CHAPTER 9500
DEPARTMENT OF HUMAN SERVICES
ASSISTANCE PAYMENTS PROGRAMS

9500.0010 [Repealed, 11 SR 212]

9500.0020 [Repealed, 11 SR 212]

9500.0030 [Repealed, 11 SR 212]

9500.0040 [Repealed, 11 SR 212]

9500.0050 [Repealed, 11 SR 212]

9500.0060 [Repealed, 11 SR 212]

9500.0070 [Repealed, 11 SR 212]

9500.0080 [Repealed, 11 SR 212]

9500.0090 [Repealed, 11 SR 212]

9500.0100 [Repealed, 11 SR 212]

9500.0110 [Repealed, 11 SR 212]

9500.0120 [Repealed, 11 SR 212]

9500.0130 [Repealed, 11 SR 212]

9500.0140 [Repealed, 11 SR 212]

9500.0150 [Repealed, 11 SR 212]

9500.0160 [Repealed, 11 SR 212]

9500.0170 [Repealed, 11 SR 212]

9500.0180 [Repealed, 11 SR 212]

9500.0190 [Repealed, 11 SR 212]

9500.0200 [Repealed, 11 SR 212]

9500.0210 [Repealed, 11 SR 212]

9500.0220 [Repealed, 11 SR 212]

9500.0230 [Repealed, 11 SR 212]

9500.0240 [Repealed, 11 SR 212]

9500.0250 [Repealed, 11 SR 212]

9500.0260 [Repealed, 11 SR 212]

9500.0270 [Repealed, 11 SR 212]

9500.0280 [Repealed, 11 SR 212]

9500.0290 [Repealed, 11 SR 212]

9500.0300 [Repealed, 11 SR 212]

9500.0310 [Repealed, 11 SR 212]

9500.0320 [Repealed, 11 SR 212]

9500.0330 [Repealed, 11 SR 212]

9500.0340 [Repealed, 11 SR 212]

9500.0350 [Repealed, 11 SR 212]

9500.0360 [Repealed, 11 SR 212]

9500.0361 [Repealed, 11 SR 212]

9500.0370 [Repealed, 11 SR 212]

9500.0500 [Repealed, 10 SR 1715]

9500.0510 [Renumbered 9500.1202]

9500.0520 [Renumbered 9500.1204]

9500.0530

A. [Renumbered 9500.1208, item A]

B. [Renumbered 9500.1208, item B]

C. [Renumbered 9500.1208, item C]

D. [Renumbered 9500.1208, item D]

E. [Repealed, 10 SR 1715]

9500.0531 [Renumbered 9500.1210]

9500.0532 [Renumbered 9500.1212]

9500.0540 [Renumbered 9500.1234]

9500.0550 [Renumbered 9500.1236]

9500.0560 [Renumbered 9500.1238]

9500.0570 [Renumbered 9500.1240]

9500.0580 [Renumbered 9500.1242]

9500.0590 [Renumbered 9500.1244]

9500.0600 [Renumbered 9500.1246]

9500.0610 [Renumbered 9500.1248]

MINNESOTA SUPPLEMENTAL AID

9500.0650 STATUTORY AUTHORITY FOR MINNESOTA SUPPLEMENTAL AID PROGRAM.

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

Statutory Authority: *MS s 256D.41*

9500.0660 PURPOSE OF MINNESOTA SUPPLEMENTAL AID PROGRAM.

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

Statutory Authority: *MS s 256D.41*

9500.0670 DEFINITIONS.

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

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

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

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

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

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

Subp. 7. **Supplemental security income.** "Supplemental security income" means benefits paid under the federal program of supplemental security income for the aged, blind, and disabled, title XVI of the Social Security Act, as enacted by section 301 of the Social Security Amendments of 1972.

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

Statutory Authority: *MS s 256D.41*

History: *L 1984 c 654 art 5 s 58; 17 SR 1279*

9500.0680 ELIGIBILITY REQUIREMENTS.

Minnesota supplemental aid shall be granted to any person:

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

B. whose net equity in real property:

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

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

C. whose net equity in personal property:

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

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

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

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

(5) if blind and single, does not have in excess of $2,000 in undifferentiated liquid assets, or if blind and married, together with a spouse does not have in excess of $4,000

in undifferentiated liquid assets, including therein up to $750 per person for a prepaid funeral contract plus an accrual of interest not over $200 per person; and

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

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

Statutory Authority: *MS s 256D.41*

History: *17 SR 1279*

9500.0690 EVALUATION OF PROPERTY TRANSFERS.

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

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

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

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

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

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

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

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

Statutory Authority: *MS s 256D.41*

History: *17 SR 1279*

9500.0700 DETERMINATION OF COUNTY OF FINANCIAL RESPONSIBILITY.

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

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

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

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

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

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

Statutory Authority: *MS s 256D.41*

History: *17 SR 1279*

9500.0710 MINNESOTA SUPPLEMENTAL AID STANDARDS AND STATE PARTICIPATION.

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

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

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

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

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

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

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

Statutory Authority: *MS s 256D.41*

History: *17 SR 1279*

9500.0750 [Repealed, 11 SR 1069]

9500.0760 [Repealed, 11 SR 1069]

9500.0770 [Repealed, 11 SR 1069]

9500.0780 [Repealed, 11 SR 1069]

9500.0790 [Repealed, 11 SR 1069]

9500.0800 [Repealed, 11 SR 1069]

9500.0810 [Repealed, 11 SR 1069]

9500.0820 [Repealed, 11 SR 1069]

9500.0830 [Repealed, 11 SR 1069]

9500.0840 [Repealed, 11 SR 1069]

9500.0850 [Repealed, 11 SR 1069]

9500.0860 [Repealed, 11 SR 1069]

9500.0900 [Repealed, 12 SR 624]

9500.0910 [Repealed, 11 SR 1069]

9500.0920 [Repealed, 11 SR 1069]

