CHAPTER 256D

GENERAL ASSISTANCE

256D.01 DECLARATION OF POLICY; CITATION.

[For text of subd 1, see M.S.1998]

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 6, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The commissioner shall set the standard of assistance for an assistance unit consisting of an adult recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian. When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance is the amount that the aid to families with dependent children standard of assistance, in effect on July 16, 1996, would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone. Benefits received by a responsible relative of the assistance unit under the supplemental security income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the social security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods, income deductions, exclusions, and disregards used when calculating the countable income for a single adult or childless couple must be used.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program in effect on July 16, 1996. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program as of July 16, 1996.

[For text of subd 1b, see M.S.1998]

Subd. 1e. **Rules regarding emergency assistance.** The commissioner shall adopt rules under the terms of sections 256D.01 to 256D.21 for general assistance, to require use of the emergency program under MFIP as the primary financial resource when available. The commissioner shall adopt rules for eligibility for general assistance of persons with seasonal income and may attribute seasonal income to other periods not in excess of one year from receipt by an applicant or recipient. General assistance payments may not be made for foster

care, child welfare services, or other social services. Vendor payments and vouchers may be issued only as authorized in sections 256D.05, subdivision 6, and 256D.09.

[For text of subd 2, see M.S.1998]

History: *1999 c 159 s 56,57*

256D.02 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1998]

Subd. 8. "Income" means any form of income, including remuneration for services performed as an employee and net earnings from self–employment, reduced by the amount attributable to employment expenses as defined by the commissioner. The amount attributable to employment expenses shall include amounts paid or withheld for federal and state personal income taxes and federal social security taxes.

Income includes any payments received as an annuity, retirement, or disability benefit, including veteran's or workers' compensation; old age, survivors, and disability insurance; railroad retirement benefits; reemployment compensation benefits; and benefits under any federally aided categorical assistance program, supplementary security income, or other assistance program; rents, dividends, interest and royalties; and support and maintenance payments. Such payments may not be considered as available to meet the needs of any person other than the person for whose benefit they are received, unless that person is a family member or a spouse and the income is not excluded under section 256D.01, subdivision 1a. Goods and services provided in lieu of cash payment shall be excluded from the definition of income, except that payments made for room, board, tuition or fees by a parent, on behalf of a child enrolled as a full–time student in a post–secondary institution, and payments made on behalf of an applicant or recipient which the applicant or recipient could legally demand to receive personally in cash, must be included as income. Benefits of an applicant or recipient, such as those administered by the Social Security Administration, that are paid to a representative payee, and are spent on behalf of the applicant or recipient, are considered available income of the applicant or recipient.

[For text of subds 11 to 19, see M.S.1998]

History: *1999 c 107 s 66*

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

[For text of subds 1 to 2a, see M.S.1998]

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c); and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program–statewide (MFIP–S), who is having a payment made on the person's behalf under sections 256I.01 to 256I.06, or who resides in group residential housing as defined in chapter 256I and can meet a spenddown using the cost of remedial services received through group residential housing; or

(2)(i) who is a resident of Minnesota; and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in chapter 256B, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; and

(ii) who has countable income not in excess of the assistance standards established in section 256B.056, subdivision 4, or whose excess income is spent down according to section

256B.056, subdivision 5, using a six–month budget period. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall follow section 256B.056, subdivision 1a. However, if a disregard of $30 and one–third of the remainder has been applied to the wage earner's income, the disregard shall not be applied again until the wage earner's income has not been considered in an eligibility determination for general assistance, general assistance medical care, medical assistance, or MFIP–S for 12 consecutive months. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first $50 of earned income is not allowed;

(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal Health Care Financing Administration to be an institution for mental diseases; or

(4) who is ineligible for medical assistance under chapter 256B or general assistance medical care under any other provision of this section, and is receiving care and rehabilitation services from a nonprofit center established to serve victims of torture. These individuals are eligible for general assistance medical care only for the period during which they are receiving services from the center. During this period of eligibility, individuals eligible under this clause shall not be required to participate in prepaid general assistance medical care.

(b) Beginning January 1, 2000, applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are:

(i) adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines; or

(ii) adults without children with earned income and whose family gross income is between 75 percent of the federal poverty guidelines and the amount set by section 256L.04, subdivision 7, shall be terminated from general assistance medical care upon enrollment in MinnesotaCare.

(c) For services rendered on or after July 1, 1997, eligibility is limited to one month prior to application if the person is determined eligible in the prior month. A redetermination of eligibility must occur every 12 months. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the department of human services or sent directly to the department of human services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (e).

