CHAPTER 9500
DEPARTMENT OF HUMAN SERVICES
ASSISTANCE PAYMENTS PROGRAMS

9500.1070 SERVICES COVERED BY MEDICAL ASSISTANCE.

[For text of subps 1 to 3, see M.R.]

Subp. 4. [Repealed, 14 SR 8]

[For text of subp 5, see M.R.]

Subp. 6. [Repealed, 14 SR 8]

[For text of subps 7 to 22, see M.R.]

Subp. 23. [Repealed, 14 SR 8]

[For text of subp 24, see M.R.]

9500.1100 DEFINITIONS.

[For text of subps 1 to 19, see M.R.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the list of diagnosis related groups in the diagnostic classification system established under Minnesota Statutes, section 256.969, subdivision 2, according to the diagnosis 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	
	A.1.	(2, 7, 10, 16, 18, 28, 34)
	A.2.	(1, 3-5, 9, 11-15, 20, 22, 27, 29, 35)
	A.3.	(6, 8, 17, 19, 21, 23-26, 30-33)
B.	Diseases and Disorders of the Eye	(36-48)

C.	Diseases and Disorders of the Ear, Nose, Mouth, and Throat	
	C.1.	(70, 74)
	C.2.	(64-69, 71-73, 185-187)
	C.3.	(49-63, 168, 169)
D.	Diseases and Disorders of the Respiratory System	
	D.1.	(75-89, 93, 94, 101, 474, 475)
	D.2.	(90-92, 95-97, 99, 100, 102)
E.	Diseases and Disorders of the Circulatory System	
	E.1.	(121-127, 129-133, 135-140, 144, 145)
	E.2.	(103-118, 120)
	E.3.	(128, 134, 141-143)
	E.4.	(119)
F.	Diseases and Disorders of the Digestive System	
	F.1.	(172-176, 179, 180, 188)
	F.2.	(177, 178, 181-183, 189, 190)
	F.3.	(146-156, 159, 161, 164-166, 170, 171)
	F.4.	(157-158, 160, 162, 163, 167)
G.	Diseases and Disorders of the Hepatobiliary System and Pancreas	
	G.1.	(191-201)
	G.2.	(202-208)
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	
	H.1.	(209-215, 217-219, 223, 226, 228, 233, 234, 471)
	H.2.	(243, 246-252, 254-256)
	H.3.	(235-242, 244, 245, 253)
	H.4.	(216, 220-222, 224-225, 227, 229-232)
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	
	I.1.	(259-262, 267, 268, 270, 276-284)
	I.2.	(257, 258, 263-266, 269, 271-275)
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	
	J.1.	(285-289, 292, 293, 296, 297, 300, 301)
	J.2.	(290, 291, 294, 295, 298, 299)

K.	Diseases and Disorders of the Kidney and Urinary Tract	
	K.1.	(302-310, 313, 315, 316, 318-320, 331, 333)
	K.2.	(311, 312, 314, 317, 321-330, 332)
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	
P.	Diseases and Disorders of the Blood and Blood-Forming Organs and Immunity Disorders	
	P.1.	(395, 397, 398)
	P.2.	(396, 399)
	P.3.	(392-394)
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms NEC	
	Q.1.	(400-402, 406-408, 473)
	Q.2.	(403-405, 409-414)
R.	Infectious and Parasitic Diseases (Systemic or Unspecified Sites)	
	R.1.	(415-418, 423)
	R.2.	(419-422)
S.	Mental Diseases and Disorders	(424-425, 427-429, 432)
T.	Substance Use and Substance Induced Organic Mental Disorders (Ages 0-20)	(433, 434, 435)
U.	Substance Use and Substance Induced Organic Mental Disorders (Ages over 20)	(433, 434, 435)
V.	Injury, Poisoning, and Toxic Effects of Drugs	
	V.1.	(445, 452-454)
	V.2.	(444, 446-451, 455)
	V.3.	(439-443)
W.	Burns	
	W.1.	(457-459)
	W.2.	(456, 460, 472)
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	(370-371)
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, 476, 477)
JJ.	Cases which could not be assigned to other diagnostic categories	(469-470)
KK.	Extreme Immaturity	(386)
LL.	Prematurity with Major Problems	(387)
MM.	Prematurity without Major Problems	(388)
NN.	Full term Neonates or Neonates Died or Transferred	(385, 389, 390)

[For text of subps 21 to 52, see M.R.]

