CHAPTER 9500
DEPARTMENT OF HUMAN SERVICES
ASSISTANCE PAYMENTS PROGRAMS

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9500.0530

A. [Renumbered 9500.1208, item A]

B. [Renumbered 9500.1208, item B]

C. [Renumbered 9500.1208, item C]

D. [Renumbered 9500.1208, item D]

E. [Repealed, 10 SR 1715]

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9500.0600 [Renumbered 9500.1246]

9500.0610 [Renumbered 9500.1248]

MINNESOTA SUPPLEMENTAL AID

9500.0650 STATUTORY AUTHORITY FOR MINNESOTA SUPPLEMENTAL AID PROGRAM.

Parts 9500.0650 to 9500.0710 governs the administration of the Minnesota supplemental aid program as enacted by Laws of Minnesota 1974, chapter 487.

Statutory Authority: *MS s 256D.41*

9500.0660 PURPOSE OF MINNESOTA SUPPLEMENTAL AID PROGRAM.

The purpose of the Minnesota supplemental aid program is to provide financial assistance to recipients of supplemental security income for the aged, blind, disabled (SSI), or to persons who, but for excess income or resources, would be receiving SSI, and who are found to have maintenance needs as determined by the application of the state standards in effect for the adult categories in December 1973, which exceed their income from SSI and other sources, and who would otherwise have qualified for the benefits under the programs of OAA, AB, or AD as such former programs were then in effect.

Statutory Authority: *MS s 256D.41*

9500.0670 DEFINITIONS.

Subpart 1. **Scope.** The terms defined in this part shall have the meanings given them unless otherwise provided as indicated by the context.

Subp. 2. **Applicant for supplemental security income.** "Applicant for supplemental security income" means an individual who has applied for supplemental security income and who, but for excess income or resources, would be a recipient of supplemental security income.

Subp. 3. **Commissioner.** "Commissioner" means the commissioner of human services or his designee.

Subp. 4. **Department.** "Department" means the Department of Human Services.

Subp. 5. **Income.** "Income" means earned and unearned income from any source whatsoever, reduced by amounts paid for federal and state personal income taxes and federal social security taxes.

Subp. 6. **Local agency.** "Local agency" means the county welfare boards in the several counties of the state except that it may also include any multicounty welfare boards or departments where those have been established in accordance with law.

Subp. 7. **Supplemental security income.** "Supplemental security income" means benefits paid under the federal program of supplemental security income

for the aged, blind, and disabled, title XVI of the Social Security Act, as enacted by section 301 of the Social Security Amendments of 1972.

Subp. 8. **Supplemental aid.** "Supplemental aid" means state and county payments to eligible applicants for or recipients of supplemental security income, in accordance with the provisions of this act and rules promulgated by the commissioner of welfare.

Statutory Authority: *MS s 256D.41*

History: *L 1984 c 654 art 5 s 58*

9500.0680 ELIGIBILITY REQUIREMENTS.

Minnesota supplemental aid shall be granted to any person:

A. who has attained the age of 65 years or who has met SSI criteria for blindness or disability; and

B. whose net equity in real property:

(1) if aged or disabled, does not exceed $10,000, which maximum will be increased to $12,000, effective July 1, 1974, and to $15,000 effective January 1, 1975; or

(2) if blind, does not exceed $15,000; and

C. whose net equity in personal property:

(1) if aged or disabled, convertible into cash does not exceed $300 if single or if married does not exceed $450;

(2) if aged, does not have in excess of $1,000 in cash surrender value of life insurance; or

(3) if disabled, does not have in excess of $500 in cash surrender value of life insurance; or

(4) if aged, blind, or disabled, does not have in excess of $750 in prepaid funeral contract plus accrual of interest therein not exceeding $200;

(5) if blind and single, does not have in excess of $2,000 in undifferentiated liquid assets, or if blind and married, together with his spouse does not have in excess of $4,000 in undifferentiated liquid assets, including therein up to $750 per person for a prepaid funeral contract plus an accrual of interest not over $200 per person; and

(6) in the form of a mobile home used as a living abode will not be a bar to eligibility; and

D. whose current income and resources, and those of his spouse if married, are insufficient for maintaining a standard of living necessary for health and decency as determined by the application of the standards of allowances in effect in the adult categories of OAA, AB, and AD in December 1973 in the county wherein he is presently residing.

Statutory Authority: *MS s 256D.41*

9500.0690 EVALUATION OF PROPERTY TRANSFERS.

The establishment of an applicant's initial eligibility for, or a recipient's redetermination of eligibility for Minnesota supplemental aid in situations wherein the applicant or recipient has divested himself of resources without receiving a reasonable consideration therefor and which resources might otherwise have been available for his support, is contrary to public policy and, in some instances, may constitute a criminal offense on behalf of both the donor and the donee of the resource. To prevent this practice, county agencies shall employ the following procedure and presumptions in assessing eligibility for Minnesota supplemental aid.

A. Each applicant or recipient shall be required to divulge whether within the preceding three years he has transferred any property, real or personal, totaling in excess of $300 if single, or $450 if married, to any person or persons without receiving adequate consideration therefor.

B. Any property transfer as defined in item A shall be presumed to be a gift in contravention of public policy, and the property so transferred shall be presumed to remain available for the support of the applicant or recipient if reasonable effort is expended for its recovery.

C. The applicant or recipient who has transferred property in violation of this part shall be required to provide to the county agency a description, including value, of the property, the name or names of all persons who received such property, and the circumstances under which the property was transferred.

D. The applicant or recipient who has transferred property in violation of this part shall be required to make a reasonable effort, in cooperation with the county agency, to reacquire the property so transferred.

E. The information required by item C and the efforts made to reacquire the property under item D shall be entered on the appropriate application or eligibility redetermination forms.

F. If the county agency is unable to persuade the donor and/or donee of the transferred property to have it returned to the applicant or recipient for his current support, then the matter of the property transfer shall be reported with full documentation to the county attorney for possible criminal prosecution.

G. A transfer of property in violation of this part shall not of itself constitute grounds for ineligibility for Minnesota supplemental aid if application of items C to F has failed to make the transferred property available for the support of the applicant or recipient.

Statutory Authority: *MS s 256D.41*

9500.0700 DETERMINATION OF COUNTY OF FINANCIAL RESPONSIBILITY.

Subpart 1. **Definition.** In all matters concerning payment of the county-administered Minnesota supplemental aid, "county of financial responsibility" means:

A. the county from which the applicant is receiving the federally administered supplemental aid;

B. if the applicant was receiving old age assistance or aid to the blind or aid to the disabled in December 1973, but did not qualify for the federally administered supplement and now qualifies for the county-administered supplement, that county from which he was receiving OAA, AB, or AD in December 1973;

C. if the applicant is a recipient of medical assistance either as an "MA only" case, or by having qualified for SSI benefits after January 1, 1974, the county from which he is receiving medical assistance; or

D. if the applicant does not qualify under subpart 1, item A, B, or C it means the county in which he was residing as of the date his effective application for the county administered supplemental aid was signed.

Subp. 2. **Duration of county of financial responsibility status.** The county thus determined to be financially responsible for payment for the county administered supplemental aid shall remain responsible for so long as his application remains in effect irrespective of his residence in other counties within this state thereafter. This supplemental grant is to be canceled whenever the recipient has been absent from the state for one calendar month or more.

Statutory Authority: *MS s 256D.41*

9500.0710 MINNESOTA SUPPLEMENTAL AID STANDARDS AND STATE PARTICIPATION.

Subpart 1. **Determination of need.** Local agencies shall determine need in individual cases in accordance with the standards of assistance and related income exemptions as were in effect in the adult programs of OAA, AB, and AD in December 1973.

Subp. 2. **Amount of grant.** The amount of the supplemental aid grant is the difference between what the applicant would have received in an OAA, AB, or AD grant in December 1973 and his current SSI including the federally administered supplement. If the applicant is not eligible for SSI by reason of excess income and resources, then the supplemental grant shall be the difference between what he would have received in December 1973 in an OAA, AB, or AD grant and the total of his current income.

Subp. 3. **Grant recipient.** The county administered supplemental aid grants shall be issued by the local agencies to the recipient or his protective-representative payee or his conservator or guardian of estate in the form of county warrants immediately redeemable in cash.

Subp. 4. **State reimbursement to local agencies.** The state will reimburse local agencies on a monthly basis for 50 percent of the actual payments made under this county-administered supplemental aid program. Payment for nonrecurring special needs is to be allowed for catastrophic major home repairs or replacement of a furnace, water heater, plumbing, or the electrical system. Other allowable special needs are for necessary repairs or replacement of household furniture and appliances, for moving expenses, and for annual fuel and utility adjustments for the difference between the standard allowances and verified consumption by recipients.

Subp. 5. **Allocation of net income.** An applicant or recipient may allocate all his net income to provide for the basic unmet needs, not to exceed the total amount of the needs as determined by statewide standards, of persons that he is legally responsible to support, before he is expected to use such income for his own needs in all instances except:

A. statutes exist which make provision for support of legal dependents in institutions; and

B. the income is from a trust fund or other source which designates its use only for the applicant or recipient, or for some specific purpose.

Statutory Authority: *MS s 256D.41*

9500.0750 [Repealed, 11 SR 1069]

9500.0760 [Repealed, 11 SR 1069]

9500.0770 [Repealed, 11 SR 1069]

9500.0780 [Repealed, 11 SR 1069]

9500.0790 [Repealed, 11 SR 1069]

9500.0800 [Repealed, 11 SR 1069]

9500.0810 [Repealed, 11 SR 1069]

9500.0820 [Repealed, 11 SR 1069]

9500.0830 [Repealed, 11 SR 1069]

9500.0840 [Repealed, 11 SR 1069]

9500.0850 [Repealed, 11 SR 1069]

9500.0860 [Repealed, 11 SR 1069]

GENERAL ADMINISTRATION

9500.0900 FREE CHOICE OF PROVIDER.

Subject to the following limitations, the MA program shall provide eligible recipients with free choice of participating local medical providers. The term "local" as used herein means that geographic area surrounding the recipient's residence which is viewed by the local welfare agency as reasonable for obtaining

any given medical service. Free choice is limited by the choice available to the local population. Eligible recipients may exercise free choice by enrolling in participating Health Maintenance Organizations (HMO). While enrolled in an HMO, the recipient is limited to free choice within that HMO. No long term care facility shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from requiring any resident of the facility to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0910 [Repealed, 11 SR 1069]

9500.0920 [Repealed, 11 SR 1069]

9500.0930 RECORDS.

Subpart 1. [Repealed, 11 SR 1069]

Subp. 2. [Repealed, 11 SR 1069]

Subp. 3. [Repealed, 11 SR 1069]

Subp. 4. **Provider records.** Medical providers participating in the MA program shall:

A. maintain for at least five years, in the manner prescribed by the Department of Human Services in accordance with applicable federal regulations, medical and financial records fully disclosing the extent of service provided, the medical necessity for such service and payment claimed under the MA program;

B. on request, and upon being provided a copy of the recipient's written consent, make their records available to the Department of Human Services, the state legislative auditor and the Department of Health, Education and Welfare (or representatives of those agencies) in order to justify all payments made to such provider and the propriety of all services rendered by such provider under the MA program;

C. not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to Minnesota Statutes, chapter 256B.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0940 [Repealed, 11 SR 1069]

9500.0950 [Repealed, 11 SR 1069]

9500.0960 AGREEMENTS WITH PROVIDERS.

An eligible provider is a vendor of medical care, services, or supplies which meets federal and state standards for participation in the MA program, complies with all requirements of parts 9500.0750 to 9500.1080, and executes a provider agreement. Providers shall complete and sign an appropriate provider agreement in the form stipulated by the Department of Human Services. Failure by the provider to comply with federal and state statutes, rules, and regulations pertinent to the MA program shall result in termination of the provider agreement, ineligibility to receive MA program reimbursement and, where appropriate, action to recover medical assistance funds. In order to be eligible for reimbursement under the Minnesota MA program, out-of-state providers must complete and sign an appropriate provider agreement and comply with all licensing and certification requirements of the state or Canadian province in which they are located.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0970 QUALIFICATION OF ELIGIBLE PROVIDERS.

The state agency shall determine the eligibility of each provider of medical care, services, and supplies. Any medical vendor who, on request, and upon being provided a copy of the recipient's written consent, refuses to allow a proper survey and/or reimbursement agency access to its records, shall become an ineligible provider upon written notification from the Department of Human Services. The commissioner may terminate payments under Minnesota Statutes, chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been determined to be ineligible for payments under Title XIX of the Social Security Act. Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of medical assistance funds by the commissioner of human services. The commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible without prior notice and an opportunity for a hearing, pursuant to Minnesota Statutes, chapter 14, on the commissioner's proposed action.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0980 [Repealed, 10 SR 842]

9500.0990 UTILIZATION CONTROL.

Subpart 1. **Statewide program.** A statewide surveillance and utilization control program is established subject to applicable federal law and regulations. Such program shall include:

A. an ongoing evaluation of the necessity for the quality and timeliness of the services provided to eligible individuals under the MA program in order to promote the most effective and appropriate use of available services and facilities;

B. a postpayment review process which allows for the development and review of recipient utilization profiles, provider service profiles, exception criteria, and one which identifies exceptions in order to rectify misutilization practices of recipients, providers, and institutions.

Subp. 2. **Inpatient hospital services and services provided in skilled and intermediate care facilities.** Under this surveillance and utilization control program, all inpatient facilities shall:

A. have in effect a written utilization review plan which meets the requirements of applicable state law and federal regulations;

B. provide that the committee performing the utilization review activities will review each eligible individual's discharge plan to be developed in accordance with applicable state law and federal regulations;

C. obtain physician certification prior to or at the time of admission that such inpatient services are medically necessary or, in the case of an individual who applies for medical assistance while in an institution, obtain physician certification prior to authorization of payment;

D. obtain physician recertification at least every 60 days thereafter that such services continue to be medically necessary;

E. develop written plans of care in accordance with applicable state law and federal regulations; and

F. cooperate in a quality assurance and review program established by the Minnesota Department of Health in cooperation with the Department of Human Services and in accordance with the provisions of applicable state law and federal regulations.

Subp. 3. **Long-term care facility requirements.** In accordance with the surveillance and utilization control program, all long-term care facilities (i.e., skilled nursing facilities, intermediate care facilities, mental hospitals) shall provide for:

A. A periodic review and evaluation of the necessity for admission and continued stay of each eligible individual receiving inpatient long-term care facility services. Such review and evaluation shall be performed by medical and other appropriate professional staff who are not themselves directly responsible for the care of eligible individuals, nor financially interested in any such institution nor (except in the case of mental hospitals) employed by such institution. Such reviews and evaluations shall be carried out in accordance with the requirements specified in applicable federal regulations.

B. Review by the state agency (or its designee) of the recommendations for admission, in accordance with applicable federal regulations.

Subp. 4. **Medical and independent professional review.** Under the surveillance and utilization control program, the state agency shall establish and implement a program of medical review (including medical evaluation and on-site inspection) of the care provided patients in mental hospitals and skilled nursing facilities, and a program of independent professional review (including medical evaluation and on-site inspection) of the care provided residents in intermediate care facilities both of which shall satisfy the requirements of applicable federal regulations.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.1000 TRANSPORTATION.

The MA program shall pay for transportation through the centralized payment system only in accordance with part 9500.1070, subpart 22, item A. However, local welfare agencies may approve and pay for transportation when furnished by someone other than an enrolled medical provider. Such service must receive prior authorization and shall be reimbursable from the local welfare agency's medical assistance administrative account.

Statutory Authority: *MS s 256B.04 subd 2*

SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM

9500.1060 SERVICES NOT COVERED BY MEDICAL ASSISTANCE.

The following services are not covered under the MA program:

A. medical services or supplies paid for directly by the recipient;

B. medications dispensed by a physician that could reasonably be obtained from a licensed pharmacy (see part 9500.1070, subpart 18);

C. medical services or supplies where the requisite prior authorization was not submitted or was denied;

D. autopsies;

E. missed appointments;

F. telephone calls or other non face-to-face communication between the provider and the recipient;

G. routine reports (e.g., Social Security, insurance) unless requested by the state agency;

H. investigational surgery or procedures (e.g., research efforts not clearly essential to the patient's health);

I. illegal operations and other procedures prohibited by law;

J. artificial insemination;

K. transsexual surgery;

L. aversion therapy (including cash payments from recipients) unless provided in accordance with DPW 39 (12 MCAR section 2.039);

M. cosmetic surgery aimed at beautification only;

N. weight reduction programs unless the program treats a medical condition causing obesity, or obesity interferes with the health, well-being, or employability of the recipient;

O. billing charges;

P. mileage charged by eligible providers;

Q. reversal of voluntary sterilization procedures;

R. medical care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility (i.e., an individual who is under the care or control of a correctional authority);

S. duplication of services by more than one provider without appropriate medical referrals; and

T. abortion services unless specifically provided in part 9500.1070, subpart 24.

Statutory Authority: *MS s 256B.04 subd 2*

NOTE: 12 MCAR section 2.039 (DPW 39) has been repealed.

9500.1070 SERVICES COVERED BY MEDICAL ASSISTANCE.

Subpart 1. **In general.** The following services are covered under the MA program.

Subp. 2. **Inpatient hospital services.** "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive medical assistance under title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the secretary of the Department of Health, Education, and Welfare. All inpatient hospitals certified for participation under medicare (title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

The following inpatient hospitalization services must receive prior authorization: medical care of marginal medical necessity.

The following limitations apply to inpatient hospital services:

A. A private room must be certified by a licensed physician as medically necessary, unless the private room rate does not exceed the semiprivate room rate in that hospital.

B. The hospital must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by the Department of Human Services.

The following inpatient hospital services are not covered under the MA program: leave days, leaves-of-absence, and reserved beds as defined under federal regulations.

Subp. 3. **Long term care facility services.** "Long term care facility services" are those services provided in facilities (or distinct parts thereof) licensed by the Minnesota Department of Health and certified as eligible providers of skilled nursing facility services, intermediate care facility services, tuberculosis or mental hospital services, or those facilities similarly licensed in another state or a Canadian province. The term "long term care facilities" (LTC) as used herein

includes skilled nursing facilities (SNF), intermediate care facilities (ICF), and tuberculosis or mental hospitals.

A. "Skilled nursing facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided in a SNF. A SNF is a facility certified by MDH as meeting the requirements of Title XVIII of the Social Security Act, except that the exclusion contained therein with respect to institutions which are primarily for the care of tuberculosis or mental disease shall not apply; and which meets the requirements of applicable federal regulations.

B. "Intermediate care facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided for individuals who are determined, in accordance with Title XIX of the Social Security Act, to be in need of the care provided in an ICF. An ICF is an institution which:

(1) is licensed under state law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities;

(2) satisfies the standards prescribed by the secretary of health, education and welfare as necessary for the proper provision of such care as enumerated in applicable federal regulations; and

(3) meets such standards of safety and sanitation as mandated by federal regulations.

The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements described above. With respect to services furnished to individuals under age 65, the term intermediate care facility does not include any public institution for mental diseases or mental defects except it may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

"Intermediate care facility, services/nursing home" means services provided in an ICF-NH. An "ICF-NH" is an institution licensed as a nursing home and which meets each of the conditions described above. "Intermediate care facility services/boarding care home" means services provided in an ICF-BCH or which could be provided in an ICF-BCH. An "ICF-BCH" is an institution licensed at least as a boarding-care home and which meets each of the conditions described above.

"Intermediate care facility services/mentally retarded" means services provided in an ICF/MR. An "ICF/MR" is an institution licensed by the Minnesota Department of Health, licensed in accordance with parts 9525.0230 to 9525.0430 and which meets each of the conditions described above.

"Intermediate care facility services/chemically dependent" means services provided in an ICF/CD. An "ICF/CD" is a facility licensed by the Minnesota Department of Health, licensed under parts 9530.2600 to 9530.4000 and which meets each of the conditions described above.

C. "Inpatient psychiatric hospital services for individuals under age 21" are those services provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. Such services include only inpatient services which, in the case of an individual:

(1) involve active treatment which meets the standards prescribed by the secretary of health, education and welfare;

(2) are provided by a team (consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment thereof) and determined to be necessary on an inpatient basis and which can reasonably be expected to improve the condition giving rise to the

need for such services, to the extent that eventually such services will no longer be necessary; and

(3) are provided prior to the date such individual attains age 21, or if the individual was receiving such services during the period immediately preceding his 21st birthday, such services may be continued up to the date the individual no longer requires such services or the date the individual attains age 22, whichever date comes first.

D. Inpatient hospital, SNF, and ICF services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

(1) "Inpatient hospital services in an institution for mental diseases" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements of title XVIII of the Social Security Act.

(2) "Inpatient hospital services in an institution for tuberculosis" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements of title XVIII of the Social Security Act.

(3) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined by applicable federal regulations.

(4) "Intermediate care facility services" are those items and services furnished by an intermediate care facility, as defined by applicable federal regulations, to residents who have been determined in accordance with such federal regulations to be in need of such care.

(5) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

(6) An "institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis including medical attention, nursing care, and related services.

E. Levels of care. Reserved for future use.

F. General limitations. Payment will be made only to facilities that have in effect an approved utilization review plan and which meet all other requirements of the surveillance and utilization control program prescribed by applicable federal regulations. Medical assistance is not available on behalf of any individual who is an inmate of a public institution (except where a patient is in a medical institution (see Minnesota Statutes, chapter 256B) or is a resident of an intermediate care facility) or any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. An individual on provisional discharge or convalescent leave from an institution for mental diseases is not considered to be a patient in such institution. An institution for the mentally retarded or an institution for the chemically dependent is not considered an institution for mental diseases. Payments to institutions for the mentally retarded or persons with related conditions shall not include reimbursement for vocational and educational activities. Payment will be made to facilities only in accordance with applicable federal reimbursement formula regulations.

G. Health care facility report. Every facility required by state law to be licensed by the Minnesota Department of Health shall provide such annual reports to the commissioner of human services as may hereafter be required. Each health care facility participating under the MA program shall provide the commissioner of human services with a full and complete financial report of the facility's operations, including:

(1) an annual statement of income and expenditures;

(2) a complete statement of fees and charges;

(3) the names of all individuals, partnerships, and corporations

(other than mortgage companies) owning any interest of ten percent or more of the facility; and

(4) the names of all owners of interest in the facility as defined in subitem (3), or the children, parents, or spouses of such owners who own an interest in any other health care facility or organization doing business with the MA program or who are otherwise enrolled as providers.

A chapter 9510 cost report shall satisfy this requirement. The financial records, reports, and supporting data of each participating facility shall be accessible for inspection and audit by the commissioner of human services or designees.

Subp. 4. **Physician services.** Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MA program. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MA program. The MA program shall pay for all emergency and medically-necessary health care.

A. The following physician services must receive prior authorization:

(1) all medical, surgical, or behavioral modification services aimed specifically at weight reduction;

(2) surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment or employability;

(3) removal of tattoo;

(4) [Repealed, 10 SR 842]

(5) individual hourly sessions with a psychiatrist licensed to practice medicine in the United States or Canada in excess of ten per calendar year.

B. The following are limitations to physicians' services:

(1) [Repealed, 10 SR 842]

(2) The MA program will pay for up to 26 additional hourly sessions with a psychiatrist licensed to practice medicine in the United States or Canada per calendar year when all of the following conditions exist:

(a) three or more members of one family unit are all seen together at every session;

(b) the 26 hourly sessions extend over a period of time greater than six consecutive months; and

(c) at least one of the family members is under age 18.

(3) The MA program will pay for ongoing chemotherapy management on a once-a-week average basis, provided that both of the following conditions apply: the medication required is an antipsychotic or antidepressant, and no more than 52 sessions take place within a 12-month period.

(4) The MA program will pay for family psychotherapy of two family members (conjoint psychotherapy with continuing medical diagnostic evaluation and drug management) as needed for up to two hours per week for a 20-week period. (When more than two family members are involved. See item B, subitem (2)).

(5) [Repealed, 10 SR 842]

Subp. 5. **Health maintenance organization (HMO).** Health maintenance organizations are organizations licensed by the state which provide comprehensive health care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMOs through a prenegotiated and fixed per capita payment determined in accordance with applica-

ble federal regulations made on behalf of enrolled recipients. HMOs shall provide, either directly or through arrangements with other medical providers, for all medical services and supplies covered under the offical medical assistance state plan. HMO services shall be provided in accordance with the HMO contract and shall not be subject to service limitations, prior authorization requirements, and billing and recovery procedures under parts 9500.0750 to 9500.1080.

Subp. 6. **Other licensed practitioners.** The MA program shall pay for medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of his practice as defined by state law. Out-of-state practitioners who are licensed in the state of service are also eligible to participate in Minnesota's MA program. This category is limited to services provided by licensed chiropractors, podiatrists, vision care providers, psychologists, nurse-midwives, osteopaths not licensed to practice medicine and surgery, and by public health nurses. Limitations on the number of treatments pertain to each eligible recipient per calendar year.

A. Chiropractors. Chiropractors must be licensed and conform to the uniform minimum standards promulgated by the secretary of health, education and welfare under title XVIII of the Social Security Act, as amended. The MA program limits payment for services provided by chiropractors as follows:

(1) The request for chiropractic services must originate with the recipient, his family or caseworker and may proceed only with the recipient's full knowledge and consent.

(2) Payment is limited to manual manipulation of the spine for a diagnosis of subluxation of the spine. No other chiropractic service is covered under the MA program.

(3) Payment is limited to six treatments per month and 24 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(4) The MA program shall not cover Xrays nor any other diagnostic or laboratory procedure provided by a chiropractor.

B. Podiatrists. The MA program limits payment for podiatry services as follows:

(1) The request for podiatry services must originate with the recipient, his family, his caseworker or, where applicable, the staff of the long term care facility wherein he resides, and may proceed only with the patient's full knowledge and consent.

(2) A limit of three vists per month and 12 visits per year is placed on the following: total office and outpatient visits, total home or long term care facility visits, and hospital visits.

(3) Treatment in excess of these maxima must receive prior authorization.

(4) The following podiatry services are not covered under the MA program for long term care facility patients: ordinary foot hygiene, use of skin creams to maintain skin tone, and normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

C. Vision care. "Optometric services" are those services provided by or under the personal supervision of a licensed optometrist within the scope of his profession as defined by state law. "Eyeglasses" are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, to aid or improve vision. Eligible providers include optometrists currently licensed by the Board of Optometry, ophthalmologists currently licensed by the state, opticians who are normally associated with the fabrication and/or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

(1) The following vision care services must receive prior authorization:

(a) Contact lenses: supplemental contact lens evaluation; contact lens check-up; spherical lens fitting (single vision); cylindrical, lenticular, aphakic, or prism ballast lenses; keratoconus lenses; cosmetic lenses (disfigurement only); fitting previous contact lens wearer; soft contact lens fitting; fitting monocular patient;

(b) Custom-fit prosthetic eye;

(c) Amblyopia therapy: "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.

(d) Strabismus therapy: "Strabismus" includes all test procedures necessary for classification, degree of squint, and determination of expecteds.

(e) Vision therapy-supplemental evaluation and report.

(f) More than one pair of eyeglasses in any single 12-month period.

(g) Photochromatic lenses: must be accompanied by a statement of medical necessity.

(h) Sunglasses: must be accompanied by statement of medical necessity.

(i) Lens coating-surface or edge.

(2) The following vision care services are not covered under the MA program:

(a) services provided principally for cosmetic reasons, including contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, or marked acuity improvement over spectacle correction; and replacement of lenses or frames due to a recipient's personal preference for a change of style or color;

(b) technical services related to the provision of noncovered services.

D. Psychologists. Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas.

(1) The following psychological services must receive prior authorization: services in excess of the limitation on the number of visits (see below).

(2) The MA program limits payment for services provided by psychologists as follows:

The MA program will pay for up to ten hourly sessions with a licensed psychologist per calendar year for any eligible recipient.

The MA program will pay for up to 26 additional hourly sessions with a licensed psychologist per calendar year when all of the following conditions exist: three or more members of one family unit are all seen together at every session, the 26 hourly sessions extend over a period of time greater than six consecutive months, and at least one of the family members is under age 18.

The MA program will pay for family psychotherapy of two family members as needed for up to two hours per week for a 20-week period. When more than two family members are involved, see subitem (2).

(3) The following psychological services are not covered under the MA program: medical supplies and equipment.

E. Public health nurses. A "public health nurse" is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse. The MA program limits payment for public health nurses to the following services:

(1) health assessment and screening;

(2) health promotion and preventive counseling;

(3) EPSDT screening if approved by the Minnesota Department of Health; and

(4) Health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided.

Subp. 7. **Outpatient hospital services.** "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under Medicare (title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

A. The following outpatient hospital services must receive prior authorization:

(1) kidney dialysis not covered by Medicare;

(2) oral surgery (except in emergencies);

(3) hemodialysis back-up service;

(4) supplemental and tube feedings for patients who have special nutritional needs; and

(5) all physician services which must receive prior authorization (see subpart 4, item A).

B. The following is a limitation to services provided by outpatient hospitals:

Each hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply will result in denial of payment under the MA program.

C. The following outpatient hospital services are not covered under the MA program: hypoallergenic foods, baby foods; diapers; charges for services of house staff, interns, residents, administrative or supervisory staff (including physician-owners) who are paid by the hospital or by other sources.

Subp. 8. **Clinic services.** "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

"Family planning agencies" are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. Such services include both fertility and infertility programs.

The following are limitations to services provided by family planning agencies: the request for such services must originate with the recipient and proceed with his full knowledge and consent. The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment under the MA program.

Subp. 9. **Home health care services.** "Home health care services" are any of the following items and services when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, SNF, or ICF:

A. intermittent or part-time nursing services furnished by a home health agency;

B. intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available;

C. medical supplies, equipment, and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home;

D. services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

A "home health agency" is a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program: homemaker services and social services provided by a home health agency.

Subp. 10. **Medical supplies.** The term "medical supplies" as used herein includes the most cost effective nondurable medical supplies, durable medical equipment, prostheses, orthoses, and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

A. "Nondurable medical supplies" means those items which have a limited life expectancy (e.g., atomizers, nebulizers, fountain syringes, and incontinence pads).

B. "Durable medical equipment" means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheel chairs, hospital beds, and side rails).

C. "Prostheses" and "orthoses" mean replacement, corrective, or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

D. The MA program pays for oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician so long as prior authorization is obtained.

Payment for equipment repair will be allowed only when that equipment is medically necessary. Routine periodic servicing such as testing, cleaning, regulating, and checking of a recipient's equipment will not be covered. Extensive, complex maintenance may be covered as a necessary repair. Payment on equipment will not continue after the recipient's need for that equipment ceases to exist. The MA program will pay for supplies essential to the effective use of medically necessary durable equipment.

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Medical supply and hearing aid dealers must complete a "Performance Agreement" to be eligible to participate in the MA program. Performance agreement as used herein means a written agreement between a provider of service and the state agency, as required by federal regulations.

E. The following medical supplies must receive prior authorization:

(1) nondurable medical supplies, when the cost exceeds the performance agreement limitations;

(2) durable medical equipment, when the purchase, projected cumu-

lative rental, repair, or maintenance cost exceeds the performance agreement limitation;

(3) prostheses and orthoses, when:

(a) the purchase, projected cumulative rental, or repair cost exceeds the performance agreement limitations;

(b) [Repealed, 10 SR 842]

(c) [Repealed, 10 SR 842]

(4) [Repealed, 10 SR 842]

(5) Medical supplies for recipients who are residents of long term care facilities may be authorized under the following conditions:

(a) the cost of a specific item cannot be covered in the per diem rate;

(b) the item is necessary for the continuous care and exclusive use of this recipient to meet an unusual medical need; and

(c) the need is identified and documented in the recipient's plan of care.

F. The following items are not covered under the MA program:

(1) Equipment primarily and customarily used for nonmedical purposes, i.e.: air conditioners, food blenders, exercycles, orthopedic mattresses, dehumidifiers, humidifiers, air filters, auto modifications, books, TV sets, bicycles, household items, safety bars, and training equipment;

(2) comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs);

(3) stock orthopedic shoes unless attached to a leg brace;

(4) medical equipment and supplies for recipients who are residents of long term care facilities, except as provided in item E, subitem (5);

(5) the three follow-up visits per year at the hearing aid dealer's office or service center specified in the hearing aid performance agreement; and

(6) reimbursement to long term care facilities for any medical equipment or supplies other than allowed under chapter 9510.

Subp. 11. **Private duty nursing services.** "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his own home or in a hospital or SNF, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization, or facility.

The MA program pays for private duty nursing services only:

A. when ordered in writing by the patient's primary physician or consulting physician;

B. in hospitals having no intensive care unit capable of meeting the patient's needs;

C. in the family residence when there is no available home health care agency to provide the required level of nursing care which meets the requirements for participation under title XVIII of the Social Security Act; or

D. if the private duty nurse is not a member of the patient's family.

Subp. 12. **Rehabilitative and therapeutic services.** "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined as follows and include the use of such supplies and equipment as necessary, when pursuant to physician orders and when purchased by a facility, agency, or independent practitioner.

Subp. 13. **Rehabilitative and therapeutic services in long-term care facilities.** Such services must be provided in accordance with applicable federal regulations, state law, and the Department of Human Services rules.

A. "Physical therapy" means those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A "qualified physical therapist" is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration (as soon as such certificate is available from the Minnesota Department of Health).

B. "Occupational therapy" means those services prescribed by a physician and provided to a patient by a qualified occupational therapist. In addition, other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A "qualified occupational therapist" is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

C. "Services for individuals with speech, hearing, and language disorders" means those diagnostic, screening, preventive, or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of his profession. A "qualified speech pathologist" or "qualified audiologist" shall have a certificate of clinical competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

D. Specialized rehabilitative service requirements, inpatient and outpatient are:

(1) Restorative therapy. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonably and generally predictable period of time. This expectation shall be based on an assessment made by the attending physician of the patient's restorative potential after consultation with qualified rehabilitative personnel.

(2) Specialized maintenance therapy. Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. Such therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

E. Billing and reimbursement. The long term care facility in which the recipient resides shall bill on behalf of the rehabilitative personnel, agency or hospital for services provided. In cases where a patient residing in a facility is provided specialized rehabilitative services in a setting other than his residential facility, the residential facility shall bill for services provided pursuant to agreement with the agency, hospital, or other institution where the service is provided.

Reimbursement to qualified rehabilitative personnel (including rehabilitative assistants and aides) under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it.

Reimbursement to qualified rehabilitative personnel (including supervised rehabilitative assistants and aides) salaried by the facility. Each facility shall bill on behalf of salaried, qualified rehabilitative personnel for the services provided. At the end of each fiscal year, the facility shall:

(1) Determine the total number of treatment sessions provided by each salaried, qualified rehabilitative employee during the fiscal year. A "treatment session" is defined as one or more treatment procedures and/or modalities provided to one patient during one session.

(2) Determine, for each qualified rehabilitative employee, the total number of treatment sessions (as defined herein) provided to eligible recipients and indicate this number as a percentage of the total number of treatment sessions provided by the employee.

(3) Multiply the resulting percentage by the salary of the employee. "Salary" means all direct costs related to employment. If medical assistance reimbursement exceeds the percentage of salary related to treatment sessions provided to medical assistance recipients, the excess amount shall be applied to and, therefore, reduce the "general and administration" expenses on the health facility cost report submitted by the respective facility.

F. The following rehabilitative and therapeutic services are not reimbursable as a separate charge under the MA program when furnished in a long term care facility:

(1) Services authorized by a physician but not documented in the patient's medical record.

(2) Services provided by unsupervised assistants, aides and/or other supportive personnel. Salaries and costs related to these personnel are to be included as part of the facility's rate determination in accordance with the health facility cost report.

(3) Rehabilitative services provided by nursing personnel.

(4) Services for personal comfort.

(5) Services of qualified rehabilitative personnel related to training or consultation of facility staff.

(6) Activities programs.

(7) Services of a rehabilitative nature provided by living unit personnel, qualified mental retardation professionals, direct care staff, and training or habilitational personnel.

(8) Screening procedures not ordered by a physician.

(9) Services not reasonable and necessary to the treatment of the patient's condition.

(10) Services provided without written orders of the patient's attending physician.

(11) Services provided without physician review of the patient's progress and plan of care at least once every 30 days, with written certification and recertification by the physician.

(12) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(13) Physical therapy services not authorized after the initial 90-day service period by an independent medical consultant or the facility's utilization review committee, or through the local welfare agency's approved review plan only if authorization by an independent medical consultant or the utilization committee is not possible.

(14) Outpatient services provided by a facility not certified as an outpatient provider.

(15) Outpatient services provided off the facility's premises.

(16) Services billed for by any source other than the skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

Subp. 14. **Speech pathology, audiology, and physical therapy provided by independent practitioners.** Such services are of a diagnostic, screening, preventive, or corrective nature and provided to individuals with speech, hearing and language disorders, or physical impairments. Such services must be provided in accordance with the applicable federal regulations, state law, and the Department of Human Services rules.

A. "Speech pathology" means those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A "qualified speech pathologist in independent practice" shall have received a certificate of clinical competence from the American Speech and Hearing Association (ASHA) or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

B. "Audiology" means those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A "qualified audiologist in independent practice" shall have received the certificate of clinical competence from ASHA or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

C. "Physical therapy" means those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A "qualified physical therapist in independent practice" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration (as soon as such certificate is available from the Minnesota Department of Health), and has been certified as an independent practitioner by the Minnesota Department of Health.

D. The following services are not covered as independent practitioner services under the MA program:

(1) services provided by an independent practitioner speech pathologist, audiologist, or physical therapist not maintaining at his own expense an office or office space and the necessary equipment to provide an adequate treatment program;

(2) services which are not physician prescribed;

(3) any service authorized by a physician but not documented in the clinical record of the patient;

(4) training or consultation provided by a speech pathologist, audiologist, or physical therapist to an agency, facility, or other institution;

(5) screening procedures not physician authorized;

(6) services provided under a written treatment plan which is not reviewed at least once every 30 days with certification and recertification by the ordering physician.

E. The following services of independent practitioners must be billed through the contracting or employing facility, agency, or person and will not be reimbursed directly to the practitioner:

(1) Services provided in settings other than the independent practitioner speech pathologist's, audiologist's, or physical therapist's own office or the recipient's place of residence. "Place of residence" excludes skilled nursing facilities, intermediate care facilities, hospitals, rehabilitation agencies, home health agencies, public health agencies, clinics, and day activity centers.

(2) Services of a speech pathologist, audiologist, or physical therapist employed and salaried by physicians.

Subp. 15. **Rehabilitation agencies.** A "rehabilitation agency" is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the medicare program (title XVIII) who have signed and returned to the state agency a provider agreement within 60 days after receipt thereof. "Rehabilitation agency services" are those services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law, and the Department of Human Services rules and defined as follows:

A. "Medical services" are those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

B. "Psychological services" are those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

C. "Psychosocial services" are those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician himself. To receive reimbursement under the MA program all psychosocial services shall be ordered by a licensed physician.

D. "Physical therapy" means those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

E. "Occupational therapy" are those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

F. "Speech pathology or audiology services for individuals with speech, hearing, and language disorders" are those diagnostic, screening, preventive, or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

G. "Special services" are physician-ordered and monitored evaluations, classes, clinics, or programs provided to patients generally by a rehabilitation team.

H. The MA program will reimburse for services provided only by the following qualified personnel:

(1) Physicians. A qualified physician who is currently licensed in the state of Minnesota to practice medicine or, if an out-of-state physician, who is licensed in the state of service.

(2) Psychologists. A qualified psychologist who is currently licensed by the Minnesota State Board of Examiners of Psychologists as a licensed consulting psychologist or a licensed psychologist.

(3) Social workers. A qualified social worker is an individual with a master's degree from a school of social work accredited by the Council on Social Work Education.

(4) Physical therapists. A qualified physical therapist is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, and has a valid Minnesota certificate of registration.

(5) Occupational therapists. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(6) Speech pathologists and audiologists. A qualified speech pathologist or audiologist is an individual with a certificate of clinical competence from the American Speech and Hearing Association or an individual who has completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or, who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

I. Rehabilitation agencies, noncovered services include:

(1) services provided without physician orders (excluding psychological services);

(2) psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services;

(3) services authorized by a physician but not documented in the patient's clinical record; and

(4) services provided in day activity centers which are subsidiaries of rehabilitation agencies.

Subp. 16. **Dental services.** "Dental services" are diagnostic, preventive, or corrective procedures administered by or under the supervision of a licensed dentist. The MA program pays for all emergency care and basic medically necessary oral health needs. "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist. Eligible providers are dentists licensed to practice dentistry in Minnesota, another state, or a Canadian province.

A. The following dental services and procedures must receive prior authorization:

(1) pedodontics (only when the secondary tooth has completed two-thirds of its development);

(2) hospitalization for dental treatment;

(3) periodontics;

(4) root canal therapy (molars only and only if more than one needs treatment);

(5) gold restorations and/or inlays (including cast nonprecious and semi-precious metals);

(6) fixed prosthodontics;

(7) orthodontics;

(8) surgical services except emergencies and alveolectomies;

(9) removal of impacted teeth.

B. The following are limitations on the MA dental program:

(1) Oral hygiene instruction: one time only.

(2) Dentures (any type): one per five-year period, except under special circumstances and only then if prior authorization is received. Dentures that are lost and/or destroyed by recipient negligence will not be replaced during such five-year period.

(3) Relines or rebase: one every three years, except under special circumstances and only then if prior authorization is received.

(4) Patients in hospitals or long term care facilities: three visits by the dentist to the hospital or LTC facility per diagnosis. (As used here, "diagnosis" means evaluation, determination of medical condition, and plan of treatment. This limitation applies to inpatient hospital facilities only if the recipient has been hospitalized in order to treat a dental condition. This does not limit the number of visits a recipient can make to the dentist's office.)

C. The following services are not covered under the MA dental program:

(1) additional clasps for partial dentures;

(2) bases;

(3) sealants;

(4) local anesthetics when billed as a separate procedure;

(5) toothbrushes and/or other hygiene aids;

(6) services provided to a recipient in his home.

Subp. 17. **Other laboratory and X-ray services.** "Other laboratory and X-ray services" include professional and technical laboratory and radiological service ordered by a licensed physician, dentist, or other licensed practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory. The MA program shall pay for such services only when provided by or under the direction of a physician or licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. Such laboratory must be qualified to participate under title XVIII of the Social Security Act, or be currently determined to meet the requirements for such participation. Eligible providers are facilities that render professional and technical laboratory services as described herein.

Subp. 18. **Pharmacy services.** A "pharmacy" is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals, and poisons are compounded, dispensed, vended, or sold on a retail basis. "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed for the care, mitigation, or prevention of disease or for health maintenance, by a physician, dentist, or other licensed medical practitioner within the scope of his professional practice as defined by state law. The MA program covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a licensed pharmacist. All licensed pharmacies are eligible to participate in the MA program when the pharmacist in charge has enrolled as a provider in accordance with state agency requirements. The MA program shall pay for pharmaceuticals prescribed and dispensed by a physician or dentist in his office when there is no licensed pharmacy within the recipient's local trade area, as defined in part 9500.0900.

A. The following are service limitations of the MA pharmacy program:

(1) Pharmaceuticals must be prescribed by a licensed physician, dentist or other authorized licensed practitioner of the healing arts. The drug dispenser must keep the signed prescription on file for five years, subject to audit at any reasonable time. See part 9500.0930, subpart 4.

(2) Telephone orders, where legal, must be reduced to writing with the name of the prescribing physician shown and must be signed by the pharmacist.

(3) Prescription refills: the prescriber must indicate, either verbally or by specification on the original prescription, approval for refilling the prescription. As many as five refills may be authorized by the prescriber, but in such cases the total amount authorized must be dispensed within six months of the original prescription date, except when the patient is in a long term care facility where no such limit shall exist. In the absence of specific refill instructions, the prescription will be interpreted to be not refillable. Refills are covered only when refilled by the pharmacy where the original prescription was filled.

(4) The quantity supplied will depend on the usual and customary prescribing practice of the physician provided that the quantity does not exceed 30 days for acute illness and 100 days for maintenance therapy.

B. The following services must receive prior authorization: supplemental and tube feedings for patients who have special nutritional needs. The patient's dietary requirements must be identified on a physician's prescription and the product(s) must be available from an eligible supplier.

C. The following items are not covered under the MA pharmacy program:

(1) nonlegend drugs, stocked by a long term care facility and administered to a patient in such facility for short term (up to 36 hours) therapy;

(2) cosmetic products (including hypoallergenic cosmetics);

(3) toiletries (nonmedicated soaps, body lotions, powders) used for personal cleaning and grooming;

(4) oral antiseptics;

(5) dentifrices and other dental hygiene equipment and supplies;

(6) throat lozenges;

(7) contact lens wetting solutions and cleaners;

(8) investigational drugs;

(9) biologicals (i.e., vaccines, serums, toxoids) generally considered inappropriate for self-administration;

(10) amphetamines, amphetamine derivates, and any other Drug Enforcement Agency Schedule II anorexiant agents for weight control purposes, except as provided in part 9500.1060, item N;

(11) nutritional services:

(a) modified diets consisting of conventional foods;

(b) salt and sugar substitutes; salt or sugar-free specialty food and beverage products;

(c) baby foods;

(d) hypoallergenic foods (see item C);

(e) alcoholic beverages.

(12) any medication not prescribed by a licensed physician, dentist, or other licensed practitioner authorized by the state to prescribe drugs within the scope of practice.

Subp. 19. **Other diagnostic, screening, preventive, and rehabilitative services.** The MA program provides for these services as described herein:

A. "Diagnostic services," other than those for which provision is made

elsewhere in this rule, include any medical procedure or supplies recommended for a patient by his physician or other licensed medical practitioner within the scope of his practice as defined by state law, as necessary to enable him to identify the existence, nature or extent of illness, injury, or other health deviation of the patient.

B. "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify suspects for more definitive studies.

C. "Preventive services" are those services provided by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, to prevent illness, disease, disability, and other health deviations or their progression, and to prolong life and promote physical and mental health efficiency.

D. "Rehabilitative services" include any medical remedial items or services, except those expressly excluded under this rule, which are prescribed by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, for the purpose of reducing physical or mental disability and restoring the patient to his best possible functional level. Prior authorization must be obtained on any services for which payment is claimed under this section.

Subp. 20. **Early periodic screening, diagnosis, and treatment (EPSDT).** The MA program provides for early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Services rendered by providers other than licensed physicians are reimbursable only if the Minnesota Department of Health has previously approved the screening activities.

In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

A. notify in writing on an annual basis all recipients eligible for EPSDT services about the existence of such services;

B. provide or arrange for provision of screening services when they are requested;

C. arrange for needed corrective treatment; and

D. maintain adequate EPSDT records and report activities as required by federal and state agencies.

In order to comply with federal and state EPSDT requirements, providers shall follow required EPSDT billing/reporting procedures and adhere to free choice of provider policy when making referrals for recipients.

Subp. 21. **Health care insurance premiums.** The MA program shall pay health insurance premiums determined by the state agency to be cost-effective, for:

A. eligible recipients not covered under Title XVIII of the Social Security Act, when coverage under the insurance policy justifies the premium charged and the policy provides coverage only for health care;

B. supplemental medical insurance (SMI) on a buy-in basis for eligible recipients covered under title XVIII of the Social Security Act.

C. such other insurance programs as the state agency may approve for eligible recipients.

Subp. 22. **Other medical care.** The MA program shall pay for other necessary medical and/or remedial care as follows:

A. Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health. See part 9500.0910.

The following services rendered by medical transportation providers are not

covered under the MA program: any routine service determined by the local welfare agency not to be medically necessary, and ambulance service in cases where another means of transportation would have sufficed.

B. Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital equipped to furnish such services even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act or the definitions of inpatient or outpatient services.

C. Personal care services in a recipient's home rendered by an individual, other than a member of the patient's family, who is qualified to provide such services, when the services are prescribed by a physician and supervised by a registered nurse in accordance with a plan of treatment.

D. Whole blood, including items and services required in the collection, storage and administration thereof, when it has been ordered by a licensed physician and is not available to the patient from other sources.

E. Crippled children services program (CCS). Pursuant to a cooperative agreement between the Minnesota Department of Human Services and the Minnesota Department of Health, the Department of Human Services will reimburse the state's CCS program (title V) for diagnosis, evaluation, and ongoing medical follow-up services in CCS field clinics for medical assistance eligible children up to 21 years of age. The Department of Human Services will also reimburse CCS for evaluation, diagnosis, and/or consultation provided medical assistance eligible children who are residents of the Minnesota School for the Deaf, the Minnesota School for the Blind and Visually Handicapped, and certain other state institutions.

Subp. 23. **Mental health centers.** "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with parts 9520.0010 to 9520.0230. Services provided by mental health centers must be provided under the auspices and direction of a physiciatrist licensed to practice medicine in the United States or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of long term care facilities only if the attending physician helped develop the plan of treatment and periodically reviews that plan.

Mental health centers are subject to the same service limitations and prior authorization requirements as is the practitioner under whose auspices or direction the services are rendered. See part 9500.1070, subpart 4, items A and B, and subpart 6, item D.

The following mental health center services are not covered under the MA program: community planning, community consultation, program consultation, program and service monitoring and evaluation, public information and education, resource development, and training and education.

Subp. 24. **Abortions.** The cost of abortion services shall be paid only when the conditions under items A, B, and C are met:

A. The abortion is necessary to prevent the death of the mother. The cost of the abortion shall be covered only if the following documentation accompanies the provider's invoice to the state agency:

(1) the signed written statement of two physicians that it was their professional judgment that the abortion was necessary to prevent the death of the mother; and

(2) the signed written statement of the recipient that she voluntarily consented to the abortion. In the event that the recipient is physically or legally incapable of providing informed consent, consent may be obtained as is otherwise provided by law.

B. The abortion is to terminate a pregnancy which is the result of a sexual assault. The cost of the abortion shall be covered only if a report of the assault was made to a valid law enforcement agency within 48 hours of the time the assault occurred and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. In the event the recipient was physically unable to make the report within 48 hours of the assault, the report must have been made within 48 hours after the recipient became physically able to make the report.