(d) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and social security number, signed and dated, to the county agency or the department of human services. If the applicant is unable to provide an initial application when health care is delivered due to a medical condition or disability, a health care provider may act on the person's behalf to complete the initial application. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary. On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) has gross income less than 90 percent of the applicable income standard;

(2) has liquid assets that total within $300 of the asset standard;

(3) does not reside in a long–term care facility; and

(4) meets all other eligibility requirements.

The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.

(e) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(f) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(g) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance. General assistance medical care is limited to payment of emergency services only for applicants or recipients as described in paragraph (b), whose MinnesotaCare coverage is denied or terminated for nonpayment of premiums as required by sections 256L.06 and 256L.07.

(h) In determining the amount of assets of an individual, there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(i) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104–193, sections 421 and 422, and subsequently set out in federal rules.

(j)(1) An undocumented noncitizen or a nonimmigrant is ineligible for general assistance medical care other than emergency services. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(2) This paragraph does not apply to a child under age 18, to a Cuban or Haitian entrant as defined in Public Law Number 96–422, section 501(e)(1) or (2)(a), or to a noncitizen who is aged, blind, or disabled as defined in Code of Federal Regulations, title 42, sections 435.520, 435.530, 435.531, 435.540, and 435.541, or effective October 1, 1998, to an individual eligible for general assistance medical care under paragraph (a), clause (4), who cooperates with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify the individual for medical assistance with federal financial participation.

(3) For purposes of this paragraph, "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.

(k) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

[For text of subds 3a and 3b, see M.S.1998]

Subd. 4. **General assistance medical care; services.** (a) For a person who is eligible under subdivision 3, paragraph (a), clause (3), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X–ray services;

(10) physician's services;

(11) medical transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) a service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(b) Except as provided in paragraph (c), for a recipient who is eligible under subdivision 3, paragraph (a), clause (1) or (2), general assistance medical care covers the services listed in paragraph (a) with the exception of special transportation services.

(c) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(d) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. Notwithstanding the provisions of subdivision 3, an individual who becomes ineligible for general assistance medical care because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible for general assistance medical care coverage through the last day of the month in which the enrollee became ineligible for general assistance medical care.

(e) The commissioner of human services may reduce payments provided under sections 256D.01 to 256D.21 and 261.23 in order to remain within the amount appropriated for general assistance medical care, within the following restrictions:

(i) For the period July 1, 1985 to December 31, 1985, reductions below the cost per service unit allowable under section 256.966, are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 30 percent; payments for all other inpatient hospital care may be reduced no more than 20 percent. Reductions below the payments allowable under general assistance medical care for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than ten percent.

(ii) For the period January 1, 1986 to December 31, 1986, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 20 percent; payments for all other inpatient hospital care may be reduced no more than 15 percent. Reductions below the payments allowable under general assistance medical care for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(iii) For the period January 1, 1987 to June 30, 1987, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent; payments for all other inpatient hospital care may be reduced no more than ten percent. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(iv) For the period July 1, 1987 to June 30, 1988, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent; payments for all other inpatient hospital care may be reduced no more than five percent. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(v) For the period July 1, 1988 to June 30, 1989, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent; payments for all other inpatient hospital care may not be reduced. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(f) There shall be no copayment required of any recipient of benefits for any services provided under this subdivision. A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

[For text of subds 5 to 7, see M.S.1998]

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518.171, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county–based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county–based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one–third of the net recovery after attorney fees and collection costs.

[For text of subd 9, see M.S.1998]

History: *1999 c 245 art 4 s 86–88*

256D.05 ELIGIBILITY FOR GENERAL ASSISTANCE.

Subdivision 1. **Eligibility.** (a) Each assistance unit with income and resources less than the standard of assistance established by the commissioner and with a member who is a resident of the state shall be eligible for and entitled to general assistance if the assistance unit is:

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;

(2) a person whose presence in the home on a substantially continuous basis is required because of the professionally certified illness, injury, incapacity, or the age of another member of the household;

(3) a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved chemical dependency domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative;

(4) a person who resides in a shelter facility described in subdivision 3;

(5) a person not described in clause (1) or (3) who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as mentally retarded or mentally ill, and that condition prevents the person from obtaining or retaining employment;

(6) a person who has an application pending for, or is appealing termination of benefits from, the social security disability program or the program of supplemental security income for the aged, blind, and disabled, provided the person has a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;

(7) a person who is unable to obtain or retain employment because advanced age significantly affects the person's ability to seek or engage in substantial work;

(8) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

(9) a person who is determined by the county agency, according to permanent rules adopted by the commissioner, to be learning disabled, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan;