Statutory Authority: *MS s 256.969 subd 2*

History: *14 SR 8*

9500.1272 ASSIGNMENT OF REPRESENTATIVE PAYEE FOR RECIPIENTS WHO ARE DRUG DEPENDENT.

Subpart 1. **Definitions.** As used in this part, the following terms have the meanings given them in this subpart.

A. "Basic needs" means the minimum personal requirements of subsistence and is restricted to:

(1) shelter;

(2) utilities;

(3) food;

(4) clothing; and

(5) other items the loss or lack of which is determined by the county agency to pose a direct, immediate threat to the physical health or safety of the applicant or recipient.

B. "Chemical use assessment" means the assessment defined in part 9530.6605, subpart 8.

C. "Client" means an applicant for or recipient of general assistance.

D. "Detoxification" means the program of services provided under Minnesota Statutes, section 254A.08.

E. "Disconjugate gaze" means an inability to move both eyes in unison.

F. "Drug abuse" means chemical abuse as defined in part 9530.6605, subpart 6.

G. "Drug dependency" means chemical dependency as defined in part 9530.6605, subpart 7.

H. "Representative payee" means a person or agency selected to receive and manage general assistance benefits provided by the county agency on behalf of a general assistance recipient.

I. "Vendor payment" means a payment made by a county agency directly to a provider of goods or services.

Subp. 2. **Referral for chemical use assessment.** A county agency may refer an applicant or a recipient for a chemical use assessment by an assessor as defined in part 9530.6605, subpart 4, when there is a reasonable basis for questioning whether a person is drug dependent. A reasonable basis for referral exists when:

A. The person has required detoxification two or more times in the last 12 months;

B. The person appears intoxicated at the county agency as indicated by two or more of the following:

(1) odor of alcohol;

(2) slurred speech;

(3) disconjugate gaze;

(4) impaired balance;

(5) difficulty in remaining awake;

(6) consumption of a chemical;

(7) responding to sights or sounds that are not actually present; and

(8) extreme restlessness, fast speech, or unusual belligerence;

C. The person has been involuntarily committed for drug dependency at least once in the past 12 months; or

D. The person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

Subp. 3. **Referral procedures for chemical use assessment.** A referral for a chemical use assessment must be made according to items A and B.

A. When the county agency decides to refer a client for a chemical use assessment, the county agency shall notify the client of the referral in writing. The notice must inform the client of:

(1) the basis for the referral;

(2) the name, address, and phone number of the individual to contact to schedule the assessment, or the time, date, and location of the chemical use assessment if one has already been scheduled by the county agency;

(3) the fact that the applicant's general assistance benefits will be paid in the form of vendor payments or emergency general assistance as specified in subpart 4 until the local agency decides whether to assign a representative payee under subpart 8;

(4) the fact that if the recipient has been receiving cash general assistance that those benefits will be changed to emergency general assistance payments or general assistance vendor payments under subpart 4 until the county agency decides whether to assign a representative payee under subpart 8;

(5) the effect under subpart 8 of failing to participate in the chemical use assessment within 30 days of the date of referral;

(6) the client's right to appeal the county agency's decision to refer the client for an assessment, and the right to appeal the assessment results when the assessment has been completed; and

(7) the need to contact the county agency and consult with the county agency concerning the choice of representative payee.

B. The client must be given the opportunity to participate in a chemical

use assessment within 15 days after the date the notice of referral is mailed or delivered to the client.

Subp. 4. **Form of payment pending completion of assessment.** A county agency shall provide only emergency general assistance (EGA) or general assistance vendor payments to a client who has been referred for a chemical use assessment under subpart 2. EGA may be provided to clients only in emergency situations as provided in part 9500.1238. All other payments made under this subpart must be general assistance vendor payments.

Subp. 5. **Timing and duration of general assistance vendor payments or EGA.** A county agency shall not change the form of a recipient's benefit payments from cash general assistance to general assistance vendor payments under subpart 4 until ten days after the notice of referral under subpart 3 is mailed or delivered to the recipient. If the client meets the criteria for assignment of a representative payee under subpart 8, the county agency shall continue to provide EGA or general assistance vendor payments until the county agency begins making general assistance payments through the client's representative payee. If the client does not meet the criteria under subpart 8 for assignment of a representative payee, the county agency shall provide future general assistance benefits to which the client is entitled in cash beginning on the first day of the payment month immediately following the date of the determination that the client does not meet the criteria for assignment of a representative payee.