9500.0930 Subpart 1. [Repealed, 11 SR 1069]
Subp. 2. [Repealed, 11 SR 1069]
Subp. 3. [Repealed, 11 SR 1069]
Subp. 4. [Repealed, 12 SR 624]

9500.0940 [Repealed, 11 SR 1069]

9500.0950 [Repealed, 11 SR 1069]

9500.0960 [Repealed, 12 SR 624]

9500.0970 [Repealed, 12 SR 624]

9500.0980 [Repealed, 10 SR 842]

9500.0990 [Repealed, 12 SR 624]

9500.1000 [Repealed, 12 SR 624]

9500.1060 [Repealed, 12 SR 624]

SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM

9500.1070 SERVICES COVERED BY MEDICAL ASSISTANCE.

Subpart 1. **In general.** The following services are covered under the MA program.
Subp. 2. [Repealed, 12 SR 624]
Subp. 3. [Repealed, 12 SR 624]
Subp. 4. [Repealed, 14 SR 8]
Subp. 5. [Repealed, 12 SR 624]
Subp. 6. [Repealed, 14 SR 8]
Subp. 7. [Repealed, 12 SR 624]
Subp. 8. [Repealed, 12 SR 624]
Subp. 9. [Repealed, 12 SR 624]
Subp. 10. [Repealed, 10 SR 842; 12 SR 624]
Subp. 11. [Repealed, 12 SR 624]
Subp. 12. [Repealed, 15 SR 2404]
Subp. 13. [Repealed, 15 SR 2404]
Subp. 14. [Repealed, 15 SR 2404]
Subp. 15. [Repealed, 15 SR 2404]
Subp. 16. [Repealed, 12 SR 624]
Subp. 17. [Repealed, 12 SR 624]
Subp. 18. [Repealed, 12 SR 624]

Subp. 19. [Repealed, 12 SR 624]

Subp. 20. [Repealed, 12 SR 624]

Subp. 21. [Repealed, 12 SR 624]

Subp. 22. [Repealed, 12 SR 624]

Subp. 23. [Repealed, 14 SR 8]

Subp. 24. [Repealed, 12 SR 624]

Statutory Authority: *MS s 252.28 subd 2; 256.991; 256B.04; 256B.092 subd 6; 256B.503*

History: *L 1984 c 654 art 5 s 58; 10 SR 842; 12 SR 624; 12 SR 1148; 15 SR 2404*

9500.1080 [Repealed, 12 SR 624]

HOSPITAL MEDICAL ASSISTANCE REIMBURSEMENT

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1140 establish a prospective payment system for inpatient hospital services provided under the medical assistance and general assistance medical care programs.

Parts 9500.1090 to 9500.1140 are not applicable to inpatient hospital services provided by state owned hospitals.

If it is determined that any provision of parts 9500.1090 to 9500.1140 conflicts with requirements of the federal government with respect to federal financial participation in medical assistance, the federal requirements prevail.

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 11 SR 1688; 13 SR 1689; 18 SR 1115*

9500.1095 STATUTORY AUTHORITY.

Parts 9500.1090 to 9500.1140 are authorized by Minnesota Statutes, sections 256.9685, 256.9686, 256.969, and 256.9695. Parts 9500.1090 to 9500.1140 must be read in conjunction with Titles XVIII and XIX of the Social Security Act, Code of Federal Regulations, title 42, Minnesota Statutes, chapters 256, 256B, and 256D, parts 9505.0170 to 9505.0475 which govern covered services, parts 9505.5000 to 9505.5030 which govern prior authorization, parts 9505.0545 and 9505.5035 to 9505.5105 which govern second surgical opinion, and parts 9505.0500 to 9505.0540 which govern admission certification.

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 13 SR 1689; 18 SR 1115*

9500.1100 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1090 to 9500.1140, the terms in subparts 1a to 51 are defined as follows.

Subp. 1a. **Accommodation service.** "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. Accommodation services are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency care units.

Subp. 2. **Adjusted base year operating cost.** "Adjusted base year operating cost" means a hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.

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

Subp. 4. [Repealed, 18 SR 1115]

Subp. 4a. [Repealed, 18 SR 1115]

Subp. 5. **Allowable base year operating cost.** "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day, that is adjusted for case mix and excludes property costs.

Subp. 6. **Ancillary service.** "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, pharmacy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, therapy, medical supplies, renal dialysis, psychiatric, and chemical dependency services customarily charged in addition to an accommodation service charge.

Subp. 7. [Repealed, 18 SR 1115]

Subp. 8. [Repealed, 18 SR 1115]

Subp. 8a. [Repealed, 18 SR 1115]

Subp. 9. **Base year.** "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish medical assistance and general assistance medical care rates.

Subp. 10. [Repealed, 18 SR 1115]

Subp. 11. **Case mix.** "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.

Subp. 12. [Repealed, 18 SR 1115]

Subp. 12a. **Charges.** "Charges" means the usual and customary payment requested by the hospital of the general public.

Subp. 13. [Repealed, 18 SR 1115]

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

Subp. 15. [Repealed, 18 SR 1115]

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

Subp. 17. [Repealed, 18 SR 1115]

Subp. 18. **Day outlier.** "Day outlier" means an admission whose length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.

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

Subp. 20. [Repealed, 18 SR 1115]

Subp. 20a. **Diagnostic categories.** "Diagnostic categories" means the diagnostic classifications containing one or more diagnosis related groups (DRGs) used by the Medicare program and identified in parts 9500.1090 to 9500.1140. The DRG classifications must be assigned according to the base year program and specialty groups with modifications as specified in subparts 20b to 20g.