(10) a child under the age of 18 who is not living with a parent, stepparent, or legal custodian, and only if: the child is legally emancipated or living with an adult with the consent of an agency acting as a legal custodian; the child is at least 16 years of age and the general assistance grant is approved by the director of the county agency or a designated representative as a component of a social services case plan for the child; or the child is living with an adult with the consent of the child's legal custodian and the county agency. For purposes of this clause, "legally emancipated" means a person under the age of 18 years who: (i) has been married; (ii) is on active duty in the uniformed services of the United States; (iii) has been emancipated by a court of competent jurisdiction; or (iv) is otherwise considered emancipated under Minnesota law, and for whom county social services has not determined that a social services case plan is necessary, for reasons other than the child has failed or refuses to cooperate with the county agency in developing the plan;

(11) a person who is eligible for displaced homemaker services, programs, or assistance under section 268.96, but only if that person is enrolled as a full–time student;

(12) a person who lives more than four hours round–trip traveling time from any potential suitable employment;

(13) a person who is involved with protective or court–ordered services that prevent the applicant or recipient from working at least four hours per day;

(14) a person over age 18 whose primary language is not English and who is attending high school at least half time; or

(15) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a; if the applicant is determined to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a.

(b) As a condition of eligibility under paragraph (a), clauses (1), (3), (5), (8), and (9), the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256D.06, subdivision 5, and must comply with efforts to determine the recipient's eligibility for those other maintenance benefits.

(c) The burden of providing documentation for a county agency to use to verify eligibility for general assistance or for exemption from the food stamp employment and training program is upon the applicant or recipient. The county agency shall use documents already in its possession to verify eligibility, and shall help the applicant or recipient obtain other existing verification necessary to determine eligibility which the applicant or recipient does not have and is unable to obtain.

[For text of subd 2, see M.S.1998]

Subd. 3. **Residents of shelter facilities.** Notwithstanding the provisions of subdivisions 1 and 2, general assistance payments shall be made for maintenance costs and security costs which are related to providing 24–hour staff coverage at the facility incurred as a result of residence in a secure crisis shelter, a housing network, or other shelter facilities which provide shelter services to women and their children who are being or have been assaulted by their spouses, other male relatives, or other males with whom they are residing or have resided in the past.

These payments shall be made directly to the shelter facility from general assistance funds on behalf of women and their children who are receiving, or who are eligible to receive, Minnesota family investment program or general assistance.

In determining eligibility of women and children for payment of general assistance under this subdivision, the asset limitations of the Minnesota family investment program shall be applied. Payments to shelter facilities shall not affect the eligibility of individuals who reside in shelter facilities for the Minnesota family investment program or general assistance or payments made to individuals who reside in shelter facilities through the Minnesota family investment program or general assistance, except when required by federal law or regulation.

[For text of subds 3 to 4, see M.S.1998]

Subd. 5. **Transfers of property.** The equity value of real and personal property transferred without reasonable compensation within 12 months preceding the date of application for general assistance must be included in determining the resources of an assistance unit in the same manner as in the Minnesota family investment program under chapter 256J.

[For text of subds 6 to 8, see M.S.1998]

History: *1999 c 159 s 58–60*

NOTE: Subdivisions 3 and 3a are repealed by Laws 1999, chapter 216, article 6, section 26, effective July 1, 2000. Laws 1999, chapter 216, article 6, section 27.

256D.051 FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM.

[For text of subds 1 to 2, see M.S.1998]

Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) based on this section and section 256D.052 and Code of Federal Regulations, title 7, section 273.7, supervise the administration of food stamp employment and training services to county agencies;

(2) disburse money appropriated for food stamp employment and training services to county agencies based upon the county's costs as specified in section 256D.051, subdivision 6c;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for food stamp employment and training services;

(4) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

(5) in cooperation with the commissioner of economic security, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

[For text of subd 3, see M.S.1998]

Subd. 3a. **Persons required to register for and participate in the food stamp employment and training program.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of food stamps is required to register for work as a condition of eligibility for food stamp benefits. Applicants and recipients are registered by signing an application or annual reapplication for food stamps, and must be informed that they are registering for work by signing the form.

(b) The commissioner shall determine, within federal requirements, persons required to participate in the food stamp employment and training (FSET) program.

(c) The following food stamp recipients are exempt from mandatory participation in food stamp employment and training services:

(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;

(2) a child;

(3) a recipient over age 55;

(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;

(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;

(6) a recipient receiving unemployment compensation or who has applied for unemployment compensation and has been required to register for work with the department of economic security as part of the unemployment compensation application process;

(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the food stamp employment and training program;

(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or

(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.

[For text of subd 3b, see M.S.1998]

Subd. 6. [Repealed, 1999 c 245 art 6 s 89]

[For text of subd 6b, see M.S.1998]

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of food stamp employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's food stamp employment and training program shall not exceed an average of $400 per participant. No more than 15 percent of program funds may be

used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of food stamp cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

Subd. 7. **Registrant status.** A registrant under this section is not an employee for the purposes of workers' compensation, reemployment compensation benefits, retirement, or civil service laws, and shall not perform work ordinarily performed by a regular public employee.