Subp. 6. **Amount of vendor payments.** EGA or general assistance vendor payments may be provided only to the extent needed to meet the client's basic needs. If the county agency is unable to vendor pay the entire standard of assistance to which the client is entitled, the remaining amount of the standard of assistance must not be issued until a representative payee is assigned or until the county agency decides not to assign a representative payee. If a representative payee is assigned, the unissued amount must be provided to the representative payee within 15 days after the date the county agency begins making payments through the representative payee. If the client does not meet the criteria under subpart 8 for assignment of a representative payee, the unissued amount must be provided directly to the client within 15 days after the date of the determination that the client does not meet the criteria for assignment of a representative payee.

Subp. 7. **Assessment.** The chemical use assessment must be conducted according to parts 9530.6600 to 9530.6655.

Subp. 8. **Criteria governing assignment of representative payee.** The county agency may assign a representative payee to manage a client's general assistance if the client fails, without good cause as defined in part 9500.1206, subpart 15, to participate in a chemical use assessment within 30 days after referral under subparts 2 and 3; or if an assessment performed within the last six months indicates that the client is drug dependent and eligible for placement in extended care under part 9530.6640.

Subp. 9. **Procedures governing assignment of representative payee after referral under subparts 2 and 3.** A representative payee must be assigned according to items A to C.

A. The county agency shall provide the client with an opportunity to consult with the county agency in selecting a representative payee. The county agency shall consider the client's preferences for particular individuals to serve as payees but the county agency's preference must prevail.

B. The county agency shall notify the client in writing of:

(1) its decision to assign a representative payee;

(2) the basis for its decision to assign a representative payee;

(3) the identity, address, and phone number of the representative payee;

(4) the date the county agency will begin making payments through the representative payee;

(5) the circumstances under which a representative payee may be removed or replaced; and

(6) the client's right to appeal the assignment under Mmnesota Statutes, section 256.045.

C. The notice under item B must be mailed or delivered to the client or the client's last known address within 15 days after the date of the chemical use assessment on which the assignment is based, or within 30 days after the date of the referral under subparts 2 and 3 if a representative payee is assigned because of the client's failure to participate in an assessment. The notice must also be mailed or delivered at least ten days before the county agency begins making payments through the representative payee.

Subp. 10. **Procedures governing assignment of representative payee without referral under subparts 2 and 3.** A county agency may assign a representative payee to a client who meets the criteria for assignment under subpart 8 but who has not been referred for a chemical use assessment under subparts 2 and 3. A representative payee assigned under this subpart must be assigned according to items A to E.

A. The county agency may provide only emergency general assistance or general assistance vendor payments to a client who meets the criteria for assignment of a representative payee under subpart 8 until the county agency begins making general assistance payments through the client's representative payee or until the first day of the payment month following a determination that the client does not meet the criteria for assignment of a representative payee. Payments under this item shall be made according to subparts 4 and 6 and shall not begin until the date the county agency mails or delivers the notice under item C.

B. The county agency shall provide a client with an opportunity to consult with the county agency on the choice of representative payee as provided in subpart 9, item A.

C. The county agency shall notify a client in writing of:

(1) its decision to assign a representative payee;

(2) the basis for its decision to assign a representative payee;

(3) the client's right to consult with the county agency on the choice of representative payee;

(4) the date by which the county agency must select a representative payee under item D; and

(5) the fact that the county agency will provide the client's general assistance benefits in the form of emergency assistance or vendor payments until the county agency begins making payments through a representative payee.

D. The county agency shall notify a client in writing of its selection of a representative payee within 15 days after issuing the notice required under item C. The notice shall inform the client of:

(1) the identity, address, and phone number of the representative payee assigned to the client;

(2) the date the county agency will begin making payments through the representative payee;

(3) the circumstances under which a representative payee may be removed or replaced; and

(4) the client's right to appeal the assignment of a representative payee under Minnesota Statutes, section 256.045.

E. The county agency shall not begin making payments through a representative payee until at least ten days after the notice under item D is mailed or delivered to the client.

Subp. 11. **Criteria governing the choice of representative payee.** A county agency shall appoint as representative payee an individual or agency who is likely

to manage the client's income and resources in a manner that meets the client's basic needs. A county agency shall not appoint as representative payee any individual to whom the client is in financial debt. In selecting the representative payee, the county agency shall consider all factors relevant to the prospective payee's ability to manage the client's general assistance to meet the client's basic needs, including the following factors:

A. the prospective payee's experience and training in managing the finances of others;

B. the prospective payee's familiarity with the geographic area and the community resources available to meet the client's basic needs; and

C. the relationship between the prospective payee and the client, including any legal authority the prospective payee has to act on behalf of the client.