The statement of the law enforcement agency shall include the following information:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the report alleges at least one of the following:

(a) circumstances existing at the time of the assault caused the recipient to have a reasonable fear of imminent great bodily harm to herself or to another;

(b) the assailant was armed with a dangerous weapon or an article used or fashioned in a manner which led the recipient to reasonably believe it to be a dangerous weapon, and used or threatened to use the weapon or article to cause the complainant to submit;

(c) the assailant caused personal injury to the complainant and used force or coercion to accomplish sexual penetration;

(d) the assailant was aided or abetted by one or more accomplices and either an accomplice used force or coercion to cause the recipient to submit, or an accomplice was armed with a dangerous weapon or an article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the recipient to submit.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the sexual assault reported, and a statement, signed by the recipient's physician, that in his/her professional opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

C. The abortion is to terminate a pregnancy which is the result of incest. The cost of the abortion shall be covered only if a report of incest was made to a valid law enforcement agency prior to the time of the abortion and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. The statement shall include the following information:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the name of the relative who allegedly committed incest with the victim appears in its report.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the incest reported, and a statement, signed by the recipient's physician, that in his/her professional opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

D. For the purposes of this subpart only, the following definitions apply:

(1) "Abortion services" mean medical service performed for the purpose of terminating a pregnancy. This shall not be construed to include drugs or devices which prevent implantation of the fertilized ovum, or medical procedures necessary for the termination of an ectopic pregnancy.

(2) "Assailant" means a person who allegedly committed the sexual assault reported to the law enforcement agency.

(3) "Incest" means sexual intercourse with another nearer in kin than first cousin, of the whole or half-blood.

(4) "Valid law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States, or of any state or local jurisdiction.

Statutory Authority: *MS s 256.991; 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58; 10 SR 842*

9500.1080 REIMBURSEMENT.

Subpart 1. **Payments to eligible providers.** Participation in the MA program is limited to those providers of medical care, service and supplies who accept as payment in full amounts paid in accordance with the Department of Human Services's maximum allowable charges. Providers are prohibited from requesting or receiving additional payment from the recipient, his relatives or guardian, except to meet the spend-down provision of state law. Providers will be directly paid for providing medical care and services rendered within the scope of practice recognized under federal and state law and regulations. The state agency or, where appropriate, the local welfare agency, may pay an agency, institution or group pursuant to a contract with an approved provider only if required under a written contract between the provider and the agency, institution or group. The state agency shall have access to all such contracts at its request.

Subp. 2. **Billing procedures.** Providers of medical care and services shall bill the state agency up to their usual and customary fee and only after the medical care or services have been provided. Providers proven to consistently bill in excess of their usual and customary fee shall be referred to the SURS program for investigation and, if appropriate, shall be determined ineligible to participate in the MA program. Medical bills should be presented for payment at the conclusion of each month's service. Providers shall bill within 12 months of the date of service or, in unusual circumstances, in accordance with applicable federally-imposed time restrictions. The state agency shall deny payment until the following criteria have been met:

A. Providers submit all necessary forms and reports to the appropriate state or local welfare agency.

B. All prior authorization requirements are fulfilled.

C. Providers bill for care or services rendered on prescribed forms according to state agency instructions. The state agency shall require providers to submit diagnosis and procedure codes on all billings when deemed necessary for proper administration of the MA program, to comply with applicable federal regulations and to maximize federal financial participation.

D. Providers shall bill the state agency directly, except as follows:

(1) where a written contract or other formal arrangement exists between the provider of the service and any agency, institution or group, in which case such agency, institution, or group shall bill the state agency;

(2) if a provider of service who is eligible to accept Medicare assignments wishes to be paid by the MA program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the MA program.

Subp. 3. **Authority to recover from medical providers.** The state agency is authorized to recover any medical assistance funds paid to providers when it determines that such payment was obtained fraudulently or erroneously. Such recovery may be accomplished through withholding current obligations due the provider or by demanding that the provider refund amounts so received. Recovery under the MA program is permitted for intentional as well as unintentional error on the part of the provider or state or local welfare agency; for failure to comply fully with all utilization control requirements, prior authorization procedures or billing procedures; for failure to properly report third-party payments; and for fraudulent actions on the part of the provider.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

HOSPITAL MEDICAL ASSISTANCE REIMBURSEMENT

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for inpatient hospital services provided under medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 5, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1095 STATUTORY AUTHORITY.

Parts 9500.1090 to 9500.1155 are authorized by Minnesota Statutes, section 256.969, subdivisions 2 and 6, and Laws of Minnesota 1983, chapter 312, article V, section 39. Parts 9500.1090 to 9500.1155 must be read in conjunction with Titles XVIII and XIX of the Social Security Act, Code of Federal Regulations, title 42, and Minnesota Statutes, chapters 256, 256B, and 256D.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227*

9500.1100 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1090 to 9500.1155, the terms in subparts 2 to 50 have the meanings given them.

Subp. 2. **Adjusted base year cost per admission.** "Adjusted base year cost per admission" means an allowable base year cost per admission cumulatively multiplied by the hospital cost index through a hospital's current year.

Subp. 3. **Admission.** "Admission" means the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to

Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy families with dependent children.

Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission that is adjusted for case mix, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. **Ancillary service.** "Ancillary service" means inpatient hospital services that include laboratory, radiology, drugs, delivery room, operating room, therapy services, and other special items and services customarily charged for in addition to a routine service charge.

Subp. 7. **Appeals board.** "Appeals board" means the board that advises the commissioner on a hospital's request for adjustments to reimbursements made under the prospective reimbursement system.

Subp. 8. **Arithmetic mean cost per admission.** "Arithmetic mean cost per admission" means the number obtained by dividing the sum of a set of reimbursable inpatient hospital costs per admission by the number of admissions in the set.

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. **Base year.** "Base year" means a hospital's fiscal year ending during calendar year 1981.

Subp. 10. **Budget year.** "Budget year" means a hospital's fiscal year for which a prospective reimbursement system is being determined.

Subp. 11. **Case mix.** "Case mix" means a distribution of admissions in the diagnostic categories.

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the [(adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. **Claims.** "Claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for inpatient hospital services provided to a recipient.

Subp. 14. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized representative of the commissioner.

Subp. 15. **Cost outlier.** "Cost outlier" means an admission whose reimbursable inpatient hospital cost exceeds the geometric mean cost per admission for diagnostic category O, under subpart 20 by one standard deviation and diagnostic category W, under subpart 20, by three standard deviations.

Subp. 16. **Cost-to-charge ratio.** "Cost-to-charge ratio" means a ratio of a hospital's reimbursable inpatient hospital costs to its charges for inpatient hospital services.

Subp. 17. **Current year.** "Current year" means a hospital's fiscal year which occurs immediately before that hospital's budget year.

Subp. 18. **Day outlier.** "Day outlier" means an admission whose length of stay exceeds the geometric mean length of stay for diagnostic categories A to N, and P to II, under subpart 20 by two standard deviations or for diagnostic category O, under subpart 20 by one standard deviation.

Subp. 19. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (DRGs) under medicare with adjustments as follows:

	Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A.	Diseases and Disorders of the Nervous System	(1-35)
B.	Diseases and Disorders of the Eye	(36-48)
C.	Diseases and Disorders of the Ear, Nose, and Throat	(49-74)
D.	Diseases and Disorders of the Respiratory System	(75-97, 99-102)
E.	Diseases and Disorders of the Circulatory System	(103-145)
F.	Diseases and Disorders of the Digestive System	(146-183, 185-190)
G.	Diseases and Disorders of the Hepatobiliary System and Pancreas	(191-208)
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	(209-256)
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	(257-284)
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	(285-301)
K.	Diseases and Disorders of the Kidney and Urinary Tract	(302-333)
L.	Diseases and Disorders of the Male Reproductive System	(334-352)
M.	Diseases and Disorders of the Female Reproductive System	(353-369)
N.	Pregnancy, Childbirth, and the Puerperium	(376-384)
O.	Newborns and Other Neonates with Conditions Originating in the Perinatal Period	(385-390)
P.	Diseases and Disorders of the Blood and Blood-Forming Organs and Immunity Disorders	(392-399)
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms NEC	(400-414)
R.	Infectious and Parasitic Diseases (Systemic or Unspecified Sites)	(415-423)
S.	Mental Diseases and Disorders	(424-425, 427-429, 432)
T.	Substance Use and Substance Induced Organic Mental Disorders (Ages 0-20)	(433-438)
U.	Substance Use and Substance Induced Organic Mental	

	Disorders (Ages over 21)	(433-438)
V.	Injury, Poisoning, and Toxic Effects of Drugs	(439-455)
W.	Burns	(456-460)
X.	Factors Influencing Health Status and Other Contacts with Health Services	(461-467)
Y.	Bronchitis and Asthma (Ages 0-1)	(98)
Z.	Bronchitis and Asthma (Ages 2-17)	(98)
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 0-1)	(184)
BB.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 2-17)	(184)
CC.	Caesarean sections	(370-372)
DD.	Vaginal delivery with complicating diagnosis or operating room procedures	(372,374-375)
EE.	Vaginal delivery without complicating diagnosis or operating room procedures and Normal newborns	(373), (391)
FF.	Depressive neurosis	(426)
GG.	Psychosis	(430)
HH.	Childhood mental disorders	(431)
II.	Unrelated Operating room procedure	(468)
JJ.	Cases which could not be assigned to other diagnostic categories	(469-470)

Subp. 21. **Discharge.** "Discharge" means a release of a recipient from a hospital.

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards of practice accepted by the medical community.

Subp. 22. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the program established by Minnesota Statutes, section 256D.03.

Subp. 23. **Geometric mean cost per admission.** "Geometric mean cost per admission" means the nth root of the product of the reimbursable inpatient hospital costs per admission for n admissions.

Subp. 24. **Geometric mean length of stay.** "Geometric mean length of stay" means the nth root of the product of the number of days spent in a hospital for each admission for n admissions.

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. **Hospital.** "Hospital" means an institution that, except for state-operated facilities, is approved to participate as a hospital under medicare.

Subp. 26. **Hospital cost index or HCI.** "Hospital cost index" or "HCI" means a single percentage annually multiplied by the adjusted base year cost per admission or the adjusted base year costs to adjust for inflation.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided under the supervision of a physician and furnished in a hospital for the care and treatment of a recipient. The inpatient hospital service may be furnished by a physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical assistance reimbursement.

Subp. 28. **Local agency.** "Local agency" means a county or multicounty agency authorized under Minnesota Statutes as the agency responsible for determining eligibility for medical assistance.

Subp. 29. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under Title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. **Medicare.** "Medicare" means the federal health insurance program established under Title XVIII of the Social Security Act.

Subp. 32. **Medicare crossover claims.** "Medicare crossover claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for medicare eligible inpatient hospital services provided to a recipient who is also eligible for medicare.

Subp. 33. **Metropolitan statistical area hospital or MSA hospital.** "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare.

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. **Non-metropolitan statistical area hospital or non-MSA hospital.** "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a hospital not located in a metropolitan statistical area as determined by Medicare.

Subp. 35. **Operating costs.** "Operating costs" means reimbursable inpatient hospital costs excluding pass-through costs.

Subp. 36. **Outlier.** "Outlier" means a day outlier or a cost outlier.

Subp. 37. **Out-of-area hospital.** "Out-of-area hospital" means any hospital outside of Minnesota.

Subp. 38. **Pass-through costs.** "Pass-through costs" means reimbursable inpatient hospital costs not subject to the HCI.

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to 9505.5030 and 9505.5105.

Subp. 40. **Prior year.** "Prior year" means the hospital's fiscal year immediately before the current year.

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission that occurs within seven days of a discharge of the same recipient.

Subp. 43. **Recipient.** "Recipient" means a person who has applied to a local agency and has been determined eligible for medical assistance.

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. **Reimbursable inpatient hospital costs.** "Reimbursable inpatient hospital costs" means those costs allowable under Title XVIII of the Social Security Act for inpatient hospital services.

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all the diagnostic categories on a statewide basis.

Subp. 46. **Routine service.** "Routine service" means those inpatient hospital services included by a hospital in a daily room charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units including nursery care units, coronary care units, and intensive care units.

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. **Total hospital admissions.** "Total hospital admissions" means the total number of acts that allow persons to officially enter a hospital during the base year to receive a service provided under the supervision of a physician and furnished in a hospital by a physician, or a vendor of an ancillary service prescribed by a physician.

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing Administration (HCFA) Form 2552, 1981 revision, Worksheet A, column 7, line 84. The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital to another.

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 987; 11 SR 1688*

9500.1105 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES.

The department shall use a prospective reimbursement system to reimburse hospitals for inpatient hospital services provided to recipients.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227*

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. select all claims for all hospitals statewide for state fiscal years 1983 and 1984;

B. assign each claim from item A to the specific admission which generated the claim except as provided in item C;

C. exclude from item B the following claims:

(1) medicare crossover claims,

(2) claims submitted by out-of-area hospitals, and

(3) claims not reimbursed as of February 28, 1985;

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(3) determine the cost of services rendered by interns and residents not in an approved teaching program for each admission in item B by multiplying the number of days for the appropriate routine services by the per diem cost identified in Worksheet D-2, Part I of the base year, and

(4) sum subitems (1) to (3) to determine the reimbursable inpatient hospital cost for each admission in item B;

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using a version of the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all determinations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. assign each admission to a diagnostic category;

G. identify outliers for each diagnostic category;

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital costs for all admissions less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions including outliers;

K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic category less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category including outliers; and

L. determine the relative value for each diagnostic category by dividing item K by item J.

Subp. 2. **Redetermination of relative values.** The department shall redetermine the relative values of the diagnostic categories prior to the beginning of each state fiscal biennium. The redetermination of the relative values shall be based on claims from the two most recently completed state fiscal years reimbursed on or before March 1 of the second year of the biennium and the cost-to-charge ratios determined during the base year.

These redetermined relative values shall be the basis of reimbursement for the next biennium.

Subp. 3. **Publication of relative values.** The department shall publish in the State Register the relative values of each diagnostic category at least 30 days prior to the start of a biennium.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. determine reimbursable inpatient hospital costs for each hospital's base year admissions according to part 9500.1110, subpart 1, item D, substituting the terms and data for base year admissions for the terms and data referenced for state fiscal years 1983 and 1984;

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital including outliers;

D. adjust item C for case mix as follows:

(1) assign each base year admission a diagnostic category as specified in part 9500.1110, subpart 1, items E and F,

(2) multiply the hospital's number of base year admissions within each diagnostic category including outliers by the relative value of that diagnostic category,

(3) sum the products determined in subitem (2),

(4) divide the sum from subitem (3) by the number of base year admissions including outliers, and

(5) divide the cost per admission as determined in item C by subitem (4).

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1120 DETERMINATION AND PUBLICATION OF HOSPITAL COST INDEX (HCI).

Subpart 1. **Adoption of Health Care Costs.** The most recent Health Care Costs published by Data Resources Incorporated (DRI) is incorporated by reference. The health care costs report is available through the minitex interlibrary loan system. The report is published monthly.

Subp. 2. **Determination of HCI.** For each calendar quarter the department shall determine the HCI as follows:

A. For each calendar quarter obtain from Health Care Costs published by Data Resources, Inc., inflation estimates for the following operating costs:

(1) salaries
(2) employee benefits
(3) medical fees
(4) raw food
(5) medical supplies
(6) pharmaceuticals
(7) utilities
(8) repairs and maintenance
(9) insurance (other than malpractice)
(10) other operating costs

B. During the fourth quarter of each calendar year, obtain data for operating costs as found in the aggregate of hospitals in Minnesota which indicate the proportion of operating costs attributable to each of item A, subitems (1) to (10). These proportions will be used in the determination of the HCI for the next calendar year.

C. Multiply each proportion for item A, subitems (1) to (10) by each subitem's inflation estimate.

D. Sum the products determined in item C and round the sum to one decimal place.

Subp. 3. **Publication of HCI.** The department shall publish the HCI in the State Register 30 days prior to the start of each calendar quarter. A hospital whose budget year starts during a given calendar quarter is subject to the HCI published 30 days prior to the start of that quarter.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227*

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total general assistance admissions. A pass-through cost report for a hospital budget year that begins on or after July 1, 1987, must separate medical assistance admissions data into AFDC or non-AFDC admissions data. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days before the start of each hospital's budget year and must include the following information:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
(1)	Depreciation			
(2)	Rents and leases			
(3)	Property taxes			
(4)	Property insurance			
(5)	Interest			
(6)	Malpractice insurance			
(7)	Total Pass-Through Costs (Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to medical assistance. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/medical assistance cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. **Determination of budget year pass-through cost per admission.** The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs			
B.	Pass-through costs as specified in subpart 1, item A, subitem (7), pultiplied by item A			
C.	Number of			

Medical Assistance admissions including outliers	_____	_____	_____
D. Pass-through cost per admission (item B divided by item C)	_____	_____	_____

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category), plus the budget year pass-through cost per admission]

Subp. 4. **Pass-through cost adjustment.** After the end of each budget year, the commissioner shall redetermine the budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This determination produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as determined in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. Determine the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs determined in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted pass-through cost per-admission used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated.

G. Subtract the amount determined at item F from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be paid by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the 66th day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [Repealed, 11 SR 1688]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. **Submittal of claims.** Claims may be submitted to the department after a recipient is discharged or after 30 days, whichever occurs first. A hospital that submits a claim to the department after 30 days from admission but before discharge shall submit a final claim after discharge, but must not submit any other interim claims except as part of an appeal.

Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.** The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. **Adjustment to reimbursement.** Reimbursements shall be adjusted by the department for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be by debit.

Subp. 5. **Rejection of claims.** Claims will not be reimbursed for a hospital's failure to:

A. obtain prior authorization;

B. provide documentation of a confirming second surgical opinion;

C. receive admission certification; and

D. assign a claim to one of diagnostic categories A to II in part 9500.1100, subpart 20.

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	Medicare deductibles, plus Medicare coinsurance less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[((The product of the adjusted base year cost per admission and the budget year HCI multiplied by the relative value of the appropriate diagnostic category, divided by the arithmetic mean length of stay of the diagnostic category) and multiplied by the number of days of inpatient hospital services), plus the budget year pass-through cost per admission]

In no case of a transfer may a hospital receive a reimbursement that exceeds the applicable categorical rate per admission, or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a transfer recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's

available services and the readmission to another hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if eligible. The combined stay of the admission and readmission shall be used to determine eligibility for outlier reimbursement. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission. An admission and subsequent readmission to a different hospital shall be reimbursed as specified under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the arithmetic mean length of stay for the diagnostic category;

(3) multiply the per day amount as determined in subitem (2) by 60 percent for diagnostic categories A to N, and P to II, under part 9500.1100, subpart 20 or 80 percent for diagnostic category O, under part 9500.1100, subpart 20 to determine the per day rate for the diagnostic category;

(4) subtract the day outlier trim point for the appropriate diagnostic category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) multiply the product determined in subitem (3) by the number of days determined in subitem (4).

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) multiply the hospital's billed charges by the statewide cost-to-charge ratio;

(3) subtract the cost at three standard deviations for diagnostic category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item H from the adjusted cost from subitem (2); and

(4) multiply the difference determined in subitem (3) by 60 percent for diagnostic category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse an out-of-area hospital for an admission based on the lesser of billed charges for the admission or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each hospital statewide by that hospital's HCI and by the number of admissions in that hospital's base year, including outliers;

B. sum the products in item A;

C. divide the sum from item B by the sum of all admissions for all hospitals statewide, including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base year, including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission	=	[(statewide budget year adjusted base year cost per admission multiplied by the relative value of the appropriate diagnostic category), plus statewide budget year pass-through cost per admission]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

A. Multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of the admissions for all MSA hospitals statewide, including outliers, to determine the statewide allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission must be determined according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per		[(adjusted base year cost per admission for MSA hospitals

Admission for MSA Hospitals Statewide That Do Not Have Admissions In The Base Year	=	statewide multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category) plus budget year pass-through cost per admission]

F. Determine the categorical rate per admission for non-MSA hospitals by substituting non-MSA hospitals terms and data for the MSA hospitals terms and data used in items A to E.

Subp. 12. **Payor of last resort.** A hospital may not submit a claim to the department until a final determination of the recipient's eligibility for potential third party payment has been made by a hospital. Any and all available third party benefits must be exhausted prior to billing medical assistance and the amounts collected must be shown on the claim.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 10 SR 867; 11 SR 1688*

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Determination of disproportionate population adjustment.** The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are MA and GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. **Limitation on disproportionate population adjustment.** In no case

shall the disproportionate population adjustment exceed twice the HCI as determined in part 9500.1120.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1140 APPEALS.

Subpart 1. **Appeals board.** The commissioner shall appoint an appeals board to review hospitals' requests for changes in their reimbursement rates. The appeals board shall consist of two public representatives, two representatives of the hospital industry, and one representative of the business or consumer community. Any hospital that desires to have its rate reviewed by the appeals board shall submit to the commissioner a written request which states the rate and reasons for the request. Within 90 days of the request, the appeals board shall meet with persons selected by the hospital and persons from the department. The appeals board shall make a written report and recommendation to the commissioner. The commissioner shall issue a written decision on the request for a change in the hospital's rate within 30 days after receiving the report of the appeals board.

Subp. 2. **Contested case hearing.** A hospital may appeal a decision of the commissioner issued pursuant to subpart 1, by filing a written notice of appeal with the commissioner within 30 days of the date of service of the decision appealed. The appeal must be conducted as a contested case hearing under Minnesota Statutes, chapter 14 and the rules of the Office of Administrative Hearings.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227*

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

Subpart 1. **Statutory limit.** Under Minnesota Statutes, section 256.969, the annual increase in the cost per service unit for inpatient hospital services under medical assistance or general assistance medical care shall not exceed five percent for hospital rate years beginning during the 1985 biennium.

Subp. 2. **Definitions.** As used in this part, the following terms have the meanings given to them.

A. "Adjusted base year costs" means an allowable base year costs cumulatively multiplied by the hospital cost index through a hospital's current year, and adjustments resulting from appeals.

B. "Allowable base year costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's base year medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total reimbursable costs; and

(3) add the lower of cost or charge limitations for costs disallowed on the medicare/medical assistance cost report as provided by Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233.

C. "Minimal participation" means a hospital with fewer than 100 combined medical assistance and general assistance medical care admissions in the base year.

D. "Rate per admission" means the adjusted base year cost for each admission multiplied by the budget year HCI and adding the budget year pass-through cost per admission.

E. "Rate per day" means the adjusted base year cost per day of inpatient hospital services multiplied by the budget year HCI and adding the budget year pass-through cost per day of inpatient hospital services.

Subp. 3. **Determination of allowable base year costs, allowable base year cost for each admission, and allowable base year cost per day.** The department shall determine allowable base year costs from the base year medicare/medical assistance cost report, using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determination following the steps outlined in items A to P:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5);

C. reimbursable professional services (Worksheet E-5, Part I, line 11);

D. net reimbursable inpatient hospital costs (subtract items B and C from item A);

E. total reimbursable costs (Worksheet A, column 7, line 84);

F. ratio of net reimbursable inpatient hospital costs to total reimbursable costs (item D divided by item E);

G. pass-through costs, except malpractice insurance costs;

H. medical assistance pass-through costs, except malpractice insurance costs (item F multiplied by item G);

I. routine service costs before limitation (Worksheet D-1, line 57);

J. reimbursable routine service costs (Worksheet D-1, line 61);

K. reimbursable routine service costs subject to limitation (subtract item J from item I);

L. allowable base year costs (subtract item H from item D and add item K);

M. base year admissions excluding medicare crossovers;

N. allowable base year cost for each admission (item L divided by item M);

O. base year patient days excluding medicare crossovers; and

P. allowable base year cost per day (item L divided by item O).

Subp. 4. **Determination of rate per admission and rate per day.** The department shall determine the rate per admission and rate per day according to items A to G.

A. For each hospital's budget year, each hospital shall submit to the department a written report of pass-through costs. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days prior to the start of each hospital's budget year and must include the following information:

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Depreciation	_____	_____	_____
(2) Rents and leases	_____	_____	_____
(3) Property taxes	_____	_____	_____
(4) License fees	_____	_____	_____
(5) Interest	_____	_____	_____
(6) Malpractice insurance	_____	_____	_____
(7) Total Pass-Through	_____	_____	_____

Costs [subitems (1) to (6)]	_____	_____	_____

Pass-through costs are limited to subitems (1) to (6) as defined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

B. The department shall determine the budget year pass-through cost per admission or per day, or both, from the submitted pass-through cost reports as specified in item A as follows:

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Ratio of net reimbursable inpatient hospital costs to total reimbursable costs [subpart 3, item F]	_____	_____	_____
(2) Pass-through costs [subpart 4, item A, subitem (7)]	_____	_____	_____
(3) Base year admissions [subpart 3, item M]	_____	_____	_____
(4) Pass-through cost per admission [subitem (2) divided by subitem (3)]	_____	_____	_____
(5) Base year patient days [subpart 3, item O]	_____	_____	_____
(6) Pass-through cost per day of inpatient hospital services [subitem (2) divided by subitem (5)]	_____	_____	_____

C. The department shall determine the rate per admission for a budget year as follows:

Rate Per Admission = [(Adjusted base year cost for each admission) multiplied by (budget year HCI), plus (budget year pass-through cost per admission)]

D. The department shall determine the rate per day for a budget year as follows:

Rate Per Day = [(Adjusted base year cost per day of inpatient hospital services) multiplied by (budget year HCI), plus (budget year pass-through cost per day of inpatient hospital services)]

E. After the end of each budget year, the commissioner shall redetermine the rate per admission or rate per day, or both. The commissioner shall substitute actual pass-through costs as determined by medicare for budgeted costs in item B, subitem (2) for that year. If an adjustment indicates an overpayment to the hospital, the hospital shall pay the commissioner the overpayment

within 60 days of written notification from the commissioner. If the adjustment indicates an underpayment to the hospital, the department shall pay that hospital the underpayment within 60 days of written notification from the commissioner. Interest charges will be assessed according to part 9500.1125, subpart 5.

F. A hospital with minimal participation shall be reimbursed on a rate per day in lieu of a rate per admission unless the hospital elects to be reimbursed on a rate per admission basis. To obtain reimbursement on a rate per admission basis, the hospital shall submit a written request to the commissioner at least 30 days prior to the beginning of the budget year for which reimbursement is sought.

G. The department shall apply the disproportionate population adjustment as specified in part 9500.1135, subpart 1, substituting the term adjusted base year cost per admission with the term rate per admission or rate per day.

H. Reimbursement procedures are as specified in part 9500.1130, subparts 1 to 6.

I. Appeals must be made according to parts 9500.1140 and 9500.1145.

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. **Purpose.** Under Minnesota Statutes 1982, section 256.966, the annual increase in the cost per service unit paid to any vendor under medical assistance or general assistance medical care shall not exceed eight percent for services provided from January 1, 1982, until part 9500.1150 becomes applicable.

Subp. 2. **Definitions.** As used in this part, the following terms have the meanings given them:

A. "Adjusted base year costs" means allowable base year costs cumulatively multiplied by the eight percent cap for a hospital's fiscal years prior to the rate year, and adjustments resulting from appeals.

B. "Allowable base year costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's base year medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total hospital costs; and

(3) add the lower of cost or charge limitations for costs disallowed on the medicare/medical assistance cost report as provided by Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233.

C. "Allowable rate period costs" means a hospital's reimbursable inpa-

tient hospital costs as identified in a hospital's rate period medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total hospital costs.

D. "Eight percent cap" means the limit on the annual cost increase per service unit under Minnesota Statutes, section 256.966.

E. "Rate per admission" means the allowable base year cost for each admission multiplied by the eight percent cap and adding the rate year pass-through cost per admission.

F. "Rate per day" means the allowable base year cost per day of inpatient hospital services multiplied by the eight percent cap and adding the rate year pass-through cost per day of inpatient hospital services.

G. "Rate period" means any portion of a hospital's fiscal year that includes any portion of the period from January 1, 1982, until part 9500.1150 becomes applicable.

H. "Total hospital costs" means the costs identified in the hospital's base year medicare/medical assistance cost report, HCFA Form 2552, 1981 revision, Worksheet A, column 3, line 84.

Subp. 3. **Determination of allowable base year costs, allowable base year cost for each admission, and allowable base year cost per day.** The department shall determine allowable base year costs from the base year medicare/medical assistance cost report, using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to Q:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5);

C. net reimbursable inpatient hospital costs (subtract item B from item A);

D. total hospital costs (Worksheet A, column 3, line 84);

E. malpractice insurance costs (Worksheet A, column 5, line 71);

F. net total hospital costs (subtract item E from item D);

G. ratio of net reimbursable inpatient hospital costs to net total hospital costs (item C divided by item F);

H. pass-through costs, except malpractice insurance costs;

I. medical assistance pass-through costs, except malpractice insurance costs (item G multiplied by item H);

J. routine service costs before limitation (Worksheet D-1, line 57);

K. reimbursable routine service costs (Worksheet D-1, line 61);

L. reimbursable routine service costs subject to limitation (subtract item K from item J);

M. allowable base year costs (subtract item I from item C and add item L);

N. base year admissions excluding medicare crossovers;

O. allowable base year cost for each admission (item M divided by item N);

P. base year patient days excluding medicare crossovers; and

Q. allowable base year cost per day of inpatient hospital services (item M divided by item P).

Subp. 4. **Determination of allowable rate period costs, allowable rate period cost for each admission, and allowable rate period cost per day.** The department shall determine allowable rate period costs from the rate period medicare/medical assistance cost report using data from the HCFA Form 2552 worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to N:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5);

C. net reimbursable inpatient hospital costs (subtract item B from item A);

D. total hospital costs (Worksheet A, column 3, line 84);

E. malpractice insurance costs (Worksheet A, column 5, line 71);

F. net total hospital costs (subtract item E from item D);

G. ratio of net reimbursable inpatient hospital costs to net total hospital costs (item C divided by item F);

H. pass-through costs, except malpractice insurance costs;

I. medical assistance pass-through costs except malpractice insurance costs (item G multiplied by item H);

J. allowable rate period costs (subtract item I from item C);

K. rate period admissions excluding medicare crossovers;

L. allowable rate period cost for each admission (item J divided by item K);

M. rate period patient days excluding medicare crossovers; and

N. allowable rate period cost per day of inpatient hospital services (item J divided by item M).

Subp. 5. **Determination of rate per admission and rate per day.** The following data shall be determined:

A. The department shall determine the rate period pass-through costs per admission or per day of inpatient hospital services, or both, for the rate period as specified in part 9500.1150, subpart 4, item B.

B. The department shall multiply the allowable base year costs by the eight percent cap.

C. The department shall determine the rate per admission for a rate period as follows:

Rate Per Admission	=	Lesser of the [(allowable base year cost for each admission) multiplied by (eight percent cap), or the allowable rate period cost for each admission plus (rate period pass-through cost per admission)]

After the initial year, adjusted base year costs are used in the rate per admission formula instead of allowable base year costs.

D. The department shall determine the rate per day for a rate period as follows:

Rate Per Day	=	Lesser of the [(allowable base year cost per day of inpatient hospital services) multiplied by (eight percent cap), or the allowable rate period cost per day of inpatient hospital services plus (rate period pass-through cost per day of inpatient hospital services)]

After the initial year, adjusted base year costs are used in the rate per day formula instead of allowable base year costs.

E. A hospital with minimal participation, as specified in part 9500.1150, subpart 4, item F, shall be reimbursed on a rate per day in lieu of rate per admission unless the hospital elects to be reimbursed on a rate per admission basis.

F. The department shall apply the disproportionate population adjustment as specified in part 9500.1135, substituting the term adjusted base year cost per admission with the term rate per admission or rate per day.

G. Reimbursement procedures are as specified in part 9500.1130, subparts 1 to 6.

H. Appeals must be made according to parts 9500.1140 and 9500.1145.

Subp. 5a. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. **Four percent reduction.** Reimbursement for admissions is reduced four percent from January 1, 1983, through June 30, 1983, as provided in Laws of Minnesota 1982, Third Special Session, chapter 1, article 2, section 2, subdivision 4, paragraph (a), clause (4). Each rate per admission and each rate per day as determined under subpart 4 for each admission during the period from January 1, 1983, through June 30, 1983, shall be reduced by four percent.

Statutory Authority: *MS s 256.969 subds 2,6; L 1983 c 312 art 5 s 39*

History: *10 SR 227; 11 SR 1688*

GENERAL ASSISTANCE

9500.1200 PURPOSE AND APPLICABILITY.

Subpart 1. **Purpose.** Parts 9500.1200 to 9500.1270 establish the rights and responsibilities of the Department of Human Services, local agencies, and recipients of general assistance as they pertain to the administration of the general assistance program.

Subp. 2. **Applicability.** Parts 9500.1254 to 9500.1256 govern application for maintenance benefits from other sources, execution of an interim assistance authorization agreement, provision of special services to assist the applicant or recipient in applying for other maintenance benefits, reimbursement for interim assistance, and reimbursement for provision of special services. When parts 9500.1254 to 9500.1256 conflict with parts 9500.1236 to 9500.1248, then parts 9500.1254 to 9500.1256 shall prevail.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.06 subd 5; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *10 SR 1715; 11 SR 134*

9500.1202 PURPOSE OF GENERAL ASSISTANCE PROGRAM.

The purposes of the general assistance program are:

A. to provide financial assistance and services to persons unable to provide for themselves, who have not refused suitable employment, and who are not otherwise provided for by law;

B. to strengthen and preserve the family unit;

C. to aid those persons who can be helped to become self-supporting or to attain self-care; and

D. to provide property tax relief by providing state financing for some welfare costs historically financed by county property tax levies.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1204 [Repealed, 10 SR 2322]

9500.1205 FINANCIAL DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9500.1200 to 9500.1256 have the meanings given them in this part.

Subp. 2. **Affidavit.** "Affidavit" means a written and signed declaration.

Subp. 3. **Allowable deductions.** "Allowable deductions" means income or expenses that are subtracted from gross income under part 9500.1228 when determining countable income. Allowable deductions include:

A. the first $50 of monthly earned income for each individual who receives earned income;

B. the cost of transportation to and from employment, including transporting a minor child to and from child care services, based on actual cost or the amount allowed for use of a personal car in the United States Internal Revenue Code for a maximum of 100 miles per day;

C. a meal allowance of $2 per day for each day that the individual eats a meal at work or has a break for a meal during work hours, unless the individual can establish that higher costs are both necessary and reasonable;

D. the cost of uniforms, tools, and equipment needed to retain a job;

E. health insurance premiums and any other type of insurance required by the employer as a condition of employment;

F. union dues;

G. professional association dues if they are required to obtain or retain employment;

H. public liability insurance premiums if they are required by the employer when an automobile is used in employment and the premiums are not paid by the employer;

I. the amount withheld or paid from gross income for mandatory retirement fund contributions;

J. the amount withheld or paid from gross income for FICA;

K. child care costs for each child if both parents are absent from the home and at work or in school, unless these costs are paid for or reimbursed to the individual by any other individual or entity;

L. state and federal personal income tax payments and withholdings;

M. other work expenses required for employment and approved by the local agency;

N. a minor child's income, including support and maintenance payments received, that exceeds the standard of assistance applicable to that child;

O. food stamps;

P. payments made pursuant to litigation and subsequent appropriation by the United States Congress, of funds to compensate members of Indian tribes for the taking of tribal lands by the federal government;

Q. cash payments to displaced persons who face relocation as a result of the Housing Act of 1965, the Housing and Urban Development Act of 1965, or the Uniform Relocation Act of 1970;

R. AFDC payments received by women residing in facilities for battered women as described in Minnesota Statutes, section 256D.05, subdivision 3, for whom general assistance payments are made to pay for residence in the facility;

S. stipends received from the displaced homemaker services program;

T. payments for basic care, difficulty of care, and clothing allowances received for and used to provide family foster care to children or adults under parts 9545.0010 to 9545.0260 and 9555.5100 to 9555.6400;

U. benefits under title IV and title VII of the Older Americans Act of 1965;

V. a title I loan provided through the Minnesota Housing Finance Agency for the first nine months following the date of issuance of the loan;

W. state and federal personal income tax refunds, including Minnesota property tax refunds;

X. in-kind income, except for payments made for room, board, tuition, or fees by a parent on behalf of a child enrolled as a full-time student in a postsecondary institution;

Y. reverse mortgage loan proceeds received by the applicant or recipient;

Z. payments made for services provided by volunteers under title I, title II, and title III of the Domestic Service Act of 1973;

AA. payments from VISTA to VISTA volunteers;

BB. reimbursements for employment training received through the Job Training Partnership Act, except for wage payments for on-the-job training;

CC. reimbursement for personal out-of-pocket expenses incurred while performing volunteer services, jury duty, or employment, except for expenses that have been or will be reimbursed;

DD. loans, except for educational loans on which payment is deferred, whether from private, public, or governmental lending institutions, governmental agencies, and private individuals, if the individual and the lender provide written documentation to the local agency that the individual must repay the loan and that the loan is not a gift;

EE. payments by the vocational rehabilitation program administered by the state under Minnesota Statutes, chapter 129A, except for payments that are for current living expenses;

FF. general assistance payments to correct underpayments in a current or previous month;

GG. the first $30 of each nonrecurring cash gift, such as a gift received for a holiday, birthday, or graduation;

HH. proceeds from the sale of real or personal property owned by a member of the individual's filing unit, if the property was excluded from consideration under part 9500.1209 because its equity value was less than the real and personal property limits;

II. funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made from public agencies, issued by insurance companies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency subsequent to a presidential declaration of disaster;

JJ. an energy assistance payment made by the Low Income Home Energy Assistance Program, payments made directly to energy providers by other public and private agencies, and a credit or rebate payment issued by energy providers;

KK. payments made for subsidized adoptions under United States Code, title 42, sections 670 to 676, and Minnesota Statutes, section 259.40;

LL. court ordered child support payments actually paid for a minor child by an individual who is not a member of an assistance unit; and

MM. income that is otherwise specifically excluded under federal or state law from inclusion as income for state funded public assistance programs.

Subp. 4. **Application.** "Application" means the submission to the local agency of a signed and dated form prescribed by the commissioner that indicates the desire to receive general assistance.

Subp. 5. **Assistance unit.** "Assistance unit" means the individuals from a filing unit who are applying for or receiving general assistance, whose eligibility must be determined in accordance with part 9500.1209, subpart 4, and whose needs are included when determining the standard of assistance and the monthly general assistance payment.

Subp. 6. **Countable income.** "Countable income" means gross income calculated in accordance with part 9500.1227 minus allowable deductions.

Subp. 7. **Earned income.** "Earned income" means compensation from lawful employment or lawful self-employment, including salaries, wages, tips, gratuities, commissions, earnings from self-employment, earned income tax credits, incentive payments from work or training programs, payments made by an employer for regularly accrued vacation or sick leave, earnings under title I of the Elementary and Secondary Education Act, employee bonuses and profit sharing, jury duty pay, picket duty pay, and profit from other lawful activities earned by the individual's effort or labor. Earned income does not include returns from capital investment or benefits that accrue as compensation for lack of employment. Earned income must be calculated in accordance with part 9500.1225.

Subp. 8. **Earned income tax credit.** "Earned income tax credit" means the payment that can be obtained by a qualified low income person from an employer or from the United States Internal Revenue Service under United States Code, title 26, section 32.

Subp. 9. **Equity value.** "Equity value" means the amount of equity in real or personal property owned by an individual. Equity value is determined by subtracting any outstanding encumbrances from the fair market value of the real or personal property.

Subp. 10. **Federal Insurance Contributions Act or FICA.** "Federal Insurance Contributions Act" or "FICA" means the federal law under United States Code, title 26, section 3101 to 3126, that requires withholding or direct payment of income to the federal government.

Subp. 11. **Filing unit.** A "filing unit" is the individual or group of family members specified under part 9500.1209, subpart 2, who may elect to apply for general assistance together, and who, if eligible, must receive a single monthly payment.

Subp. 12. **Gross income.** "Gross income" means the total amount of cash or in-kind payment or benefit, whether earned or unearned, that is received by, actually available to, or paid for the benefit of an individual, including income specified in Minnesota Statutes, section 256D.02, subdivision 8. Gross income does not include personal property previously established as an asset, and subject to the limitations under Minnesota Statutes, section 256.73, subdivision 2. Gross income must be calculated in accordance with part 9500.1227.

Subp. 13. **In-kind income.** "In-kind income" means income, benefits, or payments that are provided in a form other than money or liquid asset, including goods, produce, services, privileges, or third-party payments made on behalf of a person for whom the income is intended.

Subp. 14. **Month.** "Month" means a calendar month.

Subp. 15. **Parent.** "Parent" means a child's natural or adoptive parent who is legally obligated to support that child.

Subp. 16. **Payment month.** "Payment month" means the month for which a local agency issues a general assistance payment.

Subp. 17. **Prospective budgeting.** "Prospective budgeting" means a method of determining the amount of a monthly general assistance payment in which the countable income that the local agency anticipates will be available to the assistance unit in the payment month is applied against the standard of assistance applicable to the assistance unit for the payment month.

Subp. 18. **Recipient.** "Recipient" means an individual currently receiving general assistance. The term "recipient" includes any person whose needs are included in the payment to an assistance unit.

Subp. 19. **Unearned income.** "Unearned income" means any form of gross income that does not meet the definition of earned income. Unearned income includes an annuity, retirement, or disability benefit, including veteran's or worker's compensation, social security disability, railroad retirement benefits, or unemployment compensation; benefits under a federally funded categorical assistance program including supplemental security income, or other assistance programs; gifts, rents, dividends, interest and royalties, support and maintenance payments, pension payments, return on capital investment, insurance payments or settlements; severance payments, employment benefits, and rewards for past employment; and educational grants, deferred payment loans, and scholarships. Unearned income must be calculated in accordance with part 9500.1226.

Subp. 20. **Verification.** "Verification" means the process a local agency must use to establish the accuracy or completeness of information from an applicant, a recipient, a third party, or other source as that information relates to an assistance unit's eligibility for general assistance or the amount of a monthly general assistance payment.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1206 PROGRAM DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1200 to 9500.1270 and 9500.1300 to 9500.1320, the following terms have the meanings given them.

Subp. 2. **Adult child.** "Adult child" means a person aged 18 years or older.

Subp. 3. **Advanced age.** "Advanced age" means the condition that applies to a recipient who:

A. is age 55 or older and whose work history shows a marked deterioration compared to his or her work history prior to age 55 as indicated by decreasing occupational status, reduced hours of employment, or decreased periods of employment; or

B. if less than age 55, is evaluated by a vocational specialist as having significantly limited ability to obtain or retain suitable employment because of advancing age.

Subp. 4. **AFDC.** "AFDC" means the program authorized by title IV-A of the Social Security Act to provide financial assistance to needy families with dependent children.

Subp. 5. **Applicant.** "Applicant" means a person who has an application pending with the local agency for general assistance or work readiness.

Subp. 6. **Assistance standard.** "Assistance standard" means the amount established by the commissioner under Minnesota Statutes, section 256D.01, to provide for an assistance unit's shelter, fuel, food, clothing, utilities, necessary household supplies, and personal need items.

Subp. 7. [Repealed, 10 SR 2322]

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or a designated representative.

Subp. 9. **Costs or disbursements.** "Costs" or "disbursements" means a qualified provider's actual out-of-pocket expenses incurred for the provision of special services to an applicant or recipient.

Subp. 10. [Repealed, 10 SR 2322]

Subp. 11. **Department.** "Department" means the Department of Human Services.

Subp. 12. **Director of the local agency.** "Director of the local agency" means the director of the local agency or the director's designated representative.

Subp. 13. **Fees.** "Fees" means a qualified provider's charge for the hours of direct provision of special services to an applicant or recipient.

Subp. 14. **Full-time student.** "Full-time student" means a student attending a postsecondary institution who:

A. attends training for a minimum of 25 hours per week if the training does not involve shop practice and for a minimum of 30 hours per week if the training does involve shop practice for a vocational or technical student; or

B. registers for and attends a minimum of 12 credit hours per semester or quarter.

Subp. 15. **Good cause.** "Good cause" means a reason for taking an action or failing to take an action that is reasonable and justified when viewed in the context of surrounding circumstances including: illness of the person, illness of another family member that requires the applicant's or recipient's presence, a family emergency, or the inability to obtain transportation.

Subp. 16. **Initial supplemental security income payment or initial SSI payment.** "Initial supplemental security income payment" or "initial SSI payment" means the first payment of retroactive SSI benefits to the recipient that includes a period when general assistance benefits were also paid.

Subp. 17. **Interim assistance.** "Interim assistance" means the total amount of general assistance provided for the recipient, based on the state assistance standards and the negotiated rate provisions of part 9500.1249, to cover the period for which the initial payment of other maintenance benefits is made. The amount of general assistance considered interim assistance is limited to the amount the monthly payments for the assistance unit would have been reduced if the applicant or recipient had not been included in the assistance unit. The interim assistance period begins with the month of application for general assistance, the first month of eligibility for the other maintenance benefits, or the date the interim assistance authorization agreement is signed, whichever is latest. The interim assistance period ends with the last month covered by the initial payment of the other maintenance benefits. The term does not include per diem payments made to shelters for battered women pursuant to Minnesota Statutes, section 256D.05, subdivision 3.

Subp. 18. **Interim assistance authorization agreement.** "Interim assistance authorization agreement" means the agreement in which the general assistance applicant or recipient agrees to reimburse the local agency for the amount of general assistance provided for him or her during the period when eligibility for another maintenance benefit program is being determined. The agreement must require reimbursement to the local agency only when the general assistance applicant or recipient is found eligible for another maintenance benefit program and the initial payment of those other maintenance benefits has been made.

Subp. 19. **Local agency.** "Local agency" means a county or a multicounty agency that is authorized under Minnesota Statutes as the agency responsible for the administration of the general assistance program.

Subp. 19a. **Local labor market.** "Local labor market" means the geographic area in which a registrant can reasonably be expected to search for suitable employment. The geographic area must be limited to an area within two hours' round trip of the registrant's residence, exclusive of time needed to transport his or her children to and from child care.

Subp. 20. **Medical certification.** "Medical certification" means a statement about a person's illness, injury, or incapacity that is signed by a licensed physician, licensed consulting psychologist, or licensed psychologist whose professional training and experience qualifies him or her to diagnose or certify the person's condition.

Subp. 21. **Mental illness.** "Mental illness" means the condition of a person who has a psychological disorder resulting in behavior that severely limits the person in obtaining, performing, or maintaining suitable employment.

Subp. 22. **Mental retardation.** "Mental retardation" means the condition of a person who has demonstrated deficits in adaptive behavior and intellectual functioning which is two or more standard deviations below the mean of a professionally recognized standardized test and the condition severely limits the person in obtaining, performing, or maintaining suitable employment.

Subp. 23. **Minor child.** "Minor child" means a person under the age of 18.

Subp. 24. **Negotiated rate.** Except for shelter facilities provided for under Minnesota Statutes, section 256D.05, subdivision 3, "negotiated rate" means a general assistance payment that includes room and board and is either set by the state or local agency or is negotiated by one of those agencies with a party not included in the assistance unit. The set or negotiated rate provides for an assistance unit's shelter, fuel, food, utilities, household supply need items, and other costs necessary to provide room and board. The rate shall pay only for those items. It shall not include the clothing and personal needs allowance under Minnesota Statutes, section 256D.06, subdivision 3, payments for foster care, child welfare services, medical care, dental care, hospitalization, nursing care, drugs or medical supplies, program costs, or other social services.

Subp. 25. **Other maintenance benefits.** "Other maintenance benefits" means any of the following:

A. workers' compensation benefits as provided by Minnesota Statutes, chapter 176 and rules adopted thereunder;

B. unemployment compensation benefits as provided by Minnesota Statutes, sections 268.07 to 268.10 and rules adopted thereunder;

C. railroad retirement benefits as provided by United States Code, title 45, sections 231 to 231s;

D. veteran's disability benefits as provided by United States Code, title 38, sections 301 to 363;

E. supplemental security income benefits as provided by United States Code, title 42, sections 1381 to 1383c;

F. social security disability insurance benefits as provided by United States Code, title 42, section 423; or

G. other programs identified by the local agency that provide periodic payments that can be used to meet basic needs and that, if received, would reduce or eliminate the need for general assistance.

Subp. 26. **Potentially eligible.** "Potentially eligible" means that the local agency has determined that the applicant or recipient appears to meet the eligibility requirements of another maintenance benefit program.

Subp. 27. **Qualified provider.** A "qualified provider" means the local agency, or:

(1) a nonprofit legal assistance organization;

(2) an agency that employs licensed practitioners or accredited counseling staff or staff with a master's degree from an accredited program in social work, psychology, counseling, occupational therapy, or physical therapy;

(3) a private attorney at law; or

(4) another organization or person determined by the local agency to have sufficient training or experience to be effective in assisting persons to apply for and establish eligibility for SSI benefits.

Subp. 28. [Repealed, 10 SR 2322]

Subp. 29. **Responsible relative.** "Responsible relative" means the spouse of an applicant or recipient, the parent of a minor child who is an applicant or recipient, or the parent of an adult child who resides with the parent and is an applicant or recipient.

Subp. 30. **SSI.** "SSI" means the supplemental security income program administered by the Social Security Administration under United States Code, title 42, sections 1381 to 1383c.

Subp. 31. **State participation.** "State participation" means state aid to local agencies for general assistance expenditures as specified in Minnesota Statutes, section 256D.03, subdivision 2.

Subp. 32. **Suitable employment.** "Suitable employment" means a job within the local labor market that:

A. meets existing health and safety standards set by federal, state, or local regulations;

B. is within the physical and mental ability of a person;

C. pays at least the minimum wage prescribed by state or federal law and provides a gross income of at least $268 per month; and

D. includes employment offered through the Job Training Partnership Act, Minnesota Employment and Economic Development Act, and other employment and training options, but does not include temporary day labor.

Subp. 33. **Vocational specialist.** "Vocational specialist" means a counselor of the Department of Jobs and Training or Division of Vocational Rehabilitation, or another similarly qualified person who advises persons about occupational goals and employment.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.06 subd 5; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *9 SR 593; 10 SR 1715; 11 SR 134*

9500.1208 [Repealed, 10 SR 2322]

9500.1209 ELIGIBILITY DETERMINATION.

Subpart 1. **Local agency duties.** The local agency must determine the composition of a filing unit, the composition of an assistance unit, and the eligibility of an assistance unit according to subparts 2 to 4. The local agency must determine the standard of assistance applicable to an assistance unit according to parts 9555.1216 to 9555.1222, the amount of the assistance unit's countable income in accordance with part 9500.1228, and the monthly payment to an assistance unit as prescribed in part 9500.1230.