Subp. 20b. **Diagnostic categories eligible under the medical assistance program.** The following diagnostic categories are for persons eligible under the medical assistance program except as provided in subpart 20c, 20d, 20e, or 20f:

	DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTER-NATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	Nervous System Conditions		
	(1) Treated with Major Surgical Procedure	001–005, 007	
	(2) Other Nervous System Conditions	006, 008–035	
B.	Eye Diseases and Disorders	036–048	
C.	Ear, Nose, Mouth, And Throat Diseases	049–074, 168 169, 185–187	

D.	Respiratory System Conditions	
	(1) Treated with Surgical Procedure	075–077, 482, 483
	(2) Treated with Ventilator Support	475
	(3) Other Respiratory System Conditions	078–097, 099–102
E.	Circulatory System	
	(1) Conditions Treated with Surgical Procedure	104–108, 110–120, 478, 479
	(2) Other Circulatory System Conditions	121–145
F.	Digestive System Diseases and Disorders	146–167, 170–183, 188–190
G.	Hepatobiliary System	
	(1) Conditions Treated with Surgical Procedure	191–201
	(2) Other Hepatobiliary System Conditions	202–208
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209–256, 471
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast	257–284
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	285–301
K.	Kidney and Urinary Tract Conditions	303–333
L.	Male Reproductive System Conditions	334–352
M.	Female Reproductive System Conditions	353–369
N.	Pregnancy Related Conditions	
	(1) Postpartum Complications Treated with Surgical Procedure and Ectopic Pregnancy	377, 378
	(2) Other Pregnancy Related Conditions	376, 379–384
O.	[Reserved for future use]	
P.	Blood and Immunity Disorders	
	(1) Treated with Surgical Procedure	392–394
	(2) Other Blood and Immunity Disorders	395–399
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms Not Elsewhere Classified	400–414, 473

R.	Infections and Parasitic Diseases	
	(1) Treated with Surgical Procedure	415
	(2) Other Infections and Parasitic Diseases	416–423
S.	Mental Diseases and Disorders	
	(1) Treated with Surgical Procedure (Ages 0+)	424
	(2) (Ages 0–17)	425, 427–429, 432
	(3) (Ages > 17)	425, 427–429, 432
T.	Substance Use and Substance Induced Organic Mental Disorder	
	(1) (Ages 0–20)	434, 435
	(2) (Ages > 20)	434, 435
U.	[Reserved for future use]	
V.	Toxic Effects of Drugs	
	(1) Treated with Surgical Procedure	439–443
	(2) Other Treatment of Toxic Effects of Drugs	444–455
W.	Burns	
	(1) Extensive Burns or Burns Treated with Surgical Procedure	457–459, 472
	(2) Nonextensive Burns Without Surgery	460
X.	Factors Influencing Health Status	461–467
Y.	Bronchitis and Asthma	
	(1) (Ages 0–1)	098
	(2) (Ages 2–17)	098
Z.	[Reserved for future use]	
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders	
	(1) (Ages 0–1)	184
	(2) (Ages 2–17)	184
BB.	[Reserved for future use]	
CC.	Caesarean Sections	
	(1) with Complicating Diagnosis	370
	(2) without Complicating Diagnosis	371
DD.	Vaginal Delivery	
	(1) With Complicating Diagnosis or Operating Room Procedures	372, 374, 375
	(2) Without Complicating Diagnosis or Operating Room Procedures	373
EE.	[Reserved for future use]	
FF.	Depressive Neurosis	
	(1) (Ages 0–17)	426
	(2) (Ages > 17)	426

GG.	Psychosis		
	(1) (Ages 0–17)	430	
	(2) (Ages > 17)	430	
HH.	Childhood Mental Disorders		431
II.	Unrelated Operating Room Procedures		
	(1) Extensive	468	
	(2) Nonextensive	476, 477	
JJ.	[Reserved for future use]		
KK.	Extreme Immaturity		
	(1) (< 750 Grams)	386	76501, 76502
	(2) [Reserved for future use]		
	(3) [Reserved for future use]		
	(4) (750 to 1499 Grams)	386	76503, 76504, 76505
		387	76500
	(5) Neonate Respiratory Distress Syndrome	386	CODES FOR DRG 386 Except 76501 to 76505
LL.	Prematurity with Major Problems		
	(1) (< 1249 Grams)	387	76511, 76512, 76513, 76514
	(2) (1250 to 1749 Grams)	387	76506, 76510 76515, 76516
	(3) (> 1749 Grams)	387	Codes for DRG 387 Except 76500, 76506, 76510 to 76516
MM.	Prematurity without Major Problems	388	
NN.	Full Term Neonates with		
	(1) Major Problems (Age 0)	389	
	(2) Other Problems	390	
OO.	Multiple Significant Trauma		484–487
PP.	[Reserved for future use]		
QQ.	Normal Newborns	391	
RR.	[Reserved for future use]		
SS.	[Reserved for future use]		
TT.	[Reserved for future use]		
UU.	Organ Transplants	103, 302 480, 481	
VV.	Conditions Originating in Perinatal Period (Age > 0)		389
WW.	Human Immunodeficiency Virus	488–490	

Subp. 20c. **Medical assistance covered diagnostic categories under the aid to families with dependent children program.** The following diagnostic categories are for persons eligible for medical assistance under the aid to families with dependent children program, except as provided in subpart 20d, 20e, or 20f:

	DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTER-NATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	Nervous System Conditions		
	(1) Treated with Major Surgical Procedure	001–005, 007	
	(2) Other Nervous System Conditions	006, 008–035	
B.	Eye Diseases and Disorders	036–048	
C.	Ear, Nose, Mouth, And Throat Diseases	049–074, 168 169, 185–187	
D.	Respiratory System Conditions		
	(1) Treated with Surgical Procedure	075–077, 482 483	
	(2) Treated with Ventilator Support	475	
	(3) Other Respiratory System Conditions	078–097, 099–102	
E.	Circulatory System		
	(1) Conditions Treated with Surgical Procedure	104–108, 110–120, 478, 479	
	(2) Other Circulatory System Conditions	121–145	
F.	Digestive System Diseases and Disorders	146–167, 170–183, 188–190	
G.	Hepatobiliary System		
	(1) Conditions Treated with Surgical Procedure	191–201	
	(2) Other Hepatobiliary System Conditions	202–208	
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209–256, 471	
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast	257–284	
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	285–301	
K.	Kidney and Urinary Tract Conditions	303–333	
L.	Male Reproductive System Conditions	334–352	
M.	Female Reproductive System Conditions	353–369	
N.	Pregnancy Related Conditions		
	(1) Postpartum Complications Treated with Surgical		

