. When an appropriate AFC facility(ies) has been located, the SEP shall:

1. Discuss the facility(ies) and with the client;

2. Arrange for the client to make an initial visit to the facility(ies); and,

3. Develop a care plan in conjunction with the client, family, SEP, and the AFC facility staff.

4. Ensure a signed provider agreement is in place prior to placement at the AFC facility. The agreement shall be:

a. Reviewed at least annually; and,

b. Be re-signed annually, contingent upon the AFC facility's ongoing appropriateness for the client and ongoing licensure as an assisted living residence by CDPHE.

C. A client shall not be placed in an AFC facility unless:

1. The competent client gives informed consent for placement; or,

2. The court-appointed guardian of the client requests placement; and,

3. The client or his/her legal representative understands and agrees to adhere to facility rules.

D. Any client admitted for respite care in an AFC shall meet the requirements for appropriate placement.

E. The SEP shall develop a care plan on the State Department prescribed form within ten (10) working days after program eligibility has been determined and prior to the arrangement for services.

1. The care plan shall be:

a. Signed by the client, SEP, and AFC facility staff.

b. Reviewed and updated at least once every twelve (12) months; and,

c. Reviewed sooner if there is a change in the client's needs; and,

d. Provided to all parties prior to admission to the facility.

2. Care planning shall include, but not be limited to, the following tasks:

a. Identify and document care plan goals and client choices.

b. Identify and document services, including type, duration and frequency.

c. Arrange for services through an AFC facility, coordinate service delivery, negotiate with the AFC facility and the client regarding service provision, and formalize the AFC agreement.

d. Complete program requirements for the authorization of services.

e. Refer the client to community resources, as needed, and attempt to develop resources for the client if a resource is not available within the client's community.

f. Explain the complaint procedures to the client, as listed on the care plan document.

g. Explain the client's right to appeal any decision.

F. The SEP shall provide ongoing case management, as follows:

Monitor the quality of care provided to clients.

1. Contact service providers concerning service coordination, effectiveness and appropriateness.

2. Review the client's assessment, care plan, and service agreements to include changes in client functioning, service effectiveness, appropriateness, and cost-effectiveness that may require a reassessment or a change in the care plan;

3. Make changes in service plans as appropriate to client needs and/or refer the client to community resources, if appropriate.

4. Provide conflict resolution and/or crisis intervention, as needed.

5. Identify and contact appropriate individuals, and resolve any problems or complaints raised by the client or others regarding service delivery, including corrective action processes, as appropriate.

6. Notify the appropriate law enforcement and/or Adult Protective Services agency of suspected abuse, neglect, or exploitation, as required by Sections 18-6.5-101 and 26-3.1-102, C.R.S.

G. The SEP shall complete a review of the client's current assessment or reassessment and the care plan with the client six (6) months following the assessment or reassessment.

1. The review shall be conducted by telephone, at the client's place of residence, at the place of service or other appropriate setting as determined by the client's needs.

2. A face-to-face home visit shall be completed when significant changes in the client's condition are identified.

H. The SEP shall complete a face-to-face functional reassessment within twelve (12) months of the initial functional assessment and every 12 months thereafter. A reassessment shall be completed sooner if the client's condition changes.

I. Reassessment shall include the following tasks:

1. Obtain diagnoses from the client's medical provider at least annually, or sooner if the client's condition changes.

2. Review the care plan, service agreement, and provider contract or agreement.

3. Evaluate service effectiveness, quality of care, and appropriateness of services.

4. Verify continuing financial and program eligibility.

5. Annually, or more often if indicated, complete a new care plan and service agreement.

6. Refer the client to community resources, as needed.

7. Determine continued appropriateness of placement.

J. The SEP shall update the information provided at the previous assessment or reassessment, utilizing the State Department prescribed functional assessment tool. When a new functional assessment is completed a copy shall be sent to the county department within thirty (30) days of the reassessment.

3.588 DENIALS, DISCONTINUATIONS, AND CASE TRANSFERS [Eff. 3/2/14]

A. The SEP shall deny or discontinue the client from the AFC program if he/she is determined functionally ineligible.

1. The client shall be informed of his/her appeal rights in accordance with rules under Section 3.850, et seq.

2. The client shall be provided appropriate referrals to other community resources within one (1) working day of discontinuation or denial.