Subp. 2. **Filing unit composition.** The local agency must permit an individual or family who requests general assistance to make application for general assistance as provided by Minnesota Statutes, section 256D.07. When an application for general assistance is made for an individual or family, and when the local agency redetermines the eligibility of a recipient, the local agency must determine the composition of the applicant's or recipient's filing unit. The local agency must require a separate application and conduct a separate eligibility determination for each filing unit. The composition of a filing unit shall be limited to the individuals specified in items A to D.

A. Except as provided in items C and D, if the applicant or recipient is an adult, the filing unit must include the applicant or recipient and the following individuals who reside with the applicant or recipient:

(1) the applicant's or recipient's spouse; and

(2) the minor children of the applicant or recipient and the minor children of the applicant's or recipient's spouse.

B. Except as provided in items C and D, if the applicant or recipient is a minor child, the filing unit must include the applicant or recipient and the following individuals who reside with the applicant or recipient:

(1) the applicant's or recipient's parent or parents;

(2) the spouse of the applicant's or recipient's parent; and

(3) the minor children of the applicant's or recipient's parent or parents and the minor children of the spouse of the applicant's or recipient's parent.

C. Individuals eligible for or receiving AFDC, individuals receiving AFDC-emergency assistance for current maintenance needs, or individuals who are sanctioned from receiving AFDC for failure to comply with AFDC program requirements are not eligible to be included in the general assistance filing unit.

D. An unmarried couple residing together with a common minor child whose paternity has been adjudicated or attested to through affidavit must comprise two separate filing units. The minor child shall be included in the filing unit of the parent who applies for general assistance first. If both parents apply for general assistance on the same date, the parents must choose the filing unit that shall contain the minor child.

Subp. 3. **Assistance unit composition.** The local agency must determine the composition of an applicant's or recipient's assistance unit as provided in items A and B.

A. The local agency must assess the categorical eligibility of each applicant or recipient under part 9500.1258, unless the applicant or recipient informs the local agency of his or her election not to receive general assistance. If an applicant or recipient does not meet the conditions of a category of eligibility, under part 9500.1258, or the applicant or recipient is disqualified under parts 9500.1264 to 9500.1268, or 9500.1254, subpart 5, the local agency must inform the applicant or recipient of his or her ineligibility for general assistance. The local agency may use one form per filing unit to inform the ineligible members of a filing unit of their ineligibility for general assistance.

B. The assistance unit shall be composed of applicants or recipients from a filing unit who are categorically eligible to receive general assistance as provided in item A. General assistance categorical eligibility under item A may exist for one or more members of the filing unit even though other members of the filing unit are ineligible.

Subp. 4. **Assistance unit eligibility.** The local agency must determine an assistance unit's eligibility to receive general assistance as provided in items A to E.

A. The local agency must determine the equity value of real and personal property available to the assistance unit. The equity value of real and personal property available to a member of the filing unit who is not included in the assistance unit, but who is a responsible relative of an assistance unit member must be considered real and personal property available to the assistance unit. If the local agency determines that the total equity value of real and personal property available to the assistance unit exceeds the maximum standards established under Minnesota Statutes, section 256.73, subdivision 2, the local agency must determine if the excess property must be excluded under part 9500.1210. If the excess property is not excluded from consideration, the local agency must inform the assistance unit of its ineligibility for general assistance.

B. If the local agency determines that the equity value of real and personal property available to the assistance unit is less than or equal to the maximum standards established under Minnesota Statutes, section 256.73, subdivision 2, or that property which exceeds those limits is excluded under part 9500.1210, the local agency must determine the standard of assistance applicable to the assistance unit as provided in parts 9500.1216 to 9500.1222, and the

amount of countable income available to the assistance unit as provided in part 9500.1229, subpart 2.

C. Except as provided in item D, the local agency must compare the assistance unit's countable income to the standard of assistance applicable to the assistance unit as provided in part 9500.1229, subpart 3. If the local agency determines that the countable income of the assistance unit equals or exceeds the standard of assistance applicable to the assistance unit, the local agency must inform the assistance unit of its ineligibility for general assistance. If the local agency determines that the countable income of the assistance unit is less than the standard of assistance applicable to the assistance unit the local agency must inform the assistance unit of its eligibility for general assistance.

D. An applicant or recipient who resides in a nursing home or facility with a negotiated rate must have less countable income than the total of the reduced standard provided in part 9500.1218, subpart 2, and the facility's negotiated rate to be eligible for general assistance.

E. If a filing unit member elects not to apply for or receive general assistance or is determined ineligible for general assistance, or if a parent is not included in his or her minor child's filing unit under the provisions of subpart 2, item D, that individual's financial responsibility for and ability to provide income to the assistance unit must be determined as provided in part 9500.1226.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subds 1,3; 256D.051; 256D.06 subds 1,3; 256D.07; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *10 SR 2322; 11 SR 134*

9500.1210 EXCLUSION OF EXCESS PROPERTY.

Subpart 1. **Property excluded.** In determining eligibility for general assistance, the local agency shall exclude real and personal property more than the limits in part 9500.1208, item B, when the local agency finds that:

A. the property is essential to the assistance unit's self-support or self-care or that the property is needed to obtain or retain suitable employment;

B. a reasonable expectation exists that the assistance unit will use the property as a source of self-support either within six months of the date when the applicant or recipient is determined to have property more than the limit in part 9500.1209, subpart 4, item A or, if the property produces income on a seasonal basis, during the income producing season immediately following the determination;

C. the property produces net income that is being used for the support of the assistance unit;

D. the applicant has not received general assistance within the last 60 days and the circumstances of the applicant indicate that the need for general assistance will not exceed 30 days;

E. a grant of general assistance for an emergency need is required and the excess property cannot be liquidated in time to meet that need; or

F. an undue hardship would be imposed upon the applicant or recipient by the forced disposal of the property.

Subp. 2. **Undue hardship.** An undue hardship exists when general assistance eligibility is prevented because the assistance unit owns property more than the limit in part 9500.1209, subpart 4, item A and one of the following conditions is met:

A. the property is for sale at a reasonable price but has not been sold;

B. the property is not legally available for liquidation by the applicant or recipient; or

C. the property is essential to the assistance unit for other reasons as determined by the local agency.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715; 10 SR 2322*

9500.1212 INFORMING APPLICANTS OR RECIPIENTS OF EXCLUSION CONDITIONS.

Upon determining that an assistance unit is not eligible for general assistance or emergency assistance under the general assistance program due to owning property more than the limit in part 9500.1209, subpart 4, item A, the local agency shall inform in writing the applicant or recipient of the conditions under which excess property may be excluded.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715; 10 SR 2322*

9500.1214 VERIFICATION OF INCOME.

Subpart 1. **Verification of an applicant's or recipient's income and circumstances.** An applicant or recipient shall provide verification of the assistance unit's income and circumstances relevant to its eligibility, standard of assistance, and monthly payment. If the applicant or recipient cannot verify income or circumstances, the local agency must help him or her to obtain verification. If the applicant or recipient, with the local agency's help, cannot provide the verification, the assistance unit's eligibility, standard of assistance, and monthly payment must be determined based on the income and circumstances that have been verified or sworn to through affidavit. If the applicant or recipient refuses to provide the required verification of income or circumstances, the assistance unit is ineligible for general assistance and general assistance must be denied or terminated.

Subp. 2. **Verification of responsible relative's income and circumstances.** When an assistance unit is subject to a reduced standard under part 9500.1220 or 9500.1222, or income allocation provisions under part 9500.1226 or 9500.1227, the responsible relative or individual not included in the assistance unit shall provide verification of his or her income and circumstances relevant to the reduced standard and income allocation provisions. If the responsible relative or the individual not included in the assistance unit cannot provide verification of his or her income or circumstances, the local agency must help him or her to obtain verification. If the responsible relative or the individual not included in the assistance unit cannot provide the verification with the local agency's help, the reduced standard and the allocations of income must be determined based on the income and circumstances that the responsible relative or individual has verified or sworn to through affidavit. If the assistance unit is subject to part 9500.1220, 9500.1222, or 9500.1226, subpart 3, items A to C, and the responsible relative refuses to provide the required verification of income or circumstances, the assistance unit is ineligible for general assistance and general assistance must be denied or terminated. If a responsible relative is not included in the assistance unit under part 9500.1209, subpart 2, item D, and the responsible relative refuses to provide the required verification of income or resources, only the common minor child who is a member of the assistance unit shall be ineligible for general assistance. If the assistance unit is subject to part 9500.1227, subpart 3, and the individual not included in the assistance unit refuses to provide the required verification of income or circumstances, the assistance unit shall not allocate income for the individual's needs until the required verification is provided.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1216 FULL STANDARDS.

Except as provided by parts 9500.1218 to 9500.1222, the full standards of assistance must be used to determine the eligibility of an assistance unit under part 9500.1209, subpart 4, and the minimum monthly payment to an assistance unit under part 9500.1229, subpart 4. The full standard must be based on the number of individuals in the assistance unit and must be computed as follows:

A. The full standard for an assistance unit composed of one individual when that individual is an adult is the amount specified in part 9500.1217, subpart 1.

B. The full standard for an eligible adult in an assistance unit that contains more than one individual is:

(1) the first adult standard specified in part 9500.1217, subpart 2, if the adult is the first or only adult in the assistance unit; or

(2) the second adult standard specified in part 9500.1217, subpart 2, if the adult is the second adult in the assistance unit.

C. Except as provided in item D, the full standard for an eligible minor child in an assistance unit must be determined based on the number of minor children in the assistance unit according to the table in part 9500.1217, subpart 3.

D. When an assistance unit contains no adult because a parent or parents are disqualified from receiving general assistance under parts 9500.1264 to 9500.1268 or 9500.1254, subpart 5, and the parent or parents do not have countable income in an amount equal to or in excess of their own needs, the full standard applicable to the assistance unit is the special child standard provided by this item. The parent's or parents' needs are equal to the full standard for adults as specified in item B. The special child standard must be determined as follows:

(1) The special child standard for an assistance unit composed only of one minor child is the special child only standard for one child, specified in part 9500.1217, subpart 4.

(2) When an assistance unit includes more than one minor child, the special child standard must be determined by substituting the first adult standard provided by item B, subitem (1), for the needs of the last minor child in the assistance unit and combining that amount with the full standard provided by item C that is applicable to the number of remaining minor children.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subds 1,3; 256D.051; 256D.06 subds 1,3; 256D.07; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *10 SR 2322; 11 SR 134*

9500.1217 AMOUNT OF FULL STANDARDS.

Subpart 1. **Adult only standard.** The full standard for an assistance unit composed of one individual when that individual is an adult is $203.

Subp. 2. **Adult standards.** The full standards for adults in an assistance unit that is composed of more than one individual are $187 for the first or only adult in the assistance unit and $73 for the second adult in the assistance unit.

Subp. 3. **Child standards.** The full standards for minor children in an assistance unit are specified in the following table:

Number of minor children in the assistance unit	Full state assistance standard for the minor children
1	$250

2	345
3	434
4	510
5	586
6	663
7	729
8	793
9	848
10	902

If the assistance unit contains more than ten minor children, the full standard for each additional minor child is $53.

Subp. 4. **Child only standard.** The full standard for an assistance unit composed of one individual when that individual is a minor child is $337.

Subp. 5. **Tie to AFDC standards.** The full standards of subparts 2 to 4 must increase or decrease to remain equal to the equivalent AFDC standards whenever AFDC standards are increased or decreased.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1218 REDUCED STANDARD FOR AN APPLICANT OR RECIPIENT IN A NURSING HOME, FACILITY WITH A NEGOTIATED RATE, OR STATE HOSPITAL.

Subpart 1. **Applicability.** The reduced standard of this part must be used to determine the eligibility of an assistance unit under part 9500.1209, subpart 4, and the minimum monthly payment amount to an assistance unit under part 9500.1229, subpart 4, if the assistance unit is composed of one individual who resides in a nursing home, facility with a negotiated rate, or a state hospital.

Subp. 2. **Reduced standard.** The reduced standard for an assistance unit composed of one individual who resides in a nursing home, facility with a negotiated rate, or a state hospital is the amount established as the clothing and personal needs allowance for medical assistance recipients under Minnesota Statutes, section 256B.35, subdivision 1.

Subp. 3. **Battered women's shelters excluded.** This part does not apply to an applicant or recipient residing in a shelter facility provided for under Minnesota Statutes, section 256D.05, subdivision 3.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1220 REDUCED STANDARD FOR AN ASSISTANCE UNIT SHARING A RESIDENCE WITH A RESPONSIBLE RELATIVE WHO RECEIVES OR HAS BEEN SANCTIONED OR DISQUALIFIED FROM RECEIVING GENERAL ASSISTANCE OR AFDC.

Subpart 1. **Applicability.** The reduced standards in this part must be applied to determine the eligibility of an assistance unit under part 9500.1209, subpart 4, and the minimum monthly payment to an assistance unit under part 9500.1229, subpart 4, if the assistance unit resides with an individual who is a responsible relative of one or more of the assistance unit members, and if one of the following conditions exists:

A. The applicant's or recipient's filing unit and assistance unit are composed of only one individual, the individual is an adult, and the individual shares a residence with a parent who receives general assistance or AFDC, or would be receiving general assistance or AFDC except for sanction or disqualification from either of those programs. If the one-person assistance unit

shares a residence with both a parent and a spouse, the parent's income must not be considered and the standard of assistance applicable to the assistance unit must be based on the relationship to the spouse.

B. The assistance unit is composed of one or more individuals, the assistance unit members share a residence with a parent or spouse of one or more of the assistance unit members, and the parent or spouse would be included in the general assistance filing unit except that he or she receives AFDC or would be receiving AFDC but is sanctioned from that program for failure to comply with program requirements.

C. If an assistance unit that meets the conditions under item A or B resides with two parents who have income from both general assistance or AFDC and from another source, and the assistance unit is potentially subject to a reduced standard under both this part and part 9500.1222, the reduced standard applicable to the assistance unit must be determined based on this part.

Subp. 2. **Reduced standard.** The reduced standard applicable to an assistance unit provided for by subpart 1 must be determined according to items A to C.

A. The reduced standard applicable to the assistance unit must equal the amount the standard of assistance applicable to the responsible relative's assistance unit would increase if the assistance unit members were added to the responsible relative's general assistance or AFDC assistance unit.

B. When determining the amount the responsible relative's general assistance or AFDC standards would increase due to the addition of the assistance unit members, the following standards shall apply to the added members:

(1) The standard applicable to a minor child is the standard for another minor child added to the responsible relative's general assistance or AFDC grant.

(2) The standard applicable to an adult child who meets the conditions under subpart 1, item A, is the standard for another minor child, added to his or her parent's general assistance or AFDC grant.

(3) Except as provided in subitem (4), the standard of assistance applicable to a spouse is the standard for a second adult added to the responsible relative's general assistance or AFDC grant.

(4) The standard of assistance applicable to the spouse of an AFDC recipient who is the sole individual in the AFDC assistance unit and whose AFDC payment is determined using the special adult standard is the difference between the AFDC standard for a married couple and the AFDC special adult standard.

C. The reduced standard applicable to an assistance unit that shares a residence with a responsible relative must not exceed the standard of assistance that would apply to the assistance unit if the assistance unit did not share a residence with a responsible relative.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1222 REDUCED STANDARD FOR AN ASSISTANCE UNIT SHARING A RESIDENCE WITH A RESPONSIBLE RELATIVE WHO HAS INCOME OTHER THAN GENERAL ASSISTANCE OR AFDC.

Subpart 1. **Applicability of reduced standards.** The reduced standards in this part must be applied to determine the eligibility of an assistance unit under part 9500.1209, subpart 4, and the minimum monthly payment to an assistance unit under part 9500.1229, subpart 4, when the conditions in items A to C apply to the assistance unit.

A. The applicant's or recipient's filing unit and assistance unit are

composed of only one individual, the individual is an adult, and the individual does not meet an eligibility category under part 9500.1258, subpart 1, item A, B, H, I, J, O, or P.

B. The assistance unit member shares a residence with a parent who has income other than general assistance or AFDC.

C. The parent is not included in the filing unit according to part 9500.1209, subpart 2. If the one-person assistance unit shares a residence with both a parent and a spouse, the parent's income must not be considered and the standard applicable to the assistance unit must be based on part 9500.1220.

Subp. 2. **Reduced standard.** The reduced standard applicable to an assistance unit provided for in subpart 1 must be determined as follows:

A. Calculate the standard of assistance applicable to the household as provided in part 9500.1216. In this part, "household" means individuals with whom the applicant or recipient shares a residence, and includes only the applicant or recipient and the applicant's or recipient's parent or parents. The applicant or recipient must be considered the first child when determining the household standard.

B. Calculate the amount of the parent's or parents' countable income. In this part "parent's or parents' countable income" means the parent's or parents' monthly gross income minus the following deductions:

(1) income that is disregarded as an allowable deduction under part 9500.1205, subpart 3;

(2) income that has been counted in calculating the payment to an AFDC assistance unit;

(3) benefits received from the worker's compensation program, Minnesota supplemental aid program, supplemental security income program, or social security disability program;

(4) benefits received from the social security retirement program if the parent was receiving benefits under the social security disability or supplemental security income program at the time he or she became eligible for the social security retirement program or if the parent meets a category of eligibility under part 9500.1258, subpart 1, item A, B, H, or J;

(5) other benefits based on the parent's disability; and

(6) income allocated to meet the unmet needs of the parent's spouse who resides with the parent if the spouse is not a responsible relative of the applicant or recipient, and income allocated to meet the unmet needs of the parent's minor children who reside with the parent. The spouse's needs are equal to the standard of assistance for a second adult as provided by part 9500.1216, item B, subitem (2). To determine if the spouse's needs are unmet, the spouse's countable income must first be allocated to provide for the unmet needs of the parent's or spouse's minor children. The needs of a minor child are equal to the standard of assistance for an additional child as provided by part 9500.1216, item C, and are unmet to the extent that the child's countable income is less than the standard of assistance applicable to the child. The spouse's countable income that exceeds the unmet needs of the parent's or spouse's minor children must then be compared to the needs of the spouse. If the spouse's remaining countable income is greater than the spouse's needs, the parent shall not allocate countable income for the spouse's needs, and the spouse's excess countable income, up to and including the first adult standard, as provided by part 9500.1216, item B, subitem (1), must be considered countable income available to the parent. If the spouse's countable income is less than the spouse's needs, the parent's countable income must be allocated to meet the spouse's unmet needs. The parent's countable income must also be allocated to meet the needs of his or her minor children which are unmet with the spouse's or child's countable income.

C. Subtract the amount of the parent's or parents' countable income

calculated in item B from the household standard of assistance calculated in item A.

D. The reduced standard for the applicant or recipient is the amount calculated in item C or the full standard provided by part 9500.1216, whichever is less.

E. When two or more assistance units are subject to this part and share a residence with a responsible relative common to each assistance unit, the members of each of those assistance units must be included when determining the household standard of assistance in item A. The reduced standard determined in item D must be divided equally among the assistance units to determine the reduced standard applicable to each assistance unit.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subds 1,3; 256D.051; 256D.06 subds 1,3; 256D.07; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *10 SR 2322; 11 SR 134*

9500.1224 INCOME EVALUATION.

Subpart 1. **Local agency duty to evaluate income.** When the local agency determines the eligibility of an assistance unit under part 9500.1209, subpart 4, and the minimum monthly payment to an assistance unit under part 9500.1229, subpart 4, the local agency must evaluate income received by the following individuals:

A. the members of the assistance unit;

B. responsible relatives whose income is considered in determining a reduced standard under part 9500.1220 or 9500.1222, or whose income is considered available to an assistance unit member under part 9500.1228, subpart 2; and

C. individuals to whom an assistance unit member may allocate income under part 9500.1227, subpart 3.

Subp. 2. **Distribution of income.** Income evaluated under parts 9500.1224 to 9500.1228, must be attributed to the individual who earns it or to the individual beneficiary of the income, subject to items A to C.

A. The local agency must consider funds distributed from a trust, whether from the principal holdings or sale of trust property or from the interest and other earnings of the trust holdings, to be unearned income to the beneficiary of the trust when the funds are legally available to the beneficiary. Trusts are presumed legally available unless a beneficiary can document that the trust is not legally available.

B. The local agency must divide the income from jointly owned property equally among the property owners unless the terms of ownership prescribe a different distribution of equity.

C. The local agency must not allow deductions from an individual's gross income to meet a current or prior debt.

Subp. 3. **Evaluation of assistance unit's income.** The local agency must determine the amount of an assistance unit's earned income as provided in part 9500.1225, and the amount of the assistance unit's unearned income as provided in part 9500.1226. The local agency must add the assistance unit's earned income to the assistance unit's unearned income to determine the assistance unit's gross income as provided in part 9500.1227. The local agency must subtract allowable deductions from the assistance unit's gross income to determine the assistance unit's countable income as provided in part 9500.1228.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1225 EARNED INCOME.

Subpart 1. **Local agency duty to determine earned income.** The local agency must determine the total amount of earned income available to the individuals identified in part 9500.1224, subpart 1. Earned income from self-employment must be calculated in accordance with subpart 2. Earned income from contractual agreements must be calculated in accordance with subpart 3. The total amount of earned income available to an individual for a month must be determined by combining the amounts of earned income calculated under subparts 2 to 4. The total amount of earned income available to an assistance unit for a month must be determined by combining the total earned income of each assistance unit member.

Subp. 2. **Earned income from self-employment.** The local agency must determine the amount of earned income from self-employment by subtracting business costs from gross receipts according to items A to D.

A. Self-employment expenses must be subtracted from gross receipts except for the expenses listed in subitems (1) to (14):

(1) purchases of capital assets;

(2) payments on the principal of loans for capital assets;

(3) depreciation;

(4) amortization;

(5) the wholesale costs of items purchased, processed, or manufactured that are unsold inventory with a deduction for the costs of those items allowed at the time they are sold;

(6) transportation costs that exceed the amount allowed for use of a personal car in the United States Internal Revenue Code;

(7) the cost of transportation between the individual's home and his or her place of employment;

(8) salaries and other employment deductions made for members of an individual's assistance unit or for individuals who live in the individual's household for whom the individual is legally responsible;

(9) monthly expenses in excess of $70 for a roomer;

(10) monthly expenses in excess of $85 for a boarder;

(11) monthly expenses in excess of $155 for a roomer-boarder;

(12) annual expenses in excess of $102 or two percent of the estimated market value on a county tax assessment form, whichever is greater, as a deduction for upkeep and repair against rental income;

(13) expenses not allowed by the United States Internal Revenue Code for self-employment income; and

(14) expenses which exceed 60 percent of gross receipts for child care performed in an individual's home unless the individual can document a higher amount. When funds are received from the quality child care program, those funds are excluded from gross receipts, and the expenses covered by those funds must not be claimed as a business expense that offsets gross receipts.

B. Gross receipts from self-employment must be budgeted in the month in which they are received. Expenses must be budgeted against gross receipts in the month in which those expenses are paid except for subitems (1) to (3):

(1) The purchase cost of inventory items, including materials that are processed or manufactured, must be deducted as an expense at the time payment is received for the sale of those inventory items, processed materials, or manufactured items, regardless of when those costs are incurred or paid.

(2) Expenses to cover employee FICA, employee tax withholding, sales tax withholding, employee worker's compensation, employee unemployment compensation, business insurance, property rental, property taxes, and

other costs that are commonly paid at least annually, but less often than monthly, must be prorated forward as deductions from gross receipts over the period they are intended to cover, beginning with the month in which the payment for these items is made.

(3) Gross receipts from self-employment may be prorated forward to equal the period of time over which the expenses were incurred except that gross receipts must not be prorated over a period that exceeds 12 months. This provision applies only when gross receipts are not received monthly but expenses are incurred on an ongoing monthly basis.

C. Farm income must be annualized. Farm income is gross receipts minus operating expenses, subject to item A. Gross receipts include sales, rents, subsidies, soil conservation payments, production derived from livestock, and income from sale of home-produced foods.

D. Income from rental property must be considered self-employment earnings when effort is expended by the owner to maintain or manage the property. A local agency must deduct an amount for upkeep and repairs, in accordance with item A, subitem (11), for real estate taxes, insurance, utilities, and interest on principal payments. When an individual lives on the rental property, the local agency must divide the expenses for upkeep, taxes, insurance, utilities, and interest by the number of rooms to determine the expense per room. The local agency shall deduct expenses from rental income only for the number of rooms rented, not for rooms occupied by an individual's assistance unit. When no effort is expended by the owner to maintain or manage the property, income from rental property must be considered unearned income. The deductions described in this item must be subtracted from gross rental receipts.

Subp. 3. **Earned income from contractual agreements.** The local agency must prorate the amount of earned income received by individuals employed on a contractual basis over the period covered by the contract even if the payments are received over a shorter period of time.

Subp. 4. **Other earned income.** The local agency must consider all other forms of earned income not specifically provided for under subparts 2 and 3 to be earned income available to the individual in the month it is received.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1226 UNEARNED INCOME.

Subpart 1. **Local agency duty to determine unearned income.** The local agency must determine the total amount of unearned income available to the individuals identified in part 9500.1224, subpart 1. Educational grants, loans, and scholarships must be calculated as unearned income in accordance with subpart 2. Income allocated to a member or members of an assistance unit from a responsible relative must be calculated as unearned income in accordance with subpart 3. The total amount of unearned income available to an individual for a month must be determined by combining the amounts of unearned income calculated under subparts 2 to 4. The total amount of unearned income available to an assistance unit for a month must be determined by combining the total unearned income of each assistance unit member.

Subp. 2. **Educational grants, scholarships, and loans.** Educational grants, deferred payment loans, and scholarships received by an individual must be considered unearned income. The local agency must subtract tuition, fees, books, supplies, and transportation expenses from the total amount of the individual's grants, deferred payment loans, and scholarships, and prorate the remainder over the period the funds are intended to cover.

Subp. 3. **Income allocated from a responsible relative.** Income allocated to a

member or members of an assistance unit from a responsible relative who is in the filing unit but not in the assistance unit, or from a responsible relative who would have been a member of the filing unit but is not due to receipt of or sanction or disqualification from AFDC, or income allocated by a parent who is not included in his or her minor child's filing unit under the provisions of part 9500.1209, subpart 2, item D, must be considered unearned income available to the member or members of the assistance unit. The local agency must determine how much of the responsible relative's countable income is considered unearned income available to the member or members of an assistance unit in accordance with items A to D.

A. If the responsible relative is not included in the assistance unit because he or she receives AFDC, none of the responsible relative's countable income is considered unearned income available to the member or members of the assistance unit.

B. If the responsible relative is not included in the assistance unit because he or she is disqualified or sanctioned from receiving AFDC or general assistance, the responsible relative's countable income that is not used to determine an AFDC payment must be considered unearned income available to the member or members of the assistance unit, as provided in item C, except that a subtraction for the responsible relative's need, as provided in item C, subitem (1) must not be made.

C. If the responsible relative is not included in the assistance unit because he or she elects not to apply for or receive general assistance or because he or she is not categorically eligible for general assistance as determined under part 9500.1209, subpart 3, item A, the responsible relative's countable income that is considered unearned income available to the member or members of the assistance unit must be calculated as follows:

(1) An amount equal to the responsible relative's needs must be subtracted from his or her countable income. The responsible relative's needs must be equal to the amount the standard of assistance applicable to the assistance unit would increase if the responsible relative were added to the assistance unit.

(2) From the responsible relative's countable income remaining after the subtraction in subitem (1), subtract an amount equal to the unmet needs of the minor children and the responsible relative's spouse who are included in the filing unit but not included in the assistance unit. The spouse's needs are equal to the standard of assistance for a second adult as provided by part 9500.1216, item B, subitem (2). To determine if the spouse's needs are unmet, the spouse's countable income must first be allocated to provide for the unmet needs of the minor children included in the filing unit but not included in the assistance unit. The needs of a minor child are equal to the standard of assistance for an additional child added to the assistance unit as provided by part 9500.1216, item C, and are unmet to the extent that the child's countable income is less than the standard of assistance applicable to the child. The spouse's countable income that exceeds the unmet needs of the minor children must then be compared to his or her own needs. If the spouse's remaining countable income exceeds his or her own needs, the responsible relative shall not allocate countable income for the spouse's needs, and the spouse's excess countable income must be considered countable income available to the responsible relative. If the spouse's countable income is less than his or her needs, the responsible relative's countable income must be allocated to meet the spouse's unmet needs. The responsible relative's countable income must also be allocated to meet the needs of minor children who are included in the filing unit but not included in the assistance unit and whose needs are unmet with the child's or spouse's countable income.

(3) The amount of the responsible relative's countable income remaining after the calculations required in subitem (2) is unearned income available to the member or members of the assistance unit.

D. If a parent is not included in his or her minor child's filing unit as provided under part 9500.1209, subpart 2, item D, the parent's countable income that is considered unearned income available to the minor child must be calculated as follows:

(1) An amount equal to the needs of the parent must be subtracted from the parent's countable income. The parent's needs must equal the standard of assistance that would be applicable to the parent if the parent were to apply for general assistance.

(2) From the parent's countable income remaining after the subtraction in subitem (1), subtract an amount equal to the unmet needs of the parent's other minor children who reside with the parent and who are not included in the assistance unit. A minor child's needs are unmet to the extent that the minor child's countable income is less than the standard of assistance applicable to the minor child if the minor child were to apply for general assistance with the parent.

(3) The amount of the parent's countable income remaining after the calculations required in subitem (2) must be considered unearned income available to the common minor child who is a member of the assistance unit, up to and including the standard of assistance applicable to the member of the assistance unit under part 9500.1216, item C.

Subp. 4. **Other unearned income.** The local agency must consider all other forms of unearned income not provided for in subparts 2 and 3 to be unearned income available to the individual in the month of receipt.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1227 GROSS INCOME.

Subpart 1. **Local agency duty to determine gross income.** The local agency must determine the total amount of gross income available to the individuals identified in part 9500.1224, subpart 1. The total amount of gross income available to an individual for a month must be calculated in accordance with subparts 2 to 4. The total amount of gross income available to an assistance unit for a month must be determined by combining the total gross income of each assistance unit member.

Subp. 2. **Total earned and unearned income.** The local agency must add the total amount of earned income received by or available to an individual for a month, as calculated in part 9500.1225, to the total amount of unearned income received by or available to an individual for a month, as calculated in part 9500.1226.

Subp. 3. **Allocation of income from assistance unit members to other individuals.** To determine the amount of gross income available to a member of an assistance unit for a month, the amount of income that must be allocated in that month from the assistance unit member to a member of the filing unit who is not included in the assistance unit and for whom the assistance unit member is a responsible relative must be subtracted from the amount calculated in subpart 2. The amount that must be allocated must be determined in accordance with items A and B.

A. If the individual is not included in the assistance unit because the individual receives AFDC or is sanctioned or disqualified from receiving AFDC or general assistance, the assistance unit member shall not allocate income for the individual's needs.

B. If the individual is not included in the assistance unit because the individual elects not to apply for or receive general assistance or because the individual is not categorically eligible for general assistance as determined under

part 9500.1209, subpart 3, item A, the assistance unit member's income must be allocated for the individual's unmet needs. The individual's needs equal the amount the standard of assistance applicable to the assistance unit would increase if the individual were added to the assistance unit. The individual's needs are unmet to the extent that the individual's countable income is less than his or her needs.

Subp. 4. **Determination of total amount of gross income.** The amount of earned and unearned income calculated in subpart 2 minus the amount of income allocated under subpart 3 is the amount of gross income available to an individual for the month.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1228 COUNTABLE INCOME.

Subpart 1. **Local agency duty to determine countable income.** The local agency must determine the amount of countable income available to the individuals identified in part 9500.1224, subpart 1. The total amount of countable income available to an assistance unit for a month must be determined by combining the countable income of each assistance unit member.

Subp. 2. **Determination of countable income.** The local agency must determine the amount of countable income available to an individual for a month as follows:

A. The local agency must determine the amount of gross income available to the individual for a month in accordance with part 9500.1227.

B. From the amount determined in item A, the local agency must subtract income or expenses that must be disregarded as an allowable deduction under part 9500.1205, subpart 3. The remaining amount is the individual's countable income for the month.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1229 PROSPECTIVE BUDGETING.

Subpart 1. **Local agency duty to make prospective determinations.** The local agency must make a monthly prospective determination of an assistance unit's countable income, the assistance unit's eligibility for general assistance, and the amount of the monthly payment the assistance unit is eligible to receive.

Subp. 2. **Prospective determination of countable income.** The local agency must prospectively determine the amount of countable income available to an individual for a month when the local agency determines the eligibility of an assistance unit under subpart 3 and part 9500.1209, subpart 4, and when the local agency determines the amount of a monthly payment to an assistance unit under subpart 4.

To prospectively determine the amount of countable income available to an individual for a month, the local agency must estimate the amount of gross income the individual is expected to receive in a month, and subtract the income or expenses that must be disregarded as an allowable deduction under part 9500.1205, subpart 3.

The local agency may base its prospective determination of an individual's countable income on the amount of countable income the individual actually received two months before the current payment month. The local agency must adjust its estimate of an individual's countable income when it has verification that the individual's income will be increasing or decreasing, or when the individual has lost a source of income.

Subp. 3. **Prospective determination of eligibility.** The local agency must compare the amount of countable income the assistance unit is expected to receive in the payment month, with the standard of assistance applicable to the assistance unit for the payment month. If the assistance unit meets the conditions under part 9500.1209, subpart 4, the assistance unit is prospectively eligible for general assistance. If the assistance unit's estimated countable income is equal to or exceeds the standard of assistance applicable during the payment month, the assistance unit is prospectively ineligible for that payment month and must be denied general assistance or terminated from general assistance.

Subp. 4. **Determination of monthly payment amounts.** The local agency must determine the monthly general assistance payment to an assistance unit for the payment month by subtracting the estimated amount of countable income for the payment month as determined in subpart 2, from the standard of assistance applicable to the assistance unit during the payment month. The local agency must issue a supplemental payment to an assistance unit equal to the difference between the amount of countable income actually received by the assistance unit and the amount of estimated countable income for the payment month if the difference is $10 or more.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1230 PAYMENT PROVISIONS.

Subpart 1. **Monthly payment.** The minimum monthly payment to an assistance unit must be the applicable state assistance standard as provided by parts 9500.1216 to 9500.1222 or the higher local agency standard as provided by subpart 5 minus the assistance unit's countable income as determined under part 9500.1229, subpart 4.

Subp. 2. **Standard of assistance applies to full month.** Except when an increase must be made in the standard of assistance applicable to an assistance unit due to the addition of a member to the assistance unit, or when a recipient is discharged into the community from a negotiated rate facility, the standard of assistance applicable to an assistance unit on the first day of a payment month or at the time of application, whichever is later, applies to the assistance unit for the entire month.

Subp. 3. **Monthly payment to an applicant or recipient residing in a nursing home or facility with a negotiated rate.** If the applicant or recipient resides in a nursing home or facility with a negotiated rate, the applicant's or recipient's countable income must first be deducted from the reduced standard provided by part 9500.1218, subpart 2. The applicant's or recipient's countable income which exceeds the reduced standard must be used to reduce the amount of the negotiated rate paid to the nursing home or facility, as provided by subpart 4. The minimum monthly payment to the assistance unit must be the reduced standard minus the assistance unit's countable income. To this minimum payment, the local agency may add an additional amount in accordance with subpart 5.

Subp. 4. **Payments to a nursing home or facility with a negotiated rate.** When an applicant or recipient resides in a facility with a negotiated rate, the applicant's or recipient's countable income which exceeds the reduced state assistance standard, as determined in subpart 3, must be applied to the negotiated rate and paid to the nursing home or facility. The local agency must use general assistance funds to make monthly payments to the nursing home or facility in an amount equal to the difference between the negotiated rate and the assistance unit's excess countable income. The monthly payment to the nursing home or facility may be issued as a voucher or vendor payment.

Subp. 5. **Payment in excess of state standards.** The local agency may establish local standards of assistance for applicants and recipients in excess of the stan-

dards under parts 9500.1218 to 9500.1224, and may provide payments for items or needs which it determines are special. If the local agency chooses to provide higher local standards or special needs it must develop clear, written procedures that establish criteria for eligibility and the payment amounts for the higher standards and special needs. Payments for higher standards and special needs made according to local agency procedures must be made to all recipients who reside in the county without regard to the recipient's length of county residency.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1232 STATE PARTICIPATION.

Subpart 1. **State participation for monthly general assistance payments made based on a full state assistance standard.** Except as provided by subparts 2 and 3, the amount of state participation in the monthly general assistance payment made under Minnesota Statutes, section 256D.03, subdivision 2, must be determined by subtracting the assistance unit's countable income from the applicable full state assistance standard and multiplying the difference by 75 percent.

Subp. 2. **State participation for monthly general assistance payments made based on a reduced state assistance standard.** When an assistance unit is subject to a reduced state assistance standard as provided in parts 9500.1218 to 9555.1222, the amount of state participation in the monthly payment to the assistance unit under Minnesota Statutes, section 256D.03, subdivision 2, must be determined by subtracting the assistance unit's countable income from the applicable reduced state assistance standard and multiplying the difference by 75 percent.

Subp. 3. **State participation for monthly general assistance payments made to a negotiated rate facility.** State participation in the monthly payment to a negotiated rate facility under part 9500.1230, subpart 4, must be determined by subtracting the assistance unit's excess countable income from the negotiated rate and multiplying the difference by 75 percent.

Subp. 4. **State participation for payment in excess of state standards.** State participation is not available for special need items or the amount of the higher local agency standard provided under part 9500.1230, subpart 5, which exceed the applicable state assistance standards.

Statutory Authority: *MS s 256D.01 subds 1a,1b; 256D.03 subds 1,2; 256D.04; 256D.05 subd 3; 256D.06 subds 1,3; 256D.07*

History: *10 SR 2322*

9500.1234 [Repealed, 10 SR 2322]

9500.1236 [Repealed, 10 SR 2322]

9500.1238 GRANTS ABOVE STANDARD AMOUNTS; EMERGENCY ASSISTANCE.

Any local agency may issue grants in amounts above those described in parts 9500.1234 and 9500.1236 provided that it deletes the additional costs thus incurred from its claim for state aid reimbursement, except the state aid may be available for payments made in excess of general assistance standards in emergent situations wherein the request was for a period of less than 30 days. As used herein, an "emergency situation" refers to a circumstance that:

A. places in jeopardy one or more persons in an eligible family unit;

B. cannot be resolved by the applicant with his or her current resources; and

C. in the absence of other resources, requires immediate financial assistance.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1240 COUNTY WARRANTS.

Grants of general assistance shall be issued by the local agencies to the recipient in the form of county warrants immediately redeemable in cash. Such payments shall cover his unmet needs and may be issued in monthly, semimonthly, weekly, or daily installments as the local agency deems to be appropriate in individual situations.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1242 VENDOR PAYMENTS.

Vendor payments shall be made in the following situations:

A. When the county determines that the recipient has not used his resources in the best interest of his needs and that of his dependents. Evidence of the recipient's inability to manage his resources must be documented in the case record.

B. When an individual has remained uncooperative about registering for employment services or in seeking and/or accepting suitable employment, vendor payments shall be made for the maintenance needs of his dependents. "Suitable employment" is defined in Minnesota Statutes, section 268.09, subdivision 1, clause (4).

C. Issuance of general assistance by vendor payment is permissible in emergency situations when a cash payment cannot be processed on weekends or holidays to resolve the current crisis.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1244 [Repealed, 10 SR 2322]

9500.1246 STATE PAYMENTS FOR EMERGENCY ASSISTANCE.

The state will participate in actual emergency payments made pursuant to part 9500.1238, up to 50 percent of each such grant.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1248 DETERMINATION OF COUNTY OF FINANCIAL RESPONSIBILITY.

Subpart 1. **Definitions.** In all matters involving legal settlement of the poor, "county of financial responsibility" means:

A. The county in which an individual resides.

B. An individual shall be held to reside in a particular county if he has established a home there and has not established a home elsewhere.

C. If, at the time of making application, the applicant is a patient in a hospital, nursing home, or boarding care home, as defined in Minnesota Statutes, section 144.50, or is placed in a county as a result of a correctional program or a treatment plan for health, rehabilitation, foster care, child care, or training, and immediately prior thereto he had resided in another county in an established abode that was not such a like care facility, it is in the former county.

D. The above provisions notwithstanding, if an individual is a recipient of medical assistance, the county from which he is receiving medical assistance.

E. The above provisions notwithstanding, the county of financial responsibility shall not change as a result of successive placements in one or more

counties pursuant to a plan of treatment for health, rehabilitation, foster care, child care or training; nor as a result of placement in any correctional program.

Subp. 2. **Procedures.** If, upon investigation of an application for general assistance, the local agency finds that the applicant is otherwise eligible for assistance but that his county of financial responsibility is some other county, it shall within 15 days, while providing assistance in the meanwhile, transmit a copy of the application together with a record of its investigation to the local agency of the other county. If, within 15 days, the local agency of such other county concludes that it is not the county of financial responsibility for the applicant, it shall forward concurrently copies of the application and the investigation reports of both counties to the state agency and to the county of origin. The state agency shall thereupon promptly decide the question of which county is the county of financial responsibility and issue an order referring the application to the proper county and include therein directives as necessary for any reimbursement of general assistance advanced to the recipient in the meanwhile. The order of the state agency shall be binding on the local agency so named and shall be complied with until such state agency decision is changed upon appeal to the district court.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1249 [Repealed, 10 SR 2322]

9500.1250 LOCAL AGENCY REPORTS.

The local agencies shall collect and report information necessary to administer, monitor, and evaluate the general assistance program, including work requirements and the MEED program. The local agency shall enter information on all general assistance applicants and recipients in the welfare information system on the schedules established by the department. In addition, the local agency shall enter and maintain information on the case information file or supply supplemental information as needed to:

A. minimize the occasions on which similar information is obtained from applicants and recipients;

B. improve coordination of services to recipients;

C. minimize the possibility of duplicate payments;

D. report to the legislature on general assistance recipients' participation in the MEED program.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1252 PREPARATION OF WRITTEN MATERIALS.

Subpart 1. **Use of language.** All referral forms, notices, and other written information prepared by the commissioner or a local agency for use in the general assistance program by applicants or recipients must be prepared in clear and easily understood English and other languages that the commissioner determines appropriate for the applicants or recipients. A local agency, subject to prior approval from the department, may translate referral forms, notices, and other written information used in the implementation of the general assistance program into as many languages as the local agency determines appropriate to address the needs of its applicants and recipients.

Subp. 2. **Language use accompanying forms.** The commissioner shall prepare a written statement in English, Spanish, Laotian, Vietnamese, Cambodian, Hmong, and other languages that the commissioner determines appropriate for the applicants and recipients, that states that the written document accompanying the statement is very important, and that if the reader does not understand the

document, the reader should seek immediate assistance. The written statement must accompany all written information given by the department or a local agency to an applicant or recipient.

Subp. 3. **Commissioner's determination of languages appropriate for applicants and recipients.** The commissioner's determination of languages appropriate for translation in preparation of written materials for applicants and recipients as in subparts 1 and 2 shall be based upon relevant factors including:

A. the percentage of persons in the statewide general assistance program caseload who speak a particular language;

B. the need expressed by persons or organizations which are composed of or represent applicants or recipients; and

C. the anticipated benefit to applicants and recipients.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1254 REFERRAL TO OTHER MAINTENANCE BENEFIT PROGRAMS.

Subpart 1. **Screening requirement.** The local agency must determine the potential eligibility of each general assistance applicant or recipient for other maintenance benefits as follows:

A. The local agency must determine an applicant's potential eligibility for other maintenance benefits when application for general assistance is made.

B. The local agency must determine a recipient's potential eligibility for other maintenance benefits at the recipient's semiannual redetermination of eligibility for general assistance. The local agency must also determine a recipient's potential eligibility for other maintenance benefits whenever it determines that changes in the recipient's circumstances, including eligibility for medical assistance, indicate potential eligibility for other maintenance benefits.

C. If the local agency determines that the applicant or recipient is potentially eligible for other maintenance benefits, the local agency must document its determination on forms prescribed by the commissioner and must retain the forms in the local agency case record for the applicant or recipient.

Subp. 2. **Informing and referral requirement.** When the local agency determines that the applicant or recipient is potentially eligible for other maintenance benefits, the local agency shall refer the applicant or recipient to the other maintenance benefit program on a form prescribed by the commissioner by informing the applicant or recipient orally and in writing of the following:

A. that the applicant or recipient must apply for the other maintenance benefit program, in accordance with subpart 4, item A;

B. that the applicant or recipient must execute an interim assistance authorization agreement, in accordance with subpart 4, item D;

C. that the applicant or recipient must comply with all procedures necessary to determine his or her eligibility or ineligibility for the other maintenance benefits in accordance with subpart 4, item C;

D. that the applicant or recipient must authorize the local agency and the qualified provider, when one is chosen, to exchange relevant data concerning the applicant's or recipient's eligibility with the other maintenance benefit program office, in accordance with subpart 4, item B;

E. the estimated amount of benefits the applicant or recipient may be eligible to receive under the other maintenance benefit program, if known;

F. the address at which the applicant or recipient shall apply for the other maintenance benefit program;

G. general instructions regarding how to apply for the other maintenance benefit program;

H. that the applicant or recipient may elect to receive special services to assist him or her in applying for SSI benefits, in accordance with part 9500.1256, subpart 1, and that the applicant or recipient has a right to choose to receive special services from a qualified provider;

I. notice of the actions which the local agency must take, in accordance with subpart 5, if the applicant or recipient fails to comply with the requirements under subpart 4, items A to D; and

J. notice of the applicant's or recipient's right to appeal a determination of ineligibility for general assistance due to noncompliance with subpart 4, items A to D.

Subp. 3. **Special referral provisions.** When the local agency determines that the applicant or recipient is potentially eligible for another maintenance benefit program, the local agency shall refer the applicant or recipient to a chosen qualified provider and the other maintenance benefit program in accordance with items A and B:

A. If the applicant or recipient is determined to be potentially eligible for maintenance benefits from SSI, the local agency shall:

(1) offer to provide special services to the applicant or recipient in accordance with part 9500.1256, subpart 1, to assist him or her in applying for and obtaining SSI;

(2) furnish the applicant or recipient with a list of qualified providers with whom the local agency has contracted to provide special services to applicants or recipients or who have asked to be included on the list;

(3) notify the Social Security Administration's local office of the applicant's or recipient's potential eligibility for SSI on the date of referral so that the earliest potential date of eligibility for SSI can be established; and

(4) if the applicant or recipient elects at any time to receive the special services specified in part 9500.1256, subpart 1 from a qualified provider other than the local agency, the local agency shall refer the applicant or recipient to the chosen provider. If the local agency has not contracted with the chosen provider, the local agency must enter into a contract with that qualified provider to provide special services to applicants or recipients who apply for SSI benefits.

B. If the local agency determines that an applicant or recipient is potentially eligible for another maintenance benefit program, and the applicant or recipient has previously applied for and been found ineligible for that other maintenance benefit program, he or she shall not be required to appeal from that decision or to reapply for that other maintenance benefit program unless one of the following conditions is met:

(1) the local agency determines that the applicant's or recipient's health or circumstances have changed and the change may result in eligibility for that other maintenance benefit program; or

(2) the eligibility requirements or procedures of the other maintenance benefit program have changed and the change may result in the applicant or recipient being found eligible for that other maintenance benefit program.

Subp. 4. **Requirements upon referral for other maintenance benefits.** When the local agency refers an applicant or recipient to another maintenance benefit program as provided under subpart 2, the applicant or recipient shall do the following:

A. The applicant or recipient shall apply for those benefits within 30 days of the date of referral. If the recipient has not provided the local agency with verification of his or her application for those benefits within 30 days of the date of referral, the local agency must contact the other maintenance benefit program local office to determine if the recipient has applied for benefits. If the local office of the other maintenance benefit program verifies that the recipient has applied for those benefits, the recipient shall be deemed to have met the requirement of

applying for other maintenance benefits. If the local office of the other maintenance benefit program verifies that the recipient has not applied for those benefits, the local agency shall mail or give the recipient notice of termination from general assistance in accordance with subpart 5.

B. The applicant or recipient shall, within 30 days of the date of referral, provide his or her informed written consent and authorization for the local agency or a qualified provider, if one is chosen, to exchange data concerning the applicant or recipient with the other maintenance benefit program local office. The data exchanged must be relevant to a determination of the applicant's or recipient's eligibility or ineligibility for benefits from the other program.

For purposes of exchanging private or confidential data about a person for whom a qualified provider has contracted to provide special services, a qualified provider other than the local agency shall not be considered part of the welfare system under Minnesota Statutes, section 13.46, subdivision 1.

If the local agency determines that the recipient has not given informed written consent and authorization for the local agency or a qualified provider to exchange data concerning his or her eligibility or ineligibility for the other maintenance benefit program within the prescribed 30 days, the local agency shall mail or give the recipient notice of termination from general assistance in accordance with subpart 5.

C. A recipient shall comply with all procedures necessary to determine his or her eligibility or ineligibility for the other maintenance benefit program.

If the local agency determines that the recipient has not complied with the procedures necessary to determine his or her eligibility or ineligibility for other maintenance benefits, the local agency shall mail or give the recipient notice of termination from general assistance in accordance with subpart 5.

D. An applicant or recipient shall execute an interim assistance authorization agreement with the local agency within 30 days of the date of referral.

If the recipient fails to execute an interim assistance authorization agreement within the 30 days prescribed, the local agency shall mail or give the recipient notice of termination from general assistance in accordance with subpart 5.

Subp. 5. **Ineligibility.** This subpart governs termination of general assistance eligibility for a recipient who fails, without good cause, to comply with the requirements of subpart 4.

A. Upon determining that a recipient has failed, without good cause, to comply with the requirements of subpart 4, items A to D, the local agency shall mail or give the recipient notification of termination from general assistance. The local agency shall hand deliver or mail the written notice to the recipient at least 30 days before reducing, suspending, or terminating the recipient's monthly general assistance payment. The notice must be on a form prescribed by the commissioner and must:

(1) list the requirements with which the local agency believes the recipient has not complied and inform the recipient that he or she must comply with the requirements to avoid or end a period of ineligibility;

(2) inform the recipient that he or she will be terminated from general assistance if the recipient fails to comply with the listed requirements, specify the date that the recipient's general assistance will be terminated if he or she does not comply, and explain the recipient's right to appeal the action in accordance with subpart 6;

(3) offer assistance to resolve the circumstances or concerns which prevent the recipient from complying with the requirements of subpart 4; and

(4) inform the recipient of the continued availability of special services provided under part 9500.1256, subpart 1.