Subp. 12. **Responsibilities of the representative payee.** The representative payee assigned to a client must:

A. use the client's general assistance benefits to meet the client's current basic needs;

B. maintain clear and current records of all expenditures made on behalf of the client; and

C. complete a report every six months containing the client's general assistance financial records and a recommendation as to whether the client continues to require a representative payee. The report must be provided to the county agency and the client on request.

Subp. 13. **Review of client's representative payee status.** The county agency shall conduct a review of a client's need to continue receiving benefits through a representative payee within 12 months of the client's previous chemical use assessment. The county agency shall conduct the review under this subpart no earlier than six months after the client's previous chemical use assessment. A review requested by a client must be conducted within 15 days of the client's request. Each review conducted under this subpart must include a chemical use assessment to determine whether the recipient remains drug dependent and eligible for placement in extended care and an examination of the representative payee's report required under subpart 12.

Subp. 14. **Discontinuing a client's representative payee status.** A county agency shall discontinue the use of a representative payee only if a review conducted under subpart 13 indicates that the client is no longer eligible for placement in extended care. A county agency shall not discontinue the use of a representative payee until at least six months have elapsed since the client last underwent a chemical use assessment showing the client to be chemically dependent and eligible for placement in extended care.

Subp. 15. **Investigating need for change in representative payee.** The county agency shall review a representative payee's performance and determine whether to appoint a new representative payee if the client alleges or the county agency has reason to believe that the representative payee is not complying with the requirements of subpart 12. When an investigation is initiated in response to a client's complaint, the county agency's decision to retain the current representative payee or appoint a new one must be made within 30 days of the date the complaint is received by the county agency. An investigation conducted under this subpart must include a review of all financial records maintained by the representative payee concerning the use of the client's general assistance benefits and any other relevant evidence.

Subp. 16. **Duration of a representative payee designation.** Notwithstanding any gaps in the receipt of general assistance, the designation of a specific representative payee shall continue for at least six months unless:

A. the client no longer meets the criteria for assignment of a representative payee under subpart 8;

B. the representative payee is not fulfilling the responsibilities under subpart 12; or

C. the representative payee requests to discontinue serving as the client's representative payee.

Subp. 17. **Change in representative payee.** The county agency shall appoint a new representative payee if the current representative payee fails to comply with the requirements of subpart 12 or requests that the county agency appoint a new representative payee.

Subp. 18. **Appealable issues.** A client may appeal:

A. the proposed assignment of a representative payee, including the results of the chemical use assessment upon which the assignment is based;

B. the county agency's choice of representative payee; and

C. the decision to refer a person for an assessment.

However, notwithstanding any provision of Minnesota Statutes, section 256.045 to the contrary, an applicant or recipient who is referred for an assessment and is otherwise eligible to receive a general assistance benefit may only be provided with emergency general assistance or vendor payments pending the outcome of an administrative or judicial review.

If a representative payee is assigned under subpart 8 without a chemical use assessment, the client may appeal the county agency's determination that the client did not have good cause for failing to participate in the chemical use assessment.

Subp. 19. **Appeal procedures and timing of appeals.** If the client appeals before the date the representative payee is scheduled to begin receiving the client's general assistance benefits, the county agency shall continue to vendor pay the client's general assistance and shall not make general assistance payments through the representative payee until after the appeal is decided unless the client requests in writing to have payments made through the representative payee pending the outcome of the appeal.

Statutory Authority: *MS s 256D.09*

History: *15 SR 120*

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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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 copayments.** 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and 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, 1990 See Minnesota Statutes, section 256B 69, subdivision 16, and the Notice of Adoption published at 11 State Register, page 1107 on December 22, 1986

9500.2060 DEFINITIONS.

[For text of subps 1 to 34, see M.R.]

Subp. 35. **County of financial responsibility.** "County of financial responsibility" means the county liable for the county share of a recipient's assistance under Minnesota Statutes, chapter 256G.

[For text of subps 36 to 38, see M.R.]

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 and B:

A. is less than 18 years of age; or

B. is 18 years of age and is a full-time student, as defined in subpart 58, at an accredited high school or its equivalent in vocational or technical training, and is expected to graduate or complete the school program before reaching age 19.

[For text of subps 40 to 57, see M.R.]

Subp. 58. **Full-time student.** "Full-time student" means a person who is

enrolled in a graded or ungraded primary, intermediate, secondary, GED preparatory, trade, technical, vocational, or postsecondary school, and who meets the school's standard for full-time attendance.