	Procedure and Ectopic Pregnancy	377, 378
	(2) Other Pregnancy Related Conditions	376, 379–384
O.	[Reserved for future use]	
P.	Blood and Immunity Disorders	
	(1) Treated with Surgical Procedure	392–394
	(2) Other Blood and Immunity Disorders	395–399
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms Not Elsewhere Classified	400–414, 473
R.	Infections and Parasitic Diseases	
	(1) Treated with Surgical Procedure	415
	(2) Other Infections and Parasitic Diseases	416–423
S.	Mental Diseases and Disorders	
	(1) Treated with Surgical Procedure (Ages 0+)	424
	(2) (Ages 0–17)	425, 427–429, 432
	(3) (Ages > 17)	425, 427–429, 432
T.	Substance Use and Substance Induced Organic Mental Disorder	
	(1) (Ages 0–20)	434, 435
	(2) (Ages > 20)	434, 435
U.	[Reserved for future use]	
V.	Toxic Effects of Drugs	
	(1) Treated with Surgical Procedure	439–443
	(2) Other Treatment of Toxic Effects of Drugs	444–455
W.	Burns	
	(1) Extensive Burns or Burns Treated with Surgical Procedure	457–459, 472
	(2) Nonextensive Burns Without Surgery	460
X.	Factors Influencing Health Status	461–467
Y.	Bronchitis and Asthma	
	(1) (Ages 0–1)	098
	(2) (Ages 2–17)	098
Z.	[Reserved for future use]	
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders	
	(1) (Ages 0–1)	184
	(2) (Ages 2–17)	184
BB.	[Reserved for future use]	

CC.	Caesarean Sections		
	(1) with Complicating Diagnosis	370	
	(2) without Complicating Diagnosis	371	
DD.	Vaginal Delivery		
	(1) With Complicating Diagnosis or Operating Room Procedures	372, 374, 375	
	(2) Without Complicating Diagnosis or Operating Room Procedures	373	
EE.	[Reserved for future use]		
FF.	Depressive Neurosis		
	(1) (Ages 0–17)	426	
	(2) (Ages > 17)	426	
GG.	Psychosis		
	(1) (Ages 0–17)	430	
	(2) (Ages > 17)	430	
HH.	Childhood Mental Disorders		431
II.	Unrelated Operating Room Procedure		
	(1) Extensive	468	
	(2) Nonextensive	476, 477	
JJ.	[Reserved for future use]		
KK.	Extreme Immaturity		
	(1) (< 750 Grams)	386	76501, 76502
	(2) [Reserved for future use]		
	(3) [Reserved for future use]		
	(4) (750 to 1499 Grams)	386	76503, 76504, 76505
		387	76500
	(5) Neonate Respiratory Distress Syndrome	386	Codes for DRG 386 Except 76501 to 76505
LL.	Prematurity with Major Problems		
	(1) (< 1249 Grams)	387	76511, 76512, 76513, 76514
	(2) (1250 to 1749 Grams)	387	76506, 76510 76515, 76516
	(3) (> 1749 Grams)	387	Codes for DRG 387 Except 76500, 76506, 76510 to 76516
MM.	Prematurity without Major Problems	388	
NN.	Full Term Neonates with		
	(1) Major Problems	389	
	(2) Other Problems	390	
OO.	Multiple Significant Trauma		484–487
PP.	[Reserved for future use]		
QQ.	Normal Newborns	391	

RR.	[Reserved for future use]	
SS.	[Reserved for future use]	
TT.	[Reserved for future use]	
UU.	Organ Transplants	103, 302, 480, 481
VV.	[Reserved for future use]	
WW.	Human Immunodeficiency Virus	488–490

Subp. 20d. **Diagnostic categories for persons eligible under the general assistance medical care program.** The following diagnostic categories are for persons eligible under the general assistance medical care program except as provided in subpart 20e or 20f:

	DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTER-NATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	Nervous System Conditions		
	(1) Treated with Major Surgical Procedure	001–005, 007	
	(2) Other Nervous System Conditions	006, 008–035	
B.	Eye Diseases and Disorders	036–048	
C.	Ear, Nose, Mouth, And Throat Diseases	049–074, 168 169, 185–187	
D.	Respiratory System Conditions		
	(1) Treated with Surgical Procedure	075–077, 482, 483	
	(2) Treated with Ventilator Support	475	
	(3) Other Respiratory System Conditions	078–102,	
E.	Circulatory System		
	(1) Conditions Treated with Surgical Procedure	103–108, 110–120, 478, 479	
	(2) Other Circulatory System Conditions	121–125 127–145	
	(3) Acute and Subacute Endocarditis	126	
F.	Digestive System Diseases and Disorders	146–167, 170–184, 188–190	
G.	Hepatobiliary System Conditions		
	(1) Treated with Surgical Procedure	191–201, 480	
	(2) Other Hepatobiliary System Conditions	202–208	
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209–256, 471	