B. If the recipient complies with the requirements specified in the notice

in item A prior to the termination date stated in the notice, a period of ineligibility must not be imposed.

C. A recipient who fails to comply with the requirements specified in the notice in item A prior to the termination date stated in the notice is ineligible for general assistance. The period of ineligibility begins on the date specified in the notice and continues until the person fulfills the requirements of subpart 4. The period of ineligibility always begins on the first day of a calendar month. If the ineligible person subsequently applies for general assistance, the application must be denied unless the requirements of subpart 4 have been met.

D. If the person is determined to be ineligible under item C, the assistance standard applicable to the person's assistance unit must be based on the number of remaining eligible members of the assistance unit.

Subp. 6. **Appeals.** A recipient to whom the local agency has given or mailed a notice of termination in accordance with subpart 5 may appeal the determination by submitting a written request for a hearing in accordance with Minnesota Statutes, section 256.045. If the recipient files a written request for an appeal on or before the first day of the period of ineligibility under subpart 5, item C, the recipient shall continue to receive general assistance while the appeal is pending, provided that the recipient is otherwise eligible for general assistance.

Subp. 7. **Reimbursement for interim assistance.** A local agency must seek reimbursement for the interim assistance provided to a person who has executed an interim assistance authorization agreement under subpart 4, item D, when the person receives a retroactive payment from the other maintenance benefit program unless reimbursement is prohibited under federal or state law. Reimbursement for interim assistance and special services provided to an SSI applicant or recipient is governed by part 9500.1256, subpart 2.

The local agency must request reimbursement for interim assistance from the person receiving other retroactive maintenance benefits, except for SSI. If a request for reimbursement under this subpart is denied, the local agency may institute a civil action to recover the interim assistance based on the interim assistance authorization agreement. The local agency must take no action other than a civil action to recover the interim assistance. From the interim assistance recovered, the local agency may retain 25 percent as reimbursement for the county's share of the interim assistance provided, and must credit the balance to the state as an advance payment to the local agency for the state's share of the next month's general assistance grants.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

9500.1256 SPECIAL SERVICES FOR SSI APPLICANTS.

Subpart 1. **Special services.** A recipient who is referred to SSI in accordance with part 9500.1254, subparts 2 and 3, item B, may elect to receive special services to assist him or her in obtaining SSI benefits. Special services for which reimbursement for fees, costs, or disbursements may be claimed under subpart 2 or 3 are limited to the following:

A. explaining to or counseling the applicant or recipient about the application procedures and benefits available through the SSI program;

B. assisting the applicant or recipient in completing the application for SSI and arranging appointments related to application for SSI;

C. assisting the applicant or recipient in assessing his or her disability in relation to SSI eligibility, and identifying probable issues that may arise during the SSI eligibility determination process;

D. providing the applicant or recipient with medical or vocational evidence, social history, or expert testimony currently available to substantiate the presence and severity of the applicant's or recipient's blindness or disability;

E. assisting the applicant or recipient in obtaining and using medical or vocational evidence, social history, or expert testimony and in cooperating with the Social Security Administration and its agents, procedures, and requirements;

F. assisting the applicant or recipient with necessary transportation;

G. preparing for and representing the applicant or recipient at interviews, hearings, or appeals related to application for SSI or appeal of the Social Security Administration's determination of ineligibility for SSI;

H. the local agency's preparation of a contractual agreement with a qualified provider chosen by the applicant or recipient; and

I. providing other services to assist the applicant or recipient to establish eligibility for SSI benefits.

Subp. 2. **Reimbursement for interim assistance and special services.** A local agency must be reimbursed for providing interim assistance and special services to an SSI applicant or recipient in the following manner:

A. Upon receiving the initial SSI payment for a person who has executed an interim assistance authorization agreement as specified in part 9500.1254, subpart 4, item D, the local agency may recover the amount of interim assistance provided. After recovering the interim assistance from the initial SSI payment, the local agency shall pay the remainder to the person or to a representative payee identified by the Social Security Administration within ten days of receiving the initial SSI payment. From the amount of interim assistance recovered, the local agency:

(1) shall retain 25 percent as reimbursement for the county's share of the interim assistance provided;

(2) may retain, subject to the provisions of subpart 3, item E, an additional 25 percent as an advocacy incentive for providing the special services specified in subpart 1, items A to D;

(3) may retain from the remaining 50 percent, subject to the provisions of subpart 3, item E, reimbursement for actual reasonable fees, costs, and disbursements related to appeals and litigation and provision of special services under subpart 1.

B. The local agency may not seek reimbursement from the applicant or recipient for the fees, costs, or disbursements of providing special services except as provided in item A.

C. The balance of the amount of interim assistance that is not retained by the local agency pursuant to item A or paid to another qualified provider under subpart 3 must be credited to the state as an advance payment to the local agency for the state's share of the next month's general assistance grants.

D. The local agency must document the fees, costs, and disbursements which it incurs in providing the special services to claim reimbursement. The local agency shall be reimbursed under item A, subitem (3), only for the direct costs of providing special services.

Subp. 3. **Reimbursement to qualified providers under contract with the local agency to provide special services.** Qualified providers under contract with the local agency to provide special services to general assistance applicants or recipients shall be reimbursed from the amount of interim assistance recovered by the local agency under subpart 2 in the following manner:

A. To receive reimbursement for the fees, costs, and disbursements related to appeals and litigation and the provision of special services as provided in subpart 1, the qualified provider shall enter into a contract with the local agency and provide one or more of the special services specified in subpart 1.

The contract must be on a form prescribed by the commissioner except that the local agency may add to or modify the form without changing the substance of the contract in order to meet standard contracting procedures established by the county board.

B. The local agency must reimburse a qualified provider under contract with the local agency for the provider's reasonable actual fees, costs, and disbursements, including medical reports and expert testimony related to appeals, litigation, and providing special services to an applicant or recipient in accordance with the following:

(1) a qualified provider shall not be reimbursed by the local agency for any fees, costs, or disbursements unless the applicant or recipient has requested the services, the local agency has referred the applicant or recipient to the qualified provider, and the local agency has received the initial SSI payment for the recipient served;

(2) the qualified provider shall be reimbursed by the local agency for fees related to the provision of special services at the rate determined by the qualified provider, but not to exceed $75 per hour of service; and

(3) when a qualified provider requests reimbursement from the local agency for fees, costs, or disbursements related to services provided, the qualified provider shall document the total number of hours of services provided to the applicant or recipient and provide a record of its costs and disbursements.

C. A qualified provider under contract to provide special services must comply with the following:

(1) a qualified provider shall not require prepayment of any fees, costs, or disbursements from the applicant or recipient; and

(2) a qualified provider shall not seek reimbursement from the applicant or recipient for fees related to the provision of special services. If a qualified provider intends to seek reimbursement for costs and disbursements from an applicant or recipient in the event the applicant or recipient is determined to be ineligible for SSI and the qualified provider therefore will not be fully reimbursed by the local agency, the qualified provider must so inform the applicant or recipient and obtain the applicant's or recipient's written consent prior to providing the special services. The qualified provider must also inform the applicant or recipient that he or she may receive the special services from the local agency without cost to the applicant or recipient.

D. The total reimbursement for special services made by the local agency to all qualified providers must not exceed the amount of interim assistance retained by the local agency as specified in subpart 2, item A, subitems (2) and (3), unless the excess is expressly authorized by the local agency and paid for exclusively with local agency funds.

E. If more than one qualified provider provides special services to an applicant or recipient, and the amount of interim assistance retained by the local agency will not fully reimburse all qualified providers, the reimbursement to each qualified provider for fees, costs, and disbursements shall be calculated by multiplying the total amount of funds available to the local agency as specified in subpart 2, item A, subitems (2) and (3), including any excess funds authorized by the local agency under item D, by the qualified provider's reimbursement percentage. The qualified provider's reimbursement percentage shall be determined by dividing the number of hours spent by each qualified provider who provided special services by the total number of hours spent by the local agency and all other qualified providers under contract with the local agency who have provided special services to the applicant or recipient.

F. If the local agency and one or more other qualified providers provide special services to an applicant or recipient, and the amount of interim assistance recovered by the local agency under subpart 2, item A, subitems (2) and (3), exceeds the amount necessary to fully reimburse the qualified providers for fees, costs, and disbursements, the local agency may retain the excess to the extent allowed under subpart 2, item A, subitem (2).

G. The local agency shall reimburse a qualified provider for fees, costs,

and disbursements for special services provided during the six-month period before the applicant or recipient was referred to the qualified provider, unless general contracting procedures of the particular county prohibit this payment. The provider's fees, costs, or disbursements for special services provided before the person's application for general assistance may be reimbursed only if funds remain after reimbursement for special services provided to the person after the person made application for general assistance.

H. The local agency and another qualified provider may contract to jointly provide the special services specified in subpart 1.

Subp. 4. **Termination of special services and contracts.** Special services and contracts must be terminated in the following manner:

A. If an applicant or recipient requests in writing that the local agency terminate the special services agreement with a qualified provider, the special services agreement for that applicant or recipient must be terminated, and the local agency shall mail written notice of the termination to the qualified provider. The notice must include a copy of the applicant's or recipient's written request for termination of the special services agreement. Termination of the agreement is effective three days after the date when the notice is mailed. The qualified provider shall not be reimbursed for fees, costs, or disbursements for special services provided to an applicant or recipient after the effective date of termination.

B. If a qualified provider decides to stop providing special services to an applicant or recipient, the qualified provider shall give or mail the following information to the applicant or recipient and, if the qualified provider is not the local agency, to the local agency:

(1) the status of the applicant's or recipient's application for SSI benefits;

(2) any deadlines that must be met regarding the applicant's or recipient's application for SSI benefits;

(3) the right of the applicant or recipient to choose another qualified provider, and the local agency's obligation to enter into a contract with a new qualified provider to provide the special services specified if the applicant or recipient chooses a qualified provider other than the local agency; and

(4) that a list of qualified providers may be obtained from the local agency.

Termination of the contract is effective three days after the date the provider gives or mails the information required in subitems (1) to (4) to the client.

C. If a qualified provider fails to perform all or part of the terms of the contract with the local agency, the local agency may terminate the contract with the provider. The local agency shall terminate the contract and mail written notice to the qualified provider and to the recipients served by the qualified provider. The notice must specify the local agency's grounds for terminating the contract. Termination of the contract is effective three days after the notice is mailed to the qualified provider. The local agency shall also give the recipient a list of other qualified providers who have contracted with the local agency to provide the special services specified in subpart 1 or who have asked to be included on the list. The qualified provider shall not be reimbursed for fees, costs, or disbursements related to special services provided after the effective date of termination.

Statutory Authority: *MS s 256D.04 cl (2); 256D.06 subd 5*

History: *10 SR 1715*

GENERAL ASSISTANCE ELIGIBILITY

9500.1258 CATEGORIES OF ELIGIBILITY.

Subpart 1. **Categories of ongoing eligibility.** When the local agency determines the composition of an applicant's or recipient's assistance unit under part 9500.1209, subpart 3, the local agency must determine whether the applicant or recipient meets the conditions of one or more of the categories of eligibility under the following items:

A. The applicant or recipient suffers from a permanent illness, injury, or incapacity that is medically certified and prevents the applicant or recipient from obtaining or retaining suitable employment.

B. The applicant or recipient suffers from a temporary illness, injury, or incapacity that is medically certified and prevents the applicant or recipient from obtaining or retaining suitable employment for a period of at least 15 days and, if a rehabilitation plan is specified in the medical certification, the applicant or recipient is following the rehabilitation plan. An applicant or recipient is eligible under this item only for the period of the illness, injury, or incapacity.

C. The applicant or recipient is needed at home on a substantially continuous basis because another individual who resides with the applicant or recipient requires care due to the age or medically certified illness, injury, or incapacity of the other individual. The medical certification of illness, injury, or incapacity must state that the individual requiring care is unable to care for himself or herself.

D. The applicant or recipient is residing in a facility licensed under Minnesota Statutes, sections 245.781 to 245.812 and certified under Minnesota Statutes, chapter 144 for purposes of physical or mental health or rehabilitation, or in a chemical dependency domiciliary facility licensed under parts 9530.2600 to 9530.4000 or 4625.0100 to 4625.2300. Residence in the facility must be due to illness or incapacity and based on a plan developed or approved by the director of the local agency.

E. The applicant or recipient resides in a shelter facility for battered women as described in Minnesota Statutes, section 256D.05, subdivision 3.

F. The applicant or recipient is enrolled as a full-time student and is or may be eligible for displaced homemaker services, programs, or assistance under Minnesota Statutes, section 268.96.

G. The applicant or recipient is unable to communicate in the English language as assessed by an English as a second language specialist, a vocational specialist, or the local agency.

H. The applicant or recipient does not meet the condition in item A, B, or D but is medically certified as having mental retardation or mental illness.

I. The applicant or recipient has an application pending for the social security disability program or the supplemental security income program, or a pending appeal of the denial of an application or termination from those programs.

J. The applicant or recipient is unable to obtain or retain suitable employment due to advanced age.

K. The applicant or recipient is completing high school.

L. The applicant or recipient is a minor child who resides with his or her parent or stepparent, or an adult who resides with one or more of his or her minor children or the minor children of his or her spouse.

M. The applicant or recipient meets one or more of the following:

(1) lives in a local labor market with no potential suitable employment;

(2) is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day;

(3) is in the last trimester of pregnancy;

(4) is evaluated by a vocational specialist or a vocational adviser and is found to be unable to obtain or retain suitable employment;

(5) exhibits severe symptoms of chemical dependency but refuses evaluation or treatment;

(6) exhibits evidence of severely diminished functioning in areas of daily living such as social skills or personal relations;

(7) shows circumstances, at the time of application for general assistance, that indicate the need for general assistance will not exceed 30 days because of impending employment, an impending move to another state, or anticipated receipt of income, and the applicant has not received general assistance under this condition for at least 60 days; or

(8) is regularly attending a GED program with a minimum of six hours of classroom instruction per week.

N. The applicant or recipient is certified under part 3320.0025 [Emergency] by the commissioner of the Department of Jobs and Training before August 1, 1985, as lacking work skills or training or as being unable to obtain work skills or training necessary to secure employment.

O. The applicant or recipient is medically certified as being learning disabled. For purposes of this item, "learning disabled" means the individual has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. It does not include learning problems that are primarily the result of visual, hearing, or motor handicaps; of mental retardation; of emotional disturbance; or of environmental, cultural, or economic disadvantage. The condition must severely limit the individual in obtaining, performing, or maintaining suitable employment.

P. The applicant or recipient is functionally illiterate. For purposes of this item, "functionally illiterate" means the individual is unable to read at or above the eighth grade level. An applicant or recipient shall be determined functionally illiterate according to subitems (1) to (3):

(1) The local agency may determine that the applicant or recipient is obviously functionally illiterate based on personal observations or information in the applicant's or recipient's case file.

(2) If an applicant or recipient is not determined to be functionally illiterate as provided in subitem (1), but the local agency believes that the applicant or recipient may be functionally illiterate, or if the applicant or recipient asserts or presents evidence that he or she may be functionally illiterate, the local agency shall offer the applicant or recipient the opportunity to take a standardized literacy test approved by the commissioner. The test must be offered in the county at no expense to the applicant or recipient and in time to allow a determination of eligibility within the time limits prescribed under Minnesota Statutes, section 256D.07, that takes into account the results of the test. The local agency shall either administer the test or offer to make the arrangements for the test. If the applicant or recipient attains a score lower than the eighth grade, he or she shall be considered functionally illiterate unless the local agency determines, through compelling evidence documented in the applicant's or recipient's case file, that there is a substantial likelihood that the test result is inaccurately low.

(3) If, in accordance with subitem (2), the local agency determines that an applicant's or recipient's standardized test score is inaccurately low, the local agency shall inform the applicant or recipient that he or she may seek certification of the functional illiteracy from a licensed psychologist, or an individual licensed under parts 8700.3800, 8700.5300, 8700.5406, 8700.5500, 8700.5800, 8700.6300, or 8700.6310, or an individual with the equivalent or higher qualificat-

ions. The local agency shall provide the applicant or recipient with a list of individuals or agencies in the county who are qualified to make the certification. The applicant or recipient is considered functionally illiterate if the certification specifies that he or she cannot read at or above the eighth grade level.

Subp. 2. **Categories providing for six months of eligibility.** An applicant who is not eligible for general assistance under subpart 1, but who meets the conditions of part 9500.1209, subpart 4, and who has received six months of work readiness services and payments is eligible to receive general assistance for a maximum of six months during any consecutive 12-calendar month period if the conditions in item A or B are met:

A. the individual is medically certified as having borderline mental retardation, as defined in part 9500.1302, subpart 2; or

B. the individual is certified by a qualified professional, as defined in part 9500.1302, subpart 6, as exhibiting perceptible symptoms of mental illness and the mental illness interferes with medical certification of the individual's condition.

Unless the local agency has information that a recipient meets one or more of the categories of eligibility under subpart 1, the local agency shall provide the recipient with written notice of his or her termination from general assistance after issuing the monthly general assistance payment during the sixth and final month. The notice must inform the recipient of the right to appeal as specified in part 9500.1260, and that the recipient may be eligible for work readiness services and payments if he or she meets the criteria of part 9500.1306, subpart 3.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134; 1Sp1985 c 14 art 9 s 75*

9500.1260 GENERAL ASSISTANCE INELIGIBILITY; WORK READINESS NOTICE.

Subpart 1. **Determination of ineligibility and right to appeal.** Upon determining that an applicant or recipient is ineligible for general assistance, the local agency shall inform the applicant or recipient of the determination and of the right to appeal the determination under Minnesota Statutes, section 256.045.

Subp. 2. **Work readiness notice.** Upon determining that an applicant or recipient is not eligible for general assistance because he or she does not meet a category of eligibility under part 9500.1258, the local agency shall inform the individual of the availability of its work readiness program and shall determine the individual's eligibility for services and payments under part 9500.1306, subpart 3. If an applicant or recipient is eligible for work readiness services and payments, he or she shall be informed that an appeal of the general assistance determination of ineligibility may be made under Minnesota Statutes, section 256.045 while receiving work readiness services and payments. The local agency shall also inform the individual that eligibility for work readiness services and payments is time limited.

If the applicant or recipient subsequently wins the appeal, the assistance received under the work readiness program pending appeal must be considered general assistance. If a recipient files an appeal before the effective date of the termination of his or her general assistance, continues to receive general assistance pending the appeal in accordance with part 9500.1268, and does not prevail in the appeal, the assistance received pending the appeal shall be considered general assistance and not work readiness payments, and the recipient's participation in work readiness services pending the outcome of the appeal shall not be counted toward the two- or six-month limitation on eligibility for the work readiness program. If a recipient files an appeal after the effective date of the

termination of his or her general assistance, receives work readiness services and payments pending the appeal, and does not prevail in the appeal, the assistance received pending the appeal shall be considered work readiness assistance and shall be counted toward the two- or six-month limitation on eligibility for the work readiness program.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1262 REQUIREMENTS FOR CONTINUED ELIGIBILITY.

Subpart 1. **Requirements for continued eligibility for specific categories of ongoing eligibility.** A recipient of general assistance whose eligibility is based on part 9500.1258, subpart 1, item G or L, and who is not eligible under another category of eligibility under part 9500.1258, must comply with the following requirements as conditions for continued eligibility.

A. Recipients who are eligible under part 9500.1258, subpart 1, item G shall participate in an English language skills program if assigned to a program by the local agency and if the program is available in the recipient's local labor market. If the recipient fails, without good cause, to participate in the assigned English language skills program, the recipient must be disqualified from receiving general assistance as prescribed in part 9500.1266.

B. Adult recipients who are eligible for general assistance under part 9500.1258, subpart 1, item L, must comply with the following:

(1) If all of the minor children are six years of age or older, the adults must participate in and comply with the work readiness program.

(2) If one or more of the minor children are under the age of six and two adults are eligible under part 9500.1258, subpart 1, item L, one adult must participate in and comply with the work readiness program.

(3) An adult who is required to participate in and comply with the work readiness program under subitem (1) or (2) who fails, without good cause, to participate in and comply with the requirements of the work readiness program must be disqualified from general assistance as provided in part 9500.1266. The standard of assistance applicable to the disqualified member's assistance unit must be based on the number of remaining eligible members of the assistance unit.

Subp. 2. **Requirements for continued eligibility under categories of six-month eligibility.** A recipient of general assistance whose eligibility is based on part 9500.1258, subpart 2 must comply with the following requirements to remain eligible for general assistance:

A. A recipient certified as exhibiting perceptible symptoms of mental illness as provided by part 9500.1258, subpart 2, item B must cooperate with social services, treatment, or other reasonable plans developed by the local agency to address the illness. If the local agency determines that the recipient has failed, without good cause, to comply with the plan, the recipient shall be disqualified from receiving general assistance as prescribed in part 9500.1266.

B. The local agency may assign a recipient who is eligible for general assistance under part 9500.1258, subpart 2 to the work readiness program for work readiness services. A recipient so assigned must comply with the work readiness program requirements determined by the local agency to be applicable to the recipient. If the local agency determines that the recipient has failed, without good cause, to comply with work readiness requirements, the recipient is disqualified from receiving general assistance as provided in part 9500.1266.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1264 NOTICE OF DISQUALIFICATION.

If the local agency determines that a recipient must be disqualified for failing to comply with the requirements of part 9500.1262, the local agency shall notify the recipient of the determination. The notice must:

A. be in writing on a form prescribed by the commissioner;

B. be mailed or given to the recipient not later than ten days before reducing, suspending, or terminating the monthly payment; and

C. clearly state what action the local agency intends to take, the reasons for the action, the right to appeal the action, and the conditions under which assistance can be continued pending an appeal.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1266 DISQUALIFICATION.

A recipient who fails, without good cause, to comply with the requirements of part 9500.1262, is disqualified from receiving general assistance as provided in items A to D.

A. The period of disqualification is two months for each occurrence.

B. The disqualification period begins on the first calendar day of the month following the month in which the recipient is finally determined to have failed to comply. If the determination is made so late in a month that prior notice under part 9500.1264 cannot be given, the disqualification period begins on the first calendar day of the second month following the finding of noncompliance.

If the recipient appeals on or before the proposed disqualification date, the disqualification process must stop and assistance will continue under part 9500.1268 until a final decision is made. If the final decision is that the recipient is disqualified, the disqualification period begins on the first day of the month following the final decision.

C. If an individual who is disqualified applies for general assistance during the period of disqualification, the individual is considered a recipient and the application shall be denied unless the individual is eligible for general assistance on the basis of a category of eligibility other than the categories in part 9500.1258, subpart 1, item G or L.

D. If a recipient who received a notice of disqualification complies with the requirements of part 9500.1262, on or before the commencement of the disqualification period, assistance must be continued without a period of disqualification.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1268 APPEAL OF DISQUALIFICATION.

A recipient who is disqualified from receiving general assistance under part 9500.1266 may appeal the decision. The appeal must be a written request for a hearing submitted to the department or the local agency under Minnesota Statutes, section 256.045. If appeal is made on or before the commencement of the disqualification period and the recipient is otherwise eligible, he or she shall continue to receive general assistance while the appeal is pending, unless the recipient requests in writing that assistance be discontinued pending a hearing decision.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1270 SPECIAL VOUCHER OR VENDOR PAYMENT PROVISIONS.

The local agency may provide general assistance, emergency general assistance, or work readiness payments in the form of vouchers or vendor payments if the applicant, recipient, or registrant does not have a residence address. The local agency may provide separate vouchers or vendor payments for food, shelter, and other needs and may divide the monthly assistance standard into daily or weekly payments, whether in cash or by voucher or vendor payment, until the applicant, recipient, or registrant has secured an address at which he or she resides. If the local agency elects to use these provisions, the local agency shall either provide for the individual's needs through placement in a negotiated rate facility, or provide for all of the individual's food, shelter, or other daily needs, regardless of the standard of assistance. For purposes of this part, "address" includes migrant labor camp as defined in part 4630.4800, subpart 3.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

WORK READINESS PROGRAM

9500.1300 PURPOSE AND APPLICABILITY.

Subpart 1. **Purpose.** The purpose of parts 9500.1300 to 9500.1318 is to establish standards for the work readiness program provided to eligible registrants by local agencies.

Subp. 2. **Applicability.** Parts 9500.1300 to 9500.1318 apply to applicants and registrants in the work readiness program, to applicants and recipients of general assistance, and to local agencies that are required to administer the work readiness and general assistance programs under Minnesota Statutes, sections 256D.051, 256D.09, subdivision 4, 256D.101, and 256D.111, subdivision 5. Parts 9500.1300 to 9500.1318 must be read together with parts 9500.1200 to 9500.1270. When parts 9500.1300 to 9500.1318 conflict with parts 9500.1200 to 9500.1270, parts 9500.1300 to 9500.1318 prevail.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1302 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1300 to 9500.1318, the following terms have the meanings given them.

Subp. 2. **Borderline mental retardation.** "Borderline mental retardation" means the condition of an individual who has demonstrated deficits in adaptive behavior and intellectual functioning that is at least one but less than two standard deviations below the mean of a professionally-recognized standardized test. The condition must limit the individual in obtaining, performing, or maintaining suitable employment.

Subp. 3. **Distressed county.** "Distressed county" means a county or a designated portion of a county with an average unemployment rate of ten percent or more as determined annually by the commissioner of the Department of Jobs and Training.

Subp. 4. **Employment assistance programs.** "Employment assistance programs" means the Minnesota employment and economic development (MEED) program and other programs offered by public or private agencies that provide services to develop, enhance, or promote an individual's employability, job placement, and training.

Subp. 5. **Misconduct.** "Misconduct" means conduct that would result in the disqualification of a claimant for unemployment insurance benefits under Minnesota Statutes, section 268.09, subdivision 1, clauses (2) and (3).

Subp. 6. **Program month.** "Program month" means a 30-day period of eligibility for work readiness assistance beginning with the first date for which a work readiness payment is made to the registrant, and each subsequent 30-day period in which the registrant is eligible for work readiness assistance and for which the registrant is provided with work readiness payments.

Subp. 7. **Qualified professional.** "Qualified professional" means a social worker employed by the local agency, a social worker with a master's degree in social work, a licensed consulting psychologist, a licensed psychologist, a licensed physician or psychiatrist, or a public health nurse.

Subp. 8. **Registrant.** "Registrant" means an individual who has applied for work readiness services and payments, who has been determined eligible for those services and payments by the local agency, and who has elected to begin receiving those services and payments. "Registrant" also means a recipient who is required to participate in the work readiness program under part 9500.1262.

Subp. 9. **Vocational adviser.** "Vocational adviser" means an individual employed by or under contract with the local agency who has sufficient education, training, or experience to identify the types of available suitable employment in a registrant's local labor market and the qualifications required for that employment; to identify the registrant's physical, social, vocational, and educational barriers to obtaining available suitable employment; and to identify the types of services and activities necessary to enable the registrant to overcome the barriers and obtain suitable employment.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1304 LOCAL AGENCY RESPONSIBILITY TO PROVIDE WORK READINESS PROGRAM AND PROGRAM DESCRIPTION.

Subpart 1. **Requirement to provide a work readiness program.** Each local agency shall provide a work readiness program. The program must provide work readiness services and payments to all applicants residing within the local agency's jurisdiction who meet the eligibility conditions of part 9500.1306, and must provide work readiness services to adult recipients of general assistance who are eligible under part 9500.1258, subpart 1, item L. The local agency may continue to provide work readiness services to recipients of general assistance who are categorically eligible under part 9500.1258, subpart 2.

Subp. 2. **Preparation of work readiness program description.** Each local agency shall develop a written description of its work readiness program. The description must:

A. meet the standards established in part 9500.1252;

B. identify the work readiness program's purpose, service components, operating procedures, and service provider;

C. contain a summary of work readiness program requirements including a registrant's responsibility to cooperate when the local agency assesses the registrant's employability and prepares the registrant's employability development plan, and the responsibility to comply with job registration, work search, and employment acceptance and retention requirements as conditions for continuing eligibility; and

D. state that a period of disqualification will be imposed for failure to comply with work readiness requirements.

Subp. 3. **Distribution of work readiness program description.** The local agency must give a copy of the work readiness program description to an applicant at the time he or she applies for general assistance or work readiness, and to any individual upon request.

Subp. 4. **Filing of program description.** The local agency must file a copy of

its work readiness program description with the commissioner annually, on January 1. The local agency must also file a copy of amendments to its work readiness program description with the commissioner at the time it makes the amendments.

Subp. 5. **Retention of documents in case files.** The local agency shall retain copies of all work readiness program notices, assessments, plans, and other documents given to or completed by an applicant or registrant, in accordance with parts 9500.1300 to 9500.1318, in the applicant's or registrant's case file.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1306 APPLICATION PROCESS AND ELIGIBILITY CRITERIA.

Subpart 1. **Assessment of general assistance eligibility.** Before determining an applicant's eligibility for work readiness services and payments, the local agency must determine the applicant's need for emergency general assistance under Minnesota Statutes, section 256D.07, and the applicant's eligibility for the general assistance program under part 9500.1209. If the applicant is eligible for general assistance, the applicant is ineligible for work readiness services and payments except as provided in part 9500.1262, subparts 1, item B, and 2. If the applicant is ineligible for general assistance, the local agency shall notify the applicant of the determination and of the right to appeal the decision as provided under part 9500.1260.

Subp. 2. **Work readiness application.** A completed application for general assistance is considered to be a completed application for the work readiness program effective on the date that the local agency determines the applicant ineligible for general assistance. A registrant shall not be required to complete a new application for general assistance when the local agency is determining the registrant's eligibility for general assistance under part 9500.1316, subpart 2, or 9500.1258, subpart 2.

Subp. 3. **Eligibility criteria.** If the local agency determines that the applicant is ineligible for general assistance, it must determine the applicant's eligibility for the work readiness program. An applicant or registrant is eligible for the work readiness program if the applicant or registrant meets the conditions in items A to D:

A. The applicant or registrant is not categorically eligible for general assistance under part 9500.1209, subpart 3, item A.

B. The applicant or registrant meets the eligibility requirements under part 9500.1209, subpart 4. If the applicant or registrant is married and resides with his or her spouse, the income and property of the applicant or registrant and his or her spouse shall be considered in accordance with part 9500.1209, subpart 4.

C. The applicant or registrant has not exhausted his or her eligibility period as provided by part 9500.1312.

D. The applicant or registrant is not in a disqualification period under part 9500.1254, 9500.1266, or 9500.1316.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1308 REQUIREMENT TO INFORM APPLICANTS.

Subpart 1. **Duty to inform applicants of ineligibility for the work readiness program.** Upon determining an applicant ineligible for the work readiness program, the local agency must inform the applicant of the determination and the right to appeal as provided in part 9500.1318.

Subp. 2. **Duty to inform eligible applicants of work readiness requirements.** At the time the local agency determines that an applicant is eligible for the work readiness program, the local agency must provide the applicant with a notice of the determination on a form prescribed by the commissioner, a copy of the program description prescribed under part 9500.1304, subpart 2, and a written notice meeting the standards established in part 9500.1252, which informs the applicant of:

A. the limited time during which the applicant may be eligible for work readiness services and payments;

B. the applicant's right to choose the months in which he or she will receive work readiness services and payments, including the option to elect to receive work readiness services and payments immediately;

C. the disqualification that will be imposed if a registrant is terminated from suitable employment for misconduct, quits suitable employment without good cause, refuses without good cause to accept an offer of suitable employment, or fails, without good cause, to comply with other work readiness program requirements; and

D. that an assessment of continuing eligibility for work readiness services and payments will be conducted during the registrant's second program month.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1310 WORK READINESS SERVICES AND PAYMENTS.

Subpart 1. **Requirement of concurrent services and payments.** In order for a program month to count toward the two or six program month limitation on eligibility for the work readiness program, as provided by part 9500.1312, the registrant must receive work readiness services during the program month for which a work readiness payment is made. Upon an eligible applicant's election to begin receiving work readiness services and payments, the local agency shall provide the services and payments to the registrant. A program month preceding the program month in which the written employability assessment and the employability development plan are completed, in accordance with subpart 2, items A and B, must not be counted against a registrant's total program months of work readiness eligibility, provided the registrant did not fail, without good cause, to cooperate with the assessment and plan development. A program month during which a registrant fails, without good cause, to comply with the requirements of the work readiness program but for which the registrant receives a work readiness payment shall be considered a program month during which work readiness services and payments were received.

Subp. 2. **Work readiness services.** The following services must be provided to a work readiness registrant;

A. In consultation with the registrant, a vocational adviser shall complete a written employability assessment. The assessment must include an examination of the registrant's education, training, prior work experience, and suitable employment that is or may become available, and must identify barriers to the registrant successfully seeking and securing suitable employment.

B. The vocational adviser shall develop a written employability development plan for each registrant within the registrant's first program month. The plan must be based on the assessment provided under item A and the vocational adviser's knowledge of the level of competition for employment that is or may become available, and must be designed to address the registrant's barriers to employment and prepare the registrant for suitable employment. The registrant must be given a copy of his or her plan and the plan must:

(1) include an estimation of the length of time it will take the registrant to obtain suitable employment;

(2) require the registrant to accept any offer of suitable employment;

(3) provide for referral to appropriate employment assistance programs;

(4) require a registrant to spend at least eight but no more than 32 hours per week in job search or other work readiness activities;

(5) specify the registrant's job search requirements, which must be limited to the local labor market, must be reasonable, and must be based upon the assessment performed under item A;

(6) specify any other reasonable activities designed to prepare the registrant for permanent suitable employment that are required of the registrant; and

(7) include provisions for assessing the registrant's progress in securing suitable employment.

C. No work readiness program shall require a registrant to travel to a potential job, training, or other activity site unless the local agency provides funds in advance to the registrant, in addition to the monthly program payment, to cover the cost of the transportation or unless transportation is otherwise available to the registrant without cost, or is unnecessary.

D. A registrant who is categorically eligible under part 9500.1258, subpart 1, item L, and who is the sole parent or stepparent residing with one or more children under the age of 12 shall not be required to participate in any work readiness program activities during hours in which the child is at home unless the local agency provides funds in advance to the registrant, in addition to the monthly program payment, to cover the cost of child care.

E. A local agency that requires a registrant to participate in any type of employment experience program shall require that the employment experience program meet the standards established in Minnesota Statutes, section 256D.113, and that the work to be done is not work ordinarily performed by a regular public employee.

F. A local agency may contract with a public or private entity to perform any or all of the services prescribed by this subpart if the entity can document that it has the resources and expertise necessary to perform the services. A contract entered into under this item must contain a description of the services to be performed under the contract. The local agency must monitor the entity to ensure that it is performing the services required under this subpart and specified in the contract. Upon request, the local agency shall provide the department with a copy of the contract and a description of the resources and expertise of the entity under contract with the local agency.

Subp. 3. **Work readiness payments.** A registrant who meets the eligibility conditions of part 9500.1306, subpart 3, shall receive work readiness payments during the applicable period of work readiness eligibility. If the registrant is married and lives with his or her spouse, the couple is considered a filing unit comprised of two individuals. If the registrant's spouse is also a registrant, the couple shall be considered one assistance unit composed of two persons for purposes of determining the applicable standard of assistance, the amount of countable income, the amount of real and personal property, and the monthly work readiness payment amount.

The payment amount must be equal to the amount of assistance that would be paid to the registrant's assistance unit if the assistance unit was eligible for general assistance under part 9500.1209. If the registrant resides with his or her spouse and the spouse receives general assistance, the monthly work readiness payment to the registrant under this part must be equal to the amount the general assistance monthly payment made to the registrant's spouse would increase if the registrant were added to the spouse's general assistance grant.

The first work readiness payment must be prorated to cover the period beginning with the effective date of the completed application for the work readiness program, the date that the applicant is determined eligible for work readiness services and payments, or the date that the eligible applicant elects to begin receiving work readiness services and payments, whichever is later, and ending with the last day of that month. The amount of the first payment must be determined by dividing the number of days to be covered by the payment by the number of days in the month, to determine the percentage of days in the month that are covered by the payment, and multiplying the monthly payment amount by this percentage.

Subsequent work readiness payments must be made monthly on the first day of the month. A registrant shall continue to receive work readiness payments during the months that he or she elects to receive work readiness services and payments and meets the eligibility requirements of part 9500.1306. The final payment must be prorated to cover the number of program days for which the registrant is eligible in that month. The amount of the final payment must be determined by subtracting the percentage of days in the first month covered by the first work readiness payment from 100 percent, and multiplying the final monthly payment amount by the remaining percentage. Emergency general assistance is available to a registrant in accordance with Minnesota Statutes, section 256D.06, subdivision 2.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1312 ASSESSMENT FOR ADDITIONAL ELIGIBILITY; NOTICES TO REGISTRANTS.

Subpart 1. **Required assessment.** Except for registrants participating in work readiness under part 9500.1262, the local agency shall conduct an assessment of the registrant's progress in securing suitable employment and an assessment of the registrant's eligibility for an additional four program months of work readiness services and payments during the registrant's second program month of work readiness services and payments under part 9500.1310.

The local agency must offer the registrant an opportunity to meet with the local agency and to provide information relevant to the assessment. If the registrant does not meet with the local agency or provide information relevant to the assessment, the local agency must complete the assessment based on the information contained in the registrant's case file.

Subp. 2. **Notice of assessment.** The local agency shall provide a written notice meeting the standards established under part 9500.1252 to inform the registrant that the local agency will be assessing the registrant's eligibility for an additional four program months of work readiness services and payments. The notice must be mailed or given to the registrant no later than ten days before the assessment and must include the following:

A. The notice must identify the conditions that must be met in order for the registrant to be eligible for an additional four program months.

B. The notice must inform the registrant that the registrant will not receive work readiness payments beyond the second program month until the assessment has been completed and the registrant found eligible for four additional program months.

C. The notice must offer the registrant an opportunity to meet with the local agency in order to provide information relevant to the assessment.

D. The notice must inform the registrant that the registrant has a right to submit to the local agency information relevant to the determination within ten days from the date that the notice is mailed or given to the registrant.

Subp. 3. **Assessment of additional eligibility.** A registrant is eligible for four additional program months of work readiness services and payments if the registrant meets one or more of the following conditions:

A. The registrant lives in a distressed county.

B. The registrant is medically certified as having borderline mental retardation.

C. The registrant is certified by a qualified professional as exhibiting perceptible symptoms of mental illness but the registrant is not eligible for general assistance under part 9500.1258, subpart 1, because the mental illness interferes with the medical certification process.

D. The registrant, as determined by a vocational adviser, cannot reasonably be expected to secure suitable employment at this time given the registrant's work history, skills, education, physical and mental ability, and the availability of suitable employment.

If the local agency believes that the registrant may have borderline mental retardation, or if the registrant or a representative of the registrant asserts that he or she has borderline mental retardation, the local agency shall seek medical certification of the registrant's condition. If medical certification establishes that the registrant has borderline mental retardation, the condition in item B is met.

If the registrant's behavior, mood, conduct, or appearance suggests or demonstrates that the individual has a mental illness, or if the registrant or a representative of the registrant asserts that the registrant has a mental illness, the local agency shall seek medical certification of the registrant's condition. If the registrant's mental illness interferes with the medical certification, the local agency shall seek an assessment of the registrant's condition from a qualified professional. If the qualified professional certifies that the registrant exhibits symptoms of mental illness, the condition in item C is met.

Subp. 4. **Notice of determination.** If the local agency determines through the assessment that the registrant meets one or more of the conditions in subpart 3, items A to D, the local agency must notify the registrant that he or she is eligible for work readiness services and payments for a combined total of six program months in any consecutive 12-calendar month period. If the local agency determines, upon completion of the assessment under subpart 1, that the registrant does not meet one or more of the conditions in subpart 3, items A to D, the local agency must terminate the registrant's work readiness services and payments effective at the end of the registrant's second program month of participation in the work readiness program. If the local agency determines that the registrant is ineligible for continued work readiness services and payments, the local agency shall notify the registrant of its determination and that the registrant is not eligible to receive work readiness services and payments for more than two program months during any consecutive 24-calendar month period.

Subp. 5. **Registrant moves to another county after assessment for additional eligibility is completed.** If a registrant moves to another county after the assessment for additional eligibility required under subpart 1 is completed, the new county of residence must complete another assessment for additional eligibility and determine the registrant's eligibility for additional work readiness services and payments. A registrant shall not receive more than a total of six program months of work readiness services and payments in any consecutive 12-month period, regardless of the number of assessments conducted.

Subp. 6. **Notice of termination.** A registrant who is in the last program month of his or her two or six program months of work readiness services and payments shall be notified of the termination of services and payments and of the appeal rights in accordance with the procedures specified in part 9500.1318.

Subp. 7. **Assessment following reapplication.** If an individual, whose eligibility for work readiness was terminated after two program months because the local

agency determined that the individual did not meet one or more of the conditions under subpart 3, items A to D, applies for work readiness, the local agency must determine if the applicant's circumstances have changed and if the applicant is eligible for any additional work readiness services or payments.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1314 REGISTRANT DUTIES.

A registrant shall comply with all requirements of the local agency work readiness program, including the requirements explained under part 9500.1308, subpart 2, and the requirements specified in the employability development plan provided under part 9500.1310, subpart 2, item B. Except for registrants participating in work readiness under part 9500.1262, a registrant who fails, without good cause, to comply with the local agency work readiness requirements shall be disqualified from the receipt of work readiness services and payments under part 9500.1316.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1316 FAILURE TO COMPLY WITH WORK READINESS REQUIREMENTS AND DISQUALIFICATION.

Subpart 1. **Determination and notice of failure to comply.** If a local agency determines that a registrant has failed, without good cause, to comply with the requirements of the work readiness program, the local agency must notify the registrant of its determination. The notice must meet the standards established in part 9500.1252, and must contain the information in items A to E.

A. The notice must state the specific work readiness requirement the registrant has failed to meet and the facts that support the local agency's determination.

B. The notice must specify the particular action the registrant must take to meet the requirements.

C. The notice must specify a certain date by which the action must be taken. The registrant must be given a minimum of 15 calendar days to take the specified action following the date the notice is mailed or given to the registrant.

D. The notice must explain that the registrant will be disqualified from receiving work readiness services and payments if he or she fails to take the required actions by the specified date.

E. The notice must advise the registrant that he or she may request and shall be granted a conference to discuss the notice with the local agency.

Subp. 2. **Disqualification.** A registrant who is notified of the local agency determination as provided in subpart 1 shall comply with the requirements of the work readiness program as stated in the notice by the specified date.

If the local agency determines that a registrant has taken the required action on or before the date specified in the notice, a period of disqualification must not be imposed. If the local agency determines that the registrant failed, without good cause, to take the required action by the specified date, the local agency must assess the registrant's eligibility for general assistance under part 9500.1209 before disqualifying the registrant for not meeting the requirements.

If the local agency determines that the registrant is eligible for general assistance, the registrant shall be terminated from work readiness services and payments and shall be eligible for general assistance.

If the local agency determines that the registrant is ineligible for general

assistance under part 9500.1209, the registrant shall be disqualified from receiving work readiness services and payments.

Subp. 3. **Notice of disqualification.** The local agency shall notify the registrant of the disqualification from receiving work readiness services and payments under subpart 2 and of the registrant's appeal rights as provided in part 9500.1318.

Subp. 4. **Period of disqualification.** A registrant disqualified under subpart 2 is ineligible during the period of disqualification for any remaining or additional work readiness services or payments for which he or she would otherwise be eligible in accordance with the provisions in items A to F.

A. The period of disqualification shall be two months.

B. The disqualification period begins on the first day of the work readiness payment period following the date on which the determination was made. If the notice of disqualification is given or mailed so late in a payment period that ten-day prior notice required under part 9500.1318 cannot be given, the disqualification period begins on the first day of the second work readiness payment period following the date the determination was made. If the registrant appeals on or before the proposed disqualification date, the disqualification process must stop and work readiness payments and services must continue until a final decision is made or until the registrant's period of eligibility is exhausted, and payments and services are terminated in accordance with part 9500.1312, subpart 6, whichever is earlier. If the registrant loses the appeal, the disqualification period must begin on the first day of the next work readiness payment period.

C. If an individual who is disqualified applies for the work readiness program during the period of disqualification, eligibility for work readiness services and payments must be denied.

D. Disqualification under subpart 2 must not affect a registrant's eligibility for general assistance or general assistance medical care.

E. The period of disqualification under subpart 2 must not be counted against a registrant's two or six program months of work readiness eligibility. Following a period of disqualification a registrant who has been disqualified under subpart 2 must complete a new application for work readiness and the local agency must determine if the registrant is eligible for any additional or remaining work readiness services or payments.

F. If a registrant is disqualified under subpart 2, the local agency may use vouchers and vendor payments, or both, to meet the financial needs of the remaining eligible members of the registrant's assistance unit. The assistance standard used must be based on the number of remaining eligible members in the registrant's assistance unit.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

9500.1318 NOTICE OF ADVERSE ACTION AND APPEAL RIGHTS.

Subpart 1. **Actions requiring notice.** The local agency shall notify an applicant or registrant of the following determinations before taking any adverse actions:

A. a determination of ineligibility for work readiness services or payments under part 9500.1306, subpart 3;

B. a determination of ineligibility for four additional program months of work readiness services or payments under part 9500.1312, subpart 1;

C. a determination of disqualification from receiving work readiness services and payments under part 9500.1316, subpart 2; and

D. a determination that the registrant has exhausted eligibility to receive work readiness services and payments under part 9500.1312, subpart 3.

Subp. 2. **Notice requirements.** The notice required under subpart 1 must meet the standards established in part 9500.1252, and must:

A. be in writing on a form prescribed by the commissioner;

B. be mailed or given to the applicant or registrant no later than ten days before the suspension, termination, or reduction of the work readiness payment; and

C. clearly state what action the local agency intends to take, the reasons for the action, the right to appeal the action, and the conditions under which work readiness services and payments can be continued pending an appeal.

Subp. 3. **Appeal of adverse action.** An applicant or registrant who is the subject of an adverse action under subpart 1 may appeal the local agency determination. The appeal must be a written request for a hearing submitted to the department or the local agency under Minnesota Statutes, section 256.045. If a registrant appeals on or before the effective date of the adverse action, the registrant, if otherwise eligible, shall continue to receive work readiness services and payments while the appeal is pending, unless the registrant requests in writing that assistance be discontinued pending a hearing decision. If the registrant's appeal of an action specified under subpart 1, item A, B, or D is not upheld, the registrant shall pay back to the local agency the amount of work readiness payments received during the pendency of the appeal.

Statutory Authority: *MS s 256D.04; 256D.05 subd 1; 256D.051; 256D.09 subd 4; 256D.10; 256D.101; 256D.111 subd 5*

History: *11 SR 134*

ADMINISTRATION OF THE MEDICAL ASSISTANCE PREPAID DEMONSTRATION PROJECT

9500.1450 INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.1450 to 9500.1464 govern administration of the medical assistance prepaid demonstration project (MAPDP) in Minnesota. Parts 9500.1450 to 9500.1464 shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, and waivers approved by the Health Care Financing Administration, Minnesota Statutes, chapters 256 and 256B, and rules promulgated under them, governing the administration of the title XIX program and MAPDP in Minnesota.

Subp. 2. **References.** Parts 9500.1450 to 9500.1464 shall be interpreted as necessary to comply with federal laws and regulations and state laws applicable to the medical assistance prepaid demonstration project.

Subp. 3. **Geographic area.** MAPDP shall be operated in the counties of Dakota, Hennepin, and Itasca.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1450 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1451 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9500.1450 to 9500.1464, the following terms have the meanings given them in this part.

Subp. 2. **Actual costs.** "Actual costs" means the total cost to the medicaid health plan for providing services to MAPDP enrollees during a contract year.

Subp. 3. **Broker.** "Broker" means an organization under contract with the state to develop and present to consumers educational material on the MAPDP so that consumers understand the medicaid health plan choices available to them.

Subp. 4. **Capitation.** "Capitation" means a method of payment for health

care services that involves a monthly per person rate paid on a prospective basis to a medicaid health plan.

Subp. 5. **Consumer.** "Consumer" means a medical assistance recipient who is participating in MAPDP.

Subp. 6. **Department.** "Department" means the Department of Human Services.

Subp. 7. **Enrollee.** "Enrollee" means a consumer who is enrolled in a medicaid health plan.

Subp. 8. **Health services.** "Health services" means the services and supplies given to a recipient by a provider for a health related purpose under Minnesota Statutes, section 256B.02, subdivision 8.

Subp. 9. **Insolvency.** "Insolvency" means the condition in which a medicaid health plan is financially unable to meet the financial and health care service delivery obligations in the contract between the department and the medicaid health plan.

Subp. 10. **Local agency.** "Local agency" means a county or multicounty agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, as the agency responsible for determining recipient eligibility for the medical assistance program.

Subp. 11. **Medical Assistance Prepaid Demonstration Project or MAPDP.** "Medical Assistance Prepaid Demonstration Project" or "MAPDP" means the medical assistance prepaid demonstration project established by Minnesota Statutes, section 256B.69.

Subp. 12. **Medicaid health plan or MHP.** "Medicaid health plan" or "MHP" means the organization contracting with the department to provide to enrollees the medical assistance services in parts 9500.1450 to 9500.1464 in exchange for a capitation payment.

Subp. 13. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 14. **Medical assistance population or MA population.** "Medical assistance population" or "MA population" means an aged, blind, disabled, or Aid to Families with Dependent Children (AFDC) category of eligibility for the medical assistance program, the eligibility standards for which are in parts 9500.0780 to 9500.0860.

Subp. 15. **Provider.** "Provider" means a person or entity providing health care services.

Subp. 16. **Rate cell.** "Rate cell" means a grouping of recipients by demographic characteristics, established by the department for use in determining capitation rates. Demographic characteristics include the recipient's age, sex, medicare status, basis of medical assistance eligibility, and county of residence, and whether the recipient is a resident of a long-term care facility.

Subp. 17. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for the medical assistance program.