[For text of subps 59 to 89, see M.R.]

Subp. 90. **Minor caretaker.** "Minor caretaker" means

A. a person under the age of 18 years; and

B. who has applied as a caretaker on behalf of himself or herself and his or her dependent child.

[For text of subps 91 to 112, see M.R.]

Subp. 113. **Recipient.** "Recipient" means a person who is currently receiving assistance. A person who fails to withdraw or access electronically any portion of his or her assistance payment by the end of the payment month transfer or who returns an uncashed assistance check and withdraws from the program is not a recipient. A person who withdraws an assistance payment by electronic transfer or 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 payment 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.

[For text of subps 114 to 117, see M.R.]

Subp. 118. [Repealed, 15 SR 117]

[For text of subps 119 to 154, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2100 APPLICATION FOR ASSISTANCE.

[For text of subps 1 to 3, see M.R.]

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.

When an emergency does not exist, a local agency may issue assistance 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.

[For text of subp 5, see M.R.]

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 30 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 30-day processing period, the local agency may not use the expiration of that period as the basis for denial.

[For text of subps 7 and 8, see M.R.]

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, when a caretaker requests the addition of another person to the assistance unit, or when a person required to be in the filing unit must be added to the assistance unit.

An addendum to an existing application may be used to add persons to an assistance unit regardless of whether the persons being added are required to be in the filing unit. When a person is added by addendum to an assistance unit and that person is required to be in a filing unit, eligibility begins on the date the new member enters the home or the date the new member is required to be included in the assistance unit, whichever is later. When a person is added by addendum to an assistance unit and the person is not required to be included in the filing unit, eligibility begins on the date the signed addendum is submitted to the local agency or all eligibility criteria are met, whichever is later.

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2140 BASIC ELIGIBILITY REQUIREMENTS.

[For text of subpart 1, see M.R.]

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 residence nor an intent to remain in Minnesota is required.

B. A person who voluntarily 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.

[For text of items C to E, see M.R.]

[For text of subps 3 and 4, see M.R.]

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.

[For text of items A and B, see M.R.]

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 placement in foster care as defined in Minnesota Statutes, section 260.015, subdivision 7, 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.

[For text of subp 6, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2340 PROPERTY LIMITATIONS.

[For text of subpart 1, see M.R.]

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 surrounding property which is not separated from the home by intervening property owned by others. Additional property must be assessed as to its 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.

[For text of item B, see M.R.]

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:

[For text of item A, see M.R.]

B. The value of personal property needed to produce earned income, including tools, implements, farm animals, and inventory, business checking and savings accounts used exclusively for the operation of a self-employment business, and any motor vehicles if the vehicles are essential for the self-employment business.

[For text of items C to G, see M.R.]

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 annually.

[For text of item I, see M.R.]

J. Income received in a budget month through the end of the budget month.

[For text of items K to P, see M.R.]

Q. Lump sums that create a period of ineligibility are excluded from the date of receipt through the period of ineligibility. Lump sums that do not create a period of ineligibility are excluded only through the budget month.

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2380 INCOME.

[For text of subpart 1, see M.R.]

Subp. 2. **Excluded income.** A local agency shall exclude items A to DD from income:

[For text of items A to E, see M.R.]

F. all educational grants and loans, including income from work study programs;

G. loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

H. loans from private individuals, regardless of purpose, provided an applicant or recipient documents that the lender expects repayment;

I. state and federal income tax refunds including the earned income tax credit;

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

K. the portion of an insurance settlement that is designated and used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

L. reimbursements for medical expenses which cannot be paid by medical assistance;

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

N. in-kind income, including any payments directly made by a third party to a provider of goods and services;

O. assistance payments to correct underpayments, but only for the month in which the payment is received and for the following month;

P. payments to an applicant or recipient issued under part 9500.2820;

Q. payments issued under part 9500.2800;

R. Minnesota property tax refund credits received by an applicant or recipient who does not receive AFDC housing allowances under part 9500.2800, subpart 2;

S. 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;

T. tribal settlements excluded under Code of Federal Regulations, title 45, section 233.20(a)(4)(ii)(e), (k), and (m);

U. 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;

V. the first $50 of child support paid under Code of Federal Regulations, title 45, section 302.51(b)(1);

W. income, including retroactive payments, from supplemental security income;

X. income, including retroactive payments, from Minnesota supplemental aid;

Y. proceeds from the sale of real or personal property;

Z. payments made from state funds for subsidized adoptions under Minnesota Statutes, section 259.40;

AA. state-funded Family Subsidy Program payments made under Minnesota Statutes, section 252.32, to help families care for children with mental retardation or related conditions;

BB. 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;

CC. income which is otherwise specifically excluded from AFDC program consideration in federal law, state law, or federal regulation;

DD. rebates of rental payments paid by an applicant or recipient.