I.	Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast	257–284
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	285–301
K.	Kidney and Urinary Diseases and Disorders	302–333
L.	Male Reproductive System Conditions	334–352
M.	Female Reproductive System Conditions	353–369
N.	Pregnancy Related Conditions	
	(1) Postpartum Complications Treated with Surgical Procedure and Ectopic Pregnancy	377, 378
	(2) Other Pregnancy Related Conditions	376, 379–384
O.	Neonate – Premature or with Problems	386–390
P.	Blood and Immunity Disorders	
	(1) Treated with Surgical Procedure	392–394
	(2) Other Blood and Immunity Disorders	395–399
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms Not Elsewhere Classified	400–414, 473 481
R.	Infections and Parasitic Diseases	
	(1) Treated with Surgical Procedure	415
	(2) Other Infections and Parasitic Diseases	416–423
S.	Mental Diseases and Disorders	
	(1) Treated with Surgical Procedure	424
	(2) [Reserved for future use]	
	(3) [Reserved for future use]	
	(4) Not Treated with Surgical Procedure	425, 427–429, 431–432
T.	Substance Use and Substance Induced Organic Mental Disorder	
	(1) [Reserved for future use]	
	(2) [Reserved for future use]	
	(3) (Ages 0+)	434, 435
U.	[Reserved for future use]	
V.	Toxic Effects of Drugs	
	(1) Treated with Surgical Procedure	439–443
	(2) Other Treatment of Toxic Effects of Drugs	444–455
W.	Burns	
	(1) Extensive Burns or Burns	

	Treated with Surgical Procedure	457–459, 472	
	(2) Nonextensive Burns Without Surgery	460	
X.	Factors Influencing Health Status	461–467	
Y.	[Reserved for future use]		
Z.	[Reserved for future use]		
AA.	[Reserved for future use]		
BB.	[Reserved for future use]		
CC.	Caesarean Sections		
	(1) with Complicating Diagnosis	370	
	(2) without Complicating Diagnosis	371	
DD.	Vaginal Delivery		
	(1) With Complicating Diagnosis or Operating Room Procedures	372, 374, 375	
	(2) Without Complicating Diagnosis or Operating Room Procedures	373	
EE.	[Reserved for future use]		
FF.	Depressive Neurosis	426	
GG.	Psychosis		430
HH.	[Reserved for future use]		
II.	Unrelated Operating Room Procedure		
	(1) Extensive	468	
	(2) Nonextensive	476, 477	
JJ.	[Reserved for future use]		
KK.	[Reserved for future use]		
LL.	[Reserved for future use]		
MM.	[Reserved for future use]		
NN.	[Reserved for future use]		
OO.	Multiple Significant Trauma		484–487
PP.	[Reserved for future use]		
QQ.	Normal Newborns	391	
RR.	[Reserved for future use]		
SS.	[Reserved for future use]		
TT.	[Reserved for future use]		
UU.	[Reserved for future use]		
VV.	[Reserved for future use]		
WW.	Human Immunodeficiency Virus	488–490	

Subp. 20e. **Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part.** The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part regardless of program eligibility:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTER–NATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A. Nervous System Diseases and Disorders	001–035	

B.	[Reserved for future use]	
C.	[Reserved for future use]	
D.	[Reserved for future use]	
E.	[Reserved for future use]	
F.	[Reserved for future use]	
G.	[Reserved for future use]	
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209–256, 471
I.	[Reserved for future use]	
J.	[Reserved for future use]	
K.	[Reserved for future use]	
L.	[Reserved for future use]	
M.	[Reserved for future use]	
N.	[Reserved for future use]	
O.	[Reserved for future use]	
P.	[Reserved for future use]	
Q.	[Reserved for future use]	
R.	[Reserved for future use]	
S.	[Reserved for future use]	
T.	[Reserved for future use]	
U.	[Reserved for future use]	
V.	[Reserved for future use]	
W.	[Reserved for future use]	
X.	[Reserved for future use]	
Y.	[Reserved for future use]	
Z.	[Reserved for future use]	
AA.	[Reserved for future use]	
BB.	[Reserved for future use]	
CC.	[Reserved for future use]	
DD.	[Reserved for future use]	
EE.	[Reserved for future use]	
FF.	[Reserved for future use]	
GG.	[Reserved for future use]	
HH.	[Reserved for future use]	
II.	[Reserved for future use]	
JJ.	[Reserved for future use]	
KK.	[Reserved for future use]	
LL.	[Reserved for future use]	
MM.	[Reserved for future use]	
NN.	[Reserved for future use]	
OO.	[Reserved for future use]	
PP.	Burns and Skin Diseases and Disorders	263–273, 277–284, 457–460, 472
QQ.	[Reserved for future use]	
RR.	Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders	424–432, 434, 435
SS.	Multiple Significant Trauma/Unrelated Operating Room Procedures	468, 476–477, 484–487
TT.	Other Conditions Requiring Rehabilitation Services	036–108, 110–208, 257–262,

		274–276, 285–423, 439–455, 461–467, 473, 475 478–483, 488–490	
UU.	[Reserved for future use]		
VV.	[Reserved for future use]		
WW.	[Reserved for future use]		

Subp. 20f. **Diagnostic categories for neonatal transfers.** The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units regardless of program eligibility:

	DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTER–NATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	[Reserved for future use]		
B.	[Reserved for future use]		
C.	[Reserved for future use]		
D.	[Reserved for future use]		
E.	[Reserved for future use]		
F.	[Reserved for future use]		
G.	[Reserved for future use]		
H.	[Reserved for future use]		
I.	[Reserved for future use]		
J.	[Reserved for future use]		
K.	[Reserved for future use]		
L.	[Reserved for future use]		
M.	[Reserved for future use]		
N.	[Reserved for future use]		
O.	[Reserved for future use]		
P.	[Reserved for future use]		
Q.	[Reserved for future use]		
R.	[Reserved for future use]		
S.	[Reserved for future use]		
T.	[Reserved for future use]		
U.	[Reserved for future use]		
V.	[Reserved for future use]		
W.	[Reserved for future use]		
X.	[Reserved for future use]		
Y.	[Reserved for future use]		
Z.	[Reserved for future use]		
AA.	[Reserved for future use]		
BB.	[Reserved for future use]		
CC.	[Reserved for future use]		
DD.	[Reserved for future use]		
EE.	[Reserved for future use]		
FF.	[Reserved for future use]		
GG.	[Reserved for future use]		
HH.	[Reserved for future use]		
II.	[Reserved for future use]		
JJ.	[Reserved for future use]		
KK.	Extreme Immaturity		
	(1) (< 750 Grams)	386	76501, 76502
	(2) (750 to 999 Grams)	386	76503