Subp. 18. **Total capitation payments.** "Total capitation payments" means the sum of all capitation payments made to the medicaid health plan by the department during a contract year.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1451 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1452 ELIGIBILITY TO ENROLL IN MEDICAID HEALTH PLAN.

Only persons who have been determined eligible for medical assistance

under parts 9500.0750 to 9500.1060 shall be eligible to participate in the medical assistance prepaid demonstration project.

"Personal care assistant" means a provider of personal care services prescribed by a physician and supervised by a registered nurse and provided to a medical assistance recipient. A personal care assistant must not be a relative or a family member of the medical assistance recipient. "Rate cell year" means the period beginning with the consumer's case open date or effective date of enrollment in the MHP, whichever is earlier, and ending one year from the consumer's case open date.

"State institution" means all regional treatment centers, as defined in Minnesota Statutes, section 245.0312; and state operated nursing homes Ah-gwah-ching and Oak Terrace.

A person who belongs to a category listed in items A to D is ineligible to enroll in a medicaid health plan under the medical assistance prepaid demonstration project:

A. a person who is eligible for medical assistance with a six-month spend-down under part 9500.0810;

B. a person who is currently receiving the services of a personal care assistant, or MAPDP enrollees who at the end of their rate cell year are using the services of one or more personal care assistants;

C. a person who is a resident of a state institution; or

D. a person who is a refugee and is receiving benefits under the Refugee Assistance Program, established at United States Code, title 8, section 1522(e).

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1452 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1453 MANDATORY PARTICIPATION; FREE CHOICE OF MEDICAID HEALTH PLAN.

The department shall select recipients to participate as consumers in the medical assistance demonstration project and notify the recipients, in writing, of the MHP choices available to them. A recipient who is selected as a consumer must participate in a MHP. The recipient shall have the right to select the MHP of his or her choice. No reimbursement from the Medical Assistance Program shall be made for health services received by a recipient enrolled in a MHP that are not payable through the MHP. Consumers shall be given no less than ten days after receiving written notification from the department to notify the department of their health plan choice. However, if the department is not notified of the consumer's choice, the department shall assign the consumer to a MHP. The department shall notify the recipient in writing of the effective date of his or her enrollment, and the MHP in which the recipient will be enrolled. This notice must be given to the recipient before the effective date of enrollment.

A consumer shall be enrolled in a MHP for one year from the date of enrollment but shall have the right to change to another MHP once within the first 60 days of enrollment in MAPDP. A consumer shall have the right to change to another MHP during the annual 30-day period of open enrollment. The department shall notify consumers of the opportunity to change to another MHP annually, at least 30 days before the start of the annual open enrollment period.

An enrollee may change to another MHP between enrollment periods on demonstrating to the state grievance panel that the enrollee:

A. requires substantially more travel time than is normally required by non-MAPDP participants in the same geographic area to travel to receive medical services;

B. has not received satisfactory services from the MHP; or

C. has other good cause for changing to another MHP.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1453 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1454 RECORDS.

A MHP shall maintain fiscal and medical records as required in part 9500.0930. A local agency shall comply with parts 9500.0920 and 9500.0930 and maintain a list showing the enrollment choices of recipients who participate in the medical assistance prepaid demonstration project.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1454 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1455 THIRD-PARTY LIABILITY.

A local agency and a MHP shall comply with part 9505.0211 [Emergency] in regard to third party payer liability.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1455 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1456 IDENTIFICATION OF ENROLLEES.

A MHP shall identify enrollees in a way convenient to its normal operational procedures.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1456 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1457 SERVICES COVERED BY MAPDP.

Subpart 1. **In general.** Services currently available under the medical assistance program in Minnesota Statutes, chapter 256B and parts 9500.0750 to 9500.1080 are covered under MAPDP.

Subp. 2. **Additional services.** A MHP may provide services in addition to those available under the medical assistance program.

Subp. 3. **Prior authorization of services.** A MHP shall be exempt from the requirements of Minnesota Statutes, chapter 256B, parts 9500.0750 to 9500.1080 and 9505.5000 to 9505.5030, that require prior authorization before providing health services to an enrollee.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1457 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1458 DATA PRIVACY.

Under Minnesota Statutes, section 13.46, subdivisions 1 and 2, a MHP under contract with the department is considered an agent of the department and shall have access to information on enrollees to the extent necessary to carry out its responsibilities under the contract. The MHP must comply with Minnesota Statutes, chapter 13, the Minnesota Government Data Practices Act.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1458 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1459 CAPITATION POLICIES.

Subpart 1. **Rates.** In demonstration counties designated by the department under Minnesota Statutes, section 256B.69, medical assistance payments for services included in the MAPDP will be made according to the contract between the MHP and the department. Capitation rates must be developed on an historical cost basis. Base rates must be determined by calculating an average per capita cost for each rate cell by county of participation. If rate cell population in a county is insufficient to support a statistically valid sample size, the average per capita cost for that rate cell shall be determined from statistics from the metropolitan area, consisting of Hennepin, Ramsey, Anoka, Scott, Carver, Dakota, and Washington counties, or from a group of contiguous or demographically similar rural counties. The actual rate offered under the contract must be a specified percentage of the county average per capita cost.

The historical cost basis of the rates must be from fiscal year 1982 for Itasca and Hennepin counties, and fiscal year 1983 for Dakota county, adjusted forward to the implementation year. This adjustment must not exceed the per capita cost increase based on department projections, taking into account changes in legislation, title XIX state plan, and rules affecting the medical assistance program. "Title XIX state plan" refers to the document submitted for approval to the United States Department of Health and Human Services, Health Care Financing Administration, defining the conditions of medical assistance program eligibility and services authorized by title XIX of the Social Security Act of 1965 and Minnesota Statutes, chapter 256B.

Rates must be adjusted on a state fiscal year basis, July 1 to June 30. The adjusted rates shall be effective on January 1 of the next state fiscal year. Rate cells shall also be adjusted to reflect differences in health status if analysis of historical costs and available survey data indicates that this adjustment is feasible.

Subp. 2. **Risk sharing arrangements.** In addition to the capitation rate, the department shall provide the two types of risk-sharing in subparts 3 and 4.

Subp. 3. **Aggregate loss-sharing.** Under aggregate loss-sharing, the department and the MHP shall share the loss if the allowable actual costs of serving enrollees exceed the aggregate payment provided through the capitation.

Loss-sharing expenses are expenses incurred by the MHP for services rendered directly to enrollees. The MHP shall submit claim data as specified by the department for these services. This data shall be used to calculate the MHP aggregate cost of serving its enrollees. If the MHP aggregate cost of serving its enrollees exceeds the aggregate amount received by the MHP in capitation revenues, the MHP is eligible for aggregate loss-sharing.

Aggregate loss-sharing shall be implemented as specified in items A and B, unless otherwise specified in the contract between the department and the MHP.

A. The following provisions apply only to the total capitation payments made to the MHP for AFDC enrollees:

(1) For the contract period ending December 31, 1986, the department shall pay to the MHP 50 percent of the actual costs of the MHP that exceed the total capitation payments to the MHP but that are equal to or less than 110 percent of the costs on which the department based the capitation rates.

(2) For the contract period ending December 31, 1987, the department shall pay to the MHP 50 percent of the actual costs of the MHP that exceed the total capitation payments to the MHP but that are equal to or less than 100 percent of the costs on which the department based the capitation rates.

B. The following provisions apply only to the total capitation payments made to the MHP for aged, blind, and disabled enrollees:

(1) For the contract period ending December 31, 1986, the department shall pay to the MHP 50 percent of the actual costs of the MHP that exceed

the total capitation payments to the MHP but that are equal to or less than 115 percent of the costs on which the department based the capitation rates.

(2) For the contract period ending December 31, 1987, the department shall pay to the MHP 50 percent of the actual costs of the MHP that exceed the total capitation payments to the MHP but that are equal to or less than 105 percent of the costs on which the department based the capitation rates.

C. There shall be no aggregate loss-sharing available after December 31, 1987.

Subp. 4. **Individual stop-loss coverage.** Individual stop-loss coverage must be available for the duration of MAPDP. Stop-loss coverage is the amount the department will pay in excess of capitation rates described in items A and B.

A. Individual stop-loss coverage must be provided by the department for 80 percent of the following costs within a 12-month period unless otherwise specified in the contract between the department and the MHP:

(1) inpatient hospital claims exceeding $15,000 for an AFDC enrollee and $30,000 for an aged, blind, or disabled enrollee; and

(2) over 90 days of long-term care facility services, as defined in part 9500.1070, subpart 3, or in-home care provided as an alternative to long-term care facility services.

Only costs that would be allowable medical assistance charges are eligible for individual stop-loss coverage.

B. MHPs may choose not to take part in the department's individual stop-loss coverage. MHPs not participating in the individual stop-loss coverage must submit to the department evidence that:

(1) the plan has an adequate financial reserve separate from operating funds to cover catastrophic liabilities;

(2) not more than 30 percent of the organization's operating budget is medical assistance related; and

(3) the MHP waives the right of 90-day termination of contract and instead agrees to a 180-day termination notice period.

The capitation rate must be adjusted to include the cost of the department's individual stop-loss. Additional costs of buying private reinsurance must not be covered in the capitation nor be eligible expenses for aggregate loss-sharing as described in subpart 3.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1459 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1460 ADDITIONAL REQUIREMENTS.

Subpart 1. **MHP requirements.** An organization that seeks to participate as a MHP under the medical assistance prepaid demonstration project shall meet the criteria in subparts 2 to 16.

Subp. 2. **Medical assistance populations covered.** A MHP may choose to serve all medical assistance populations or a single medical assistance population. If the MHP chooses to serve a medical assistance population of AFDC or blind recipients, the MHP must serve at least one other medical assistance population.

Subp. 3. **Services provided.** A MHP shall provide or ensure its enrollees access to all health services eligible for medical assistance payment under part 9500.1070.

Subp. 4. **Prohibition against co-payments.** A MHP shall not charge its enrollees for any health service eligible for medical assistance payment under part 9500.1070 or for a medically necessary health service that is provided as a substitute for a health service eligible for medical assistance payment.

Subp. 5. **Plan organization.** A MHP may choose to organize itself as either a profit or not-for-profit organization.

Subp. 6. **Contractual arrangements.** A MHP shall contract with providers as necessary to meet the health service needs of its enrollees. The MHP shall verify these contracts to the department by providing written summary information before a contract can be entered into between the MHP and the department.

Subp. 7. **Service capacity.** A MHP shall accept, up to the limit of its enrollment capacity, all consumers who choose the MHP, regardless of the consumers' health conditions, if the consumers are from the medical assistance category or categories and the geographic area or areas specified in the contract between the MHP and the department.

Subp. 8. **Financial capacity.** A MHP shall demonstrate its financial risk capacity through a reserve fund or other mechanism agreed upon by the providers within the MHP in the contract with the department. A MHP that is licensed as a health maintenance organization under Minnesota Statutes, chapter 62D, or a nonprofit health plan licensed under Minnesota Statutes, chapter 62C, is not required to demonstrate a financial risk capacity beyond the financial risk capacity required to comply with the requirements of Minnesota Statutes, chapter 62C or 62D.

Subp. 9. **Insolvency.** A MHP must have a plan approved by the department for transferring its enrollees to other sources of health services if the MHP becomes insolvent.

Subp. 10. **Limited number of contracts.** The department may limit the number of MHP contracts in effect under MAPDP.

Subp. 11. **Liability for payment for unauthorized services.** Except for emergency health services under Minnesota Statutes, section 256B.02, subdivision 8, clause (4), a MHP shall not be liable for payment for unauthorized health services rendered by a provider who is not part of the MHP. The department is not liable for payment for health services rendered by a provider who is not part of the MHP.

Subp. 12. **Termination of participation as a MHP.** The department or a MHP may terminate a contract upon 90 days' written notice to the other party unless the department and the MHP have agreed to a different notice requirement in the contract and except as set forth at part 9500.1459, subpart 4, item B, subitem (3). If a contract between the department and a MHP is going to be terminated, the entity terminating the contract must notify the MHP's enrollees in writing at least 30 days before the termination.

Subp. 13. **Financial requirements placed on MHP.** The MHP shall accept the capitation rate and risk-sharing adjustments derived under part 9500.1459 as full payment for health services provided under the contract to enrollees. A MHP under contract with the department shall be accountable to the department for the fiscal management of the health services it provides enrollees. The department shall be held harmless for the payment of obligations incurred by a MHP if the MHP or a provider contracted by the plan to provide health services to enrollees becomes insolvent and if the department has made the payments due the MHP under part 9500.1459.

Subp. 14. **Required educational materials.** When contracting with the department, a MHP must provide to the department educational materials to be given to the medical assistance population specified in the contract. The material should explain the services to be furnished to enrollees. No educational materials designed to solicit the enrollment of consumers shall be disseminated without the department's prior approval. A MHP and the department may agree, as a term of the contract, that a broker shall have the responsibility for developing and distributing the educational materials required in this subpart. If the contract specifies the use of a broker to develop and disseminate educational materials

designed specifically for consumers, the broker must get the department's written approval of the educational materials before distributing them.

Subp. 15. **Required case management system.** "Case management" means a method of providing health care in which one individual or organization or an interdisciplinary team coordinates the provision of health care services to a consumer. A MHP shall implement a system of case management providing the enrollee an individual needs assessment, development and implementation of an individual plan of care for the enrollee, and evaluation, monitoring, and revision of an individual plan of care.

Subp. 16. **Required submission of information.** The contract between the department and the MHP shall specify the information the medicaid health plan shall submit to the department and the Health Care Financing Administration, and the form in which the information shall be submitted. The information submitted must enable the department to make the calculations required under part 9500.1459 and to carry out the requirements of parts 9505.1750 to 9505.2150 and the Health Care Financing Administration. The MHP shall record complaints from enrollees and consumers applying for enrollment, actions taken to resolve the complaints, and results of the actions. A MHP shall make the required information available to the department annually, or at other times specified in the contract or, if the department requires additional information for the purposes in this subpart, within ten days of the date of the department's written request for the additional information.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1460 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1462 SECOND MEDICAL OPINION.

A MHP must provide, at its expense, a second medical opinion within the MHP when the department or the enrollee requests a second medical opinion.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1462 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1463 GRIEVANCE PROCEDURES.

Subpart 1. **Internal grievance procedure.** A MHP shall have, in writing, a grievance procedure for receiving and reviewing the complaints of consumers and enrollees. The procedure must be approved by the department. The MHP shall give each enrollee a written description of the MHP grievance procedure and the state grievance procedure. This written description must also explain an enrollee's right to a second medical opinion. The grievance procedure must include an informal review in which a determination is made within ten calendar days after the MHP receives a verbal complaint and a formal procedure to hear written grievances. The formal procedure shall provide a hearing and a decision about the grievance within 30 days from the time the written grievance is received by the MHP.

The MHP shall provide the enrollee with written notice of the resolution of the grievance. This notice must state the enrollee's right to file a grievance with the state and provide appropriate information regarding the procedure for filing the grievance.

A MHP that revises its grievance procedures must notify its enrollees of the revised procedure, in writing, at least two weeks before the revision is effective. A revision of a MHP grievance procedure must be submitted to and approved in writing by the department before its implementation. Within 30 days from the time the written grievance is received by the MHP, the MHP shall give the

enrollee written notice of the resolution of the grievance. This written notice must inform the enrollee of the right to file a grievance with the state and explain how to file the grievance.

Subp. 2. **State grievance procedure; appeal of provider's delay or refusal to provide services.** An enrollee may appeal to the department if the MHP delays or refuses to provide medically necessary services. The appeal shall be heard by a panel that includes health practitioners as specified in Minnesota Statutes, section 256B.69, subdivision 11. For enrollees residing in Hennepin county, the local agency may hold the grievance hearing on behalf of the department, using the same panel as appointed by the department. The MHP shall pay for nonemergency medically needed services if the enrollee is successful in the appeal. The hearing before the panel shall be conducted according to Code of Federal Regulations, title 42, sections 431.200 to 431.246. The panel's decision is a final agency action that may be appealed under the contested case provisions of Minnesota Statutes, chapter 14.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1463 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

9500.1464 SURVEILLANCE AND UTILIZATION REVIEW.

The provisions of parts 9505.1750 to 9505.2150 apply to MAPDP.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

NOTE: Part 9500.1464 is repealed effective December 31, 1988. See the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986.

COMMISSIONER'S CONSENT TO PATERNITY SUIT SETTLEMENTS

9500.1650 APPLICABILITY.

Parts 9500.1650 to 9500.1663 govern the procedures and the standards applicable to the way in which the commissioner decides, as a party under Minnesota Statutes, section 257.60, whether to agree to a particular lump sum settlement or compromise agreement in a paternity action under Minnesota Statutes, sections 257.51 to 257.74. Parts 9500.1650 to 9500.1663 apply equally to lump sum settlements and compromise agreements proposed as part of a maternity suit under Minnesota Statutes, section 257.71.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1655 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9500.1650 to 9500.1663, the following terms have the meanings given to them in this part.

Subp. 2. **Admission of paternity.** "Admission of paternity" means a written acknowledgment by a male that he is the biological father of a child.

Subp. 3. **Aid to families with dependent children or AFDC.** "Aid to families with dependent children" or "AFDC" means the program authorized by title IV-A of the Social Security Act to provide financial assistance services to needy families with dependent children.

Subp. 4. **Alleged father.** "Alleged father" means a male alleged to be the biological father of a child.

Subp. 5. **Blood test.** "Blood test" means a test using blood group identification of a mother, child, and alleged father that is used to predict the probability or exclude the possibility that the alleged father is the biological father of the child.

Subp. 6. **Child.** "Child" means an individual under age 18 whose parental

relationship with the alleged father is being determined and whose legal rights and privileges are at issue.

Subp. 7. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 8. **Compromise agreement.** "Compromise agreement" has the meaning given it by Minnesota Statutes, section 257.64, subdivision 1, clause (b).

Subp. 9. **Costs.** "Costs" has the meaning given it under Minnesota Statutes, section 257.69.

Subp. 10. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 11. **Depository.** "Depository" means a person or organization entrusted to safekeep a father's or an alleged father's lump sum settlement or compromise agreement payments and to make periodic payments of the money on behalf of the child.

Subp. 12. **Guardian ad litem.** "Guardian ad litem" means the person designated by the court to represent the interests of a child in a paternity suit, according to Minnesota Statutes, section 257.60.

Subp. 13. **Income.** "Income" has the meaning given it under Minnesota Statutes, section 518.54, subdivision 6.

Subp. 14. **Interest rate.** "Interest rate" means the rate of interest used to calculate the present value of periodic payments a father is required to pay and is equal to the current market rate of interest on a United States Treasury obligation using as its maturity date the child's 18th birthdate.

Subp. 15. **Liability for past support.** "Liability for past support" means the financial obligation of the noncustodial parent to reimburse the local child support enforcement agency for all or a portion of past expenses furnished on behalf of a child under Minnesota Statutes, sections 257.66 and 257.67.

Subp. 16. **Local IV-D agency.** "Local IV-D agency" means the county or multicounty agency that is authorized under Minnesota Statutes, section 393.07, to administer the child support enforcement program under the requirements of title IV-D of the Social Security Act, United States Code, title 42, sections 651 to 658, 660, 664, 666, 667, 1302, 1396(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

Subp. 17. **Lump sum settlement.** "Lump sum settlement" means a single payment to satisfy the remaining obligations of a noncustodial parent for support of the parent's minor child.

Subp. 18. **Medical support.** "Medical support" has the meaning given it under Minnesota Statutes, section 518.171.

Subp. 19. **Mother.** "Mother" means a woman who was not married to her child's father when the child was born or when the child was conceived.

Subp. 20. **Office of Child Support Enforcement.** "Office of Child Support Enforcement" means the office within the department that administers the child support enforcement program for the purposes of locating absent parents, establishing paternity, and establishing and enforcing orders for support under the requirements of title IV-D of the Social Security Act, United States Code, title 42, sections 651 to 658, 660, 664, 666, 667, 1302, 1396(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

Subp. 21. **Party.** "Party" means a person as defined in Minnesota Statutes, sections 257.57 and 257.60, who is involved in a paternity suit.

Subp. 22. **Paternity suit.** "Paternity suit" means a legal action brought to establish that a man is the biological father of a child and has legally enforceable duties and responsibilities in regard to that child.

Subp. 23. **Periodic payments.** "Periodic payments" means payments of support on a schedule established by the court under Minnesota Statutes, section 518.551, subdivision 5.

Subp. 24. **Present value.** "Present value" means the current monetary worth of future periodic payments. The formula used to determine present value is An = V $1-(1+i)^{-n}/i$ where:

"An" means present value of the periodic payments,

"V" means value of the periodic payments,

"n" means number of periodic payments, and

"i" means interest rate.

Subp. 25. **Reimbursement.** "Reimbursement" means payment of a sum for public funds expended for the care and support of a child under Minnesota Statutes, sections 256.87; 257.66, subdivisions 3 and 4; 257.69; and 393.07, subdivision 9.

Subp. 26. **Support.** "Support" has the meaning given to "support money" under Minnesota Statutes, section 518.54, subdivision 4.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1656 CONSENT BY COMMISSIONER TO A COMPROMISE AGREEMENT.

The commissioner shall not consent to a compromise agreement.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1657 COMMISSIONER'S CONSENT TO A LUMP SUM SETTLEMENT.

The commissioner shall consider each proposed lump sum settlement that is submitted to the commissioner. If a submitted proposed lump sum settlement does not comply with parts 9500.1650 to 9500.1663, the commissioner shall not consent to the proposed lump sum settlement.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1658 STANDARDS USED BY COMMISSIONER TO DETERMINE WHETHER TO CONSENT TO A PROPOSED LUMP SUM SETTLEMENT.

Subpart 1. **Standards.** The commissioner shall consent to a proposed lump sum settlement only if the conditions of subparts 2 to 6 are met.

Subp. 2. **Admission of paternity.** The alleged father must admit paternity and either waive blood tests or the results of blood tests indicate a likelihood of more than 92 percent that the alleged father is the biological father of the child.

Subp. 3. **Comparison of proposed lump sum settlement to present value of periodic payments.** The proposed lump sum settlement must be equal to or greater than the present value of periodic payments.

Subp. 4. **Liability for past support and costs.** A provision must be made for a partial or full reimbursement consisting of the alleged father's liability for past support and costs. The alleged father's liability for past support and costs includes:

A. all or a proportion of the amount of assistance furnished the child during the two years immediately preceding the start of the paternity action under Minnesota Statutes, section 257.66, subdivision 4;

B. expenses of the mother's pregnancy and confinement under Minnesota Statutes, section 257.66, subdivision 3; and

C. all or a proportion of costs and fees detailed under Minnesota Statutes, section 257.69, subdivision 2.

If a reimbursement is to be made through payments to the local IV-D agency, provisions for income withholding shall be included in the proposed lump sum settlement agreement under Minnesota Statutes, section 518.611.

Subp. 5. **Protection over lump sum settlement amount.** A plan to invest the lump sum settlement to meet the child's future needs and to prevent rapid depletion of the lump sum settlement must be made part of the lump sum settlement. The plan to invest the lump sum settlement must include:

A. an agreement to deposit the lump sum settlement amount in an interest bearing account with a rate of interest based on a United States Treasury obligation that matures on the date of the child's 18th birthday;

B. provisions for making periodic payments to the child until the child is 18 years of age;

C. provisions for making the periodic payments under item B to the public agency, if the child receives AFDC or becomes eligible to receive AFDC and rights to support are assigned under Minnesota Statutes, section 256.74, subdivision 5;

D. the name of the depository that will hold and disburse the lump sum settlement under this subpart;

E. the name of the person or agency designated to make decisions on managing the lump sum settlement account; and

F. the amounts charged by the depository for the costs of administering the lump sum settlement account.

Subp. 6. **Medical benefits.** The lump sum settlement must provide for maintenance of health and dental insurance for the child under Minnesota Statutes, section 518.171.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1659 CONTENTS OF PROPOSED LUMP SUM SETTLEMENT AGREEMENT.

A proposed lump sum settlement must include:

A. the names and addresses of the parties to the paternity suit;

B. a statement indicating whether there has been an admission of paternity;

C. the amount of reimbursement agreed to be paid to the local IV-D agency and the method by which payments will be made as required under part 9500.1658, subpart 4;

D. the amount of the proposed lump sum settlement;

E. a plan for distributing the lump sum settlement amount on behalf of the child under part 9500.1658, subpart 5;

F. a written statement showing compliance with part 9500.1658, subpart 6, by the responsible parent; and

G. a signature line for each of the parties and the guardian ad litem.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1660 DOCUMENTS THAT MUST ACCOMPANY A PROPOSED LUMP SUM SETTLEMENT AGREEMENT.

The documents in items A to G must accompany the proposed lump sum settlement submitted to the commissioner:

A. the statement of blood test results or a statement that blood tests were waived by the alleged father;

B. a statement of the reasons a lump sum settlement is proposed rather than periodic payments;

C. a copy of the alleged father's affidavit of earnings, income, and resources, including real and personal property;

D. the mathematical calculation used to make the computation required under part 9500.1658, subpart 3;

E. an itemization of amounts previously expended by each public agency as support on behalf of the child, including dates and amounts of AFDC expended, pregnancy and confinement expenses, costs of blood tests, filing fees, service of process fees, and county attorney's fees;

F. a written statement showing how the plan for reimbursement of the alleged father's liability for support and costs owed to the local IV-D agency was derived; and

G. a written, signed statement from the guardian ad litem that indicates how the proposed lump sum settlement is in the best interest of the child.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1661 TIME FOR SUBMISSION OF PROPOSAL.

The proposed lump sum settlement agreement under part 9500.1659 and documents required under part 9500.1660 must be submitted to the Office of Child Support Enforcement for review at least 30 days before the date scheduled for the court hearing on the proposed lump sum settlement. If the 30-day period is not complied with, parties must not presume that the commissioner has consented to the proposed lump sum settlement unless a written statement to that effect is made by the commissioner and submitted to the parties.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1662 REVIEW PROCESS.

On receipt of a proposed lump sum settlement, the commissioner shall review the submitted proposal and documents for compliance with parts 9500.1650 to 9500.1663. If the commissioner consents to the proposal, the commissioner will sign the proposal and return it to the submitting party. If the commissioner does not consent to the proposal, the commissioner will send a letter to the submitting party indicating the reasons for not consenting to the proposal. The commissioner will send copies of either response to the court of jurisdiction. The commissioner will also send copies of either response to the other parties and guardian ad litem if addresses for those parties are provided by the submitting party.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1663 NOTIFICATION OF FINAL DISPOSITION.

If the lump sum settlement or compromise agreement is approved by the court, a copy of the final order must be provided to the commissioner within 30 days of the date of the court order. If the submitted agreement is not approved by the court, the commissioner must be notified in writing of any other disposition made regarding the paternity suit. The parties other than the commissioner must agree between themselves as to the party responsible for notification to the commissioner in accordance with this part.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

CHILD SUPPORT INCENTIVE AWARD

9500.1800 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1810 to 9500.1821, the following terms have the meanings given them.

Subp. 2. **AFDC collections.** "AFDC collections" means money paid by an individual to a county IV-D agency to satisfy an assignment of support obligation under Code of Federal Regulations, title 45, section 232.11, or United States Code, title 42, section 671(a)(17).

Subp. 3. **Collections.** "Collections" means AFDC collections and non-AFDC collections.

Subp. 4. **County IV-D agency.** "County IV-D agency" means the county agency responsible for child support enforcement to whom collections are paid.

Subp. 5. **County IV-D costs.** "County IV-D costs" means the expenditures reported quarterly by a county IV-D agency to the department for the operation of the county child support enforcement program minus amounts reported for fees, interest collected, and recovered costs.

Subp. 6. **County IV-D agency quarterly incentive award.** "County IV-D agency quarterly incentive award" means the amount of money determined quarterly by the department to reimburse the county for a portion of its contribution toward AFDC assistance payments.

Subp. 7. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 8. **Dollar amount.** "Dollar amount" means the amount of money calculated according to part 9500.1811 which is used to determine a county IV-D agency's quarterly incentive award under parts 9500.1815 and 9500.1820.

Subp. 9. **Federal fiscal year or FFY.** "Federal fiscal year" or "FFY" means the period from October 1 of each year through September 30 of the next year.

Subp. 10. **Fees.** "Fees" means money paid by individuals to a county IV-D agency for child support enforcement services.

Subp. 11. **Interest collected.** "Interest collected" means the money collected by a county IV-D agency from the obligor which represents a charge for a late payment and which is calculated as a percent of the money owed by the obligor for a certain time period.

Subp. 12. **Non-AFDC collections.** "Non-AFDC collections" means the money paid by individuals to a county IV-D agency to satisfy support obligations which have not been assigned under Code of Federal Regulations, title 45, section 232.11, and United States Code, title 42, section 671(a)(17).

Subp. 13. **Quarter.** "Quarter" means one-fourth of the federal fiscal year with the following starting and ending dates:

A. October 1 through December 31;

B. January 1 through March 31;

C. April 1 through June 30; and

D. July 1 through September 30.

Subp. 14. **Ratio.** "Ratio" means the quotient of the total of a county IV-D agency's collections for a quarter divided by the total of that county IV-D agency's county IV-D costs less optional subtractions from county IV-D costs for that quarter. This total is then truncated at one decimal place.

Subp. 15. **Recovered costs.** "Recovered costs" means a refund paid by an individual or a governmental agency to a county IV-D agency for county IV-D costs.

Subp. 16. **State's quarterly incentive award.** "State's quarterly incentive award" means the grant award issued quarterly by the federal government to the department to reimburse the county for a portion of its share of AFDC assistance payments.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1805 PURPOSE AND EFFECT.

Subpart 1. **Purpose.** The purpose of parts 9500.1800 to 9500.1821 is to encourage county IV-D agencies to make maximum child support collections in a cost effective manner through a financial incentive to counties according to Code of Federal Regulations, title 45, sections 302.55 and 303.52.

Under parts 9500.1800 to 9500.1821, county IV-D agencies are rewarded proportionately more as their collections increase and their costs decrease.

The reward the county IV-D agencies receive is in the form of money a county would otherwise have to pay as its portion of aid to families with dependent children assistance payments.

Subp. 2. **Effect.** Parts 9500.1800 to 9500.1821 apply to all Minnesota county human services or welfare departments. Effective October 1, 1985, the state will receive incentive payments from the federal government which will be passed through to the counties.

The extent to which a county IV-D agency is making maximum child support collections in a cost effective manner is measured by determining ratios of collections to costs for each county.

Ratios are translated into a percent and then into a dollar amount subject to certain limitations. Each county's proportionate share of the state's quarterly incentive award is then determined with adjustments to quarterly estimates made at the end of each federal fiscal year.

Parts 9500.1820 and 9500.1821 provide for an alternative award determination and redetermination formula for the first two years of the new award system to allow time for the less effective and efficient counties to improve ratios to the point that they may earn higher incentive awards under the new system.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1810 RATIO DETERMINATION.

Subpart 1. **Time frame.** The department shall use the county IV-D costs and collections reported by a county IV-D agency to the department in a quarter to determine the ratio for that quarter.

Subp. 2. **Collections credited to the county IV-D agency that makes collections on behalf of another Minnesota county IV-D agency.** Each county IV-D agency shall identify collections made on behalf of another Minnesota county IV-D agency and shall credit those collections only to the county IV-D agency that makes the collection.

Subp. 3. **Optional subtractions from county IV-D costs.** At the option of the county IV-D agency, certain costs incurred and reported to the department in determining paternity may be subtracted from county IV-D costs. These costs are costs incurred for:

A. drawing and shipping blood;

B. testing and retesting blood; and

C. human leucocyte antigen (HLA) testing.

Subp. 4. **Separate ratios.** The department shall determine separate ratios for AFDC and non-AFDC collections.

Subp. 5. **Ratio to percent.** Based on ratios determined under subparts 1 to 4, the department shall use the following schedule to determine the corresponding percent of a county IV-D agency's collections to be used in determining each county IV-D agency's dollar amounts under part 9500.1811.

Ratio		Percent
	.1 or less	3.0
at least	.2	3.5

.4		4.0
.6		4.5
.8		5.0
1.0		5.5
1.2		6.0
1.4		6.5
1.6		7.0
1.8		7.5
2.0		8.0
2.2		8.5
2.4		9.0
2.6		9.5
2.8	or more	10.0

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1811 QUARTERLY DETERMINATION OF DOLLAR AMOUNTS.

The department shall determine a county IV-D agency's quarterly AFDC dollar amount by multiplying the county's AFDC collections by the percent determined under part 9500.1810, subpart 5. The department shall determine a county IV-D agency's quarterly non-AFDC dollar amount by multiplying the county's non-AFDC collections by the percent determined under part 9500.1810, subpart 5.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1812 LIMIT ON QUARTERLY DETERMINATION OF DOLLAR AMOUNT OF NON-AFDC COLLECTIONS.

The department shall limit each quarterly determination of the dollar amount of non-AFDC collections for each county IV-D agency as determined under part 9500.1811, to a percentage of its quarterly AFDC dollar amount as follows:

A. up to 100 percent in FFY 1986 and FFY 1987;

B. up to 105 percent in FFY 1988;

C. up to 110 percent in FFY 1989; and

D. up to 115 percent in FFY 1990 and thereafter.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1815 DISTRIBUTION FORMULA.

The department shall determine each county IV-D agency's share of the state's quarterly incentive award for AFDC collections and each county IV-D agency's share of the state's quarterly incentive award for non-AFDC collections according to the formula in items A to F. Within 45 working days after the end of the quarter, the department shall inform each county IV-D agency of the determinations. The department shall add the AFDC and non-AFDC determinations for each county and pay the total amount to that county.

A. Add all county IV-D agency quarterly AFDC dollar amounts as determined in part 9500.1811.

B. Divide the state's quarterly AFDC incentive award by the total obtained in item A.

C. Multiply the quotient obtained in item B by each county IV-D agency's quarterly AFDC dollar amount as determined under part 9500.1811.

D. The product obtained in item C is the county IV-D agency's quarterly AFDC incentive award.

E. To determine a county IV-D agency's quarterly non-AFDC incentive award, the department shall follow the steps in items A to C except that it shall use the county IV-D agency's quarterly non-AFDC dollar amounts in item A instead of AFDC dollar amounts, subject to the limitations of part 9500.1812.

F. The county IV-D agency's quarterly incentive awards determined in items D and E are subject to the determinations in parts 9500.1817 to 9500.1821.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1817 ADJUSTMENTS.

Within 30 working days after the department receives the state's quarterly incentive award for the last quarter of the federal fiscal year that adjusts the estimated federal quarterly incentive awards received by the state to the actual incentive award earned by the state under Code of Federal Regulations, title 45, section 303.52(c)(3), the department shall notify each county IV-D agency of any increase or decrease in the county IV-D agency's next quarterly incentive award. This increase or decrease must be added to or subtracted from the state's quarterly incentive award for the next quarter as determined in part 9500.1815.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1820 FEDERAL FISCAL YEAR 1986 AND 1987 ALTERNATIVE INCENTIVE AWARD DETERMINATION.

For federal fiscal years 1986 and 1987, the department shall determine the yearly incentive awards for county IV-D agencies according to items A to H.

A. Determine each county IV-D agency's yearly incentive award according to United States Code, title 42, section 658 as effective for federal fiscal year 1985.

B. Multiply each of the amounts determined in item A by 0.80.

C. Multiply each of the amounts in item A by 0.81.

D. Determine an incentive award for each county according to part 9500.1817.

E. Designate as a county IV-D agency's incentive award the higher of the results obtained under items B and D.

F. Identify those county IV-D agency incentive awards from item E whose corresponding incentive award under item B is higher than the result obtained under item D.

G. Identify those county IV-D agency incentive awards from item E whose corresponding incentive award in item D is higher than in item C.

H. If a county IV-D agency's incentive award is not in item F or G, then the incentive award is the determination made in item B.

I. No further determinations are necessary if all incentive awards are included in item F.

J. All incentive awards must be redetermined according to part 9500.1821 if one or more incentive awards are included in item G.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1821 REDETERMINATION OF INCENTIVE AWARDS FOR FEDERAL FISCAL YEARS 1986 AND 1987.

When directed by part 9500.1820, item J, the department shall make the following redeterminations.

A. Add the incentive awards identified under part 9500.1820, items F

and H. This amount equals 80 percent of what the incentive award would be if determined under the incentive award system in effect for federal fiscal year 1985.

B. Add the incentive awards identified under part 9500.1820, item G.

C. Add the totals obtained in items A and B.

D. Subtract the total obtained in item C from the state's yearly incentive award.

E. Divide the result, without regard to sign, obtained in item D by the total obtained in item B.

F. Multiply the quotient obtained in item E by each county IV-D agency's incentive award included from item B.

G. Add the products in item F.

H. Item G is the redetermination adjustment to be subtracted from those counties identified in item B.

I. To apply the redetermination adjustment for those counties of item A, subtract their award from part 9500.1817 from the total identified in item A. This is the amount that is to be paid to the counties.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

ADMINISTRATION OF AID TO FAMILIES WITH DEPENDENT CHILDREN

9500.2000 SCOPE.

Parts 9500.2000 to 9500.2880 govern the administration of the aid to families with dependent children program in Minnesota. The aid to families with dependent children program provides financial assistance to qualifying families, according to assistance payment standards authorized in Minnesota law, to help them provide their children with a reasonable subsistence compatible with decency and health. Parts 9500.2000 to 9500.2880 must be read in conjunction with Minnesota Statutes, chapter 256; title IV of the Social Security Act; and Code of Federal Regulations, title 45.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2020 ADMINISTRATION.

Subpart 1. **Compliance with state and federal law.** The commissioner shall cooperate with the federal government in order to qualify for federal financial participation in the aid to families with dependent children program. Changes to the aid to families with dependent children program required by state or federal law or by court order supersede parts 9500.2000 to 9500.2880. The changes are effective on the date specified in bulletins or manuals issued by the commissioner to a local agency.

Subp. 2. **Administrative relationships.** The aid to families with dependent children program is administered by local agencies under the supervision of the commissioner.

The commissioner shall supervise the aid to families with dependent children program on a statewide basis so that local agencies comply with the standards of the program.

A local agency shall provide fair and equal treatment to an applicant or recipient according to statewide policies. The commissioner is authorized to direct a local agency to correct a policy or practice that conflicts with statewide program requirements. A local agency shall comply with procedures and forms prescribed by the commissioner of human services in bulletins and manuals to assure conformance with parts 9500.2000 to 9500.2880.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2060 DEFINITIONS.

Subpart 1. **Applicability.** The terms used in parts 9500.2000 to 9500.2880 have the meanings given them in subparts 2 to 154 unless otherwise indicated.

Subp. 2. **Absent parent.** "Absent parent" means the parent of a dependent child who does not live in the child's home.

Subp. 3. **Actual availability.** "Actual availability," when used in reference to income or property, is that which is in-hand or which can be readily obtained for current use.

Subp. 4. **Affidavit.** "Affidavit" means a written declaration made under oath before a notary public or other authorized officer.

Subp. 5. **Agency error.** "Agency error" means an error that results in an overpayment which is not caused by an applicant's or recipient's failure to provide adequate, correct, or timely information about income, property, or other circumstances.

Subp. 6. **Aid to families with dependent children or AFDC.** "Aid to families with dependent children" or "AFDC" means the program authorized under title IV-A to provide financial assistance and social services to needy families with dependent children.

Subp. 7. **AFDC family allowance.** "AFDC family allowance" means the standardized Minnesota need and assistance payment schedule for assistance units of various compositions. An assistance unit's net income is subtracted from the AFDC family allowance to determine the amount of that assistance unit's monthly assistance payment.

Subp. 8. **AFDC housing allowance.** "AFDC housing allowance" means those payments authorized under Minnesota Statutes, section 256.879 and described in part 9500.2800, subpart 2.

Subp. 9. **AFDC unit.** "AFDC unit" means the organizational entity within a local agency which is responsible for determining program eligibility and the amount of assistance payment.

Subp. 10. **Appeal.** "Appeal" means a written statement from an applicant or recipient which requests a hearing or expresses dissatisfaction with a local agency decision that can be challenged under Minnesota Statutes, section 256.045 and part 9500.2740, subpart 8.

Subp. 11. **Applicant.** "Applicant" means a person for whom an application has been submitted to a local agency, and whose application has not been approved, denied, nor voluntarily withdrawn.

Subp. 12. **Application.** "Application" means the action by which a person shows in writing a desire to receive assistance by submitting a signed and dated form prescribed by the commissioner to the local agency.

Subp. 13. **Assignment of support.** "Assignment of support" means the transfer of a person's right to support to a local agency.

Subp. 14. **Assistance.** "Assistance" means a financial benefit received from the aid to families with dependent children program.

Subp. 15. **Assistance unit.** "Assistance unit" means a group of persons who are applying for or receiving assistance and whose needs are included in the assistance payment issued under Minnesota Statutes, sections 256.72 to 256.87.

Subp. 16. **Authorized representative.** "Authorized representative" means a person who is authorized in writing by an applicant or recipient to act on that applicant's or recipient's behalf in matters involving AFDC or emergency assistance, including submitting applications, making appeals, and providing or requesting information. An authorized representative may exercise the same rights and

responsibilities on behalf of the person being represented as an applicant or recipient.

Subp. 17. **Basic needs.** "Basic needs" means food, clothing, shelter, utilities, personal hygiene items, and other subsistence items.

Subp. 18. **Blood related.** "Blood related" means a person who is related by birth rather than by marriage or adoption.

Subp. 19. **Budget month.** "Budget month" means the calendar month from which a local agency uses the income or circumstances of an assistance unit to determine the amount of the assistance payment for the payment month.

Subp. 20. **Care.** "Care" means regular and ongoing supervision and provision of services such as feeding, dressing, and cleaning.

Subp. 21. **Caretaker.** "Caretaker" means a person listed in part 9500.2440, subpart 7 who lives with and provides care to a dependent child.

Subp. 22. **Case record.** "Case record" means the eligibility file of a particular assistance unit.

Subp. 23. **Children standard.** "Children standard" means the portion of the AFDC family allowance so named in part 9500.2440, subpart 5, item A.

Subp. 24. **Child support enforcement unit.** "Child support enforcement unit" means the organizational entity within a county which is responsible for establishing paternity and collecting support according to Title IV-D of the Social Security Act.

Subp. 25. **Child support pass through.** "Child support pass through" means the payment authorized under Code of Federal Regulations, title 45, section 302.51(b)(1).

Subp. 26. **Child welfare funds.** "Child welfare funds" means funds issued under Title IV-B.

Subp. 27. **Civil judgment.** "Civil judgment" means a money judgment rendered by a court of competent jurisdiction.

Subp. 28. **Client error.** "Client error" means an error that results in an overpayment which is due to an applicant's or recipient's failure to provide adequate, correct, or timely information concerning income, property, or other circumstances or a recipient's choice to continue assistance while an appeal is pending.

Subp. 29. **Commissioner.** "Commissioner" means the commissioner of the department or the commissioner's designee.

Subp. 30. **Community Social Services Act.** "Community Social Services Act" means the system of planning for and providing community social services authorized under Minnesota Statutes, chapter 256E.

Subp. 31. **Community work experience program.** "Community work experience program" means the program authorized under Code of Federal Regulations, title 45, part 238.

Subp. 32. **Corrective payment.** "Corrective payment" means an assistance payment which is made to correct an underpayment.

Subp. 33. **Cost effective.** "Cost effective" refers to a result that is economical in terms of the goods and services received for the money spent, given feasible alternatives, or a result in which the cost is less than the value of the benefit received.

Subp. 34. **County board.** "County board" means the board of commissioners in each county established under Minnesota Statutes, chapter 393.

Subp. 35. **County of financial responsibility.** "County of financial responsibility" means the county liable for the county share of a recipient's assistance.

Subp. 36. **County of residence.** "County of residence" means the county providing AFDC administrative services to an applicant or recipient.

Subp. 37. **Date of application.** "Date of application" means the date on which a local agency receives a person's application.

Subp. 38. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 39. **Dependent child.** "Dependent child" means a child who is living in the home of a parent or other caretaker, who is deprived of the support or care of a parent as specified in parts 9500.2180 to 9500.2300, who is in financial need according to part 9500.2480, and who meets one of the conditions in items A to C:

A. is less than 18 years of age;

B. is 18 years of age and is a full-time student, as defined in subpart 58, item A, B, or F, at an accredited high school or its equivalent, and is expected to graduate or complete the school program before reaching age 19; or

C. is 18 years of age and is a full-time student, as defined in subpart 58, item C.

Subp. 40. **Deregistration from WIN.** "Deregistration from WIN" means the action taken through the WIN program by the Minnesota Department of Jobs and Training to remove a person from that program.

Subp. 41. **Disregard.** "Disregard" means a deduction from income as authorized under the Code of Federal Regulations, title 45, part 233.

Subp. 42. **Documentation.** "Documentation" means a written statement or record which substantiates or validates an assertion made by a person or an action taken by a local agency. "Primary documentation" means evidence that independently establishes a fact and that is provided by a public or private institution or organization having an official responsibility to establish that fact. "Alternative documentation" means evidence, including declarations, that supports the existence of a fact and that is provided by an individual or institution who has no official responsibility to establish that fact.

Subp. 43. **Early and periodic screening, diagnosis, and treatment or EPSDT.** "Early and periodic screening, diagnosis, and treatment" or "EPSDT" means the program authorized under Title XIX and which operates under parts 9505.1500 to 9505.1690.

Subp. 44. **Earned income.** "Earned income" means compensation from legal employment or legal self-employment, including salaries, wages, tips, gratuities, commissions, net profits from self-employment, earned income tax credits, incentive payments from work or training programs except those excluded in part 9500.2380, subpart 2, payments made by an employer for regularly accrued vacation or sick leave, and profit from other legal activity earned by an applicant's or recipient's effort or labor. Earned income does not include returns from capital investment or benefits that accrue as compensation or reward for service or for lack of employment.

Subp. 45. **Earned income tax credit.** "Earned income tax credit" means the payment which can be obtained by a qualified low income person from an employer or from the United States Internal Revenue Service under provisions of United States Code, title 26, section 32, as amended through December 31, 1985.

Subp. 46. **Emancipated minor.** "Emancipated minor" means a person under the age of 18 years who has been married, is on active duty in the uniformed services of the United States, or who has been emancipated by a court of competent jurisdiction.

Subp. 47. **Emergency.** "Emergency" means a situation that causes, or threatens to cause, a lack of a basic need item and the lack of resources to provide for that need.

Subp. 48. **Emergency assistance.** "Emergency assistance" means assistance

and services funded under Title IV-A, authorized under Minnesota Statutes, section 256.871 and Code of Federal Regulations, title 45, section 233.120, and governed by part 9500.2820.

Subp. 49. **Encumbrance.** "Encumbrance" means a legal claim against real or personal property that is payable upon the sale of that property.

Subp. 50. **Equity value.** "Equity value" means the amount of equity in real or personal property owned by a person. Equity value is determined by subtracting any outstanding encumbrances from the fair market value.

Subp. 51. **Fair hearing or hearing.** "Fair hearing" or "hearing" means the department evidentiary hearing conducted by an appeals referee to determine whether an applicant or recipient is eligible for assistance or has received an incorrect amount of assistance.

Subp. 52. **Fair market value.** "Fair market value" means the price that an item of a particular make, model, size, material, or condition would sell for on the open market in the particular geographic area.

Subp. 53. **Federal and state AFDC participation.** "Federal and state AFDC participation" means the federal and state aid to a local agency for AFDC expenditures as specified under Code of Federal Regulations, title 45, part 237, and Minnesota Statutes, sections 256.82 and 256.871, subdivision 6.

Subp. 54. **Federal Insurance Contributions Act or FICA.** "Federal Insurance Contributions Act" or "FICA" means the federal law under United States Code, title 26, sections 3101 to 3126, that requires withholding or direct payment from earned income.

Subp. 55. **Financially responsible household members.** "Financially responsible household members" means spouses, parents of dependent children and minor caretakers, legal guardians of minor caretakers, and stepparents of dependent children to the extent authorized by federal and state law.

Subp. 56. **Filing unit.** "Filing unit" means a dependent child, any blood related and adoptive minor siblings, and any natural and adoptive parents who live in the same household.

Subp. 57. **First adult standard.** "First adult standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item B.

Subp. 58. **Full-time student.** "Full-time student" means a person who is:

A. enrolled in a primary, intermediate, or secondary school and attending classes at least 20 hours a week, of which up to half may be satisfied by employment which is approved through a work study program of the school in which the person is enrolled, or enrolled in and making satisfactory progress in a graded educational program approved by the school district when a physical, emotional, or mental impairment prevents classroom attendance;

B. enrolled in a trade or technical school or in GED preparatory training which provides certification equivalent to a secondary education and attending at least 20 hours a week, of which up to half may be satisfied by employment which is approved through a work study program of the school in which the person is enrolled;

C. enrolled in and attending classes at least 20 hours a week in an ungraded educational or vocational program approved by the school district because that person has a physical, emotional, or mental impairment which precludes graded coursework;

D. enrolled in and attending a postsecondary vocational school for at least 20 hours a week, including the time spent in shop practice;

E. registered for and attending classes which total at least 12 quarter or semester credits at an accredited college or university; or

F. enrolled in a graded or ungraded primary, intermediate, secondary,

trade, technical, or vocational school, and attending that school when the school documents, at the request of the student, that the student meets the school's standard for full-time attendance.

Subp. 59. **GED.** "GED" means the general educational development certification issued by the Minnesota Board of Education as an equivalent to a secondary school diploma under part 3500.3100, subpart 4.

Subp. 60. **General assistance.** "General assistance" means the financial aid program authorized under Minnesota Statutes, chapter 256D.

Subp. 61. **General assistance medical care.** "General assistance medical care" means the program defined under Minnesota Statutes, section 256D.02, subdivision 4a.

Subp. 62. **Good cause.** "Good cause" means, generally, the circumstances, including those specified in parts 9500.2700, subparts 6, item C; 8, item B; 12; and 19; and 9500.2740, subpart 8, which are allowed to excuse a person's failure to comply with specified requirements or to meet specific conditions of eligibility.

Subp. 63. **Gross income.** "Gross income" means income, except for in-kind income, before any withholdings, deductions, disregards, or exclusions. When earnings are from self-employment, gross income is the difference between gross receipts and allowable expenses as provided in part 9500.2380, subpart 5.

Subp. 64. **Gross receipts.** "Gross receipts" means the money received by a business before the expenses of the business are deducted.