3. The SEP shall notify all providers on the care plan within one (1) working day of discontinuation.

4. The SEP shall notify the county department within one (1) working day of discontinuation.

5. The SEP shall prepare for and defend at the hearing any appeal related to functional denial or discontinuation. The SEP may request assistance and/or testimony from the county department.

B. The county department shall deny or discontinue the client from the AFC program if he/she is determined financially ineligible.

1. The client shall be informed of his/her appeal rights in accordance with rules under Section 3.850, et seq.

2. The client shall be provided appropriate referrals to other community resources within one (1) working day of discontinuation or denial.

3. The county department shall notify all providers on the care plan within one (1) working day of discontinuation.

4. The county department shall notify the Single Entry Point (SEP) within one (1) working day of discontinuation.

5. The county department shall prepare for and defend at the hearing any appeal related to financial denial or discontinuation. The county department may request assistance and/or testimony from the SEP.

C. Denial and/or discontinuation from the AFC program shall occur for the following reasons:

1. Financial and Functional Eligibility: The SEP or county department shall deny or discontinue a client if the client is not financially eligible and/or is not functionally eligible for AFC.

2. Target population: The SEP or county department shall deny or discontinue when the client:

    a. Has been diagnosed with a developmental disability, as defined in Section 27-10.5-102, C.R.S.; or,

    b. Is receiving or eligible to receive behavioral or mental health services pursuant to any provision of Title 27, C.R.S.

3. Level of Care: The SEP shall deny or discontinue when the client:

    a. Does not meet functional capacity score minimum requirements; or,

    b. Does not meet appropriateness of placement criteria.

4. Receipt of Services: The SEP or county department shall deny or discontinue when the client:

    a. Has not received services for one month;

    b. Has twice refused to schedule an appointment for an initial assessment, six (6)-month review, or reassessment within a thirty (30) day consecutive period;

    c. Has failed to keep three (3) scheduled appointments within a thirty (30) consecutive day period;

    d. Has refused to schedule an appointment for a required visit after the client's case has been transferred to a new SEP or county department;

    e. Refuses to use the AFC payment to pay for services or uses the payment for services not identified in the service agreement; or,

    f. Refuses to sign the intake form, care plan, or other documents and forms required to receive services.

5. Facility Status: The SEP or county department shall deny or discontinue when the client:

    a. Is a resident of a nursing facility, hospital, or other facility other than the approved AFC facility; or,

    b. Enters a hospital for treatment and hospitalization that continues for thirty (30) days or more.

6. Service Limitations Related to Safety: The SEP or county department shall deny or discontinue when the client cannot be safely served given the type and/or amount of services available. Evidence of safety concerns include, but are not limited to:

    a. The results of an Adult Protective Services assessment that substantiates ongoing risk.

b. A statement from the client's physician attesting to diminished cognitive capacity, debilitating mental illness, or ongoing risk.

c. Lack of available AFC facilities.

d. A functional assessment score indicating a level of need for services in excess of those available under the AFC program.

e. Other available information or evidence that will support the determination that the client's safety is at risk.

7. Service Limitations Related to Cost Effectiveness: The SEP or county department shall deny or discontinue when other more cost effective alternatives are available to meet the client's needs.

8. Living Arrangements: The SEP or county department shall deny or discontinue when the client is residing anywhere other than his/her approved AFC facility.

a. The SEP may continue to authorize services while a resident is on medical or non-medical leave.

b. Combined leave shall not exceed a total of forty-two (42) days in a twelve (12) month period beginning with the date the client was admitted into the AFC program.

9. Move Out of State: The SEP or county department shall deny or discontinue when the client has moved out of state.

a. Discontinuation shall be effective the day after the date of the move.

b. Clients who leave the state on a temporary basis with the intent to return to Colorado within thirty (30) calendar days shall not be discontinued. If the client fails to return to Colorado the client shall be discontinued on day thirty-one (31).

10. Voluntary Withdrawal from the Program: The SEP or county shall deny or discontinue when the client requests withdrawal from the AFC program.

11. Death: The SEP or county shall discontinue the AFC program effective the day after the client's date of death. No notice of discontinuation shall be sent.

D. The SEP shall complete the following procedures to transfer an AFC client to a new county department:

1. Notify the county department of the client's plans to relocate to another county and the date of transfer.

2. If the client's current service providers do not provide services in the area where the client is relocating make arrangements, in consultation with the client, for new service providers.