[For text of subps 3 to 5, see M.R.]

Subp. 6. **Self-employment deductions.** Self-employment expenses must be subtracted from gross receipts except for the expenses listed in items A to N:

[For text of items A to E, see M.R.]

F. transportation costs which exceed the maximum standard mileage rate allowed for use of a personal car in the United States Internal Revenue Code;

[For text of items G to N, see M.R.]

Subp. 7. **Self-employment budget period.** Except for farm income under subpart 8, the self-employment budget period begins in the month of application for AFDC applicants and in the first month of self-employment for AFDC recipients. 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.

[For text of items A to C, see M.R.]

[For text of subp 8, see M.R.]

Subp. 9. **Rental income.** Income from rental property must be considered self-employment earnings when the owner spends an average of 20 hours per week on maintenance or management of 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 an owner does not spend an average of 20 hours per week on maintenance or management of the property, income from rental property must be considered unearned income. The deductions described in this subpart must be subtracted from gross rental receipts.

[For text of subps 10 and 11, see M.R.]

Statutory Authority: *MS s 256 851*

History: *15 SR 117*

9500.2420 DOCUMENTING, VERIFYING, AND REVIEWING ELIGIBILITY.

[For text of subps 1 to 3, see M.R.]

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) age if required to establish eligibility;

(3) the identity of each adult applying for assistance;

(4) the resident alien status of each adult and child applying for or receiving assistance if the applicant or recipient reports that he or she is not a citizen;

(5) the incapacity of a parent when the basis of eligibility is an incapacitated parent under part 9500.2220;

(6) 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;

(7) 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;

(8) school attendance and the date of anticipated completion of school for an 18 year old child;

(9) 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;

(10) the relationship of a caretaker to the child for whom application is made; and

(11) residence.

B. A local agency shall verify the information in subitems (1) to (6) 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 at the time of application, redetermination, or a change in provider.

C. A local agency may verify additional program eligibility and assistance payment factors when it determines that information on the application is inconsistent with statements made by the applicant, other information on the current application, information on previous applications, or other information received by the local agency. The local agency must document the reason for verifying the factor in the case record of an assistance unit.

Additional factors that may be verified, subject to the approval of the commissioner, are:

(1) the presence of a child in the home;

(2) death of a parent or spouse;

(3) continued absence of a parent;

(4) citizenship;

(5) marital status; and

(6) income and property that an applicant or recipient has not acknowledged receiving or having.

[For text of subp 5, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2440 FAMILY COMPOSITION AND ASSISTANCE STANDARDS.

[For text of subpart 1, see M.R.]

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, including half-siblings, 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.

[For text of subps 3 and 4, see M.R.]

Subp. 5. **Application of standards.** The standards that apply to an assistance unit are set forth in items A to E.

[For text of items A to C, see M.R.]

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 cooperate with WIN under parts 9500.2724 and 9500.2726, or because of failure to cooperate with child support enforcement under part 9500.2700, subpart 11. 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.

[For text of item E, see M.R.]

[For text of subps 6 and 7, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2500 AFDC ELIGIBILITY TESTS.

[For text of subpart 1, see M.R.]

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 terminated prospectively for a payment month due to excess income, income received in the two budget months before termination must be reviewed. The local agency shall apply the payment eligibility test and the gross income test to determine whether there is an overpayment for one or both of these months. There is no overpayment any month both tests are met.

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.

[For text of subp 3, see M.R.]

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:

[For text of items A to F, see M.R.]

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 expenses;

(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.

[For text of subp 5, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

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 $90 work expense, whether employment is part- or full-time must be deducted from the gross earned income of each employed member of an assistance unit, except that sanctioned persons who are not allowed allocations under part 9500.2600, item C must not receive this disregard. A $75 work expense shall be 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 costs for care of a dependent child or an adult dependent who is in the assistance unit. These costs must be documented according to part 9500.2420, subpart 4, item B, subitem (6). 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 $175 for each dependent age two or older or $200 for each dependent under the age of two when employment equals or exceeds 30 hours per week. The deduction must not exceed $174 for each dependent age two or older or $199 for each dependent under the age of two 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. The deduction under this item shall be taken after the deductions in items A, C, and D.