	(3) (1000 to 1499 Grams)	386 387	76504, 76505 76500
	(4) [Reserved for future use]		
	(5) Neonate Respiratory Distress Syndrome	386	Codes for DRG 386 Except 76501 to 76505
LL.	Prematurity with Major Problems		
	(1) (< 1249 Grams)	387	76511, 76512, 76513, 76514
	(2) (1250 to 1749 Grams)	387	76506, 76510, 76515, 76516
	(3) (1250 to 1749 Grams)	387	Codes for DRG 387 Except 76500, 76506, 76510 to 76516
MM.	Prematurity without Major Problems (> 1749 Grams)	388	
NN.	Full Term Neonates		
	(1) with Major Problems (age 0)	389	
	(2) with Other Problems	390	
OO.	[Reserved for future use]		
PP.	[Reserved for future use]		
QQ.	[Reserved for future use]		
RR.	[Reserved for future use]		
SS.	[Reserved for future use]		
TT.	[Reserved for future use]		
UU.	[Reserved for future use]		
VV.	[Reserved for future use]		
WW.	[Reserved for future use]		

Subp. 20g. **Additional DRG requirements.**

A. The version of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

B. The discharge status will be changed to "discharge to home" for DRG 385, 433, and 456.

C. A diagnosis with the prefix "v57" will be excluded when grouping under subpart 20e.

Subp. 21. [Repealed, 18 SR 1115]

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

Subp. 23. [Repealed, 18 SR 1115]

Subp. 24. [Repealed, 18 SR 1115]

Subp. 24a. [Repealed, 18 SR 1115]

Subp. 25. **Hospital.** "Hospital" means a facility defined in Minnesota Statutes, section 144.696, subdivision 3, and licensed under Minnesota Statutes, sections 144.50 to 144.58, or an out–of–state facility licensed to provide acute care under the requirements of the state in which it is located, or an Indian health service facility designated by the federal government to provide acute care.

Subp. 26. **Hospital cost index.** "Hospital cost index" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Subp. 26a. **Inpatient hospital costs.** "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare without regard to adjustments in payments imposed by Medicare.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.

Subp. 28. [Repealed, 18 SR 1115]

Subp. 28a. **Local trade area hospital.** "Local trade area hospital" means a hospital that is located in a state other than Minnesota but in a county of the other state in which the county is contiguous to Minnesota.

Subp. 29. **Medical assistance.** "Medical assistance" means the program established under Title XIX of the Social Security Act and Minnesota Statutes, sections 256.9685 to 256.9695 and chapter 256B. For purposes of parts 9500.1090 to 9500.1140, "medical assistance" includes general assistance medical care unless otherwise specifically stated.

Subp. 30. [Repealed, 18 SR 1115]

Subp. 30a. [Repealed, 18 SR 1115]

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

Subp. 32. **Medicare crossover.** "Medicare crossover" means a claim submitted by a hospital to request payment for Medicare Part A covered inpatient hospital services provided to a patient who is also eligible for medical assistance.

Subp. 33. **Metropolitan statistical area hospital.** "Metropolitan statistical area hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Subp. 33a. [Repealed, 18 SR 1115]

Subp. 34. **Nonmetropolitan statistical area hospital.** "Nonmetropolitan statistical area hospital" means a hospital not located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Subp. 35. **Operating costs.** "Operating costs" means inpatient hospital costs excluding property costs.

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

Subp. 37. **Out–of–area hospital.** "Out–of–area hospital" means any hospital located outside of Minnesota excluding local trade area hospitals.

Subp. 38. **Property costs.** "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.

Subp. 39. [Repealed, 18 SR 1115]

Subp. 40. [Repealed, 18 SR 1115]

Subp. 41. [Repealed, 18 SR 1115]

Subp. 41a. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.

Subp. 42. [Repealed, 18 SR 1115]

Subp. 43. [Repealed, 18 SR 1115]

Subp. 43a. [Repealed, 18 SR 1115]

Subp. 44. [Repealed, 18 SR 1115]

Subp. 44a. **Rehabilitation distinct part.** "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Subp. 45. **Relative value.** "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within a program at subpart 20b, 20c, or 20d or specialty group at subpart 20e or 20f.

Subp. 46. [Repealed, 18 SR 1115]

Subp. 47. [Repealed, 18 SR 1115]

Subp. 47a. [Repealed, 18 SR 1115]

Subp. 48. [Repealed, 18 SR 1115]

Subp. 49. [Repealed, 18 SR 1115]

Subp. 50. **Transfer.** "Transfer" means the movement of a patient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.

Subp. 51. **Trim point.** "Trim point" means that number of inpatient days beyond which an admission is a day outlier.

Subp. 52. [Repealed, 18 SR 1115]

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 11 SR 987; 11 SR 1688; 12 SR 1617; 13 SR 1689; 14 SR 8; 14 SR 1005; 18 SR 1115*

9500.1105 BASIS OF PAYMENT FOR INPATIENT HOSPITAL SERVICES.

Subpart 1. **Reporting requirements.**

A. No later than October 1 preceding a rebased rate year or 60 days from the department's request, whichever is later, a Minnesota and local trade area hospital must provide to the department complete, true, and authorized information as outlined in subitems (1) to (7). Information called for in subitems (1) to (7) not provided in a timely manner will not be used in calculating the hospital's rates for that rate year and the following year if rebasing does not occur.

(1) The base year Medicare audited cost report of local trade area hospitals.