3. If the client is moving from one county to another county to enter a new facility, forward copies of the following client records to the facility prior to the client's admission to the facility:

a. Current client assessment;

b. Verification of financial eligibility status.

E. The SEP shall complete the following procedures to transfer an AFC client to a new SEP:

1. The transferring SEP shall contact the receiving SEP by email or telephone to give notification that the client is planning to transfer, to negotiate a transfer date, and to provide information.

2. The transferring SEP shall forward copies of the client's case records, including forms required for the AFC program, to the receiving SEP prior to the relocation, if possible, but in no case later than five (5) working days after the client's relocation.

3. If the client is moving to enter a new Adult Foster Care facility, the transferring SEP shall forward copies of the following client records to the facility prior to the client's admission to the facility:

a. Current client assessment;

b. Verification of financial eligibility status.

4. The receiving SEP shall complete a face-to-face meeting with the client and an assessment and case summary update within ten (10) working days after notification of the client's relocation.

5. The receiving SEP shall review the care plan and the assessment tool, revise as necessary, and coordinate services and providers.

3.589 COUNTY DEPARTMENT AND SEP REQUIREMENTS AND RESPONSIBILITIES [Eff. 3/2/14]

A. The AFC facility shall:

1. Be licensed by the Colorado Department of Public Health and Environment (CDPHE) and shall operate in compliance with the rules concerning “Standards for Hospitals and Health Facilities: Chapter VII: Assisted Living Residences” (6 CCR 1011-1), including operator and staff qualifications, training, records, reporting, and resident rights.

2. AFC facilities shall provide all AFC services and protective oversight as outlined in Section 3.582.

3. AFC facilities shall coordinate client care with the SEP as follows:

a. Have a copy of the AFC's current license from the CDPHE available for annual inspection.

b. Notify the SEP of any AFC facility license revocation or suspension or of any violation of codes or ordinances within twenty-four (24) hours of occurrence.

c. Notify the SEP of a potential crisis situation where intervention from the SEP may be necessary.

d. Notify the SEP of any client's death, acute illness, or accident requiring medical attention.

e. Provide updates or cooperate in periodic conferences relating to the client.

f. Immediately notify the SEP of any AFC client's planned or unplanned medical or non-medical leave of more than twenty-four (24) hours.

B. The county department shall:

1. Ensure all requirements of the county department are implemented, as appropriate for the AFC program, related to:

a. General county requirements, as outlined in Section 3.520; and,

b. Documentation, as outlined in Section 3.520.2; and,

c. Program review and oversight, as outlined in Section 3.520.3; and,

d. Application processing, as outlined in Section 3.520.4.

2. The county department shall determine financial eligibility for AFC in the statewide automated system and update any changes in the case record.

3. The county shall notify the SEP in writing:

a. Within five (5) working days of determining AFC eligibility.

b. Within five (5) working days after the eligibility worker determines that the client is no longer financially eligible for AFC.

c. Within one (1) working day when the client has filed a written appeal with the county department.

d. Within one (1) working day when the client has withdrawn the appeal or a final agency decision has been entered.

4. The county shall respond to requests for information from the SEP within ten (10) working days.

C. The SEP shall:

1. Provide intake, screening, and referral activities, as follows:

a. Determine of the appropriateness of a referral for a client assessment.

1) If appropriate, complete intake activities within two (2) working days of the referral.

2) Obtain the client's or client's authorized representative's signature on the intake form.

3) Complete the AFC functional assessment within thirty (30) calendar days of referral.

b. Provide the client information and referral to other agencies, as needed.

2. The SEP shall identify potential payment source(s), including the availability of private funding:

a. Refer the client to the county department to complete an application; or,

b. Refer the client to another community resource that can assist in completing the application; or,

c. Verify the client's ability to private pay for services.

3. The SEP shall complete a functional assessment when the county department provides written notification that the client has requested AFC and is receiving or has submitted an application for Old Age Pension (OAP), Aid to the Needy Disabled Colorado Supplement (AND-CS), or the client is receiving Supplemental Security Income (SSI).

   a. If the client is being discharged from a hospital or nursing facility, the SEP shall complete the functional assessment regardless of whether the Medicaid application date has been provided by the county department.

   b. The SEP shall complete the functional assessment within two (2) working days after notification when a client is being transferred from a hospital to the AFC program.

   c. The SEP shall complete the functional assessment within five (5) working days after notification when a client who is being transferred from a nursing facility to the AFC program.

   d. The SEP shall complete the functional assessment within ten (10) working days after notification for all other clients. However, the SEP shall have a procedure for prioritizing urgent referrals.