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 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).

[For text of subitems (1) to (6), see M.R.]

[For text of item D, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2640 CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.

[For text of subps 1 to 3, see M.R.]

Subp. 4. **Recouping overpayments from current recipient.** An overpayment may be repaid voluntarily, in part or in full, even if assistance is reduced under this subpart, until the total amount of the overpayment is repaid. 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 and deduct anticipated work expenses according to subpart 5. Once the net income 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, 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 net income, equals 99 percent of the AFDC family allowance. Once a state computerized client eligibility and information system is implemented in one or more counties, all local agencies shall reduce the assistance payment by three percent of the assistance unit's AFDC family allowance or the amount of the monthly payment, whichever is less, for all overpayments including those due solely to agency error. A local agency shall adjust the amount of recoupment when 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 deducting:

A. the first $90 of earned income and, for self-employed persons, the expenses directly related to and necessary for the production of goods and services; and

B. an amount equal to the actual expenditures for the care of each dependent child or incapacitated person living in the same household and receiving aid, except that the amount deducted shall not exceed the maximums in part 9500.2580 for persons not engaged in full-time employment.

[For text of subps 6 to 9, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2680 PAYMENT PROVISIONS.

Subpart 1. **Payments.** This subpart applies to monthly assistance payments and corrective payments.

[For text of items A to C, see M.R.]

D. A local agency that makes payments by means other than check must also comply with the time limits in items B and C when issuing payments.

Subp. 2. **Protective, vendor, and two-party payments; when allowed.** Alternatives to paying assistance directly to a recipient may be used only:

[For text of items A to D, see M.R.]

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 12 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. When choosing a protective payee, the local agency shall notify the caretaker of a consultation date. If the caretaker fails to respond to the local agency's request for consultation by the effective date on the notice, the local agency shall choose a protective payee for that payment month and subsequent payment months until the caretaker responds to the agency's request for consultation. 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 the employment search or employment requirements under part 9500.2728; 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 12 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 256.851*

History: *15 SR 117*

9500.2700 APPLICANT AND RECIPIENT RESPONSIBILITIES.

[For text of subps 1 to 4, see M.R.]

Subp. 5. **Household reports.** Each assistance unit with a member who has earned income or a recent work history, and each assistance 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. 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 following penalty:

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.

Subp. 6. **Late household report forms.** Items A to C apply to the requirements in subpart 5.

[For text of item A, see M.R.]

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. However, an assistance unit required to submit a household report form is considered to have continued its application for assistance effective the date the required report is received by the local agency if a complete household report form is received within a calendar month after the month in which assistance was received, except that no assistance shall be paid for the period beginning with the first day of the month in which the report was due and ending with the date the report was received by the local agency.

C. A local agency shall allow good cause exemptions from the penalty under subpart 5 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.

[For text of subps 7 and 8, see M.R.]

Subp. 9. **Requirement to provide social security numbers.** To receive assistance, each member of the assistance unit shall provide his or her social security number to the local agency. When a social security number is not provided to the local agency for verification, this requirement is satisfied when each member of the assistance unit 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.

[For text of subps 10 to 12, see M.R.]

Statutory Authority: *MS s 256.851*

History: *14 SR 2988; 15 SR 117*

9500.2740 APPLICANT AND RECIPIENT RIGHTS AND LOCAL AGENCY RESPONSIBILITIES TO APPLICANTS AND RECIPIENTS.

[For text of subps 1 to 6, see M.R.]

Subp. 7. **Mailing of notice.** Notices under subparts 5 and 6 must be made according to items A to C:

[For text of items A and B, see M.R.]

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 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.

[For text of subps 8 to 12, see M.R.]

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, legal guardian, or other adult caretaker or in a group or foster home licensed by the department. 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. Minor parents must be informed that all or part of their assistance may be paid in the form of protective or vendor payments if they do not participate and cooperate in the development of a social service plan.

[For text of item B, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

9500.2800 AFDC PAYMENTS FOR FUNERALS, HOUSING, AND SPECIAL NEEDS.

[For text of subps 1 and 2, see M.R.]

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 provide a base allocation from this appropriation to a local agency in proportion to the number of assistance units the local agency served through the AFDC program 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 determine whether the quarterly statewide allocation is underspent or overspent and adjust future allocations in the same fiscal year. This reallocation must be determined subject to the conditions in subitems (1) and (2).