[For text of subds 8 to 18, see M.S.1998]

Subd. 19. [Repealed, 1999 c 245 art 6 s 89]

History: *1999 c 107 s 66; 1999 c 159 s 61; 1999 c 245 art 6 s 1,2*

256D.053 MINNESOTA FOOD ASSISTANCE PROGRAM.

Subdivision 1. **Program established.** The Minnesota food assistance program is established to provide food assistance to legal noncitizens residing in this state who are ineligible to participate in the federal Food Stamp Program solely due to the provisions of section 402 or 403 of Public Law Number 104–193, as authorized by Title VII of the 1997 Emergency Supplemental Appropriations Act, Public Law Number 105–18, and as amended by Public Law Number 105–185.

Beginning July 1, 2000, the Minnesota food assistance program is limited to those noncitizens described in this subdivision who are 50 years of age or older.

[For text of subds 2 and 3, see M.S.1998]

Subd. 4. [Repealed, 1999 c 245 art 6 s 89]

History: *1999 c 245 art 6 s 3*

256D.055 COUNTY DESIGN; WORK FOCUSED PROGRAM.

The commissioner of human services shall issue a request for proposals from counties to submit a plan for developing and implementing a county–designed program. The plan shall be for first–time applicants for the Minnesota family investment program and must emphasize the importance of becoming employed and oriented into the work force in order to become self–sufficient. The plan must target public assistance applicants who are most likely to become self–sufficient quickly with short–term assistance or services such as child care, child support enforcement, or employment and training services.

The plan may include vendor payments, mandatory job search, refocusing existing county or provider efforts, or other program features. The commissioner may approve a county plan which allows a county to use other program funding for the county work focus program in a more flexible manner. Nothing in this section shall allow payments made to the public assistance applicant to be less than the amount the applicant would have received if the program had not been implemented, or reduce or eliminate a category of eligible participants from the program without legislative approval.

If the plan is approved by the commissioner, the county may implement the plan.

History: *1999 c 159 s 62*

256D.06 AMOUNT OF ASSISTANCE.

[For text of subds 1 to 2, see M.S.1998]

Subd. 5. Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (a) make application for those benefits

within 30 days of the general assistance application; and (b) execute an interim assistance authorization agreement on a form as directed by the commissioner. The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period. The commissioner shall adopt rules authorizing county agencies or other client representatives to retain from the amount recovered under an interim assistance agreement 25 percent plus actual reasonable fees, costs, and disbursements of appeals and litigation, of providing special assistance to the recipient in processing the recipient's claim for maintenance benefits from another source. The money retained under this section shall be from the state share of the recovery. The commissioner or the county agency may contract with qualified persons to provide the special assistance. The rules adopted by the commissioner shall include the methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled. This subdivision does not require repayment of per diem payments made to shelters for battered women pursuant to section 256D.05, subdivision 3.

[For text of subds 7 and 8, see M.S.1998]

History: *1999 c 245 art 6 s 4*

256D.23 TEMPORARY COUNTY ASSISTANCE PROGRAM.

Subdivision 1. **Program established.** Minnesota residents who meet the income and resource standards of section 256D.01, subdivision 1a, but do not qualify for cash benefits under sections 256D.01 to 256D.21, may qualify for a county payment under this section.

[For text of subds 2 and 3, see M.S.1998]

History: *1999 c 159 s 63*

256D.35 DEFINITIONS.

[For text of subds 1 to 12, see M.S.1998]

Subd. 13. **Maintenance benefit.** "Maintenance benefit" means cash payments, other than Minnesota supplemental aid, provided under law or rule. Maintenance benefit includes workers' compensation, reemployment compensation, railroad retirement, veterans benefits, supplemental security income, social security disability insurance, or other benefits identified by the county agency that provide periodic benefits that can be used to meet the basic needs of the assistance unit.

[For text of subds 15 to 20, see M.S.1998]

History: *1999 c 107 s 66*

256D.435 INCOME.

[For text of subd 1, see M.S.1998]

Subd. 3. **Application for federally funded benefits.** Persons who live with the applicant or recipient, who have unmet needs and for whom the applicant or recipient has financial responsibility, must apply for and, if eligible, accept the Minnesota family investment program and any other federally funded benefits.

[For text of subds 4 to 6, see M.S.1998]

History: *1999 c 159 s 64*

256D.44 STANDARDS OF ASSISTANCE.

[For text of subds 1 to 4, see M.S.1998]

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets payable under the Minnesota family investment program if the cost of those additional dietary needs cannot be met through some other maintenance benefit.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

[For text of subd 6, see M.S.1998]

History: *1999 c 159 s 65*