4. The SEP shall document all case information.

   a. Documentation of contacts and case management activities shall be entered into the BUS within five (5) working days of the contact or activity.

   b. All information related to intake, assessment, and care planning shall be thoroughly documented within ten (10) working days of the intake, assessment or care planning using State Department prescribed forms and the BUS.

   c. Additional documentation that cannot be entered into the BUS shall be maintained in the case file.

5. The SEP shall notify clients of their program status using the State Department prescribed form at the time of initial eligibility, when there is a significant change in the client's payment or services, when an adverse action is taken, or at the time of discontinuation.

6. The SEP shall notify the county department in writing:

   a. Within five (5) working days of determining AFC functional eligibility.

   b. Within five (5) working days after the SEP determines that the client is no longer functionally eligible for AFC.

   c. Within one (1) working day when the client has filed a written appeal with the SEP.

d. Within one (1) working day when the client has withdrawn the appeal or a final agency decision has been entered.

7. The SEP shall respond to requests for information from the county department within ten (10) working days.

8. The SEP shall notify the client, at the time of his or her application and at the time of reassessment or discontinuation of the right to request a fair hearing before an Administrative Law Judge in accordance with Section 3.850, and to appeal adverse actions of the SEP or county department.

9. The SEP shall inform the client's Adult Protective Services caseworker, if applicable, of the client's status. The case manager shall participate in mutual staffing of the client's case.

10. The SEP shall report to the Colorado Department of Public Health and Environment any congregate facility, with three (3) or more residents, that is not licensed.

11. The SEP shall immediately report to the county department any information that indicates an overpayment, incorrect payment, or misuse of any AFC benefit, and shall cooperate with the county department in any subsequent recovery process.

12. The SEP shall be subject to routine quality control, program monitoring, and contract management to minimally include:

    a. Targeted review of the BUS documentation;

    b. Case file review;

    c. Targeted program review conducted via phone, email, or survey; and,

    d. Onsite program review;

    e. A performance improvement plan to correct areas of identified non-compliance; and,

    f. Contract sanctions when the SEP fails to implement a performance improvement plan.

3.590 BURIAL ASSISTANCE PROGRAM

3.591 PURPOSE OF PROGRAM [Eff. 3/2/14]

Burial benefits are available to eligible clients to cover reasonable and necessary costs for burial services.

3.592 DEFINITIONS [Eff. 3/2/14]

“Burial benefit” means the State Department program to pay all or a portion of the cost of funeral, burial, or cremation services for certain deceased clients.

“Burial funds” means the funds authorized by the county department under the burial benefit.

“Burial plot” means the client's final resting place, whether a cemetery plot, vault, or crematorium.

“Burial services” means those services provided as part of funeral, burial, or cremation services, including:

A. Transportation of the body from the place of death to a funeral home or other storage facility, and/or from the funeral home to the funeral/memorial site, and/or to the burial plot;

B. Storage of the body prior to final disposition and/or storage of the cremated remains for no more than one hundred twenty (120) days, in those cases where the remains are not buried and are not claimed by the client's family or friends;

C. Embalming, where necessary for preservation of the body and/or preparation of the body for the casket or for cremation;

D. Purchase of a casket or of an urn or other receptacle for the cremated remains;

E. Purchase of a gravesite, vault, vault liner, or crematorium space;

F. Purchase and placement of the grave marker and/or of perpetual care of the gravesite, vault, or crematorium;

G. Funeral or memorial service;

H. Cremation of the body;

I. Burial or internment of the body or cremated remains in a burial plot, vault, or crematorium;

J. Any other items that are incidental to burial services.

“Contributions” means any monetary payment or donation made directly to the service provider(s) by a non-responsible person to defray the expenses of the client's burial services.

“Legally responsible person(s)” means the parent(s) of a deceased minor client or the spouse of the deceased client.