(1) When the statewide allocation is underspent, local agencies that overspent their quarterly allocation will be compensated for their overexpenditures before any remaining funds are reallocated. Remaining funds will be reallocated to all local agencies using the allocation method described in the first paragraph of this subpart.

(2) When the statewide allocation is overspent, any remaining funds from underspent local agencies will be reallocated to local agencies who overspent their quarterly allocation. The reallocation shall be in proportion to the local agency's overexpenditures for that quarter, compared to the total for all local agencies with overexpenditures.

C. In all quarters, except the final quarter of each state fiscal year, special needs funds committed but unspent by local agencies may be reserved to prevent

reallocation to over spent counties. Each quarter, committed funds plus expenditures will be limited to the local agency's quarterly allocation.

D. Local agencies which have overspent their allocation at the end of the state fiscal year will be required to reimburse the state for the state share of the overexpenditure.

[For text of subps 4 to 8, see M.R.]

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 256.851*

History: *15 SR 117*

9500.2820 EMERGENCY ASSISTANCE.

[For text of subps 1 to 3, see M.R.]

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. The brochure shall include information on how a food stamp grant is affected when emergency assistance is accepted as a cash payment instead of as a vendor or a two-party payment.

[For text of subps 5 to 14, see M.R.]

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.

[For text of item A, see M.R.]

B. A local agency must not issue assistance for utility costs for an applicant who 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.

C. Items A and B 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. 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, 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, 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.

[For text of items C to E, see M.R.]

[For text of subps 17 to 19, see M.R.]

Statutory Authority: *MS s 256.851*

History: *15 SR 117*

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, financial responsibility must be assigned to a single county beginning the first day of the calendar month after the assistance unit members are required to be in a single assistance unit. Financial responsibility must be assigned to the county that was initially responsible for the assistance unit member with the earliest date of application. The county in which the assistance unit is currently residing becomes financially responsible for the entire assistance unit beginning two full calendar months after the month in which financial responsibility was consolidated in one county.

Subp. 2. **Change in residence.** When an assistance unit moves from one county to another and continues to receive assistance, the new county of residence becomes the county of financial responsibility when that assistance unit has lived in that county in nonexcluded status for two full calendar months. When a dependent child moves from one county to another to reside with a different caretaker, the caretaker in the former county is eligible to receive assistance for that child only through the last day of the month of the move. The caretaker in the new county becomes eligible to receive assistance for the child the first day of the month following the move or the date of application, whichever is later. Nonexcluded status means the period of residence that is not considered excluded time under Minnesota Statutes, section 256G.02, subdivision 6.

[For text of items A to C, see M.R.]

[For text of subp 3, see M.R.]

Subp. 4. **Excluded time.** When an applicant or recipient resides in an excluded time facility as described in Minnesota Statutes, section 256G.02, subdivision 6, the county that is financially responsible for the applicant or recipient is the county in which the applicant or recipient last resided outside such a facility immediately before entering the facility. When an applicant or recipient has not resided in Minnesota for any time other than excluded time as defined in Minnesota Statutes, section 256G.02, subdivision 6, the county that is financially responsible for the applicant or recipient is the county in which the applicant or recipient resides on the date the application is signed.

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) send a copy of the application or transfer request, together with

the record of any investigation it has made, to the local agency it believes is financially responsible. The copy and record must be sent within 60 days of the date the application or transfer request was received.

B. The local agency receiving the copy of the application and the record of the investigation, if any, must accept or reject financial responsibility within 30 days after receiving the copy and record. If the local agency receiving the copy and record fails to respond within the 30-day period, it becomes financially responsible. If the local agency receiving the copy and record rejects financial responsibility, it should provide the department and the initially responsible local agency with a statement of all facts and documents necessary for the department to determine financial responsibility. The statement must identify the specific basis upon which the submitting local agency is denying financial responsibility.

C. The initially responsible local agency has 15 days to provide the department with its position and any supporting evidence. If the initially responsible local agency does not submit its written position to the department, the department may issue a binding order based on the evidence received.

D. The department shall decide disputes within 60 days of receipt of the initially responsible local agency's submission of its position and supporting evidence or 60 days after the deadline for submission of its position and evidence. The department may make any investigation it considers necessary to decide a dispute.

E. The department's decision binds both local agencies unless the decision is appealed to the district court within 30 days after the decision is made and the decision is reversed by the district court. Assistance payments must continue, provided the recipient remains eligible, while the district court appeal is pending.

Statutory Authority: *MS s 256.851*

History: *15 SR 117*