(2) The decision on whether certified registered nurse anesthetist services are to be paid separately from parts 9500.1090 to 9500.1140. Once elected, the decision to be paid separately is irrevocable.

(3) The identification of base year claims for admissions to a rehabilitation distinct part.

(4) The elected outlier percentage for other than neonate and burn admissions to a minimum of 60 percent and a maximum of 80 percent. The chosen percentage shall apply to all program and specialty groups of the hospital.

(5) The most recent Medicare cost report submitted to Medicare by October 1 prior to a rebased rate year.

(6) The data on low income utilization necessary to implement the disproportionate population adjustment.

(7) The Medicare adjustments to prior base year data.

B. If Medicare does not require the hospital to file a complete cost report, that hospital must, no later than February 1 preceding a rebased rate year, provide true, complete, and authorized Medicare cost report data under the cost finding methods and allowable costs in effect during the base year.

Subp. 2. **Establishment of base years.**

A. Except as provided in items B and C, the base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year for the 1993 rate year of a children's hospital shall be the hospital's most recent fiscal year ending prior to January 1, 1990. A children's hospital is one in which more than 50 percent of the admissions are individuals less than 18 years of age.

C. The base year for the 1993 rate year for a long–term hospital shall be that part of the most recent fiscal year ending prior to September 1, 1989, for which the hospital was designated a long–term hospital by Medicare.

D. The base year data will be moved forward three years for hospitals subject to item A, one year for hospitals subject to item B, and two years for hospitals subject to item C

beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995 or every one year if notice is provided at least six months prior to the rate year.

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 18 SR 1115*

9500.1110 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES.

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

A. Select medical assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

B. Exclude the claims and charges in subitems (1) to (6):

(1) Medicare crossover claims;

(2) claims paid on a per day transfer rate basis for a period that is less than the average length of stay of the diagnostic category in effect on the admission date;

(3) inpatient hospital services for which medical assistance payment was not made;

(4) inpatient hospital claims that must be paid during the rate year on a per day basis without regard to relative values during the period for which rates are set;

(5) inpatient hospital services not covered by the medical assistance program on October 1 prior to a rebased rate year; and

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges.

C. Separate claims which combine the stay of both mother and newborn into two or more claims according to subitems (1) to (4).

(1) Accommodation service charges for each newborn claim are the sum of nursery and neonatal intensive care unit charges divided by the number of newborns. Accommodation service charges for the mother are all other accommodation service charges.

(2) Ancillary charges for each claim are calculated by multiplying each ancillary charge by each claim's ratio of accommodation service charges in subitem (1) to the total accommodation service charges in subitem (1).

(3) If the newborn's inpatient days continue beyond the discharge of the mother, the claim of the newborn shall be combined with any immediate subsequent claim of the newborn.

(4) If the newborn does not have charges under subitem (1), the ancillary charges of the mother and newborn shall be separated by the percentage of the total ancillary charges that are assigned to all other mothers and newborns.

D. Combine claims into the admission that generated the claim according to part 9500.1128, subpart 4.

E. Determine operating costs for each hospital admission in item D using each hospital's base year data according to subitems (1) to (6).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost to charge ratio and add the products of all ancillary services.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

(4) Determine the cost of malpractice insurance, if that cost is not included in the accommodation and ancillary cost, by multiplying the total hospital costs of malpractice insurance by the ratio of the claim charge to total hospital charges and then multiply that product by 0.915.

(5) Add subitems (1) to (4) to determine the operating cost for each admission.

(6) Multiply the result of subitem (5) by the hospital cost index that corresponds to the hospital's fiscal year end in part 9500.1120, subpart 2, item F.

F. Assign each admission and operating cost identified in item E, subitem (6), to the appropriate program or specialty group and diagnostic category according to part 9500.1100, subparts 20a to 20e and 20g.

G. Determine the mean cost per admission for all admissions identified in item F within each program and specialty group by dividing the sum of the operating costs by the total number of admissions.

H. Determine the mean cost per admission for each diagnostic category identified in item F within each program and specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

I. Determine the relative value for each diagnostic category by dividing item H by the corresponding result of item G within the program and specialty group and round the quotient to five decimal places.

J. Determine the mean length of stay for each diagnostic category identified in item F by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

K. Determine the day outlier trim point for each diagnostic category and round to whole days.

Subp. 2. **Redetermination of relative values.** The department shall reassign the program, specialty group, and diagnostic category composition in part 9500.1100, subparts 20a to 20g, after notice of the change in the State Register and a 30–day comment period. The relative values in this part and adjusted base year operating costs in part 9500.1115 and 9500.1116 must be redetermined when changes are made to part 9500.1100, subparts 20a to 20g.

Subp. 3. [Repealed, 18 SR 1115]

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 11 SR 1688; 18 SR 1115*

9500.1115 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER.

Subpart 1. **Minnesota and local trade area hospitals.** The department will determine the adjusted base year operating cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to part 9500.1110, subpart 1, items A to F, except that the ratios in item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected by the hospital.

B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments.

For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within each program and specialty group, and divide this amount by the number of admissions within each program and specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

Subp. 2. **Minnesota and local trade area hospitals.** The department will determine the adjusted base year operating cost per day outlier for each Minnesota and local trade area hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in subpart 1, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

Subp. 3. **Out–of–area hospitals.** The department will determine the adjusted base year operating cost per admission and per day outlier by program and specialty group for out–of–area hospitals according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

Subp. 4. **Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year.** The department will determine the adjusted base year operating cost per admission or per day outlier by program and specialty group for Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year according to items A to C.

A. Multiply each adjusted base year cost per admission and day outlier in effect on the first day of a rate year for each Minnesota and local trade area and metropolitan statistical area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all metropolitan statistical area hospitals and round that amount to whole dollars.

Subp. 5. **Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year.** The department will determine the adjusted base year operating cost per admission or per day outlier by program and specialty group for Minnesota and local trade area nonmetropolitan statistical area hospitals by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under subpart 4.