3.593 ELIGIBILITY AND DETERMINATION FOR BURIAL ASSISTANCE [Eff. 3/2/14]

A. A burial benefit shall be available to cover reasonable and necessary costs for burial services when:

1. A deceased client was receiving Old Age Pension (OAP), Aid to the Needy Disabled (AND-SO or AND-CS), and/or eligible Colorado Medicaid assistance at the time of death; and,

2. The deceased client's estate is insufficient to pay all or part of the burial services; and,

3. The resources of the legally responsible person(s) for the support of the deceased client are insufficient, even with contributions from the client's estate, to enable the legally responsible person(s) to pay all or part of such expenses; and,

4. The total cost for all burial services does not total more than two thousand five hundred dollars ($2,500), except that the cost of a burial plot shall not be included in the $2,500 maximum cost limit when:

a. The client has a prepaid burial plot valued at two thousand dollars ($2,000) or less at the time of purchase; or,

b. A burial plot was purchased by someone other than the deceased client and donated to the deceased client; and,

B. The total burial benefit shall not exceed the current burial benefit rate, as determined by the program of assistance the client was receiving at the time of death.

1. Effective January 1, 2014, the burial benefit shall not exceed one thousand five hundred dollars ($1,500) for clients who were receiving Old Age Pension (OAP), Colorado Medicaid programs for persons sixty (60) years of age and older, or Colorado Medicaid for families and children, including an adult who meets the modified adjusted gross income (MAGI) criterion as defined in the Department of Health Care Policy and Financing regulations 10 CCR 2505-10 Section 8.100.4, at the time of death.

2. Effective January 1, 2014, the burial benefit shall not exceed one thousand dollars ($1,000) for clients who were receiving Aid to the Needy Disabled – State Only (AND-SO), Aid to the Needy Disabled – Colorado Supplement (AND-CS), or any other Colorado Medicaid program for clients under sixty (60) years of age at the time of death.

3. The reimbursement rate shall be adjusted by the State Department as needed to stay within the available appropriations. There shall be no appeal granted for this adjustment.

C. When assistance for funeral, burial, or cremation services is requested within one (1) year from the date of death on behalf of a deceased recipient of public or medical assistance by any interested party; an application requesting a burial benefit shall be completed and submitted to the county department for eligibility determination. The client's family or friends, or the county department when there are no known family or friends, shall make arrangements for disposition of the client's body in a reasonable, dignified manner which approximates the wishes and the religious and cultural preferences of the client or family, to the extent possible within the burial benefit rules and benefit funds.

1. The county department shall ensure that a choice of disposition by the client or a family member is made in writing. The choice of disposition may be made on the client's most recent application for benefits, in the client's will, on the application for burial benefits, or by any other document which the county department deems credible.

2. The county department shall coordinate with the client's family or interested parties to explain the burial benefit rules, including:

a. Options in the event the client's or family's burial preferences cannot be met within the limitations of the burial rules or benefit maximum; and,

b. If the family's burial preference is in opposition to the client's preference, as noted on the client's most recent application for benefits or other documentation, the burial benefit shall be used to meet the client's preference, unless all options for meeting that preference have been exhausted within the limitations of the burial benefit; and,

c. The legally responsible person's responsibility to pay the cost of burial services that exceed the approved burial benefit; and,

d. That voluntary contributions from family, friends, or other interested parties, may be used to cover some or all of the legally responsible person's costs that exceed the approved burial benefit.

3. The county department shall use the following procedures when the deceased client's burial preferences are unknown and a family member cannot be located:

    a. If a family member has not been located within twenty-four hours after the client dies, the county department shall have the body refrigerated or embalmed.

    b. If a family member has not been located within seven (7) days, the county department shall make the determination to bury or cremate the body based on the best option available.

    c. Complete and send written authorization to the appropriate funeral home or crematorium.

D. The county department shall reduce the burial benefit by applying the following monies toward the full burial costs in the order listed:

1. First, subtract monies due from any insurance policy of the deceased client to a legally responsible person or non-responsible person who is named as beneficiary or a joint beneficiary; then if costs remain,

2. Subtract the value of the deceased client's estate as of the date of death, including any cash or property of any kind which the deceased client owned at the time of death; then if costs remain,

3. Subtract monies from the legally responsible person(s) for the client, as follows:

    a. Social Security lump sum death benefits payable to a legally responsible person shall be exempt.

    b. If the legally responsible person(s) has resources below the SSI resource limit of $2,000 for an individual or $3,000 for a couple.