Subp. 65. **Guidance.** "Guidance" means regular and ongoing services provided to a dependent child, including supervision, training, discipline, and help with schoolwork.

Subp. 66. **Home.** "Home" means the primary place of residence used by a person as the base for day-to-day living and does not include locations used as maildrops.

Subp. 67. **Homestead.** "Homestead" means the real property used by a person as his or her home, as defined in Minnesota Statutes, section 256.73, subdivision 2, clause (1).

Subp. 68. **Household.** "Household" means a group of persons who live together.

Subp. 69. **Household report form.** "Household report form" means a form prescribed by the commissioner which an applicant or recipient uses to report information to a local agency about income and other circumstances according to part 9500.2700, subparts 5 to 7. The household report form is incorporated by reference. It is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota. It is subject to frequent change.

Subp. 70. **Incapacity.** "Incapacity" means the presence of a temporarily or permanently debilitating physical or mental condition which is expected to continue for a minimum of 30 days, and which reduces or eliminates the ability of a person to hold substantial gainful employment or which substantially reduces or eliminates a person's ability to care for his or her children with whom he or she lives. A person who has had disability status conferred by the Social Security Administration meets the definition of incapacity.

Subp. 71. **Income.** "Income" means cash or in-kind benefit, whether earned or unearned, received by or available to an applicant or recipient and not established as an asset under part 9500.2340.

Subp. 72. **In-kind income.** "In-kind income" means income, benefits, or payments which are provided in a form other than money or liquid asset, including the forms of goods, produce, services, privileges, or payments made on behalf of a person by a third-party.

Subp. 73. **Inquiry.** "Inquiry" means a communication to a local agency through mail, telephone, or in person, by which a parent, caretaker of minor

children, or authorized representative requests information about AFDC or emergency assistance. The local agency shall also treat as an inquiry any communication in which a person requesting assistance offers information about his or her family's circumstances which indicates that eligibility for AFDC or emergency assistance may exist.

Subp. 74. **Job Training Partnership Act.** "Job Training Partnership Act" means the act authorized under Public Law Number 97-300 and its successor programs.

Subp. 75. **Joint legal custody.** "Joint legal custody" means a court ordered arrangement under which both parents have equal rights and responsibilities, including the right to participate in major decisons determining the child's upbringing, including education, health care, and religious training.

Subp. 76. **Joint physical custody.** "Joint physical custody" means an arrangement under which the routine daily care and control of a child is divided between both parents.

Subp. 77. **Legal availability.** "Legal availability" means a person's right under the law to secure, possess, dispose of, or control income or property.

Subp. 78. **Legal guardian.** "Legal guardian" means a person or persons designated by a court to assume, on a temporary or permanent basis, those rights and responsibilities for a child that would otherwise be assigned to a parent.

Subp. 79. **Licensed adoption agency.** "Licensed adoption agency" means a public or private agency which is licensed to place children for adoption under Minnesota Statutes, sections 259.21 to 259.49.

Subp. 80. **Licensed physician.** "Licensed physician" means a person who is licensed to provide medical services within the scope of his or her profession under Minnesota Statutes, chapter 147.

Subp. 81. **Licensed psychologist.** "Licensed psychologist" means a person who is licensed or certified to act in that capacity under Minnesota Statutes, sections 148.88 to 148.98.

Subp. 82. **Local agency.** "Local agency" means a county or multicounty agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7, and 393.07, subdivision 2, to administer AFDC.

Subp. 83. **Lockout.** "Lockout" means an action taken by an employer to refuse entry of an employee due to a labor dispute which is in progress at the worksite.

Subp. 84. **Low income home energy assistance program or LIHEAP.** "Low income home energy assistance program" or "LIHEAP" means the program authorized under United States Code, title 42, sections 8621 to 8629 and administered by the Minnesota Department of Jobs and Training.

Subp. 85. **Lump sum.** "Lump sum" means nonrecurring income which is not excluded in part 9500.2380, subpart 2.

Subp. 86. **Maildrop.** "Maildrop" means an address or post office box which does not represent the actual home of the addressee and is used primarily for the receipt of mail or the establishment of AFDC eligibility.

Subp. 87. **Mandatory registrant.** "Mandatory registrant" means a person who is required to register for WIN, employment, or other employment activities as a condition of AFDC eligibility under part 9500.2700, subpart 16.

Subp. 88. **Medical assistance.** "Medical assistance" means the program established under title XIX and Minnesota Statutes, chapter 256B.

Subp. 89. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 90. **Minor caretaker.** "Minor caretaker" means

A. a person under the age of 18 years or who is age 18 and meets the definition of a dependent child under subpart 39; and

B. who has applied as a caretaker on behalf of himself or herself and his or her dependent child.

Subp. 91. **Net income.** "Net income" means the countable income remaining after allowable deductions, disregards, and exclusions have been subtracted from gross income.

Subp. 92. **Nonrecurring income.** "Nonrecurring income" means a form of income which:

A. is received only one time or is not of a continuous nature; or

B. is received in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subp. 93. **Non-WIN county.** "Non-WIN county" means a county which does not operate a WIN program within its boundaries.

Subp. 94. **Occupational Safety and Health Administration.** "Occupational Safety and Health Administration" means that organizational part of the United States Department of Labor.

Subp. 95. **Overpayment.** "Overpayment" means an assistance payment, resulting from a calculation error, a client reporting error, a misapplication of existing program requirements by a local agency, or changes in payment eligibility that cannot be effected due to notification requirements in part 9500.2740, subpart 7, which is greater than the amount for which an assistance unit is eligible.

Subp. 96. **Parent.** "Parent" means a child's natural or adoptive parent who is legally obligated to support that child.

Subp. 97. **Payee.** "Payee" means a person to whom an assistance payment is made.

Subp. 98. **Payment eligibility test.** "Payment eligibility test" means an eligibility test applied to income after the gross income test is satisfied.

Subp. 99. **Payment month.** "Payment month" means the calendar month for which assistance is paid.

Subp. 100. **Personal property.** "Personal property" means an item of value which is not real property, including the value of a contract for deed held by a seller, assets held in trust on behalf of members of an assistance unit, cash surrender value of life insurance, value of a prepaid burial, savings account, value of stocks and bonds, and value of retirement accounts.

Subp. 101. **Principal wage earner.** "Principal wage earner" means the parent who has earned the greater amount of income in the 24 months preceding application for assistance, subject to the conditions in part 9500.2300.

Subp. 102. **Probable fraud.** "Probable fraud" means the level of evidence that, if proven as fact, will establish that assistance has been wrongfully obtained.

Subp. 103. **Program.** "Program" means the aid to families with dependent children program.

Subp. 104. **Prospective.** "Prospective" means anticipating conditions in a future period, normally the following month.

Subp. 105. **Prospective budgeting.** "Prospective budgeting" means a method of determining the amount of assistance in which the budget month and payment month are the same.

Subp. 106. **Protective payee.** "Protective payee" means a person other than the caretaker of an assistance unit who receives the monthly assistance payment on behalf of an assistance unit and is responsible to provide for the basic needs of the assistance unit to the extent of that payment.

Subp. 107. **Protective payment.** "Protective payment" means the assistance payment made to a protective payee.

Subp. 108. **Quality child care program.** "Quality child care program" means the program authorized under Code of Federal Regulations, title 7, part 226.

Subp. 109. **Quality control review process.** "Quality control review process" means the review process required under Code of Federal Regulations, title 45, sections 205.40 to 205.44.

Subp. 110. **Quarter of work.** "Quarter of work" means a calendar quarter in which a principal wage earner meets the qualifications of part 9500.2300, item G.

Subp. 111. **Real property.** "Real property" means the land itself and all buildings, structures, and improvements, or other fixtures on it, belonging or appertaining to the land, and all mines, minerals, fossils, and trees on or under it.

Subp. 112. **Reasonable compensation.** "Reasonable compensation" means the value received in exchange for property transferred to another owner which equals or exceeds the seller's equity in the property, reduced by costs incurred in the sale.

Subp. 113. **Recipient.** "Recipient" means a person who is currently receiving assistance. A person who returns an uncashed assistance check and withdraws from the program is not a recipient. A person who receives and cashes an assistance check and is subsequently determined to be ineligible for assistance for that period of time is a recipient, regardless of whether that assistance is repaid. The term "recipient" includes the caretaker relative and the dependent child whose needs are included in the assistance payment. A person in an assistance unit who does not receive an assistance check because he or she has been suspended from AFDC or because his or her need falls below the $10 minimum payment level is a recipient.

Subp. 114. **Recoupment.** "Recoupment" means the actions taken by a local agency to reduce one or more monthly assistance payments in order to reclaim the value of overpayments, according to part 9500.2620, items C and D.

Subp. 115. **Recovery.** "Recovery" means actions taken by a local agency to reclaim the value of overpayments through voluntary repayment, recoupment from the assistance payment, or court actions.

Subp. 116. **Recurring income.** "Recurring income" means a form of income which:

A. is received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

B. is from the same source or of the same type that is received and budgeted in a prospective month and is received in one or both of the first two retrospective months.

Subp. 117. **Redetermination of eligibility.** "Redetermination of eligibility" means the process by which information is collected periodically by a local agency and used to determine a recipient's continued eligibility for AFDC.

Subp. 118. **Residence.** "Residence" means the county in which a child lives according to Minnesota Statutes, section 256.79 and part 9500.2140.

Subp. 119. **Retrospective.** "Retrospective" means looking back on conditions in a past month.

Subp. 120. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of assistance in which the payment month is the second month after the budget month.

Subp. 121. **Second adult standard.** "Second adult standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item C.

Subp. 122. **Secondary school.** "Secondary school" means a school which is accredited by the Minnesota Department of Education as a secondary school under Minnesota Statutes, section 120.05, subdivision 2 or equivalent level technical or vocational school or an educational program which provides a GED.

Subp. 123. **Settlement.** "Settlement" means a resolution of financial responsibility by the commissioner when there is a dispute between or among local agencies concerning which county is financially responsible for a person's assistance.

Subp. 124. **Social Security Act.** "Social Security Act" means the act authorized under United States Code, title 42, sections 301 to 1399.

Subp. 125. **Social Security Administration.** "Social Security Administration" means that organizational part of the United States Department of Health and Human Services.

Subp. 126. **Social services.** "Social services" means the services included in a county's community social services plan which are administered by the county board as described under Minnesota Statutes, section 256E.03, subdivision 2.

Subp. 127. **Special adult standard.** "Special adult standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item E.

Subp. 128. **Special child standard.** "Special child standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item D.

Subp. 129. **State medical review team.** "State medical review team" means the person or group of persons designated by the commissioner to determine incapacity under part 9500.2220.

Subp. 130. **Statewide administration.** "Statewide administration" means the administration of uniform program standards throughout Minnesota.

Subp. 131. **Strike.** "Strike" means the action by employees defined under Minnesota Statutes, section 179.01.

Subp. 132. **Substantial gainful employment.** "Substantial gainful employment" means employment which averages at least 30 hours per week on a monthly basis and which is compensated at the level of the federal minimum wage or at the minimum standard for that employment in a geographic area, whichever is greater.

Subp. 133. **Supplemental security income.** "Supplemental security income" means the program authorized under title XVI of the Social Security Act.

Subp. 134. **Support.** "Support" means the provision of financial assistance, exclusive of payments-in-kind, by an absent parent to a caretaker or a local agency. Support includes the payments made to or on behalf of an eligible child or payments made to or on behalf of the caretaker.

Subp. 135. **Title IV-A.** "Title IV-A" means that part of the Social Security Act.

Subp. 136. **Title IV-B.** "Title IV-B" means that part of the Social Security Act.

Subp. 137. **Title IV-E.** "Title IV-E" means that part of the Social Security Act.

Subp. 138. **Title XIX.** "Title XIX" means that part of the Social Security Act.

Subp. 139. **Title XX.** "Title XX" means that part of the Social Security Act.

Subp. 140. **Two-party payment.** "Two-party payment" means an assistance payment issued by a local agency to a caretaker and another person jointly so that neither party can liquidate the payment without the signature of the other party.

Subp. 141. **Underpayment.** "Underpayment" means an assistance payment, resulting from a calculation error, a client reporting error, or a misapplication of program requirements by a local agency, which is less than the amount for which an assistance unit is eligible.

Subp. 142. **Unearned income.** "Unearned income" means income received by a person which does not meet the definition of earned income. Unearned

income includes interest, dividends, unemployment compensation, disability insurance payments, veterans benefits, pension payments, return on capital investment, insurance payments or settlements, and severance payments.

Subp. 143. **Unemployment compensation.** "Unemployment compensation" means the insurance benefit paid to an unemployed worker under Minnesota Statutes, sections 268.03 to 268.231.

Subp. 144. **Uniformed services.** "Uniformed services" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, and National Oceanographic and Atmosphere Administration.

Subp. 145. **Unsubsidized employment.** "Unsubsidized employment" means employment under which the wage or salary is paid exclusively from private funds of the employer without sharing or direct incentive payments from the WIN, community work experience, Job Training Partnership Act, or similar governmental work experience program.

Subp. 146. **Vendor.** "Vendor" means a provider of goods or services.

Subp. 147. **Vendor payment.** "Vendor payment" means a payment made by a local agency directly to a vendor.

Subp. 148. **Verification.** "Verification" means the process a local agency uses to establish the accuracy or completeness of information from an applicant, a recipient, a third party, or other source as that information relates to program eligibility or the assistance payment.

Subp. 149. **Water and sewer system.** "Water and sewer system" means the fixed structures required to provide water to and to dispose of sewage from a home. The water and sewer system includes the interior plumbing of a house, exterior water and sewer mains, drainage fields, cisterns, cesspools, wells, and pumps.

Subp. 150. **Welfare fraud.** "Welfare fraud" means those actions through which assistance is wrongfully obtained and which are actionable as theft under Minnesota Statutes, section 256.98.

Subp. 151. **Willfully or intentionally.** "Willfully" or "intentionally" means knowing or having reason to know the consequences of one's action or failure to act.

Subp. 152. **Work incentive program or WIN.** "Work incentive program" or "WIN" means the program authorized under title IV-C of the Social Security Act and administered by the Minnesota Department of Jobs and Training.

Subp. 153. **Work study program.** "Work study program" means a program operated or approved by a secondary school which allows a student to earn academic credit by working for a public or private sector employer.

Subp. 154. **Wrongfully obtaining assistance.** "Wrongfully obtaining assistance" means:

A. the action of an applicant or recipient to willfully or intentionally withhold, conceal, or misrepresent information which results in a household's receipt of assistance in excess of the amount for which it is eligible under the program and the eligibility basis claimed by the applicant or recipient;

B. the receipt of real or personal property by a person without providing reasonable compensation and for the known purpose of creating another person's eligibility for assistance; or

C. the action of a person to conspire with or knowingly aid or abet another person to wrongfully obtain assistance.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2100 APPLICATION FOR ASSISTANCE.

Subpart 1. **Where to apply.** A person who wishes to apply for assistance shall apply at the local agency in the county in which that person lives.

Subp. 2. **Local agency responsibility to provide information.** A local agency shall inform a person who inquires about the program's eligibility requirements and how to apply for AFDC. A local agency shall offer the person brochures developed or approved by the commissioner that describe how to apply for AFDC.

Subp. 3. **Application form and accompanying advisory.** A local agency shall offer, by hand or mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the local agency shall inform the person that, if the person is found eligible, the local agency must use the date the application form was submitted to the local agency as the starting point for computing assistance, and that any delay in submitting an application form will reduce the amount paid for the month of application. A local agency shall inform a person that the person may submit an application before an interview appointment. A local agency shall log inquiries for information about assistance. Logs must contain the name of the person making the inquiry, the date of inquiry, the name of the local agency staff member who receives the inquiry, and the content of the inquiry.

To apply for assistance, a person shall submit an application form to a local agency. Upon receipt of an application, a local agency shall stamp the date of receipt on the face of the application.

An applicant may withdraw his or her application at any time by giving written or oral notice to the local agency. The local agency shall issue a written notice confirming the withdrawal. The notice must inform the applicant of the local agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a local agency in writing that he or she does not wish to withdraw the application, the local agency shall reinstate the application and finish processing the application.

Subp. 4. **Assessment of and issuance for initial needs.** When a person inquires about assistance, a local agency shall ask the person if immediate or emergency needs exist. When a person has emergency needs, the local agency shall determine that person's eligibility for emergency assistance unless the person's needs can be met through other sources or by promptly processing an application for monthly assistance.

A. When emergency assistance payment is issued for a person who makes application for AFDC, and that person is later determined to be eligible for assistance, the issuance under emergency assistance must be considered an assistance payment when:

(1) the emergency assistance payment is issued for basic needs included in the AFDC family allowance standard;

(2) the emergency assistance payment is issued for current needs for a payment month or months in which that person is also eligible for assistance; and

(3) the emergency assistance payment for a month does not exceed the amount that person is eligible to receive under part 9500.2620.

B. When a person qualifies under item A, subitems (1) and (2) must apply.

(1) When all of the emergency assistance payment is later counted as an assistance payment, the person shall not be considered a recipient of emergency assistance, and the limitations under part 9500.2820, subpart 12 must not apply.

(2) When emergency assistance payment for a current month's need is less than the assistance payment determined under part 9500.2620 for that same month, additional assistance must be issued for the difference.

C. When an emergency does not exist, a local agency may issue assist-

ance before it completes the verification of eligibility. However, when an applicant is later found ineligible for that assistance, the local agency may not claim federal or state AFDC financial participation in the cost of the assistance issued. When federal and state AFDC financial participation is not available, the local agency may request general assistance state financial participation retroactive to the date of application for AFDC according to general assistance payment standards if the applicant was eligible for that program.

Subp. 5. **Verification of information on application.** A local agency shall verify information provided by an applicant as specified in part 9500.2420.

Subp. 6. **Processing application.** Upon receiving an application, a local agency shall determine the applicant's program eligibility, approve or deny the application, inform the applicant of its decision according to part 9500.2740, subpart 5, and issue assistance when the applicant is eligible. When a local agency is unable to process an application within 45 days, the local agency shall inform the applicant of the reason in writing. When an applicant establishes the inability to provide required verification within the 45-day processing period, the local agency may not use the expiration of that period as the basis for denial.

Subp. 7. **Invalid reason for delay.** A local agency shall neither delay a decision on program eligibility nor delay issuing assistance:

A. by treating the 45-day processing period as a waiting period, except as provided in part 9500.2300, item E;

B. by delaying approval or issuance of assistance pending the decision of the county board;

C. by delaying issuance of initial assistance checks more than seven calendar days to accommodate the county's check issuance schedule;

D. for remaining family members when WIN registration requirements in part 9500.2700, subpart 16 have not been met by a mandatory registrant, unless that registrant is a nonexempt principal wage earner; or

E. by awaiting the result of a referral to a local agency in another county when the county receiving the application does not believe it is the county of financial responsibility.

Subp. 8. **Changes in residence during application.** The requirements of subparts 6 and 7 apply without regard to the length of time that an applicant remains, or intends to remain, a resident of the county in which application is made. When an applicant leaves the county where application was made but remains in the state, part 9500.2880 applies, and the local agency may request additional information from the applicant about changes in circumstances related to the move.

Subp. 9. **Additional applications.** Until a local agency issues notice of approval or denial, additional applications submitted by an applicant are void. However, an application for monthly assistance and an application for emergency assistance may exist concurrently. More than one application for monthly assistance or emergency assistance may exist concurrently when the local agency decisions on one or more earlier applications have been appealed to the commissioner and the applicant asserts that a change in circumstances has occurred that would allow program eligibility.

A local agency shall require additional application forms or supplemental forms as prescribed by the commissioner when a payee changes his or her name, when the basis for program eligibility changes, or when a caretaker requests the addition of another person to the assistance unit.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2140 BASIC ELIGIBILITY REQUIREMENTS.

Subpart 1. **Citizenship.** To be eligible for AFDC, a member of an assistance unit must be a citizen of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien otherwise permanently residing in the United States under color of law.

Subp. 2. **Minnesota residence.** Minnesota residence is an eligibility requirement for AFDC. A person who enters Minnesota from another state and receives assistance from that state must not be considered a Minnesota resident until the last month in which that state issues an assistance payment. Minnesota residence is established according to the provisions in items A to E.

A. A person who lives in Minnesota and who entered Minnesota with a job commitment or to seek employment in Minnesota, whether or not that person is currently employed, is considered a resident of Minnesota. Neither a length of prior or future residence nor an intent to remain in Minnesota is required.

B. A person who enters Minnesota for a reason other than seeking employment, and who intends to remain in Minnesota, is a resident of Minnesota. No length of prior residence is required.

C. A person who lives in vehicles or other temporary places, including transient facilities, is a resident of Minnesota when that person is physically present in Minnesota on an ongoing basis and meets the requirements of item A or B.

D. A person placed in Minnesota by another state under Minnesota Statutes, section 257.40 or a juvenile who enters Minnesota from another state under Minnesota Statutes, section 260.51 shall not be considered a resident of Minnesota. A person placed in another state by Minnesota under Minnesota Statutes, section 257.40 or a juvenile who enters another state from Minnesota under Minnesota Statutes, section 260.51 shall maintain Minnesota residence.

E. Subitems (1) to (3) constitute loss of Minnesota residence for purposes of the program:

(1) an absence from Minnesota for more than one month, except as allowed under subpart 5;

(2) an absence involving either the establishment of a residence outside of Minnesota or the abandonment of the Minnesota home; or

(3) an assertion of residence in another state in order to receive assistance.

Subp. 3. **Deprivation as eligibility factor.** To be eligible for AFDC, a dependent child must be deprived of parental support or care under part 9500.2180, 9500.2220, 9500.2260, or 9500.2300 due to the death, incapacity, or continued absence from the home of a parent or the unemployment of the parent who is the principal wage earner.

Subp. 4. **Dependent child.** An assistance unit shall include at least one dependent child, except that program eligibility may exist for a woman beginning with her seventh month of pregnancy and for the parents or a caretaker relative of a dependent child receiving supplemental security income with no other children in the home.

Subp. 5. **Physical presence.** To be eligible for AFDC, a dependent child and a caretaker must live together except as provided in items A to C.

A. The physical presence requirement is met when a child is required to live away from the caretaker's home to meet the need for educational curricula that cannot be met by, but is approved by, the local public school district, the home is maintained for the child's return during periodic school vacations, and the caretaker continues to maintain responsibility for the support and care of the child.

B. The physical presence requirement is met when an applicant caretaker or applicant child is away from the home due to illness or hospitalization when the home is maintained for the return of the absent family member, the absence is not expected to last more than six months beyond the month of departure, and the conditions of subitem (1), (2), or (3) apply:

(1) when the child and caretaker lived together immediately prior to the absence, the caretaker continues to maintain responsibility for the support and care of the child, and the absence is reported at the time of application;

(2) when the pregnant mother is hospitalized or out of the home due to the pregnancy; or

(3) when the newborn child and mother are hospitalized at the time of birth.

C. The absence of a caretaker or child does not affect eligibility for the month of departure when he or she received assistance for that month and lived together immediately prior to the absence. Eligibility also exists in the following month when the absence ends on or before the tenth day of that month. A temporary absence of a caretaker or a child which continues beyond the month of departure must not affect eligibility when the home is maintained for the return of the absent family member, the caretaker continues to maintain responsibility for the support and care of the dependent child, and when one of subitems (1) to (7) apply:

(1) when a recipient caretaker or recipient child is absent due to illness or hospitalization, and the absence is expected to last no more than six months beyond the month of departure;

(2) when a recipient child is out of the home due to a foster care placement, when the placement will not be paid through Title IV-E funds, and when the absence is expected to last no more than six months beyond the month of departure;

(3) when a recipient child is out of the home for a vacation, the vacation is not with an absent parent, and the absence is expected to last no more than two months beyond the month of departure;

(4) when a recipient child is out of the home due to a visit or vacation with an absent parent under part 9500.2260, the home of the child remains with the caretaker under part 9500.2260, subpart 3, the absence meets the conditions of part 9500.2260, subpart 4, item C, and the absence is expected to last no more than two months beyond the month of departure;

(5) when a recipient caretaker is out of the home due to a death or illness of a relative, incarceration, training, or employment search and suitable arrangements have been made for the care of the child, or when a recipient child is out of the home due to incarceration, and the absence is expected to last no more than two months beyond the month of departure;

(6) when a recipient caretaker and a recipient child are both absent from Minnesota due to a situation described in subitem (5) or vacation, and the absence is expected to last no more than one month beyond the month of the departure; or

(7) when a recipient child has run away from home, and another person has not made application for that child, assistance must continue for no more than two months following the month of departure.

Subp. 6. **Ineligibility of labor dispute participants.** An assistance unit is ineligible for any month in which a caretaker parent participates in a strike on the last day of that month. Participation in a strike on the last day of the month by any other member of the assistance unit renders only that member ineligible. A person is considered to be "participating" in a strike if he or she, with others, actually refuses to provide services to his or her employer. A person who is unable to work due to a lockout by his or her employer, or because a labor dispute among

other parties has reduced or eliminated demand for the person's services, is not considered on strike.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2180 DEATH OF PARENT.

The death of one or both parents constitutes deprivation of parental support or care. To be eligible for AFDC, a dependent child must live with a person who is a caretaker, as defined under part 9500.2440, subpart 7, and must meet the income and resource limitations of the program.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2220 INCAPACITY OF PARENT.

Subpart 1. **Requirements for disclosure of medical and social information.** The applicant or recipient is responsible for proving his or her incapacity. An applicant or recipient who claims incapacity shall provide supporting medical evidence to a local agency when the local agency requires that evidence to determine initial and ongoing program eligibility. When medical evidence, by itself, does not prove incapacity, a local agency shall request social information to supplement the medical evidence. The applicant or recipient shall provide the names of licensed physicians or licensed psychologists who have information relevant to their incapacity. The applicant or recipient shall provide the local agency with materials he or she has which are relevant to his or her incapacity.

Subp. 2. **Referral to state medical review team.** When a local agency cannot determine incapacity from the medical evidence and social information, the local agency shall submit the evidence and information to the commissioner so that the state medical review team can decide whether incapacity exists. The applicant or recipient and the local agency shall provide the state medical review team with additional information it requires to determine incapacity. The state medical review team's decision is binding on the local agency.

Subp. 3. **Changes in circumstances.** A local agency shall review any reported changes in circumstances for continued program eligibility based on incapacity.

A. When an incapacitated parent resumes or begins employment of less than 100 hours per month or which pays less than the federal minimum wage, the local agency shall continue to treat the parent as incapacitated for the period granted under the most recent determination of incapacity. At the end of that period, the local agency shall evaluate the parent's employment and current medical evidence and social information to determine whether the incapacitated parent can perform substantial gainful employment.

B. A recipient is no longer eligible under this part when medical evidence or social information documents that the recipient can resume substantial gainful employment or care of a dependent child, or when the recipient begins substantial gainful employment. Before ending assistance under this item, the local agency shall allow the recipient an opportunity to demonstrate another basis of AFDC eligibility.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2260 CONTINUED ABSENCE OF PARENT.

Subpart 1. **Continued absence.** Continued absence of a parent exists when a parent lives out of the home of the dependent child and the absence interrupts or ends the absent parent's support, care, or guidance of that child. There is no minimum time period used to establish absence of a parent. The absence may be permanent or temporary, and a temporary absence may be of a known or

indefinite duration. When support payments made on behalf of a dependent child are less than the AFDC family allowance standard for a dependent child, the child is considered deprived of parental support for purposes of determining continued absence. Two exceptions apply when program eligibility based on continued parental absence is determined.

A. A child is not eligible when a parent is absent solely by reason of active duty in the uniformed services of the United States. The absence must be presumed to be solely because of uniformed service duty when the parent had been living in the home immediately prior to entering active duty, no subsequent divorce or legal separation has been filed, and the parent who is in the home cannot document a reason for the absence other than, or in addition to, the active duty.

B. A child is eligible when a parent is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday. Provision must not be made for the offender's needs in computing the amount of the assistance payment described in parts 9500.2440, 9500.2600, and 9500.2620.

Subp. 2. **Visitation.** Regular or sporadic visitation by an absent parent does not, by itself, constitute the provision of care or guidance as defined in part 9500.2060. When an absent parent is present in the child's home so often that a local agency questions whether absence exists, the issue shall be resolved by determining whether the absent parent lives in the home of the child.

Subp. 3. **Evidence of home.** Evidence of a home includes: the amount of time spent there as opposed to other residences; where the majority of personal belongings are kept; the address given to a current employer; the address given for current school registration; the mailing address for government benefits which require mailing to the current address; the address recently used to apply for credit; the address for service of legal documents; the address given to creditors or utility companies as a current address; vehicle registration, driver's license, or post office address which has been changed since the absence; and the frequency, type, and length of absences. A local agency shall evaluate each applicable item of evidence together with other items when determining the home, and a local agency must consider all circumstances together to determine whether continued absence exists. A maildrop does not constitute evidence of a home.

Subp. 4. **Shared custody.** This subpart applies to court ordered and noncourt ordered custody arrangements. The language of a court order that specifies joint legal or physical custody must not, in and of itself, preclude a determination that a parent is absent. Absence must be determined based on the actual facts of the absence and according to the provisions of this part.

A. When a dependent child spends time in each of the parents' homes within a payment month, the child's home shall be considered the home in which the majority of the child's time is spent. When this time is exactly equal within a payment month, or when the parents alternately live in the child's home within a payment month, the child's home shall be with that parent who is applying for AFDC, unless the child's needs for the full payment month have already been met through the provision of assistance to the other parent for that month.

B. When the physical custody of a dependent child alternates between parents for periods of at least one payment month, each parent shall be eligible for assistance for any full payment months the child's home is with that parent, except under the conditions in item C.

C. When a dependent child's home is with one parent for the majority of time in each month for at least nine consecutive calendar months, and that child visits or vacations with the other parent under the provisions of part 9500.2140, subpart 5, item C, subitem (4), the child's home shall remain with the first parent even when the stay with the second parent is for all or the majority of the months in the period of the temporary absence.

Subp. 5. **Special circumstances.** A child is considered deprived of the support, care, or guidance of a parent when:

A. paternity has not been established under law;

B. a child has been adopted by a single parent; or

C. a child is born from artificial insemination to an unmarried mother.

Subp. 6. **Substitute parent.** The determination of whether a child is deprived of parental care or support due to the absence of the parent from the child's home must be made only in relation to the child's parent. Under this requirement, the presence of a substitute parent or another person in the household must not be a reason for denying or ending assistance.

Subp. 7. **Return of parent to child's home.** When an absent parent returns to live with the child and the other parent, financial need exists, and application is made under another basis of eligibility, the local agency shall continue assistance payment until that application is approved, withdrawn, or denied, when:

A. application is made during the month of the absent parent's return; or

B. the return of the absent parent is reported timely according to part 9500.2700, subpart 7, and application is made within ten calendar days from the date the report of the return is received by the local agency.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2300 UNEMPLOYED PARENT.

To be considered an unemployed parent, a parent must meet the requirements in items A to I.

A. The parent's family is in need according to the provisions of parts 9500.2000 to 9500.2740.

B. The parent's unemployment is not the result of participation in a labor dispute.

C. The parent is employed less than 100 hours per month. The parent may exceed that standard for a particular month when employment is intermittent and the excess hours of employment are of a temporary nature as evidenced by the fact that the hours of employment were under the 100-hour standard for the prior two months and are expected to be under the standard for the next month.

D. The parent has not quit or refused a bona fide offer of employment or training for employment in the last 30 days unless the termination or refusal was for good cause as provided under part 9500.2700, subpart 19.

E. The parent has not been fully employed during the 30-day period preceding the receipt of assistance on the basis of unemployed parent.

(1) When employment is less than 100 hours in the month employment is lost but was 100 or more hours in the preceding month, the last day of the preceding month must be considered the last day of full employment.

(2) When employment is 100 hours or more in the month employment is lost, the day employment is lost must be considered the last day of full employment.

(3) Program eligibility must be established as of the date of application, the 31st day following the last day of full employment, or the day all other eligibility factors are met, whichever is later.

F. The parent shall be:

(1) registered with WIN or qualified for an exemption from WIN. When the parent is an exempt principal wage earner, the other parent, unless exempt, shall satisfy the registration and cooperation requirements of WIN; or

(2) registered with the local job service office when the county does not operate a WIN program.

G. The parent shall have:

(1) received or been qualified to receive unemployment compensation during the year prior to the month of the original application for assistance, or shall have been qualified to receive compensation if the work performed had been covered by unemployment compensation; or

(2) worked at least six quarters during any 13 calendar quarter period ending within one year prior to the date of the original application for assistance and earned the equivalent of not less than $50 per quarter during this period. Compensation for this work may be:

(a) in United States dollars or in a foreign currency that purchases goods and services equal to or exceeding $50 in United States currency; or

(b) in the form of food, shelter, personal items, medical care, and services of a fair market value equal to or exceeding $50 if purchased in the county of residence.

Work performed includes the labor or services rendered to an employer or through self-employment that was necessary to secure that compensation.

Cooperation in the WIN program or a community work experience program qualifies as a quarter of work under this item.

H. The parent shall be the principal wage earner, having earned the greater of the two parents' incomes, except for income received in-kind, during the 24 months immediately preceding the month of application for assistance under this part. When there are no earnings or when earnings are identical for each parent, the applicant may designate the principal wage earner, and that designation must not be transferred after program eligibility is determined as long as assistance continues without interruption.

I. The parent shall apply for unemployment compensation benefits when the circumstances which cause loss of employment and the duration of and compensation for that employment indicate eligibility for those benefits. When that application establishes eligibility, the parent shall also comply with the requirements necessary to receive unemployment compensation benefits.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2340 PROPERTY LIMITATIONS.

Subpart 1. **General provisions of property ownership.** A local agency shall apply the provisions of items A to D to real and personal property. A local agency shall use the equity value of legally available real and personal property, except property excluded in subparts 2 and 3, to determine whether an applicant or recipient is eligible for assistance.

A. When real or personal property is jointly owned by two or more persons, the local agency shall assume that each person owns an equal share, except that either person owns the entire sum of a joint personal checking or savings account. When the owners document greater or smaller ownership, the local agency shall use that greater or smaller share to determine the equity value held by an applicant or recipient. Other types of ownership must be evaluated according to law.

B. Real or personal property owned by an applicant or a recipient must be presumed legally available unless the applicant or recipient documents that the property is not legally available to him or her. When real or personal property is not legally available, its equity must not be applied against the limits of subparts 2 and 3.

C. An applicant shall disclose whether he or she has transferred real or personal property valued in excess of the property limits in subparts 2 and 3 for which reasonable compensation was not received within one year prior to application. A recipient shall disclose all transfers of property valued in excess of these limits according to the reporting requirements in part 9500.2700, subpart 7. When a transfer of real or personal property without reasonable compensation has occurred, subitems (1) and (2) apply.

(1) The person who transferred the property shall provide the property's description, information needed to determine the property's equity value, the names of persons who received the property, and the circumstances of and reasons for the transfer.

(2) When the transferred property can be reasonably reacquired, or when reasonable compensation can be secured, the property is presumed legally available to the applicant or recipient.

D. A recipient may build the equity value of the recipient's real and personal property to the limits in subparts 2 and 3.

Subp. 2. **Real property limitations.** Ownership of real property by an applicant or recipient is subject to the limitations in items A and B.

A. A local agency shall exclude the homestead of an applicant or recipient, according to the provisions in subitems (1) to (3).

(1) An applicant or recipient who is purchasing real property through a contract for deed and using that property as a home is considered the owner of real property.

(2) The total amount of land that can be excluded under this subpart is limited to two contiguous platted lots in an incorporated city or town, all contiguous acres in an incorporated city or town when that land is not platted into lots, and all contiguous acres in other areas. Additional contiguous platted lots must be assessed as to their legal and actual availability according to subpart 1.

(3) When real property that has been used as a home by a recipient is sold, the local agency shall treat the cash proceeds from that sale as excluded property for a period of six months when the recipient intends to reinvest them in another home and maintains those proceeds, unused for other purposes, in a separate account.

B. The equity value of real property which is not excluded under item A and which is legally available must be applied against the limits in subpart 3. When the equity value of the real property exceeds the limits under subpart 3, the applicant or recipient may qualify to receive nine months of assistance when he or she makes a good faith effort to sell the property and signs a legally binding agreement to repay the amount of assistance issued during that nine months. When the property is sold during the nine months, the assistance unit receives assistance for the month the property is sold, and the net proceeds are less than the amount of assistance issued, the amount which must be repaid shall be the net proceeds from that sale. When the property is sold after the nine-month period, or in a month when assistance is not received by the assistance unit, the full amount of assistance received during the nine-month period must be considered an overpayment and is subject to recovery.

Subp. 3. **Other property limitations.** The equity value of all nonexcluded real and personal property must not exceed $1,000. To determine whether the value of an item of real or personal property is to be counted, a local agency shall exclude the value of real and personal property listed in items A to P:

A. One motor vehicle, when its equity value does not exceed $1,500 exclusive of the value of special equipment for a handicapped household member. To establish the equity value of a vehicle, a local agency shall subtract any outstanding encumbrances from the loan value listed in the N.A.D.A. Official

Used Car Guide, Midwest Edition, for newer model cars. The N.A.D.A. Official Used Car Guide, Midwest Edition, is incorporated by reference. It is published monthly by the National Automobile Dealers Used Car Guide Company and is available through the minitex interlibrary loan system. It is subject to frequent change. When a vehicle is not listed in the guidebook, or when the applicant or recipient disputes the value listed in the guidebook as unreasonable given the condition of the particular vehicle, the local agency may require the applicant or recipient to document the value by securing a written statement from a motor vehicle dealer licensed under Minnesota Statutes, section 168.27 stating the amount that the dealer would pay to purchase the vehicle. The local agency shall reimburse the applicant or recipient for the cost of a written statement that documents a lower value.

B. The value of personal property needed to produce earned income, including tools, implements, farm animals, and inventory, but excluding automobiles and other motor vehicles used to provide transportation of persons or goods.

C. The value of real and personal property owned by a recipient of supplemental security income or Minnesota supplemental aid.

D. The value of real and personal property owned by a parent of a minor caretaker, a stepparent, or a legal guardian, when those persons are not applying for AFDC and are not required to apply for AFDC under part 9500.2440.

E. The value of corrective payments and the AFDC housing allowance, but only for the month in which the payment is received and for the following month.

F. A mobile home used by an applicant or recipient as his or her home.

G. Money escrowed in a separate account which is needed to pay real estate taxes or insurance and which is used for this purpose at least semiannually.

H. Money held in escrow under part 9500.2380, subpart 7, item B, by a self-employed person, when the money is used for those purposes at least quarterly.

I. Monthly assistance and emergency assistance payments issued for the current month's need.

J. Income received in a budget month until the end of a corresponding payment month.

K. The value of school loans, grants, or scholarships over the period they are intended to cover.

L. The value of personal property not otherwise specified which is commonly used by household members in day-to-day living.

M. Payments listed in part 9500.2380, subpart 2, item L, which are held in escrow for the period necessary to replace or repair the personal or real property. This period must not exceed three months.

N. One burial plot per member of an assistance unit.

O. The value of a prepaid burial account, burial plan, or burial trust up to $1,000 for each member of an assistance unit who is covered by that account, plan, or trust.

P. Other real or personal property specifically disregarded by federal law, state law, or federal regulation.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2380 INCOME.

Subpart 1. **Evaluation of income.** To determine program eligibility and the assistance payment amount, a local agency shall evaluate income received by members of an assistance unit, or by other persons whose income is considered

available to an assistance unit under parts 9500.2440, 9500.2500, subparts 4 and 5, and 9500.2760. All payments, unless specifically excluded in subpart 2, must be counted as income.

Subp. 2. **Excluded income.** A local agency shall exclude items A to DD from income:

A. payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under parts 9545.0010 to 9545.0260 and 9555.5100 to 9555.6400;

B. work and training allowances, incentive payments, and reimbursements received through WIN;

C. work and training allowances received from local agency social services programs;

D. reimbursements for employment training received through the Job Training Partnership Act;

E. reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, or employment;

F. educational grants to an undergraduate student for educational or rehabilitative purposes when that grant is made or insured under a program administered by the United States Commissioner of Education;

G. educational grants issued by the Bureau of Indian Affairs, when assistance income was considered in determining the amount of the grant;

H. income from federally-funded college work study;

I. loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

J. loans from private individuals, regardless of purpose, provided an applicant or recipient documents that the lender expects repayment;

K. state and federal income tax refunds except for the earned income tax credit;

L. funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made from public agencies, issued by insurance companies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency subsequent to a presidential declaration of disaster;

M. payments issued by insurance companies which are specifically designated as compensation to a member of an assistance unit for partial or total permanent loss of function or body part or for payment of medical bills, as required by Minnesota Statutes, section 256.74, subdivision 1, clause (7);

N. reimbursements for medical expenses which cannot be paid by medical assistance;

O. payments by the vocational rehabilitation program administered by the state under Minnesota Statutes, chapter 129A, except those payments that are for current living expenses;

P. in-kind income, including any payments directly made by a third party to a provider of goods and services;

Q. assistance payments to correct underpayments in a previous month;

R. payments to an applicant or recipient issued under part 9500.2820;

S. payments issued under part 9500.2800;

T. Minnesota property tax refund credits received by an applicant or recipient who does not receive AFDC housing allowances under part 9500.2800, subpart 2;

U. nonrecurring cash gifts of $30 or less, such as those received for holidays, birthdays, and graduations, the total amount excluded not to exceed $30 per recipient in a calendar quarter;

V. tribal settlements excluded under Code of Federal Regulations, title 45, section 233.20(a)(4)(ii)(e), (k), and (m);

W. any form of energy assistance payment made by LIHEAP, payments made directly to energy providers by other public and private agencies, benefits issued by energy providers when the Minnesota Department of Jobs and Training determines that those payments qualify under Code of Federal Regulations, title 45, section 233.53, and any form of credit or rebate payment issued by energy providers;

X. the first $50 of child support paid under Code of Federal Regulations, title 45, section 302.51(b)(1);

Y. income, including retroactive payments, from supplemental security income;

Z. income, including retroactive payments, from Minnesota supplemental aid;

AA. proceeds from the sale of real or personal property;

BB. payments made from state funds for subsidized adoptions under Minnesota Statutes, section 259.40;

CC. interest payments and dividends from property which is not excluded from and which does not exceed the $1,000 limit under part 9500.2340, subpart 3;

DD. income which is otherwise specifically excluded from AFDC program consideration in federal law, state law, or federal regulation.

Subp. 3. **Distribution of income.** Income must be attributed to the person who earns it or to the beneficiary of the income according to items A to E.

A. Income may be allocated from spouse to spouse and from parents to children under age 21, according to parts 9500.2500, subpart 5 and 9500.2600, when the person to whom income is allocated is in financial need according to the standards of the AFDC family allowance table under part 9500.2440 and when that person lives with the dependent child who is applying for or receiving assistance.

B. Funds distributed from a trust, whether from the principal holdings or sale of trust property or from the interest and other earnings of the trust holdings, must be considered income when the income is legally available to an applicant or recipient. Trusts are presumed legally available unless an applicant or recipient can document that the trust is not legally available.

C. Income from jointly owned property must be divided equally among the property owners unless the terms of ownership provide for a different distribution of equity.

D. Income of the sponsors of certain aliens must be considered income to the aliens according to Code of Federal Regulations, title 45, section 233.51.

E. Except as provided under part 9500.2500, subpart 4, item G, deductions are not allowed from the gross income of a financially responsible household member or by the members of an assistance unit to meet a current or prior debt.

Subp. 4. **Earned income.** Earned income is treated according to items A to C.

A. Sick leave and vacation payments issued as a result of earned or accrued leave time are earned income.

B. Earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time.

C. The earned income tax credit, whether received from an employer or from the federal government, is earned income. An applicant or recipient who is eligible for the earned income tax credit is required to apply for it. An applicant or recipient may choose to apply for the credit either when the applicant or

recipient files an income tax return for the year in which the applicant or recipient was eligible or in advance through his or her employer.

Subp. 5. **Self-employment earnings.** A local agency shall determine gross earned income from self-employment by subtracting business costs from gross receipts according to subparts 6 to 9.

Subp. 6. **Self-employment deductions.** Self-employment expenses must be subtracted from gross receipts except for the expenses listed in items A to N:

A. purchases of capital assets;

B. payments on the principal of loans for capital assets;

C. depreciation;

D. amortization;

E. the wholesale costs of items purchased, processed, or manufactured which are unsold inventory with a deduction for the costs of those items allowed at the time they are sold;

F. transportation costs which exceed the amount allowed for use of a personal car in the United States Internal Revenue Code;

G. costs, in any amount, for mileage between applicant or recipient's home and his or her place of employment;

H. salaries and other employment deductions made for members of an assistance unit or persons who live in the household for whom an employer is legally responsible;

I. monthly expenses in excess of $71 for each roomer;

J. monthly expenses in excess of $86 for each boarder;

K. monthly expenses in excess of $157 for each roomer-boarder;

L. annual expenses in excess of $103 or two percent of the estimated market value on a county tax assessment form, whichever is greater, as a deduction for upkeep and repair against rental income;

M. expenses not allowed by either the United States Internal Revenue Code for self-employment income or the Code of Federal Regulations, title 45, section 233.20(a)(6)(v)(B); and

N. expenses which exceed 60 percent of gross receipts for child care performed in a recipient's home unless the recipient can document a higher amount. When funds are received from the quality child care program, those funds are excluded from gross receipts, and the expenses covered by those funds must not be claimed as a business expense which offsets gross receipts.

Subp. 7. **Self-employment budget period.** Gross receipts from self-employment must be budgeted in the month in which they are received. Expenses must be budgeted against gross receipts in the month in which those expenses are paid except for items A to C.

A. The purchase cost of inventory items, including materials which are processed or manufactured, must be deducted as an expense at the time payment is received for the sale of those inventory items, processed materials, or manufactured items, regardless of when those costs are incurred or paid.

B. Expenses to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs which are commonly paid at least annually, but less often than monthly, must be prorated forward as deductions from gross receipts over the period they are intended to cover, beginning with the month in which the payment for these items is made.

C. Gross receipts from self-employment may be prorated forward to equal the period of time over which the expenses were incurred except that gross receipts must not be prorated over a period which exceeds 12 months. This

provision applies only when gross receipts are not received monthly but expenses are incurred on an ongoing monthly basis.

Subp. 8. **Farm income.** Farm income is the difference between gross receipts and operating expenses, subject to subpart 6. Gross receipts include sales, rents, subsidies, soil conservation payments, production derived from livestock, and income from sale of home-produced foods. Farm income must be annualized.

Subp. 9. **Rental income.** Income from rental property must be considered self-employment earnings when effort is expended by the owner to maintain or manage the property. A local agency must deduct an amount for upkeep and repairs according to subpart 6, item L, for real estate taxes, insurance, utilities, and interest on principal payments. When an applicant or recipient lives on the rental property, the local agency must divide the expenses for upkeep, taxes, insurance, utilities, and interest by the number of rooms to determine the expense per room. The local agency shall deduct expenses from rental income only for the number of rooms rented, not for rooms occupied by an assistance unit. When no effort is expended by the owner to maintain or manage the property, income from rental property must be considered unearned income. The deductions described in this subpart must be subtracted from gross rental receipts.

Subp. 10. **Unearned income.** Unearned income is treated according to items A and B.

A. An amount must be deducted for costs necessary to secure payments of unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

B. Payments for illness or disability, except for those payments described as earned income in subpart 4, item A, must be considered unearned income whether the premium payments are made wholly or in part by an employer or by a recipient.

Subp. 11. **Lump sums.** Lump sums received by an assistance unit must be considered earned income under subparts 4 to 9 or unearned income according to subpart 10. Lump sums received by a parent excluded from an assistance unit, by a child excluded from an assistance unit due to a WIN sanction, or a member of an assistance unit must be applied to meet both current and future need of the assistance unit according to part 9500.2560. When a lump sum is received by a stepparent, a parent or legal guardian of a minor caretaker, or a legal guardian, and this person is not included in the assistance unit, the lump sum must be counted as income only in the budget month.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2420 DOCUMENTING, VERIFYING, AND REVIEWING ELIGIBILITY.

Subpart 1. **Information that must be verified.** A local agency shall only require a person to document the information necessary to determine program eligibility and the amount of the assistance payment. Information previously verified and retained by a local agency must not be verified again unless the verification no longer applies to current circumstances.

Subp. 2. **Sufficiency of documentation.** A person shall document the information required under subpart 4 or authorize a local agency to verify it. The burden of providing documents for a local agency to use to verify eligibility is upon the applicant or recipient. A local agency shall help an applicant or recipient to obtain documents which the applicant or recipient does not possess and cannot obtain. When a person and the local agency are unable to obtain primary or alternate documents needed to verify information, a local agency shall accept affidavits from an applicant or recipient as sufficient documentation. Information previously verified and retained by a local agency must not be verified again unless the verification no longer applies to current circumstances.

Subp. 3. **Contacting third parties.** A local agency must not request information about an applicant or recipient which is not of public record from a source other than local agencies, the department, or the United States Department of Health and Human Services without the person's prior written consent. An applicant's signature on an application form shall constitute this consent for contact with the sources specified on that form. A local agency may use a single consent form to contact a group of similar sources, such as banks or insurance agencies, but the sources to be contacted must be identified by the local agency prior to requesting an applicant's consent. A local agency shall not provide third parties with access to information about a person's eligibility status or any other part of the case record without that person's prior written consent, except where access to specific case information is granted to agencies designated by the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13. Information designated as confidential by the Minnesota Government Data Practices Act must only be made available to agencies granted access under that law and must not be provided to an applicant, recipient, nor a third party.

Subp. 4. **Factors to be verified.** A local agency shall verify factors of program eligibility at the time of application, when a factor of eligibility changes, and at each redetermination of eligibility under subpart 5.

A. A local agency shall verify:

(1) the social security number of each adult and child applying for assistance;

(2) the age, identity, and citizenship or resident alien status of each adult and child applying for assistance;

(3) the incapacity of a parent when the basis of eligibility is an incapacitated parent under part 9500.2220;

(4) the wage and employment history for both parents for the period preceding application when the basis of eligibility is unemployed parent under part 9500.2300. When an applicant cannot document employment, a local agency shall verify the employment by contacting the employer. When this verification and other primary or alternate forms of verification are not available, a local agency shall accept an affidavit from an applicant as a satisfactory substitute for that verification;

(5) the first day of the third trimester when either program eligibility under part 9500.2140, subpart 4, or WIN exemption status under part 9500.2700, subpart 15, item M is based on pregnancy;

(6) school attendance and the date of anticipated completion of school for an 18 year old child;

(7) the WIN registration of a nonexempt adult or child in a WIN county;

(8) the registration with a Job Service office of a principal wage earner living in a non-WIN county or exempt under part 9500.2700, subpart 15, item G;

(9) the marital status of a parent who applies for assistance on the basis of continued absence under part 9500.2260, when a stepparent of the child is living in the home;

(10) the relationship of a caretaker to the child for whom application is made;

(11) a WIN exemption based on illness, injury, incapacity, or physical or mental impairment when an applicant or child is not exempt from WIN registration on another basis under part 9500.2700, subpart 15;

(12) a WIN exemption based on 30 hours of employment when an adult or child is not exempt from WIN registration on another basis under part 9500.2700, subpart 15; and

(13) a WIN exemption based on school attendance for a 16 or 17-year old dependent child who lives in a county with a WIN program.

B. A local agency shall verify the information in subitems (1) to (7) when it is either acknowledged by an applicant or recipient or obtained through a federally mandated verification system:

(1) earned income, including gross receipts and business expenses from self-employment;

(2) unearned income;

(3) termination from employment;

(4) real property;

(5) personal property;

(6) dependent care costs of an employed caretaker; and

(7) the number of hours a person is absent from a child when the person's WIN exemption is based on part 9500.2700, subpart 15, item I.

C. A local agency may verify additional program eligibility and assistance payment factors when it either documents the reason for verifying the factor in the case record of an assistance unit or when it establishes written procedures that identify those circumstances in which additional verification may be required. Additional factors that may be verified, subject to the conditions of this item, are:

(1) the presence of a child in the home;

(2) death of a parent or spouse;

(3) continued absence of a parent;

(4) residence;

(5) marital status, except as provided under item A, subitem (9); and

(6) income and property that an applicant or recipient has not acknowledged receiving or having.

Subp. 5. **Redetermination of eligibility; frequency.** A periodic redetermination of eligibility of a recipient must occur at least annually when the recipient provides a monthly household report form or is in a low error category identified through an error-prone profile developed by the commissioner and approved by the United States Secretary of Health and Human Services; a periodic redetermination of eligibility of all other recipients must occur semiannually, or more frequently for recipients in a high error category identified through an error-prone profile developed by the commissioner. One face-to-face redetermination of eligibility of each recipient must occur every 12 months. A local agency shall redetermine the eligibility of a recipient when a recipient household has changed its county of residence. A local agency may redetermine the eligibility of a recipient when a change which affects program eligibility is reported to the local agency.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2440 FAMILY COMPOSITION AND ASSISTANCE STANDARDS.

Subpart 1. **Requirement to use standards.** A local agency shall determine who is a member of an assistance unit according to subparts 2 to 4. A local agency shall determine the amount of the AFDC family allowance which applies to the size and composition of an assistance unit according to subparts 5 and 6. Payment eligibility and the amount of the assistance payment must be determined by applying the assistance unit's income against the AFDC family allowance standard, according to parts 9500.2380 to 9500.2620.

Subp. 2. **Filing unit composition.** When an application for assistance is made for a dependent child, that child and all blood related and adoptive minor siblings

of that child, along with the parents of that child who live together, must be considered a single filing unit. Program eligibility may exist for a part of a filing unit even though one or more members are ineligible.

Subp. 3. **Assistance unit composition.** An assistance unit is a group of individuals who are applying for or receiving assistance and whose needs are included in the assistance payment under part 9500.2620. Eligible members of a filing unit who are required by federal law to apply for AFDC must be included in a single assistance unit. Members of separate filing units who live together must be included in a single assistance unit when:

A. one caretaker makes application for separate filing units; and

B. two caretakers, who are currently married to each other, make application for separate filing units.

Subp. 4. **Multiple assistance units.** When there is more than one filing unit living together, eligibility for the assistance payment must be determined separately for each filing unit except as provided in subpart 3.

Subp. 5. **Application of standards.** The standards that apply to an assistance unit are set forth in items A to E.

A. The children standard must be used for an assistance unit member who is a dependent child or who is a minor caretaker who lives with either parent.

B. The first adult standard must be used for the first eligible adult caretaker and for the first eligible minor caretaker who is emancipated or who lives apart from both parents.

C. The second adult standard must be used for an additional eligible parent caretaker when one parent caretaker is eligible for the first adult standard.

D. The special child standard must be used for an assistance unit that contains no adult because a parent or parents are excluded from an assistance unit either because of failure to register or cooperate with WIN under part 9500.2700, subparts 16 and 17, or because of failure to cooperate with child support enforcement under part 9500.2700, subpart 11, and the parent or parents do not have income to meet their need under subpart 6. The special child standard must be used whenever the only adult or adults in the household receives supplemental security income or Minnesota supplemental aid or both. When an assistance unit includes more than one eligible child, the special child standard must be determined by substituting the first adult standard for the needs of the last eligible child in an assistance unit and combining that amount with the children standard for the remaining children.

E. The special adult standard must be used for an assistance unit that contains only one adult and no dependent child when eligibility exists under part 9500.2140, subpart 4.

Subp. 6. **AFDC family allowance table.** The following table represents the standards in effect on July 1, 1986.

Children Standard		Adult Standards	
Number of Eligible Children	Monthly Standard Of Need	Eligible Adults	Monthly Standard Of Need
1	$250	first adult standard	$187
2	345	second adult standard	73
3	434		
4	510		
5	586		
6	663		
7	729		
8	793		

9	848		
10	902		
over 10	add 53 per additional child		
Special Standard for one child	337	Special Standard for one adult	250

Subp. 7. **Persons who may be caretakers.** To be eligible to receive assistance, a dependent child must live with a person who is authorized to be a caretaker under this subpart. A caretaker's eligibility to be included in an assistance unit is subject to subparts 2 and 3, and other eligibility conditions in parts 9500.2140 to 9500.2700. When parental rights to a child have been terminated, the termination must not prevent a person in items A to D, except a parent whose rights were specifically terminated, from being the child's caretaker. A person who may be a caretaker of a dependent child is:

A. a relative of at least half-blood, including a first cousin, a nephew or niece, or a person of preceding generations who are identified by prefixes of grand, great, or great-great;

B. a stepparent or step-sibling;

C. a relationship listed in items A and B when a person has been legally adopted; and

D. a spouse of a person listed in items A to C or a former spouse of that person when marriage has ended by death or divorce.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2480 DETERMINATION OF AFDC ELIGIBILITY AND ASSISTANCE PAYMENT.

A local agency must determine program eligibility prospectively for a payment month based on its best estimate of income and the circumstances which will exist in the payment month. Except as described in part 9500.2520, subparts 1 and 2, when prospective eligibility exists, a local agency must calculate the amount of the assistance payment using retrospective budgeting. To determine program eligibility and the assistance payment amount, a local agency must apply gross earned income and unearned income, described in part 9500.2380, subparts 4 to 11, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under part 9500.2500, subpart 4. This income must be applied to the AFDC family allowance, described in part 9500.2440, subpart 6, subject to the provisions in parts 9500.2500 to 9500.2620. Income received in a calendar month and not otherwise excluded under part 9500.2380, subpart 2, must be applied to the needs of an assistance unit.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2500 AFDC ELIGIBILITY TESTS.

Subpart 1. **Prospective eligibility.** A local agency shall determine whether the eligibility requirements that pertain to an assistance unit, including those in parts 9500.2140 to 9500.2380, will be met prospectively for the payment month. To prospectively assess income, a local agency shall estimate the amount of income an assistance unit expects to receive in the payment month and shall apply the gross income test in subpart 4 and the payment eligibility test in subpart 5.

Subp. 2. **When to terminate.** When an assistance unit is prospectively ineligible for AFDC for at least two consecutive months, assistance must end.

When an assistance unit is prospectively ineligible for only one month and is prospectively eligible the following month, assistance must not end. The income for the single month in which prospective ineligibility exists must be applied retrospectively as described in part 9500.2520, subpart 3 resulting in suspension for the corresponding payment month.

Subp. 3. **Retrospective eligibility.** After the first two months of program eligibility, a local agency must determine whether an assistance unit is prospectively eligible for the payment month and then determine whether the assistance unit is retrospectively eligible by applying the gross income test and the payment eligibility test to the income from the budget month. When either the gross income test or the payment eligibility test is not satisfied, assistance must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subp. 4. **Gross income test.** A local agency shall apply a gross income test both prospectively and retrospectively for each month of program eligibility. An assistance unit is not eligible when income equals or exceeds 185 percent of the AFDC family allowance for the assistance unit. The income applied against the gross income test must include the income of a parent in the filing unit even when that parent is not included in the assistance unit. It must include the earned and unearned income of an eligible relative who seeks to be included in the assistance unit. It must include the unearned income of a dependent child who seeks to be included in the assistance unit. It must include the gross earned income of a dependent child in the assistance unit who is not a full-time student and whose income is from a source other than the Job Training Partnership Act. It must also include the earned or unearned income of a dependent child who is a member of the filing unit but is excluded from the assistance unit because of failure to register or cooperate with WIN. The income in items A to G must be considered in the gross income test:

A. Gross earned income from employment, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, the disregards in part 9500.2580, and the allocations in part 9500.2600, unless the employment income is specifically excluded under part 9500.2380, subpart 2.

B. Gross earned income from self-employment less deductions for self-employment expenses in part 9500.2380, subpart 6 but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, the disregards in part 9500.2580, and the allocations in part 9500.2600.

C. Unearned income after deductions for allowable expenses in part 9500.2380, subpart 10, but prior to the allocations in part 9500.2600, unless the income has been specifically excluded in part 9500.2380, subpart 2.

D. Gross earned income from employment as determined under item A which is received through the Job Training Partnership Act by a member of an assistance unit who is a dependent child after the child has received both Job Training Partnership Act earnings and assistance for six payment months in the same calendar year.

E. Gross earned income from employment as determined under item A which is received through employment other than the Job Training Partnership Act by a member of an assistance unit who is a dependent child and a full-time student after the child has received both those earnings and assistance for six payment months in the same calendar year.

F. Child support and spousal support received or anticipated to be received by an assistance unit less the first $50 of current child support.

G. Income as determined under items A to C of a stepparent, a parent of a minor caretaker, and a legal guardian of a minor caretaker who lives in the household and is not in the assistance unit. Subitems (1) to (6) must be deducted from this income:

(1) child or spousal support paid to a person who lives outside of the household;

(2) payments to meet the need of another person who lives outside of the household and who is or could be claimed as a dependent for federal personal income tax liability;

(3) $75 for work expense when employment equals or exceeds 30 hours per week or $74 when employment is less than 30 hours per week;

(4) an amount for the needs of one parent or legal guardian of a minor caretaker or a stepparent at the first adult standard;

(5) an amount for the needs of the second parent or legal guardian of a minor caretaker at the second adult standard; and

(6) an amount for the needs of other persons who live in the household but are not included in the assistance unit and are or could be claimed by a parent of a minor caretaker, legal guardian of a minor caretaker, or stepparent as dependents for determining federal personal income tax liability. This amount must equal the AFDC family allowance for a family group of the same composition as the dependent persons described in this subitem.

Subp. 5. **Payment eligibility test.** When an assistance unit satisfies the gross income test, a local agency shall apply the payment eligibility test prospectively and retrospectively for each month of program eligibility to determine whether the assistance unit is eligible to receive assistance. The income described in subpart 4 must be used to determine payment eligibility except that:

A. earned income of a dependent child who is a part- or full-time student must be excluded;

B. disregards in part 9500.2580 must be deducted from earned income; and

C. allocations in part 9500.2600 must be deducted from earned income after the deductions in item B are deducted, and from unearned income of a member of the assistance unit who has financial responsibility for an ineligible member of the household in part 9500.2600.

Income that remains after making the adjustments described in items A, B, and C is considered the net income of the assistance unit and must be applied dollar for dollar against the AFDC family allowance to determine payment eligibility.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2520 CALCULATING PAYMENTS.

Subpart 1. **Prospective budgeting.** A local agency shall use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in Minnesota for at least one payment month preceding the first month of payment under a current application.

Subp. 2. **Limitations on prospective budgeting.** The requirements of subpart 1 are subject to items A to E.

A. Income received or anticipated in the first month of program eligibility must be applied against the need of the first month. Income received or anticipated in the second month must be applied against the need of the second month.

B. When assistance payment for any part of the first two months is based on anticipated income, an initial assistance payment amount must be determined based on information available at the time the initial assistance payment is made. When the amount of actual net income is different than the anticipated net income budgeted to determine the assistance payment for the first two months, the assistance unit is liable for an overpayment or is eligible for a corrective

payment for the difference between anticipated and actual net income for those two months.

C. The assistance payment for the first two months of program eligibility must be determined by budgeting both recurring and nonrecurring income for those two months.

D. Child support income received or anticipated to be received by an assistance unit must be budgeted to determine the assistance payment amount from the month of application through the month in which program eligibility is determined and assistance is authorized. Child support income which has been budgeted to determine the assistance payment in the initial two months is considered nonrecurring income. An assistance unit shall forward the payment of child support to the child support enforcement unit of the local agency for the months which follow the month in which assistance is authorized.

E. An assistance unit who has had assistance suspended for a month as provided by part 9500.2500, subpart 2, and who has experienced a recurring change of at least $50 in net income, exclusive of the disregards in part 9500.2580, items C and D, in the month preceding the month of suspension or in the month of suspension shall have the assistance payment amount determined prospectively according to items A to D and subpart 1.

Subp. 3. **Retrospective budgeting.** Retrospective budgeting must be used to calculate the monthly assistance payment amount after the payment for the first two months has been made under the provisions of subparts 1 and 2.

Subp. 4. **Limitations on retrospective budgeting.** The requirements of subpart 3 are subject to the limitations of items A and B.

A. Retrospective budgeting is used to determine the amount of the assistance payment in the first two months of program eligibility in the situations described in subitems (1) and (2):

(1) When an assistance unit applies for AFDC for the same month for which assistance has been terminated, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in Minnesota, and the assistance payment for the immediately preceding month was determined retrospectively.

(2) When a person applies to be added to an assistance unit, that assistance unit has received assistance in Minnesota for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

B. Income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit must be applied against the AFDC family allowance to determine the assistance payment to be issued for the payment month, except as provided in subitems (1) to (4).

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When a child is removed from an assistance unit because he or she is no longer a dependent child, the income of that child is not budgeted retrospectively for payment months in which that child is not a member of the

assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against his or her own needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2560 LUMP SUM PAYMENTS.

Subpart 1. **Budgeting lump sum payments.** When a recipient receives a lump sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to items A to E.

A. A lump sum received during the first two months prospective budgeting is used to determine payment must be combined with other earned or unearned income received in that month and budgeted in the payment month in which it is received.

B. A lump sum received after the first two months of program eligibility must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

C. When a lump sum, combined with other income according to items A and B, is less than the AFDC family allowance for the applicable payment month, the assistance payment is reduced according to the amount of the combined net income. When the combined income is greater than the AFDC family allowance, the combined income must be divided by the AFDC family allowance for the payment month to determine the period over which the lump sum must be budgeted.

(1) When the combined income is greater than the AFDC family allowance for one month and less than the AFDC family allowance for two months, eligibility does not exist in the month the lump sum is received under item A and assistance must be suspended in the first payment month under item B. The excess, and other income which must be budgeted in the month following the month of ineligibility or suspension, must be deducted from the AFDC family allowance for the second payment month.

(2) When the combined income is equal to or greater than the AFDC family allowance for two or more months, each member of the assistance unit, at the time the lump sum payment was received, shall be ineligible for the determined number of months beginning with the first payment month in which the lump sum is budgeted.

D. When a lump sum is received by an assistance unit or member of an assistance unit in a state other than Minnesota, the period of ineligibility determined by another state does not apply.

E. When a member of an ineligible assistance unit under item C, subitem (2), applies for AFDC for a child who was not a member of the ineligible assistance unit in the budget month in which the lump sum was received, program eligibility may exist for that child as an assistance unit, and only the current income and resources of a financially responsible household member must be considered to determine eligibility and the amount of the assistance payment for that child.

Subp. 2. **Reducing the period of ineligibility.** When an assistance unit is determined ineligible under subpart 1, item C, and reapplies for AFDC before

the period of ineligibility ends, a local agency shall redetermine the period of ineligibility after the first payment month by deducting items A to E from the combined income for the initial month in which the lump sum was received:

A. The amount of verified medical payments paid by the assistance unit during the period of ineligibility that, if eligibility for medical assistance had existed, would have been covered by medical assistance.

B. The amount the AFDC family allowance increased during the period of ineligibility.

C. The amount paid by the assistance unit during the period of ineligibility to cover a cost that would otherwise qualify for emergency assistance under part 9500.2820.

D. An amount documented as stolen.

E. An amount that is unavailable because a member of the assistance unit left the household with that amount and has not returned. The month in which that person returns, and any subsequent months, are months of ineligibility according to the period determined in subpart 1, item C.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2580 EMPLOYMENT DISREGARDS.

A local agency shall deduct the disregards in items A to D from gross earned income as defined in part 9500.2380:

A. A $75 work expense, whether employment is part- or full-time. This disregard must be deducted from the gross earned income of each employed member of an assistance unit and for other financially responsible household members who are ineligible or otherwise excluded from the assistance unit, except that sanctioned persons who are not allowed allocations under part 9500.2600, item C must not receive this disregard. This expense is deducted for those financially responsible persons under part 9500.2500, subpart 4, item G, subitem (3), prior to the payment eligibility test under part 9500.2500, subpart 5, and must not be deducted a second time under part 9500.2500, subpart 5, item B.

B. A monthly deduction for documented costs for care of a dependent child or an adult dependent who is in the assistance unit. This disregard must only be deducted from the gross income of a member of an assistance unit or an ineligible parent, except that sanctioned persons who are not allowed allocations under part 9500.2600, item C must not receive this disregard. The deduction must not exceed $160 per dependent when employment equals or exceeds 30 hours per week, or $159 per dependent when employment is less than 30 hours per week. A deduction for dependent care costs is not allowed when the care is provided by a member of an assistance unit, by a parent of a dependent child, or by a spouse of a caretaker of a dependent child.

C. A deduction for a $30 and one-third work incentive disregard. This disregard must be deducted for each employed member of an assistance unit. The first $30 must be applied against the balance of gross earned income after deductions for the work expense and dependent care have been allowed. A deduction of one-third of the balance must also be applied after allowing the $30 deduction. This disregard is limited by subitems (1) to (6).

(1) The disregard must not be deducted from the income of an applicant in the initial month when applying the payment eligibility test in part 9500.2500, subpart 5, except that an applicant who has received assistance in Minnesota within four months of the most recent application and who retains eligibility for this disregard from the prior period of eligibility under subitems (2) to (6) shall be eligible for this disregard when determining payment eligibility. When an applicant satisfies the payment eligibility test in the first month, this

disregard must be used to calculate the assistance payment amount for that month when the applicant is otherwise eligible to receive it.

(2) Eligibility for this disregard is limited to the four payment months in subitems (3) to (6) and cannot be deducted again from the income of that member of the assistance unit until he or she has not been a recipient in Minnesota for a period of at least 12 consecutive payment months.

(3) The four months of eligibility for this disregard are only those payment months in which any part of the $30 and one-third work incentive is applied against income. When the four months of eligibility for this disregard are interrupted for at least one payment month before the period of eligibility is completed, eligibility for the entire four months must be reestablished, with the next subsequent month of its use considered to be the first month, except as otherwise noted in subitems (4) to (6).

(4) When this disregard is not applied because income from a recurring source results in suspension of an assistance payment, that month must not be counted as a month of the four-month period, but this interruption does not establish eligibility for a new four-month period.

(5) When employment is ended, reduced, or refused without good cause according to part 9500.2700, subpart 19, a person shall not be eligible for any of the employment disregards under items A to D in the first month following the month in which that employment is ended, reduced, or refused. The month in which those disregards are disallowed must be counted as one of the four consecutive months in the period of eligibility for this disregard and the remaining months of eligibility must be counted in the consecutive months which immediately follow, regardless of loss of eligibility or change in employment status.

(6) When a recipient loses all disregards under this part due to late reporting, according to part 9500.2700, subpart 5, item A, the month in which those disregards are disallowed must be considered as one of the four consecutive months in the period of eligibility for this disregard.

D. A deduction for a $30 work incentive disregard. This disregard applies for a period of eight months to members of an assistance unit who have completed the four-month period of eligibility for the $30 and one-third work incentive disregard. This disregard is allowed beginning with the first month following the fourth month of eligibility for the $30 and one-third work incentive disregard and must be counted in consecutive months regardless of the loss of eligibility or change in employment status.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2600 ALLOCATION FOR UNMET NEED OF OTHER HOUSEHOLD MEMBERS.

An allocation of income must be allowed to meet the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caretaker is financially responsible who also lives with the caretaker. An allocation must be made from the caretaker's income to meet the need of an ineligible or excluded spouse up to the amount allowed in the second adult standard. An allocation must be made from the caretaker's income to meet the need of an ineligible or excluded child. That allocation must be made in an amount up to the difference between the payment standard allowed for the assistance unit and the payment standard allowed when that excluded or ineligible child is included in the assistance unit. These allocations must be deducted from the caretaker's net earned income after the deductions under part 9500.2580 have been made and from unearned income subject to items A to C.

A. Income of a dependent child in the assistance unit must not be

allocated to meet the need of a person who is not a member of the assistance unit, including the child's parent, even when that parent is the payee of the child's income.

B. Income of an assistance unit must not be allocated to meet the need of a member of the household who elects to receive general assistance.

C. Income of an assistance unit must not be allocated to meet the need of a person sanctioned for failure to cooperate with child support requirements under part 9500.2700, subpart 11, a person required to register with WIN under part 9500.2700, subpart 15, or a person sanctioned for failure to cooperate with WIN under part 9500.2700, subpart 18.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2620 AMOUNT OF ASSISTANCE PAYMENT.

The amount of an assistance payment must be equal to the difference between the AFDC family allowance described in part 9500.2440, subpart 6 and net income, except for items A to F.

A. When program eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision must apply when an applicant loses at least one day of program eligibility.

B. When the difference between net income and the AFDC family allowance in a payment month is less than $10, an assistance payment must not be issued, but that month must be considered a month of program eligibility.

C. Overpayments to an assistance unit identified by a local agency or by a court order prior to October 1, 1981, must be recouped by deducting an amount from the assistance payment. This amount must be equal to one-half of the work incentive disregards described in part 9500.2580, items C and D for each payment month a member of the assistance unit is eligible for those disregards.

D. Overpayments to an assistance unit identified by a local agency on or after October 1, 1981, must be recouped according to part 9500.2640, subpart 4.

E. When recoupment reduces the assistance payment, as in items C and D, and the subsequent level of payment is less than $10, the assistance payment must be made, and the limitations in item B must not apply.

F. An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2640 CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.

Subpart 1. **Scope of overpayment.** When a current or former recipient receives an overpayment, the overpayment must be recouped or recovered under the conditions of this part even when the overpayment is due to agency error or to other circumstances outside the person's responsibility or control.

Subp. 2. **Notice of overpayment.** When a local agency discovers that a person has received an overpayment for one or more months, the local agency shall notify that person of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the person's right to appeal. No limit applies to the period in which the local agency is required to recoup or recover the overpayment. A local agency

shall recoup or recover an overpayment according to the provisions of subparts 3 and 4.

Subp. 3. **Recovering overpayments from former recipient.** A local agency shall initiate efforts to recover overpayments paid to a person no longer on assistance. A person who is a member of an assistance unit at the time an overpayment occurs is jointly and individually liable for its repayment. The local agency shall request repayment from each former member of the assistance unit who is 18 years of age or older at the time eligibility for assistance ends. When an agreement for repayment is not completed within six months or when there is a default on an agreement for repayment after six months, the local agency shall initiate recovery under Minnesota Statutes, chapter 270A or section 541.05. When a person has been convicted of fraud under Minnesota Statutes, section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment balance is less than $35, and is not the result of a fraud conviction under Minnesota Statutes, section 256.98, the local agency shall not seek recovery under this subpart. The local agency shall retain information about all overpayments regardless of the amount. When a member of that assistance unit reapplies for assistance, the remaining balance must be recouped under subpart 4.

Subp. 4. **Recouping overpayments from current recipient.** When an assistance unit is currently eligible for assistance, the local agency shall recoup an overpayment by reducing one or more monthly assistance payments until the overpayment is repaid. To determine the amount of repayment to deduct from the monthly assistance payment, the local agency shall estimate the amount of income the assistance unit is expected to receive for the month of the assistance payment, deduct anticipated work expenses according to this subpart, and add the value of liquid assets available to the assistance unit at the beginning of that month using the verified information most recently reported by the caretaker. Once the total of net income and liquid assets is determined, the local agency shall determine the amount of the repayment for that month. When an overpayment occurs due to client error, the local agency shall reduce the assistance payment to an amount which, when added to the anticipated net income and current liquid assets, equals 95 percent of the AFDC family allowance. When an overpayment occurs due to agency error, or a combination of client and agency error, the local agency shall reduce the assistance payment to an amount which, when added to the anticipated liquid assets and net income, equals 99 percent of the AFDC family allowance. A local agency shall adjust the amount of recoupment when:

A. an assistance unit documents prior to the first day of the payment month that actual liquid assets are less than the estimated liquid assets; or

B. an assistance unit documents prior to the last day of the month that actual income is less than the estimated income.

Subp. 5. **Determining net income.** A local agency shall determine net income for purposes of recoupment by using:

A. estimates of federal and state income taxes, social security withholding taxes, and mandatory retirement fund deductions;

B. an estimate for dependent care costs without regard to the $159 and $160 maximums in part 9500.2580, item B;

C. other personal employment expenses equal to ten percent of an assistance unit's gross earned income unless the caretaker chooses to itemize these expenses. When a caretaker chooses to itemize expenses, the caretaker shall provide the local agency with documentation for those expenses. The local agency shall deduct the expenses in subitems (1) to (6) in lieu of the ten percent:

(1) transportation costs to and from work at the amount allowed by the Internal Revenue Service for personal car mileage;

(2) costs of work uniforms, union dues, and medical insurance premiums;

(3) costs of tools and equipment used on the job;

(4) $1 per work day for the costs of meals eaten during employment;

(5) public liability insurance required by an employer when an automobile is used in employment and the cost is not reimbursed by the employer; and

(6) the amount paid by an employee from personal funds for business costs which are not reimbursed by the employer.

Subp. 6. **Scope of underpayments.** A local agency shall issue a corrective payment for underpayments identified after September 30, 1981, made to a current recipient or to a person who would be a current recipient if an agency or client error causing the underpayment had not occurred. Issuance of corrective payments must occur according to the provisions of subparts 7 and 8.

Subp. 7. **Identifying the underpayment.** An underpayment may be identified by a local agency, by a current recipient, by a former recipient, or by a person who would be a recipient except for agency or client error.

Subp. 8. **Issuing corrective payments.** A local agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment or by issuing a separate payment to a current recipient, or by reducing an existing overpayment balance. When an underpayment occurs in a payment month and is not identified until the next payment month or later, that underpayment must first be subtracted from any overpayment balance before issuing the corrective payment. An underpayment for a current payment month must not be applied against an overpayment balance and payment must be issued within seven calendar days after the underpayment is identified.

Subp. 9. **Appeals.** A person may appeal an underpayment, an overpayment, and the amount by which an assistance payment will be reduced to recoup the overpayment under part 9500.2740, subpart 8. Appeal of each issue must be timely under Minnesota Statutes, section 256.045. When an appeal based on the notice issued under subpart 2 is not timely, the fact or the amount of that overpayment must not be considered as a part of a later appeal, including an appeal of a reduction of an assistance payment to recoup that overpayment.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2680 PAYMENT PROVISIONS.

Subpart 1. **Checks.** This subpart applies to monthly assistance payments and corrective payments.

A. A local agency shall mail assistance payment checks to the address where a caretaker lives unless the local agency approves an alternate arrangement.

B. A local agency shall mail monthly assistance payment checks within time to allow postal service delivery to occur no later than the first day of each month. Monthly assistance payment checks must be dated the first day of the month.

C. A local agency shall issue replacement checks promptly, but no later than seven calendar days after the provisions of Minnesota Statutes, section 471.415 have been met.

Subp. 2. **Protective, vendor, and two-party payments; when allowed.** Alternatives to paying assistance directly to a recipient may be used only:

A. When the needs of a caretaker are not included in the assistance unit's assistance payment because the caretaker is under sanction for noncooperation

with WIN under part 9500.2700, subpart 18. In this case, the assistance payment must be issued by protective or vendor payment in accordance with the Code of Federal Regulations, title 45, sections 224.51(b)(1) and 234.60(a)(12).

B. When the needs of a caretaker are not included in the assistance unit's assistance payment because the caretaker has failed or refused to cooperate with child support enforcement according to part 9500.2700, subpart 11. In this case, the assistance payment must be issued by protective or vendor payment in accordance with Code of Federal Regulations, title 45, section 234.60(a)(13).

C. When a local agency determines that a vendor or two-party payment is the most effective way to resolve an emergency situation under part 9500.2820.

D. When a caretaker makes a written request asking that the local agency issue part or all of the assistance payment by protective, vendor, or two-party payments. The caretaker may withdraw this request in writing at any time.

E. When a caretaker has exhibited a continuing pattern of mismanaging funds under the conditions specified in Code of Federal Regulations, title 45, section 234.60(a)(2).

(1) The director of a local agency must approve a proposal for protective, vendor, or two-party payment for money mismanagement. During the time a protective, vendor, or two-party payment is being made, the local agency shall provide services designed to alleviate the causes of the mismanagement in accordance with Code of Federal Regulations, title 45, section 234.60(a)(8).

(2) The continuing need for and method of payment must be documented and reviewed every six months. The director of a local agency must approve the continuation of protective, vendor, or two-party payment.

(3) When it appears that the need for protective, vendor, or two-party payments will continue or is likely to continue beyond two years because the local agency's efforts have not resulted in sufficiently improved use of assistance in behalf of the child, judicial appointment of a legal guardian or other legal representative must be sought by the local agency.

Subp. 3. **Choosing payees for protective, vendor, and two-party payments.** A local agency shall consult with a caretaker regarding the selection of the form of payment, the selection of a protective payee, and the distribution of the assistance payment to meet the various costs incurred by the assistance unit. The local agency shall notify the caretaker of the right to appeal the determination that a protective, vendor, or two-party payment should be made or continued and to appeal the selection of the payee.

When a local agency is not able to find another protective payee, a local agency staff member may serve as a protective payee. A person who is not to serve as protective payee is: a member of the county board of commissioners; the local agency staff member determining financial eligibility for the family; special investigative or resource staff; the staff member handling accounting fiscal processes related to the recipient; or a landlord, grocer, or other vendor dealing directly with the recipient.

Subp. 4. **Discontinuing protective, vendor, and two-party payments.** A local agency shall discontinue protective, vendor, or two-party payments in the month following compliance with WIN requirements under part 9500.2700, subpart 16; in the month following qualification as a member of an assistance unit when a WIN exemption is established under part 9500.2700, subpart 15; in the month following cooperation with the child support enforcement unit under part 9500.2700, subpart 10; and in two years or in the month following the local agency's failure to grant six-month approval to a money management plan, whichever occurs first. At least once every six months, a local agency shall review the performance of a protective payee acting under subpart 2, items A, B, and E to determine whether a new payee should be selected. When a recipient complains about the performance of a protective payee, a review must occur within 30 days.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2700 APPLICANT AND RECIPIENT RESPONSIBILITIES.

Subpart 1. **Applicant reporting requirements.** An applicant shall provide information on an application form and supplemental forms about his or her circumstances which affect program eligibility or the assistance payment. An applicant shall report any changes in those circumstances under subpart 7 while the application is pending. When an applicant does not accurately report information on an application, both an overpayment and a referral for a fraud investigation under part 9500.2780, subpart 2 may result. When an applicant does not provide information or documentation, the receipt of the assistance payment may be delayed or the application may be denied depending on the type of information required and its effect on eligibility.

Subp. 2. **Requirement to apply for other benefits.** An applicant or recipient shall apply for benefits from other programs for which they are potentially eligible and which would, if received, offset assistance payments. Failure without good cause to complete application for these benefits must result in denial or termination of assistance. Good cause for failure to apply for these benefits is allowed when circumstances beyond the control of the applicant or recipient prevent him or her from making application.

Subp. 3. **Responsibility to inquire.** An applicant or recipient who does not know or is unsure whether a given change in circumstances will affect his or her program eligibility or assistance payment shall contact the local agency for information.

Subp. 4. **Recipient's redetermination of eligibility form.** A recipient shall complete forms prescribed by the commissioner which are required for redetermination of eligibility according to part 9500.2420, subpart 5.

Subp. 5. **Household reports.** Each assistant unit with a member who has earned income or a recent work history, and each assistant unit that has income allocated to it from a financially responsible person living with that unit who has earned income or a recent work history, shall complete a monthly household report form. "Recent work history" means the individual received earned income in any one of the three calendar months preceding the current payment month. Monthly reports must also be completed by each assistance unit in a category that has a greater proportion of the state's total program errors than that category's proportion of the state's total program caseload, as identified through the quality control review process, and when monthly reporting is expected to reduce the error rate for that category. All other assistance units shall complete a quarterly household report form. To be complete, a household report form must be signed and dated by a caretaker no earlier than the last day of the reporting period; all questions required to determine assistance payment eligibility must be answered, and documentation of earned income must be included. A recipient shall submit the household report form in time for the local agency to receive it by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, a recipient must submit the household report form in time for the local agency to receive it by the first working day that follows the eighth calendar day. Delays in submitting the completed household report form may delay an assistance payment in the month following the month in which the form is due. When the household report form is late without good cause, except as qualified in subpart 6, item C, the recipient is subject to the penalties in items A and B:

A. When a completed household report form is received by a local agency after the last day of the month following the month in which the form is due, and when the delayed household report form reports earned income, an assistance unit shall lose the earned income disregards under part 9500.2580 for

the payment month corresponding to the last month covered by the household report form.

B. When a household report form is received by a local agency on or after the first day of the month following the month in which the form is due, assistance must end. When a person requests further assistance, the local agency shall require the assistance unit to reapply. The assistance unit is eligible for assistance payment on the date of reapplication or the date all other eligibility factors are met, whichever is later.

Subp. 6. **Late household report forms.** Items A to C apply to the requirements in subpart 5.

A. When a recipient submits an incomplete household report form before the last working day of the month on which a ten-day notice of termination of assistance can be issued for failure to provide a complete household report form, the local agency shall return the incomplete form on or before the ten-day notice deadline or any ten-day notice of termination which is issued due to the incomplete household report form must be invalid.

B. When a complete household report form is not received by a local agency before the last ten days of the month in which the form is due, the local agency shall send notice of proposed termination of assistance. When a recipient submits an incomplete form on or after the date the notice of proposed termination has been sent, the termination is valid unless the recipient submits a complete form before the end of the month.

C. A local agency shall allow good cause exemptions from the penalties under subpart 5, items A and B, when the factors in subitems (1) to (5), singly, or in combination, cause a recipient to fail to provide the local agency with a completed household report form before the end of the month in which the form is due.

(1) an employer delays completion of employment verification;

(2) a local agency does not help a recipient complete the household report form when the recipient asks for help;

(3) a recipient does not receive a household report form due to mistake on the part of the department or the local agency or due to a reported change in address;

(4) a recipient is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a recipient could not avoid with reasonable care which prevents the recipient from providing a completed household report form before the end of the month in which the form is due.

Subp. 7. **Changes which must be reported.** A recipient shall report the changes or anticipated changes specified in items A to M within ten days of the date they occur, within ten days of the date the recipient learns that the change will occur, at the time of the periodic redetermination of eligibility under part 9500.2420, subpart 5, or within eight calendar days of a reporting period as in subpart 5, whichever occurs first. A recipient shall report other changes at the time of the periodic redetermination of eligibility under part 9500.2420, subpart 5 or at the end of a reporting period under subpart 5 as applicable. A recipient shall make these reports in writing or in person to the local agency. When a local agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under items A to M had not occurred, the local agency shall determine whether a timely notice under part 9500.2740, subpart 7 could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under part 9500.2640. Changes in circumstances which must be reported within ten days must also be reported on the household report form for the reporting period in which those changes occurred. Within ten days, a recipient must report changes in:

A. initial employment;

B. the initial receipt of unearned income;

C. a recurring change of more than $50 per month of net earned or unearned income;

D. the receipt of a lump sum;

E. an increase in resources which may cause the assistance unit to exceed AFDC resource limits;

F. a change in the physical or mental status of an incapacitated parent;

G. a change in the employment status of an unemployed parent;

H. a change in the status of an absent parent, change in the household composition, including departures from and returns to the home of assistance unit members and financially responsible persons, or a change in the custody of a dependent child;

I. the marriage or divorce of an assistance unit member;

J. the death of a parent or a dependent child;

K. a change in address or living quarters of the assistance unit;

L. the sale, purchase, or other transfer of property; and

M. a change in school attendance of a dependent child over 15 years of age or an adult member of an assistance unit.

Subp. 8. **Requirement to cooperate with quality control review.** To receive assistance, a recipient shall cooperate with the department's quality control review process by providing information that will verify program and assistance payment eligibility upon the request of the department or the local agency.

A. Cooperation in the quality control review process includes both participating in a personal interview with a quality control staff person at a mutually acceptable time and location and assisting the quality control staff person to get the verifications necessary to establish program and assistance payment eligibility for the month of the redetermination of eligibility when those verifications do not duplicate what already exists in the local agency case record and when getting them does not cause the recipient to incur an expense.

B. When a recipient does not cooperate with the quality control review process and does not have good cause for not cooperating, a local agency must end assistance. The assistance unit shall remain ineligible until they cooperate with the quality control review process or until the last day of the annual period for reporting quality control cases to the federal government, whichever occurs first. A recipient shall have good cause under this subpart only when he or she does not cooperate because of mental or physical disability or illness of such severity and duration that he or she cannot participate within the period that is allotted to complete the quality control review process.

Subp. 9. **Requirement to provide social security numbers.** To receive assistance, an applicant or recipient shall provide his or her social security number to the local agency. When a social security number and social security card are not provided to the local agency for verification, this requirement is satisfied when an applicant or recipient cooperates with the procedures for verification of numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

Subp. 10. **Cooperation with child support enforcement.** When the basis of program eligibility for a dependent child is continued absence under part 9500.2260, the caretaker of that child shall cooperate with the efforts of the local agency to collect child and spousal support.

A. A caretaker shall assign the right to collect past due, current, and future support to the local agency. Signing an application form satisfies this requirement under Minnesota Statutes, section 256.74, subdivision 5. The assign-

ment of support ends with the last day of the last month in which a dependent child receives assistance. When assistance ends, a local agency has the right to any unpaid support for the period in which assistance was received.

B. A caretaker shall provide information known to them about an absent parent and requested by either the AFDC unit or the child support enforcement unit, which is required to establish paternity or secure support for the dependent child, unless the caretaker has good cause for refusing to cooperate under subpart 12.

C. When the paternity of a dependent child is not established under law, a caretaker shall cooperate with the child support enforcement unit to determine and establish the child's paternity unless the caretaker has good cause for noncooperation under subpart 12.

D. A caretaker shall forward to the local agency all support he or she receives during the period the assignment of support is in effect according to item A. Support received by a caretaker, and not forwarded to the local agency, must be repaid to the child support enforcement unit for any month following the month in which initial eligibility is determined, except as provided under subpart 11, item B, subitem (3).

Subp. 11. **Refusal to cooperate with support requirements.** Failure by a caretaker to satisfy any of the requirements of subpart 10 constitutes refusal to cooperate, and the sanctions under item B apply.

A. The AFDC unit of a local agency shall determine whether a caretaker has refused to cooperate within the meaning of subpart 10. Before making this determination, the AFDC unit shall:

(1) allow the child support enforcement unit to review and comment on the findings and basis for the proposed determination of noncooperation;

(2) consider any recommendations from the child support enforcement unit; and

(3) allow the child support enforcement unit to appear at a hearing under part 9500.2740, subparts 8 to 10, which results from an appeal of a local agency action involving cooperation with child support enforcement under subpart 10.

B. Determinations of refusal to cooperate shall have the following effects.

(1) A parent caretaker who refuses to cooperate must not be included in an assistance unit. Payments for the remaining members of the assistance unit are subject to the conditions of part 9500.2680, subpart 2, item B.

(2) A caretaker who is not a parent of a dependent child in an assistance unit may choose to remove that child from the assistance unit or to have his or her own needs removed from the assistance unit, unless otherwise required by federal or state law. When a caretaker chooses to remove his or her own needs, assistance payments for the remaining members of the assistance unit are subject to the conditions of part 9500.2680, subpart 2, item B.

(3) Direct support retained by a caretaker must be counted as unearned income when determining the amount of the assistance payment.

Subp. 12. **Good cause exemption from cooperating with support requirements.** Before requiring a caretaker to cooperate, a local agency shall notify an applicant that he or she may claim a good cause exemption from cooperating with the requirements in subpart 10, items B to D, under the conditions specified in Code of Federal Regulations, title 45, sections 232.12 and 232.40 to 232.49 at the time of application or at any subsequent time. When a caretaker submits a good cause claim in writing, action related to child support enforcement must stop. The caretaker shall submit evidence of a good cause claim to the local agency within 20 days of submitting the claim.

A. Good cause exists when a caretaker documents that:

(1) a dependent child for whom child support enforcement is sought was conceived as the result of incest or rape;

(2) legal proceedings for the adoption of a dependent child are pending before a court of competent jurisdiction; or

(3) a parent caretaker is receiving services from a licensed adoption agency to determine whether to keep the child or relinquish the child for adoption, and the services have not been provided for longer than three months.

B. Good cause exists when a caretaker documents that his or her cooperation would not be in the best interest of the dependent child because the cooperation could result in:

(1) physical harm to the child;

(2) emotional impairment of the child which would substantially affect the child's functioning; or

(3) physical harm to or emotional impairment of the caretaker which would substantially affect the caretaker's functioning and reduce the caretaker's ability to adequately care for the child.

C. When an applicant or recipient has difficulty obtaining evidence, the local agency shall help him or her obtain it. When a local agency requires additional evidence to make a determination on the claim for good cause, the local agency shall notify the caretaker that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

D. A local agency shall determine whether good cause exists based on the weight of the evidence.

E. Once a local agency determines that good cause exists for a caretaker, the exemption from cooperating under subpart 10, items B and C must remain in effect for the period the dependent child remains eligible under that application, except for subitems (1) to (4).

(1) A good cause exemption allowed because a child was conceived as the result of incest or rape must continue until a subsequent acknowledgment of paternity or an application for adoption by a second parent is submitted for that child.

(2) A good cause exemption allowed because of adoption proceedings must be issued for a fixed period of time based on the expected time required to complete adoption proceedings. The exemption must be extended when the required time is longer than was anticipated and must stop when adoption proceedings are discontinued or completed.

(3) A good cause exemption allowed because of adoption counseling must last no more than three months from the time the counseling began.

(4) A good cause exemption must be allowed under subsequent applications and redeterminations of eligibility without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under item B must end when the factors which led to allowing the exemption have changed.

F. A good cause exemption which has been allowed by a local agency for a caretaker must be honored by the local agency in the county of residence when the caretaker moves into that county, until the factors which led to allowing the exemption change.

G. When a local agency denies a claim for a good cause exemption, the local agency shall require the caretaker to submit additional evidence in support of a later claim for a good cause exemption before the local agency stops acting to enforce child support under this subpart.

H. Following a determination that a caretaker has good cause for refus-

ing to cooperate, a local agency shall take no further action to enforce child support until the good cause exemption ends according to item E.

Subp. 13. **Work requirements.** AFDC work requirements are based upon whether an applicant or recipient lives in a WIN or a non-WIN county.

Subp. 14. **Work requirements in non-WIN counties.** An applicant or recipient who is the principal wage earner in an assistance unit whose program eligibility is based on the unemployment of a parent under part 9500.2300 must be currently registered with the local job service office and fulfill any other employment and training participation responsibilities mandated by federal or state law. When a principal wage earner does not comply with this requirement, the entire assistance unit is ineligible for assistance.

Subp. 15. **Work requirements in WIN counties.** An applicant or recipient living in WIN counties, regardless of their basis of program eligibility under parts 9500.2180 to 9500.2300, shall register with and cooperate with the local WIN office unless the local agency determines that the applicant or recipient is exempt. An applicant or recipient who is exempt from mandatory WIN registrant status is a:

A. Child under the age of 16.

B. Student who is at least 16 but less than 18 years of age and meets the conditions of part 9500.2060, subpart 58, item A, B, C, or F.

C. Person who is 18 years of age and meets the conditions of part 9500.2060, subpart 39, items B and C.

D. Person who, for up to 90 consecutive days, is ill or injured to the extent that the illness or injury temporarily prevents participation in training or employment. Determination of an exemption under this item must be made by the AFDC unit and may be allowed without medical documentation when the illness or injury is evident. Exemptions for illnesses or injuries which extend for 90 days or more must be documented by medical evidence as described in item E.

E. Person who, for at least 90 consecutive days, is physically or mentally incapacitated when the incapacitating factors, by themselves or in conjunction with the person's age, prevent participation in training or employment. The incapacity must be documented by medical evidence. The medical evidence must include a prognosis and diagnosis of the impairment from at least one licensed physician or licensed psychologist. The local agency shall give the applicant or recipient voluntary referral to the Minnesota Department of Vocational Rehabilitation upon determination of the exemption.

F. Person who is 65 years of age or older.

G. Person who lives a distance from the local WIN office that requires round trip commuting time of more than two hours by the means of transportation available to the recipient and exclusive of the time needed to transport children to and from child care.

H. Person who is needed in the home to care for another person living in the household who is physically or mentally incapacitated. The incapacity and the need for care must be documented by medical evidence from a licensed physician or licensed psychologist.

I. Parent or caretaker of a child under the age of six years who is providing full-time care for that child. A person who is anticipated to be absent from the child for an average of at least 30 hours per week during the current and following month, exclusive of absences related to providing care for the child, does not qualify for this exemption.

J. Person who is currently employed for an average of at least 30 hours per week in each month at unsubsidized employment.

K. Parent who is not a principal wage earner but who is in an assistance

unit whose program eligibility is based on the unemployment of a parent. However, the principal wage earner in the assistance unit must be registered with and cooperating with WIN in order for the other parent to claim this exemption.

L. Person, who after applying for AFDC, volunteered to participate under the Volunteers in Service to America (VISTA) program authorized by the Domestic Volunteer Service Act of 1973, Public Law Number 93-113.

M. Pregnant woman when the pregnancy has entered the third trimester.

Subp. 16. **Registration in WIN counties.** Items A to C apply to persons and local agencies in WIN counties.

A. Upon application, a local agency shall refer an applicant who is not exempt under subpart 15 to the WIN office for registration. A local agency shall refer a previously exempt recipient to the WIN office for registration when the recipient no longer meets exemption conditions in subpart 15.

B. A local agency shall use the verified date of an applicant's registration for WIN to establish the first date of program eligibility.

C. When an applicant or recipient does not register with the WIN program and that applicant or recipient is not exempt, subitems (1) to (5) apply.

(1) When an assistance unit applies for AFDC under part 9500.2300 and the principal wage earner is the mandatory WIN registrant, no member of the assistance unit is eligible until the date the principal wage earner registers for WIN. When the basis of program eligibility for a recipient assistance unit changes to unemployed parent in a month and the principal wage earner is referred to WIN, the remaining assistance unit members are eligible for the month of change, and when the provisions of part 9500.2260, subpart 7 apply, until the application is approved, denied, or voluntarily withdrawn. Eligibility for the additional unmet need of the principal wage earner must not begin until the date the WIN registration occurs.

(2) When a mandatory WIN registrant is not the incapacitated parent in an assistance unit whose basis of program eligibility is incapacitated parent under part 9500.2220 and that mandatory registrant has not registered with WIN, assistance payment may be made for the needs of the remaining members of the assistance unit.

(3) When a mandatory WIN registrant is a parent, the basis of program eligibility is death of a parent or continued absence, and that caretaker has not registered for WIN, only the dependent child is eligible for assistance.

(4) When a mandatory WIN registrant who is a caretaker relative other than a parent is not registered for WIN, only the dependent child is eligible for assistance. The child's needs must be met at the children standard.

(5) When a mandatory WIN registrant is a dependent child who is not registered for WIN, that child is not eligible for assistance. When that child is the only dependent child in the assistance unit, the entire assistance unit is not eligible for assistance.

Subp. 17. **Cooperation with WIN.** When a mandatory WIN registrant completes WIN registration, he or she shall cooperate with WIN as a condition of continued receipt of assistance. The WIN office makes determinations of failure to cooperate. When the WIN office determines that a person is not cooperating, the local agency will be notified by the WIN office of the action taken by WIN to deregister that person.

Subp. 18. **Sanctions for failure to cooperate with WIN.** When a WIN office notifies a local agency that it has deregistered an applicant or recipient from WIN for failure to cooperate with the WIN requirements, the local agency shall apply the sanctions in items A to C beginning with the first payment month following deregistration in which notification and appeal rights under part 9500.2740, subparts 5 to 10, allow application of those sanctions.

A. When a mandatory WIN registrant is also the principal wage earner under part 9500.2300, the entire assistance unit is ineligible for three payment months for the first occasion of deregistration or for six payment months for subsequent occasions of deregistration. When, during the period of sanction, the principal wage earner leaves the home or when either parent becomes incapacitated and eligibility is established under parts 9500.2180 to 9500.2260, the sanction period ends for the remaining members of the assistance unit.

B. When a mandatory WIN registrant in an assistance unit that qualifies under part 9500.2300 is the parent who is not the principal wage earner, or when the mandatory WIN registrant is a parent caretaker in an assistance unit which qualifies under part 9500.2180, 9500.2220, or 9500.2260, that parent caretaker must be removed from the assistance unit. The parent caretaker must be ineligible for a period of three payment months for the first occasion of deregistration or for six payment months for subsequent occasions of deregistration. Protective or vendor payments must be issued for the needs of the remaining members of the assistance unit under part 9500.2680, subpart 2, item A until the period of the sanction ends or the recipient who is under sanction is no longer a member of the filing unit.