        1) If the legally responsible person is the widow(er), the individual resource limit shall apply.

        2) The legally responsible person(s) may voluntarily contribute monies toward the cost of the burial services.

    c. If the legally responsible person(s) has resources over the SSI limit, the amount of resources over the limit shall be used to reduce the burial benefit; then if costs remain,

4. The county department shall issue a written authorization for the amount of the burial benefit, up to the benefit limit, as outlined in Section 3.590.

E. Once the application and choice of burial services is determined, the family or county department shall contact the appropriate provider(s) to obtain a written estimate of the provider's proposed charges for burial services. If more than one provider is involved, a separate written estimate from each provider shall be obtained.

F. Once the proposal(s) from the provider(s) is received, the county department shall determine if a burial benefit is appropriate, as outlined in Section 3.590.

1. If the combined charges from the provider(s) exceed two thousand five hundred dollars ($2,500), no burial benefit shall be paid.

2. The county department shall allow the provider(s) to resubmit a written estimate within thirty (30) calendar days of notification that the charges exceeded the burial benefit maximum.

G. The county department of residence of the deceased individual shall authorize the approved burial benefit through the statewide automated system. The burial benefit shall be paid directly to the provider(s).

H. The county department shall have a statement of agreement between the providers, which ensures that the distribution of burial benefits is proportional to burial services provided or as the providers otherwise determine. The agreement shall be signed by all provider(s) and shall be approved and signed by the county department before the burial benefit is authorized in the statewide automated system.

Editor's Notes

Primary sections of 9 CCR 2503-1 have been recodified effective 09/15/2012. See list below. Versions and rule history prior to 09/15/2012 can be found in 9 CCR 2503-1. Prior versions can be accessed from the All Versions list on the current rule page.

Rule section 3.000 – 3.100, et seq. has been recodified as 9 CCR 2503-1, GENERAL RULES.

Rule section 3.200, et seq. has been recodified as 9 CCR 2503-2, GENERAL FINANCIAL ELIGIBILITY CRITERIA.

Rule section 3.300, et seq. has been recodified as 9 CCR 2503-3, (Reserved for Future Use).

Rule section 3.400, et seq. has been recodified as 9 CCR 2503-4, (Reserved for Future Use).

Rule section 3.500, et seq. has been recodified as 9 CCR 2503-5, ADULT FINANCIAL PROGRAMS.

Rule section 3.600, et seq. has been recodified as 9 CCR 2503-6, COLORADO WORKS PROGRAM.

Rule section 3.700, et seq. has been recodified as 9 CCR 2503-7, OTHER ASSISTANCE PROGRAMS.

Rule section 3.800, et seq. has been recodified as 9 CCR 2503-8, ADMINISTRATIVE PROCEDURES.

Rule section 3.900, et seq. has been recodified as 9 CCR 2503-9, COLORADO CHILD CARE ASSISTANCE PROGRAM.

History

Sections 3.500-3.500.63 repealed eff. 09/15/2012.

Entire rule eff. 03/02/2014.

Sections 3.530-3.530.A emer. rules eff. 05/02/2014.

Section 3.581 emer. rule eff. 06/06/2014.

Sections 3.520.4-3.520.4.D.6 emer. rules eff. 07/11/2014.

Section 3.530 eff. 08/01/2014.

Sections 3.540-3.540.A emer. rules eff. 08/06/2014.

Sections 3.520.4-3.520.4.D.6, 3.540-3.540.A, 3.581 eff. 10/01/2014.

Sections 3.530, 3.540, 3.581 emer. rules eff. 01/01/2015.

Sections 3.532, 3.543, 3.583 emer. rules eff. 01/22/2015.

Sections 3.530, 3.540, 3.581 eff. 03/20/2015.

Sections 3.532, 3.543, 3.583 eff. 04/01/2015.

Sections 3.510, 3.520.71, 3.542 eff. 06/01/2015.

Section 3.520.4 emer. rule eff. 06/05/2015.

Section 3.520.4 eff. 09/01/2015.

Sections 3.520.4-3.520.4.D eff. 01/01/2016.

Annotations

Rule 3.520.4.D.6. (adopted 08/08/2014) was not extended by Senate Bill 15-100 and therefore expired 05/15/2015.