C. When a recipient who is under sanction is a caretaker relative other than a parent or is one of several dependent children, that person must be removed from the assistance unit for three payment months for the first occasion of deregistration or for six payment months for subsequent occasions of deregistration.

Subp. 19. **Good cause for refusing or terminating employment or training.** For purposes of applying the sanctions under subpart 18, WIN must determine when good cause exists when a current WIN registrant refuses or terminates employment or training or does not cooperate with WIN. A local agency shall determine whether good cause for refusing or terminating employment or training exists under parts 9500.2300, item D, and 9500.2580, item C, subitem (5). When WIN has participated in an employment or training placement and does not apply a sanction for refusal or termination under subpart 18, a local agency shall not apply the sanctions under part 9500.2300, item D, or 9500.2580, item C, subitem (5), for that same refusal or termination. A local agency shall determine good cause by applying the conditions in items A to H.

A. Good cause exists when a job or training program is not suited to the physical or mental capacity of the person or when it will have an adverse effect on that person's physical or mental health. Evidence from a licensed physician or licensed psychologist must document this claim.

B. Good cause exists when the round trip commuting time from a person's residence to a training or job site is more than two hours by available means of transportation, exclusive of the time to transport children to and from child care.

C. Good cause exists when licensed child care is required but is not available.

D. Good cause exists when the work or training site is unsafe under health and safety standards established by the Occupational Safety and Health Administration and the Minnesota Department of Jobs and Training.

E. Good cause exists when a person documents discrimination at the job or training site on the basis of age, sex, race, religion, or place of national origin.

F. Good cause exists when the hourly gross employment earnings are less than the federal or state minimum wage for that type of employment, whichever is applicable.

G. Good cause exists when a person's net income from employment after deductions for the actual costs of subitems (1) to (8) is less than the AFDC family allowance for the assistance unit described under part 9500.2440, subpart 6:

(1) state and federal income tax withholding;
(2) FICA;
(3) health and dental insurance;
(4) transportation;
(5) mandatory retirement;
(6) union dues;
(7) meals; and
(8) the expenses required for the care of a dependent.

H. Good cause exists when the job which is offered is vacant due to a strike, lockout, or other bona fide labor dispute.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2740 APPLICANT AND RECIPIENT RIGHTS AND LOCAL AGENCY RESPONSIBILITIES TO APPLICANTS AND RECIPIENTS.

Subpart 1. **Right to information.** An applicant or recipient has the right to obtain information about the benefits, requirements, and restrictions of AFDC.

Subp. 2. **Right to apply.** A person has the right to apply, including the right to reapply, for AFDC. A local agency shall inform a person who inquires about AFDC of his or her right to apply, shall explain how to apply, and shall offer a brochure about the program. When a local agency ends assistance, the local agency shall inform the recipient in writing of the right to reapply. When a report is received that indicates a loss of basis of eligibility under parts 9500.2180, 9500.2220, 9500.2260, or 9500.2300, the local agency shall notify the caretaker of other possible bases of eligibility, the need to file an addendum or a new application and the time limit for meeting that requirement.

Subp. 3. **Information about other programs.** A local agency shall inform an applicant or recipient about other programs administered by the local agency for which, from its knowledge of the person's situation, the person may be eligible. A local agency shall display, in a public place, brochures provided by the commissioner describing the medical assistance, general assistance, general assistance medical care, emergency assistance, food stamp, and Minnesota supplemental aid programs.

Subp. 4. **Right to authorized representative.** An applicant or recipient has the right to designate an authorized representative to act in his or her behalf. An applicant or recipient has the right to be assisted or represented by an authorized representative in the application, eligibility redetermination, fair hearing process, and any other contacts with the local agency or the department.

When a local agency determines that it is necessary for a person to assist an applicant or recipient, the local agency shall designate a staff member to assist him or her. The local agency staff member may assist the applicant or recipient to take the actions necessary to submit an application to establish the date of the application.

Upon a request from an applicant or recipient, a local agency shall provide addresses and telephone numbers of organizations that provide legal services at no cost to low income persons.

Subp. 5. **Right of applicant to notice.** A local agency shall notify an applicant of the disposition of his or her application. The notice must be in writing and on forms prescribed by the commissioner. The local agency must mail the notice to the last known mailing address provided by the applicant. When an application is denied, the local agency must notify the applicant in writing of the reasons for the denial, of the right to appeal, and of the right to reapply for assistance.

Subp. 6. **Right of recipient to notice.** A local agency shall give a recipient written notice of payment reductions, suspensions, terminations, or changes in

the use of protective, vendor, or two-party payments. The notice must be on forms prescribed or approved by the commissioner and must be mailed to the last known mailing address provided by the recipient. The local agency shall state on the notice the action it intends to take, the reasons for the action, the recipient's right to appeal the action, the conditions under which assistance can be continued pending an appeal decision, and the related consequences of the action, such as the loss of eligibility for medical assistance.

Subp. 7. **Mailing of notice.** Notices under subparts 5 and 6 must be made according to items A to C:

A. A local agency shall mail a notice to a recipient no later than ten days before the effective date of the action, except as provided in items B and C.

B. A local agency shall mail a notice to a recipient no later than five days prior to the effective date of the action when the local agency has factual information which requires an action to reduce, suspend, or terminate assistance, and this action is based on probable fraud.

C. A local agency shall mail a notice to a recipient no later than the effective date of the action when:

(1) the local agency receives a recipient's monthly or quarterly household report form which includes facts that require payment reduction, suspension, or termination and which contains the recipient's signed acknowledgment that he or she understands that this information will be used to determine program eligibility or the assistance payment amount;

(2) the local agency verifies the death of a recipient or the payee;

(3) the local agency receives a signed statement from a recipient that assistance is no longer wanted;

(4) the local agency receives a signed statement from a recipient that provides information which requires the termination or reduction of assistance, and the recipient shows in that statement that he or she understands the consequences of providing that information;

(5) the local agency verifies that a recipient is hospitalized and does not qualify under part 9500.2140, subpart 5, item C, subitem (1);

(6) the local agency verifies that a recipient has entered a state hospital or a licensed residential facility for medical or psychological treatment or rehabilitation;

(7) the local agency verifies that a member of an assistance unit has been approved to receive assistance by another county or state;

(8) the local agency verifies that a member of an assistance unit has been placed in foster care, except as specified in part 9500.2140, subpart 5, item C, subitem (2); or

(9) the local agency cannot locate a caretaker's whereabouts and mail from the local agency has been returned by the post office showing that the post office has no forwarding address.

Subp. 8. **Appeal rights.** An applicant, recipient, or former recipient has a right to request a fair hearing when aggrieved by an action or by inaction of a local agency. Requests for fair hearings must be submitted in writing to a local agency or to the department. These requests must be mailed within 30 days after an applicant or recipient receives written notice of the local agency's action or within 90 days when an applicant or recipient shows good cause for not submitting the request within 30 days. A former recipient who receives a notice of overpayment may appeal the action contained in the notice in the manner and within the periods described in this subpart. Issues which may be appealed are:

A. a denial of the right to apply for assistance;

B. the failure of a local agency to promptly approve or deny an application;

C. a denial of an application for assistance;

D. a suspension, reduction, or termination of assistance;

E. the calculated amount of an overpayment and the calculated level of recoupment due to that overpayment;

F. the eligibility for and calculation of a corrective payment;

G. other factors involved in the calculation of an assistance payment; and

H. the use of protective, vendor, or two-party payments.

Subp. 9. **Rights pending hearing.** A local agency shall not reduce, suspend, or terminate payment when an aggrieved recipient requests a fair hearing prior to the effective date of the action or within ten days of the mailing of the notice, whichever is later, unless the recipient requests in writing not to receive continued assistance pending a hearing decision. A local agency may increase or reduce an assistance payment while an appeal is pending when the circumstances of the recipient change and are not related to the issue under appeal. Assistance issued pending a fair hearing is subject to recovery under part 9500.2640, subpart 3 when, as a result of the fair hearing, the commissioner finds that the recipient was not eligible for the assistance. The commissioner's order is binding on a local agency and shall be implemented subject to Minnesota Statutes, section 256.045, subdivision 7. No additional notice is required to enforce the commissioner's order.

A local agency shall reimburse appellants for reasonable and necessary expenses of their attendance at the hearing, such as child care and transportation costs and for the transportation expenses of the appellant's witnesses and representatives to and from the hearing.

Subp. 10. **Hearings.** Fair hearings shall be conducted at a reasonable time, date, and place by an impartial referee employed by the department. An applicant, recipient, or former recipient may introduce new or additional evidence relevant to the issues on appeal. Recommendations of an appeals referee and decisions of the commissioner are based on evidence introduced at the hearing and are not limited to a review of the propriety of a local agency action.

Subp. 11. **Right to review records.** A local agency shall allow an applicant or recipient to review his or her own case records that are held by a local agency and which are related to eligibility for or the assistance payment from the program, except those case records to which access is denied under Minnesota Statutes, chapter 13. A local agency shall make case records available to an applicant or recipient as soon as possible but in no event later than the fifth business day following the date of the request. When an applicant, recipient, or authorized representative asks for photocopies of material from the case record, the local agency shall provide one copy of each page at no cost.

Subp. 12. **Right to manage affairs.** An applicant or recipient has the right to manage his or her financial affairs, except as provided in part 9500.2680, subpart 2. A local agency shall not restrict the use of an assistance payment except as specified in parts 9500.2680, subpart 2, 9500.2800, and 9500.2820.

Subp. 13. **Right to protection.** Under the circumstances defined in this subpart, a local agency shall refer an applicant or recipient to the social services unit of the local agency. Neither a referral for social services nor an applicant's or recipient's cooperation with the referral is a condition of eligibility for continued assistance. Referral must be made according to items A and B.

A. Referral must be made when a minor caretaker does not live with his or her parent or legal guardian. The local agency shall inform the minor caretaker that a referral is being made to the social services unit and that use of and cooperation with the social services unit is not a requirement for the receipt of assistance.

B. Referral must be made when a local agency staff member has reason

to believe that neglect, physical abuse, or sexual abuse exists as defined under Minnesota Statutes, section 626.556, subdivision 2 or 626.557, subdivision 2. The local agency shall also fulfill the requirements for reporting to proper authorities when the conditions in Minnesota Statutes, section 626.556, subdivision 3 or 626.557, subdivision 3 exist.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2760 SUPPORT FROM PARENTS OF MINOR CARETAKERS LIVING APART.

Subpart 1. **General provisions.** A parent who lives outside the home of a dependent child who is an unemancipated minor caretaker of an assistance unit is financially responsible for that minor caretaker unless the parent is a recipient of assistance, supplemental security income, Minnesota supplemental aid, medical assistance, general assistance, or general assistance medical care, and a court order does not otherwise provide a support obligation.

Subp. 2. **Amount of support payment.** The amount of support to be paid by a parent, except a parent specified in subpart 4, must be determined according to items A to F.

A. A minor caretaker shall provide information required by the local agency to identify the whereabouts of his or her absent parent.

B. A local agency shall notify an absent parent of his or her legal responsibility to support a minor caretaker and shall request that the absent parent provide the following:

(1) the amount of the parent's earned and unearned income for the previous tax year;

(2) the amount of the parent's earned and unearned income for the current month;

(3) the number and names of dependents who are claimed or could be claimed by the parent on federal income tax forms;

(4) the amount of annual medical bills paid by the parent;

(5) the amount of annual housing costs paid by the parent;

(6) the costs for utilities and repairs to the home which are paid by the parent; and

(7) the amount of annual educational costs for family members paid by the parent.

C. When a parent of a minor caretaker does not provide the information requested under item B, the local agency shall refer the matter to the county attorney. Assistance to the minor caretaker must not be denied, delayed, reduced, or ended because of the lack of cooperation of the minor caretaker's parent.

D. When the information requested under item B is received by a local agency, the local agency shall compare the parent's income against the following scale using the conditions and procedures specified in item E.

Size of Family	Annual Cost of Living (ACL)
1	$ 7,466
2	12,084
3	17,380
4	20,774
5	23,891

Twenty percent of the ACL for a family of five must be added for each additional family member.

E. The parent's income is the parent's earned income plus unearned income, determined by the methods in part 9500.2500, subpart 4, items A to C. To determine family size, each person claimed or who could be claimed by a parent as a dependent on federal income tax forms, exclusive of the minor caretaker, must be included. A deduction from income must be allowed for the amount that medical, educational, and housing costs together exceed 30 percent of the parent's income. When the amount of income, after the allowable deduction, exceeds the annual income level in item D, a parent is liable to pay one third of the excess for the annual support of the minor caretaker. These payments must be paid monthly to the minor caretaker or to the local agency on behalf of the minor caretaker.

F. A local agency shall notify the parents of the minor caretaker that they are liable for the amount of support determined by the local agency as specified in item E. When the support payment is received by the minor caretaker, it must be treated as unearned income of the assistance unit. When the support payment is not received, or a lesser amount is received in any payment month, the local agency shall refer the matter to the county attorney.

Subp. 3. **Reviews.** A local agency shall review financial responsibility every 12 months until minor caretakers reach the age of 18 or are otherwise emancipated. The local agency shall promptly review the required amount of payment when a parent reports a change in circumstances.

Subp. 4. **Parents under court order for support.** A parent who is required under an existing court order issued under some other authority in state or federal law to pay child support for a minor caretaker is subject to the conditions of that order in lieu of the requirements and contribution levels of subpart 2.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2780 WRONGFULLY OBTAINED ASSISTANCE.

Subpart 1. **Applicability to other laws.** This part outlines procedures that apply to AFDC which anticipate their use in combination with established civil and criminal procedures and law.

Subp. 2. **Responsibility of local agency to act.** In response to welfare fraud allegations received by a local agency, the local agency shall take any or all of the actions in items A to C:

A. A local agency shall refer cases of suspected welfare fraud to the person or unit designated by the county board for investigation of welfare fraud.

B. A local agency shall issue notice under the provisions of part 9500.2740, subpart 7 to reduce or end assistance when the local agency receives facts which show that an assistance unit is not eligible for assistance or for the amount of assistance currently being received.

C. A local agency shall refer cases of probable welfare fraud to the county attorney.

Subp. 3. **Continued program eligibility.** A local agency shall issue assistance when current program eligibility exists even when welfare fraud was proven for an earlier period or is currently under investigation, subject to subpart 2.

Subp. 4. **Recoupment and recovery of wrongfully obtained assistance.** A local agency shall recoup or attempt recovery of wrongfully obtained assistance. The amount recouped or recovered must not be more than the amount wrongfully obtained unless it is based on a court judgment. A local agency shall recoup wrongfully obtained assistance according to the procedures in part 9500.2620, items C and D until the full amount of wrongfully obtained assistance is repaid, seek voluntary repayment, or initiate civil court proceedings to recover any unrepaid balance of the wrongfully obtained assistance.

Subp. 5. **Reporting requirement.** A local agency shall gather and report

statistical data required by the commissioner on local agency activities to prevent welfare fraud.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2800 AFDC PAYMENTS FOR FUNERALS, HOUSING, AND SPECIAL NEEDS.

Subpart 1. **Payment of funeral and cemetery charges.** A local agency shall pay expenses incurred, up to a maximum of $370, for the funeral of a person who was a recipient at the time of death, and who is survived by members of the AFDC assistance unit who remain eligible for AFDC. In addition to these expenses, the local agency shall pay the actual cemetery charges. The local agency shall not pay for funeral expenses or cemetery charges when relatives of the deceased recipient, who had a legal responsibility to support the deceased recipient, are able to pay the expenses according to Minnesota Statutes, section 256.935. When donations from third parties or payments from other sources, including payments from prepaid burials or insurance, are conditioned on use for specific items such as a cemetery lot, interment, transportation of the body, or a religious service, the local agency must not apply these donations or payments against other items which the local agency must otherwise provide under this subpart. Amounts paid by a local agency for funeral expenses or cemetery charges under this subpart are reimbursable by the commissioner and recoverable from the estate according to Minnesota Statutes, section 256.935, subdivision 1. To determine the sufficiency of an estate to pay for funeral expenses, the local agency shall consider the nature and marketability of the assets of the estate.

Subp. 2. **Procedures for payment of AFDC housing allowance.** A recipient is eligible to receive an AFDC housing allowance under Minnesota Statutes, section 256.879 to replace a portion of his or her housing costs attributable to the payment of local property tax. The commissioner shall pay the AFDC housing allowance to a recipient who applies for a Minnesota property tax refund credit under Minnesota Statutes, chapter 290A. The commissioner must not direct payment of the AFDC housing allowance to a recipient who has already received a Minnesota property tax refund credit for the same tax year. The AFDC housing allowance is subject to reduction as an offset against any outstanding state tax liabilities.

Subp. 3. **State appropriation for special needs.** Payments for special need items, as defined and conditioned in subparts 4 to 9, must be paid to a recipient subject to the amount appropriated by the Minnesota legislature. Each quarter, the commissioner shall allocate this appropriation to a local agency in proportion to the number of assistance units served by that local agency in the previous calendar year, compared to the number served in the state.

A. A local agency shall issue these funds to meet special needs of a recipient. Notwithstanding subparts 4 to 9, a local agency is not required to provide special need payments that are more than the amount allocated to the local agency by the commissioner. A local agency must develop written procedures for meeting priority needs of a recipient and may establish waiting lists. A local agency must inform inquirers of the procedures and assure that the procedures are applied consistently within a quarter. A local agency shall log requests for special need items and shall use this log to develop or modify procedures for future quarterly allocations. Dispositions of each request must be included in the log.

B. At the end of each quarter, a local agency shall report the amount of any remaining funds to the commissioner. The commissioner shall adjust future allocations in the same fiscal year so that the remaining funds are reallocated to local agencies which have provided special needs beyond their individual allocations. This reallocation must be made on a pro rata basis in proportion to the amount by which a local agency exceeded its allocation.

Subp. 4. **Relationship between special needs and emergency assistance.** When a person is eligible for an item to be provided from both special need and emergency assistance funds, the local agency shall provide the item through special need funds when these funds are available.

Subp. 5. **Requests for special need funds.** When a local agency receives a request for items which are covered as a special need, the local agency shall provide the recipient with the information in subpart 3, item A; shall inform the recipient that a written request must be made; and may require the recipient to document need for the item. When payment is delayed due to lack of special need funds, or when payment is denied for any reason, the local agency shall notify the recipient in writing of the delay or denial.

Subp. 6. **Household furnishings and appliances.** Items A to S specify the items and special need payment amounts for repair or replacement of household furnishings and appliances:

A. infant layette, $35;

B. infant or child car seat, $35;

C. crib and mattress, $49;

D. high chair, $16;

E. cooking stove or range, $80;

F. refrigerator, $93;

G. water heater, $186;

H. bed:

(1) twin size (complete), $72;

(2) mattress or box spring (only), $27;

(3) frame, $18;

I. bed:

(1) full size (complete), $116;

(2) mattress or box spring (only), $49;

(3) frame, $18;

J. bedding (includes blanket, pillow and case, sheets), $20;

K. chest of drawers, $26;

L. lamp, $13;

M. washing machine, $93;

N. kitchen table, $24;

O. kitchen chair, $10;

P. couch, $74;

Q. living room chair, $24;

R. living room table, $10; and

S. clothes dryer, $93.

A recipient must not receive a special need payment for the same item more than once in a three-year period unless the payment is for repair of the item or the item needs replacement because of damage, theft, normal wear and tear, or loss. Abandonment of items during a move or change in living quarters when the recipient has failed to make reasonable attempts to retake possession does not constitute loss for this purpose. When the cost of an item is greater than the special need maximum payment, a recipient must document that he or she has other available resources which can be combined with the amount payable from special needs funds to pay for the item. A credit arrangement with the vendor which provides for immediate possession of the item satisfies this requirement, but layaway arrangements which delay the possession of an item until a recipient makes an additional payment do not. A local agency shall make payment for home furnishings and appliances by direct payment to a recipient, unless the

recipient requests vendor payment or the recipient's monthly assistance payment is subject to the conditions of Code of Federal Regulations, title 45, section 234.60(a)(2). When a local agency approves a two-party or vendor payment for an item to resolve an emergency under part 9500.2820 and the quarterly special need fund appropriation becomes available before the bill for that payment is received by the local agency, payment must be made according to the conditions of the original approval for payment.

Subp. 7. **Home repairs.** A local agency shall pay for repairs to the roof, foundation, wiring, heating system, chimney, and water and sewer system of a home which is owned and lived in by a recipient. Special need payments for these repairs are conditioned by items A to E.

A. The recipient shall document and the local agency shall verify the need for and method of repair.

B. The payment must be cost effective in relation to the overall condition of the home and in relation to the cost and availability of alternative housing.

C. A recipient must have no other resources for payment. To determine whether a recipient has available resources, the local agency must consider the immediacy of the need for the repair and the likelihood that the recipient may qualify for other programs or secure other resources to cover part or all of the funds needed for the cost of the repair.

D. A recipient shall provide the local agency with one vendor's estimate for the repair. The local agency may require up to two additional estimates when it determines the first is excessive. Any charge for an estimate authorized or required by a local agency must be paid from the appropriation under subpart 3. When one or more estimate is received, a local agency shall approve payment for the estimate which is most cost effective. When a recipient requests vendor payment under item E, a local agency shall condition payment on a written agreement with the vendor and shall not issue payment until it determines that the home repair is satisfactorily completed.

E. A local agency shall make payment for home repairs directly to a recipient unless the recipient requests vendor payment or the recipient's monthly assistance payment is subject to the conditions of Code of Federal Regulations, title 45, section 234.60(a)(2). When a local agency approves a two-party or vendor payment for a home repair to resolve an emergency under part 9500.2820 and the quarterly special need funds appropriation is received by the local agency before the bill for that payment, payment must be made according to the conditions of the original approval for payment.

Subp. 8. **Special diets.** A local agency shall make special need payments to a recipient for the costs of the diets specified in item A. These diets or dietary items must be prescribed by a licensed physician. When these costs are paid by a program other than AFDC, AFDC special need payment must not be made.

A. Payment amounts must be determined as percentages of the allotment for a one person household under the thrifty food plan. The payment amounts are revised annually and published in general notices in the Federal Register. The types of diets that may be paid for, and the percentages of the thrifty food plan which must be used to determine payment amounts, are identified in subitems (1) to (11):

(1) high protein diet (at least 80 grams daily), 25 percent of thrifty food plan;

(2) controlled protein diet (40-60 grams and requires special products), 100 percent of thrifty food plan;

(3) controlled protein diet (less than 40 grams and requires special products), 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten free diet, 25 percent of thrifty food plan;

(8) lactose free diet, 25 percent of thrifty food plan;

(9) anti-dumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan;

(11) ketogenic diet, 25 percent of thrifty food plan.

B. Payment must be issued directly to a recipient as a part of the monthly assistance payment or as a separate monthly payment. Continuing need for the diet must be verified no less often than at each redetermination of eligibility. The local agency shall not require a recipient to document his or her actual expenditures for the dietary items.

Subp. 9. **Verification and preauthorization requirements.** Payments made under subparts 6 to 8 must be made only when a recipient's need for the item is verified by the local agency. A local agency may require prior authorization as a condition of payment, but when the need for a special need item occurs at a time outside of the local agency's business hours, this requirement is satisfied when a recipient contacts the local agency on the next working day to request authorization.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2820 EMERGENCY ASSISTANCE.

Subpart 1. **Applicability.** This part governs the administration of the emergency assistance program funded under title IV-A for needy families with children. This part identifies circumstances under which assistance or services must be provided, conditions of eligibility for that assistance or those services, and the conditions under which the department and a local agency shall administer the program to be consistent with federal requirements for statewide administration and equal access to program benefits by recipients and persons who are not recipients.

Subp. 2. **Definitions.** The terms used in this part have the meanings given to them in items A to O.

A. "Applicant" means a person for whom an application for assistance has been filed with a local agency.

B. "Assistance" means a financial benefit received from the emergency assistance program.

C. "Available resources" means an applicant's property that is liquid or can be liquidated within the time necessary to avoid or promptly alleviate destitution, together with income and public funds for which an applicant is eligible.

D. "Balloon payment" means an amount of money required to be paid on a specific date according to the terms of a contract for deed or mortgage loan agreement and that exceeds the monthly contract for deed or mortgage payment.

E. "Basic need items" means subsistence items necessary for life and health, including food, safe drinking water, habitable shelter, clothing, medical care; the companion items necessary to assure these needs, including heating fuel, electricity, essential household appliances and furnishings; caregiving services to children and incapacitated adults; transportation, equipment, or other expenses necessary for employment; transportation necessary for medical care; and other goods or services necessary to protect a child's health or safety.

F. "Child" means a person who is under the age of 21 years who lives with a caretaker.

G. "Destitution" means the lack of a basic need item and the lack of resources to provide for that need.

H. "Emergency" means a situation or set of circumstances that causes or threatens to cause destitution to a child.

I. "Family" means the persons who are part of the same household with a child. When the caretaker applying for a child is a parent, the term "family" includes that child, siblings or stepsiblings under the age of 21, and the other parent or stepparent of that child . When the caretaker applying for a child is not a parent, the term "family" includes that child, the eligible relative caretaker of that child, the spouse of that caretaker, and any other children under the age of 21 for whom that caretaker or spouse would qualify as an eligible relative under part 9500.2440, subpart 7.

J. "Family budgeting services" means services which help an applicant or recipient to develop the ability to use its available income and resources to improve his or her financial stability and provide himself or herself with basic need items.

K. "Habitable shelter" means housing that meets the health or safety standards provided under local ordinance, state or federal law, and any specific criteria established by a licensed physician as necessary to the life or health of a child.

L. "Program" means the program of emergency assistance for needy families with children under the age of 21 years.

M. "Threatened destitution" means the destitution that will result in the future unless action is taken.

N. "Utility budget period" means the month of application and the continuous 11-month period immediately preceding that month or a shorter period when an applicant has had no responsibility to pay for utility service for any month of the last 12 months. Unpaid utility bills covering a period of time in excess of 12 months must be divided into two or more utility budget periods.

O. "Utility costs" means charges incurred by an applicant for the provision of electrical, gas, wood, heating fuel, and municipal water and sewer service.

Subp. 3. **Statement of purpose.** The purposes of the program are to avoid and to prevent the destitution of children. The program does so by providing assistance to resolve an emergency and by providing services that reduce the risk of recurrence of destitution.

Subp. 4. **Inquiries.** A local agency shall offer, by hand or mail, an application form and an informational brochure provided by the department as soon as a person makes a written or oral inquiry about the program. A local agency shall offer an application form and brochure on the same day the inquiry is received by the local agency.

Subp. 5. **Application.** Any family with a child may apply for assistance. At that time, a local agency shall explain to an applicant the program's eligibility requirements, the limitation of annual eligibility, the extent of the program's coverage, other programs provided by the local agency or known by the local agency to be applicable to the family's circumstances, the availability of expedited issuance of food stamps for eligible persons, and the rights and responsibilities of an applicant for and recipient of assistance.

Subp. 6. **Forms.** A person must submit to a local agency a signed and dated application for emergency assistance on forms prescribed by the commissioner.

Subp. 7. **Interview.** A local agency shall conduct a personal interview with an applicant after receipt of an application for assistance. When the circumstances of an applicant show destitution is imminent or already present, a local agency shall offer to conduct a personal interview on the same day the application is received to determine the applicant's eligibility. In all other cases, the local agency shall conduct a personal interview within a time that does not inhibit the local agency's ability to provide assistance in time to prevent destitution.

Subp. 8. **Processing application.** An application must be processed in a

manner that considers the immediacy and severity of the destitution. A local agency shall help an applicant complete the verification process in time to prevent destitution. Verification must be made promptly and must be done by telephone when necessary to avoid destitution. When documentation from a third party is not secured in time, an affidavit from an applicant must be accepted. A local agency shall designate at least one staff person to authorize immediate issuance of assistance. A local agency shall not delay issuance of assistance to get formal action from the county board.

Subp. 9. **Notice of eligibility.** A local agency shall notify an applicant in writing on a form prescribed by the commissioner of its determination of his or her eligibility for assistance. The local agency shall mail or deliver the notice to the applicant within one week of the date the application was submitted unless the applicant is informed in writing within that time of the reason for the delay.

Subp. 10. **Eligibility.** A local agency shall issue assistance to a family, including a migrant family, that meets the conditions of items A to D:

A. the family must have a child under the age of 21 years who is or, within six months prior to application, has been living with the caretaker;

B. the family must have an emergency;

C. the family's available resources must not be sufficient to resolve the emergency; and

D. the emergency must not exist because a caretaker or child age 16 or over refused employment or training for employment without good cause as defined in part 9500.2700, subpart 19.

Subp. 11. **Covered emergencies.** Assistance must be authorized when a child lacks or is threatened with the loss of basic need items.

A. Emergency need may be caused by eviction, condemnation, cancellation of a contract for deed, mortgage foreclosure, or other relocation; return from residential treatment, long-term hospitalization, incarceration or other separations of a child from the caretaker; civil disorders or strikes; fire, flood, storm, or other natural disaster; or loss or theft of funds.

B. Assistance may be authorized for:

(1) shelter or shelter deposit;

(2) moving expenses;

(3) storage costs necessary to recover property described in part 9500.2800, subpart 6;

(4) necessary household furnishings described in part 9500.2800, subpart 6;

(5) necessary household appliances described in part 9500.2800, subpart 6;

(6) necessary home repairs described in part 9500.2800, subpart 7;

(7) utility service or utility hookup;

(8) clothing;

(9) food;

(10) safe drinking water;

(11) necessary medical care;

(12) necessary dependent care;

(13) transportation, equipment, or other expenses necessary for employment, subject to subpart 13;

(14) transportation necessary for medical care; or

(15) other items necessary for the health or safety of a child.

Subp. 12. **Limitations.** The limitations of the program are listed in items A to G.

A. A local agency shall issue assistance to a family during only one 30-day period in a consecutive 12-month period. A local agency shall issue assistance for needs that accrue before that 30-day period only when it is necessary to resolve emergencies arising or continuing during the 30-day period of eligibility. When emergency needs continue, a local agency may issue assistance for up to 30 days beyond the initial 30-day period of eligibility but only when assistance is authorized during the initial period.

B. A local agency must not issue assistance when uncashed AFDC checks are lost or stolen. Instead, the lost or stolen AFDC checks must be replaced under part 9500.2680, subpart 1, item C.

C. A local agency shall limit assistance for household furnishings and appliances according to part 9500.2800, subpart 6.

D. A local agency shall limit assistance for home repairs according to part 9500.2800, subpart 7.

E. A local agency shall issue assistance for storage costs that are cost effective in relation to the value of the materials in storage and to other alternatives for resolving the emergency.

F. A local agency must not deny an application for assistance because a recipient does not choose to request that future monthly AFDC payments be paid through protective, vendor, or two-party payments. When a local agency determines mismanagement of a monthly AFDC payment has occurred under part 9500.2680, subpart 2, item E, the local agency must proceed with protective, vendor, or two-party payments under that provision.

G. A local agency may deny assistance to prevent eviction from rented or leased shelter of an otherwise eligible applicant when the local agency determines that an applicant's anticipated income will not cover continued payment of shelter and utility expenses, subject to the conditions in subitems (1) to (3).

(1) A local agency must not deny assistance when an applicant can document that he or she is unable to locate habitable shelter, unless the local agency can document that one or more habitable shelters are available in the community that will result in at least a 20 percent reduction in monthly expense for shelter and utilities and that this shelter will be cost effective for the applicant. When considering cost effectiveness for an applicant, a local agency shall evaluate the appropriateness of the alternative shelter in terms of size in relation to the number of family members, location in relation to special needs of the child, and other factors which would be likely to arise due to the disruption of the move.

(2) When no alternative shelter is identified by either the applicant or the local agency, the local agency must not deny assistance because of the determination that the applicant's anticipated income will not cover continued payment of shelter and utility costs. The local agency shall issue assistance in the amount needed to prevent the eviction.

(3) When alternative living shelter is identified, the local agency shall issue assistance for moving expenses as provided in subpart 18, item D.

Subp. 13. **Issuance of payment.** A local agency shall determine the most effective method of payment to resolve the emergency. Payment may be made either by direct cash payment to an applicant or by vendor or two-party payment. When assistance is issued for employment-related expenses under subpart 11, item B, subitem (13), issuance is limited to an interest-free loan of up to $100.

Subp. 14. **Available services.** Services allowed under the program are listed in items A to D.

A. A local agency may offer family budgeting services to persons who inquire about the program. Family budgeting services may be provided by local agency staff, including social services staff, or a local agency may contract with qualified persons or agencies to provide the services. When a local agency uses its own staff, administrative costs may be attributed to the program as a part of

the local agency's cost allocation process, or the local agency may choose to use its own funds. When a local agency contracts with persons or agencies outside the local agency, the costs are considered program expenditures in the same manner as other program expenditures made on behalf of persons who apply for assistance.

B. A local agency may negotiate on behalf of an applicant with vendors or creditors at the applicant's request or under the conditions of subpart 16, item D.

C. A local agency may provide protective payee or vendor payment services at the request of a recipient for monthly AFDC payments.

D. A local agency may assist an applicant by coordinating local agency financial assistance programs with public or private resources which exist in the community.

Subp. 15. **Termination of utility service.** Assistance payments must be made when an otherwise eligible family has had a termination or is threatened with a termination of municipal water and sewer service, electric, gas, or heating fuel service, or lacks wood when that is the heating source, subject to the conditions of items A and B.

A. A local agency must not issue assistance unless the local agency receives confirmation from a utility provider that assistance combined with payment by the applicant will continue or restore the utility service.

B. A local agency must not issue assistance for utility costs for an applicant who:

(1) effective October 1, 1986, and thereafter, paid less than four percent of the family's gross income toward utility costs due during the utility budget period or while the application is pending;

(2) effective October 1, 1987, and thereafter, paid less than six percent of the family's gross income toward utility costs due during the utility budget period or while the application is pending; and

(3) effective October 1, 1988, and thereafter, paid less than eight percent of the family's gross income toward utility costs due during the utility budget period or while the application is pending.

Subp. 16. **Amounts of payment.** A local agency shall issue assistance for utility costs in an amount that is dependent upon the percent of the family's gross income paid toward utility costs and the percent of the total utility costs paid before the issuance of assistance. A local agency shall determine those amounts according to items A to E.

A. Payment of the balance owed to a utility provider must be paid in full for an applicant who:

(1) effective October 1, 1986, and thereafter, paid no less than eight percent of the family's gross income toward utility costs due during the utility budget period or while the application is pending;

(2) effective October 1, 1987, and thereafter, paid no less than 12 percent of the family's gross income toward utility costs due during the utility budget period or while the application is pending; and

(3) effective October 1, 1988, and thereafter, paid no less than 16 percent of the family's gross income toward utility costs due during the utility budget period or while the application is pending.

B. Payment on the balance owed to a utility provider must be limited to the amounts under item C for an applicant who:

(1) effective October 1, 1986, and thereafter, paid at least four percent and less than eight percent of gross income toward utility costs due during the utility budget period or while the application is pending;

(2) effective October 1, 1987, and thereafter, paid at least six

percent and less than 12 percent of gross income toward utility costs due during the utility budget period or while the application is pending; and

(3) effective October 1, 1988, and thereafter, paid at least eight percent and less than 16 percent of gross income toward utility costs due during the utility budget period or while the application is pending.

C. When an applicant pays the amounts specified in item B, a local agency shall issue assistance as follows:

Amounts Paid By The Program

Percent of total utility consumption cost paid by applicant prior to issuance of assistance	Percent of the unpaid balance which will be paid by the program	Percent of the unpaid balance which must be paid by the applicant
less than 10 percent	70 percent	30 percent
at least 10 percent and less than 20 percent	76 percent	24 percent
at least 20 percent and less than 30 percent	82 percent	18 percent
at least 30 percent and less than 40 percent	88 percent	12 percent
at least 40 percent and less than 50 percent	94 percent	6 percent
50 percent or more	100 percent	0 percent

D. When a utility provider does not offer a repayment plan to the applicant and the applicant does not have sufficient current funds which, when combined with the assistance, will allow for the continuation or restoration of utility service, a local agency may negotiate with the utility provider on behalf of the applicant. When a utility provider does not withdraw the proposed termination of service, the local agency shall assist the family in seeking alternate arrangements for utility service.

E. The provisions in items A to D must not be construed to prevent the issuance of assistance when a local agency must take immediate and temporary action necessary to protect the life or health of a child.

Subp. 17. **Mortgage and contract for deed arrearages.** A local agency shall issue assistance for mortgage or contract for deed arrearages on behalf of an otherwise eligible applicant according to items A to H.

A. Assistance for arrearages must be issued only when a home is owned, occupied, and maintained by the applicant.

B. Assistance for arrearages must be issued only when no subsequent foreclosure action is expected within the 12 months following the issuance. To make this determination, a local agency shall consider the anticipated mortgage costs over the 12-month period together with the applicant's anticipated income and other circumstances which would affect the applicant's ability to prevent foreclosures during that period.

C. Assistance for arrearages must be issued only when an applicant has been refused refinancing through a bank or other lending institution and the amount payable, when combined with any payments made by the applicant, will be accepted by the creditor as full payment of the arrearage.

D. Costs paid by a family which are counted toward the payment requirements in item E are principal and interest payments on mortgages or contracts for deed, balloon payments, homeowner insurance payments, rental payments for shelter, mobile home lot rental payments, and tax or special assessment payments related to the homestead. Costs paid which are not counted include rental deposits, and down payments and closing costs related to the sale or purchase of real property.

E. To be eligible for assistance for the costs in item D which are outstanding at the time of foreclosure, an applicant must have paid at least 30 percent of the family's gross income toward these costs in the month of application and the 11-month period immediately preceding the month of application. When an applicant has received assistance on or after October 1, 1986, for a prior foreclosure action, the applicant must have paid at least 40 percent of the family's gross income toward these costs in the month of application and the 11-month period immediately preceding the month of application.

F. When an applicant is eligible under item E, a local agency shall issue assistance for outstanding costs up to a maximum of four times the AFDC family allowance for a family of the size and composition of the family applying for assistance.

G. Payments made under item F constitute a debt owed to the county and the state, but only when the person's interest in the property is sold. A local agency shall file a lien against the property and shall notify the applicant, at the time of application for payment of the arrearage payment, that a lien will be filed.

H. When a local agency determines that an applicant is ineligible for assistance for arrearage payment, but is otherwise eligible for assistance, the local agency shall assist the family with relocation according to subpart 18.

Subp. 18. **Moving expenses.** A local agency shall issue assistance for expenses incurred when a family must move to a different shelter according to items A to D.

A. Moving expenses include the cost to transport personal property belonging to a family, the cost for utility connection, and the cost for securing different shelter.

B. Moving expenses must be paid only when the local agency determines that a move is cost effective.

C. Moving expenses must be paid at the request of an applicant, but only when destitution or threatened destitution exists.

D. Moving expenses must be paid when a local agency denies assistance to prevent an eviction because the local agency has determined that an applicant's anticipated income will not cover continued payment of shelter and utility costs in the applicant's current shelter under subpart 12, item G.

Subp. 19. **Right to appeal.** An applicant shall have the right to appeal a local agency's action or failure to act with reasonable promptness on an application for assistance.

A. A local agency shall inform an applicant in writing of the right to appeal and the procedures to follow in filing an appeal. Within two working days after receiving a written request for an appeal, the local agency shall forward the written request and an agency appeal summary to the appeals office of the department.

B. The appeals office shall schedule a hearing on the earliest available date and, following the hearing, shall promptly forward the decision of the referee to the commissioner.

C. The commissioner shall issue a written order within five working days of receipt of the referee's decision, shall immediately inform the parties of the outcome of the decision by telephone, and shall mail the written decision to the parties no later than the second working day following the date of the commissioner's decision.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2860 RELATIONSHIP TO OTHER PROGRAMS.

Subpart 1. **Medical assistance; applicants.** An applicant may qualify to receive retroactive medical assistance benefits for up to three months before the month of application. An applicant shall provide information about health insurance and other medical coverage held by or available to the applicant, including pending lawsuits or claims for medical costs. An applicant who is a policyholder of health insurance shall assign to the department any rights to policy benefits he or she has during the period of medical assistance eligibility. When an applicant refuses to assign the rights to the department, the caretaker's program eligibility is unaffected, but the caretaker is ineligible for medical assistance. An application is used to determine retroactive medical assistance eligibility and to establish current eligibility for medical assistance, according to items A and B.

A. When a person applies for AFDC, the local agency shall inform the applicant of the existence of retroactive medical assistance and shall determine eligibility for retroactive medical assistance when the applicant requests it.

B. When a local agency approves an AFDC application, the effective date of medical assistance eligibility must be the first day of the month in which program eligibility begins, unless eligibility existed for medical assistance under item A. When a local agency denies an AFDC application and medical assistance is requested, the local agency must accept a medical assistance application. The local agency shall use the date of application for AFDC as the date of application for medical assistance or general assistance medical care.

Subp. 2. **Medical assistance; recipients.** A recipient shall receive medical assistance according to items A to F.

A. A local agency shall reimburse or issue direct payment to a recipient for transportation costs for medical care from medical assistance administrative funds.

B. A local agency must not recover amounts for ineligible medical assistance claims or payments from the monthly assistance payment.

C. A recipient shall inform the local agency of injuries for which a third party payor may be liable for payment of medical costs.

D. A local agency shall allow a recipient eligibility for medical assistance for months during which monthly assistance payments are suspended due to increased earned income or for months where no monthly assistance payments are issued due to the $10 minimum issuance limitation specified in part 9500.2620, item B.

E. A local agency shall determine eligibility for medical assistance according to subpart 3, item A, when assistance is suspended for a reason other than that in item D.

F. A local agency shall offer services through the EPSDT program on behalf of each applicant or recipient who is less than 21 years of age, subject to parts 9505.1500 to 9505.1690.

Subp. 3. **Medical assistance; terminations of assistance.** A local agency shall continue medical assistance when assistance ends according to items A to C.

A. When assistance ends solely due to the increased earned income, increased hours of employment of a member of an assistance unit, or increased child support, medical assistance eligibility must be continued for four months from the month in which program eligibility ends.

B. When assistance ends solely because a member of an assistance unit is no longer eligible for the work incentive disregard under part 9500.2580, item C or D, medical assistance must continue for the assistance unit for nine months

from the month in which program eligibility ends. When at the end of that nine-month period, the assistance unit would be eligible for assistance except for the loss of the work incentive disregard under part 9500.2580, item C or D, medical assistance must continue for up to three additional months.

C. When assistance is ended due to applying the income from stepparents, grandparents, or siblings to the need of an assistance unit, the local agency shall provide the recipient with an AFDC termination notice that allows one month of medical assistance after assistance ends. To continue eligibility for medical assistance beyond the one month, eligibility must be established under parts 9500.0750 to 9500.1080 and the application supplied with the AFDC termination notice must be returned to the local agency within ten days of the date assistance ends.

Subp. 4. **Social services.** An AFDC unit staff member shall refer a recipient for social services that are offered in the county of financial responsibility according to the criteria which is established by that local agency under the Community Social Services Act. A payment issued from title XX, child welfare funds, or county funds in a payment month must not restrict program eligibility or reduce the monthly assistance payment for that recipient.

Subp. 5. **Concurrent eligibility.** A local agency shall not count an applicant or recipient as a member of more than one assistance unit in a given payment month except as provided in items A to C.

A. An applicant who receives assistance in a state other than Minnesota may be eligible in the first month of application at Minnesota payment standards. An assistance payment from another state must be considered unearned income when determining the assistance payment issued under the Minnesota program.

B. A recipient who is a member of an assistance unit in Minnesota is eligible to be included in a second assistance unit in the first full month that the recipient lives with a second assistance unit or from the date of application to include those persons, whichever is later. The assistance payment issued to and kept by the first assistance unit must be considered an overpayment and must be recouped or recovered from the first assistance unit.

C. An applicant who has his or her needs met through foster care under title IV-E for the first part of an application month is eligible to receive assistance for the remaining part of the month in which the applicant returns home. Title IV-E payments and assistance payments must be considered prorated payments rather than a duplication of AFDC need.

Subp. 6. **Other income maintenance programs.** An applicant or recipient is not eligible to receive general assistance medical care, general assistance, or Minnesota supplemental aid in the same payment month except for items A to C.

A. A general assistance recipient who applies for AFDC may be eligible for both assistance and general assistance in the months that the application for AFDC is pending. General assistance payment must be considered unearned income in determining AFDC eligibility. When a general assistance payment is issued to a battered women's shelter for an applicant or recipient, that payment must not be applied against AFDC need.

B. An applicant or recipient who is eligible for both AFDC and Minnesota supplemental aid may choose to receive benefits through either program.

C. An applicant who is receiving general assistance medical care at the time of application may continue to receive general assistance medical care until AFDC eligibility is established. Services received by applicants while they are eligible for both general assistance medical care and medical assistance must be paid under medical assistance.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2880 COUNTY OF RESPONSIBILITY POLICIES AND DISPUTES.

Subpart 1. **Determining the county of financial responsibility.** The county of financial responsibility is the county in which a dependent child lives on the date the application is signed, unless subpart 4 applies. The county in which a woman with no children lives on the date the application is signed under part 9500.2140, subpart 4 is the county of financial responsibility unless subpart 4 applies. When more than one county is financially responsible for the members of an assistance unit, the caretaker's needs must be met by the county of financial responsibility for the most children. When each county is financially responsible for the same number of children, the county of financial responsibility for the oldest child is responsible for the needs of the caretaker.

Subp. 2. **Change in residence.** When a dependent child moves from one county to another and continues to receive assistance, the new county of residence becomes the county of financial responsibility when that child has lived in that county for two full calendar months, unless subpart 4 applies.

A. When a recipient moves from one county to another, eligibility for assistance is not affected unless eligibility factors are affected in the move. A local agency must not require a recipient to reestablish program eligibility as a new applicant for assistance solely because a recipient moves. A local agency shall not require reapplication nor apply the program eligibility criteria which govern only initial applications, except as described under item B, subitem (3).

B. The requirements in subitems (1) to (3) apply when a recipient moves from one county to another.

(1) When a recipient informs the local agency in the current county of residence of a planned move, the local agency in that county shall forward to the local agency in the county of planned residence the information from the case record which the county of planned residence needs to redetermine eligibility and to determine the amount of the assistance payment. Within 30 calendar days of the recipient's move, the new county of residence shall interview the recipient and take action to increase, reduce, suspend, or end assistance due to changes in the recipient's circumstances which affect either program eligibility or the amount of the assistance payment.

(2) When a recipient informs the new county of residence that he or she has entered the county as a current recipient, the new county shall obtain from the county from which the recipient moved the information from the case record that it needs to redetermine eligibility and determine the amount of the assistance payment. Within 30 calendar days, the local agency in the new county shall interview the recipient and take action to increase, reduce, suspend, or end assistance due to changes in the recipient's circumstances which affect either program eligibility or the amount of the assistance payment.

(3) When a recipient does not inform either county that the move has occurred before the mailing of the next assistance payment and when the whereabouts of a recipient are unknown, the county of financial responsibility shall end assistance. When a recipient reapplies in another county within 30 calendar days of termination and is eligible, assistance is considered to be uninterrupted for the determination of the county of financial responsibility for members of the assistance unit. This payment must be issued by the county of financial responsibility until the recipient has lived in the new county for two full calendar months.

C. When an applicant moves from one county to another while the application is pending, the county where application first occurred is the county of financial responsibility until the applicant has lived in the new county for two full calendar months, unless the applicant's move is covered under subpart 4.

Subp. 3. **Responsibility for incorrect assistance payments.** A county of residence, when different from the county of financial responsibility, will be charged

by the commissioner for the value of incorrect assistance payments and medical assistance paid to or on behalf of a person who was not eligible to receive that amount. Incorrect payments include payments to an ineligible person or family resulting from decisions, failures to act, miscalculations, or overdue redeterminations of eligibility. However, financial responsibility does not accrue for a county when the redetermination of eligibility is overdue at the time the referral is received by the county of residence or when the county of financial responsibility does not act on the recommendation of the county of residence.

When federal or state law requires that medical assistance continue after assistance ends, the provisions of this subpart also govern financial responsibility for the extended medical assistance.

Subp. 4. **Out-of-county placement.** When a plan of treatment for health rehabilitation, foster care, child care or training, or a correctional plan requires that a recipient move from one county to another to meet the goals of the plan, the county in which the assistance unit lives at the time the plan is developed is the county of financial responsibility until the goals of the plan are met or until the plan is ended. When the family or child continues to live in the second county, the former county is the county of financial responsibility until two full calendar months have elapsed following the completion or end of the plan. This delay in the transfer of financial responsibility to another county also applies when a woman leaves her county of residence to enter a battered women's shelter or a maternity shelter in another county. When an applicant or recipient had contact with a local agency staff member before moving, the contact must be evaluated to determine whether the move was a placement pursuant to a plan of treatment or whether the local agency had an existing legal obligation to consider and undertake such a placement.

Subp. 5. **Settlement of disputes.** When a local agency receives an application for assistance or a request for transfer under subpart 2 and does not believe it is the county of financial responsibility, items A to E apply.

A. The local agency that has received the application or transfer request shall, simultaneously:

(1) accept the application, determine program eligibility, and when the applicant or recipient is eligible, calculate and issue the assistance payment; and

(2) refer the current case record within 15 days to the county it believes to be the county of financial responsibility.

B. The local agency that is alleged to be the county of financial responsibility shall determine if it accepts financial responsibility, and, within 15 days of receipt of the current case record provided for under item A, the local agency shall:

(1) notify the referring county that it accepts financial responsibility; or

(2) notify the referring county that it does not accept financial responsibility and the reasons. The referring county shall then either accept financial responsibility or submit the matter to the commissioner for a settlement.

C. The commissioner shall provide both counties with the opportunity to state their positions, review the case facts, and determine from the case facts which county is the county of financial responsibility. The commissioner's determination binds both counties unless it is appealed to district court within 30 days of the date of the determination and the commissioner's decision is reversed by that court.

D. The county that accepts financial responsibility, or is determined by the commissioner to be the county of financial responsibility, shall reimburse the other county for costs the nonresponsible county previously paid. Reimburse-

ment must be for the total costs incurred, rather than the county share, only when the nonresponsible county has not received AFDC federal and state reimbursement.

E. The provisions in this part must not be construed to require, authorize, or permit a local agency to delay either a determination of eligibility or issuance of an assistance payment when that local agency believes that another county may ultimately be financially responsible.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*