Subp. 6. **Limitation on separate payment and outlier percentage.** Hospitals that have rates established under subpart 3 may not have certified registered nurse anesthetists services paid separately from parts 9500.1090 to 9500.1140 and hospitals that have rates established under subpart 3, 4, or 5 may not elect an alternative outlier percentage.

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 11 SR 1688; 18 SR 1115*

9500.1116 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY.

Subpart 1. **Neonatal transfers.**

A. For Minnesota and local trade area hospitals, the department will determine the neonatal transfer adjusted base year operating cost per day for Minnesota and local trade area hospital admissions that result from a transfer to a neonatal intensive care unit according to subitems (1) to (3).

(1) Determine the operating cost per day for each diagnostic category in part 9500.1100, subpart 20f, according to part 9500.1110, subpart 1, items A to F, except that the ratios in part 9500.1110, subpart 1, item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected by the hospital, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

(2) Determine relative values for each diagnostic category at part 9500.1100, subpart 20f, according to part 9500.1110, subpart 1, items G, H, and I, after substituting the term "day" for "admission."

(3) Adjust the result of subitem (2) according to part 9500.1115, subpart 1, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance neonatal transfer admissions to a neonatal intensive care unit in the base year, the department will determine the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit according to subitems (1) to (3).

(1) Multiply each adjusted base year cost per day in effect on the first day of a rate year for each Minnesota and local trade area metropolitan statistical area hospital by the number of corresponding days in the hospital's base year.

(2) Add the products in subitem (1).

(3) Divide the total from subitem (2) by the total days for all metropolitan statistical area hospitals and round that amount to whole dollars.

C. For Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance neonatal transfer admissions to a neonatal intensive care unit in the base year, the department will determine the adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under item B.

Subp. 2. **Long–term hospital.** The department will determine the base year operating cost per day for Minnesota and local trade area hospital admissions to a long–term hospital as designated by Medicare for the rate year according to items A and B.

A. Determine the operating cost per day according to part 9500.1110, subpart 1, items A to E, except that claims excluded in part 9500.1110, subpart 1, item B, subitems (2) and (4), will be included and the ratios in part 9500.1110, subpart 1, item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected by the hospital.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

Statutory Authority: *MS S 256.9685; 256.9695*

History: *18 SR 1115*

9500.1120 DETERMINATION OF HOSPITAL COST INDEX.

Subpart 1. **Adoption of Hospital Cost Index.** The hospital cost index will be derived from Health Care Costs as published by Data Resources Incorporated (DRI), 1200 G Street NW, Washington, D.C. 20005. This report is published quarterly. The health care costs report is available through the Minitex interlibrary loan system and this report is incorporated by reference.

Subp. 2. **Determination of hospital cost index.** For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the department shall determine the hospital cost index according to items A to F.

A. The commissioner shall obtain from Data Resources, Inc., the average annual historical and projected cost change estimates in a decimal format for the operating costs in subitems (1) to (7):

(1) wages and salaries;

(2) employee benefits;

(3) medical and professional fees;

(4) raw food;

(5) utilities;

(6) insurance including malpractice; and

(7) other operating costs.

B. Obtain data for operating costs of hospitals in Minnesota which indicate the proportion of operating costs attributable to item A, subitems (1) to (7).

C. For each category in item A, multiply the amount determined in item B by the applicable amount determined in item A.

D. Add the products determined in item C and limit this amount to the statutory maximums on the rate of increase. Round the result to three decimal places.

E. For the period beginning October 1, 1992, through June 30, 1993, add 0.01 to the medical assistance index, excluding general assistance medical care, in item D.

F. Add one to the amounts calculated in item E and multiply these amounts together. Round the result to three decimal places.

Subp. 3. [Repealed, 18 SR 1115]

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 18 SR 1115*

9500.1121 DETERMINATION OF DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Eligibility for disproportionate population adjustment.** To be eligible for a disproportionate population adjustment, the hospital must meet the requirements of item B under general assistance medical care and item A and item C, D, or E under medical assistance.

A. The hospital, at the time that an admission occurs, must have at least two obstetricians with staff privileges who provide obstetric services to medical assistance patients. For nonmetropolitan statistical area hospitals, an obstetrician may be any physician with staff privileges at the hospital to perform nonemergency obstetrics procedures. This requirement does not apply to hospitals where the majority of admissions are predominately individuals under 18 years of age or hospitals that did not offer nonemergency obstetric services as of December 21, 1987.

B. The hospital has a base year days utilization rate of medical assistance inpatient days, excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean plus one standard deviation for Minnesota and local trade area hospitals. The difference is added to one and rounded to four decimal places.

C. The hospital has a base year days utilization rate of medical assistance inpatient days, excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean for Minnesota and local trade area hospitals. The difference is added to one and rounded to four decimal places.

D. The hospital has a base year days utilization rate of medical assistance inpatient days, excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean plus one standard deviation for Minnesota and local trade area hospitals. The difference is multiplied by 1.1 and added to one and rounded to four decimal places.

E. The hospital has a base year low–income utilization rate that exceeds 0.25. This rate is calculated by dividing medical assistance revenues, excluding general assistance medical care, plus any cash subsidies received by the hospital directly from state and local government by total revenues plus the cash subsidies amount. This rate is added to the quotient of inpatient "charity care" charges minus the cash subsidies divided by total inpatient charges. The result is added to one and rounded to four decimal places. For purposes of this part, "charity care" is care provided to individuals who have no source of payment from third–party or personal resources.

Subp. 2. **Days utilization rate used in cases where hospital qualifies under two rates.** If a hospital qualifies under both the days utilization rate at subpart 1, item C or D, and the low–income utilization rate at subpart 1, item E, the disproportionate population adjustment amount shall be the days utilization rate.

Statutory Authority: *MS S 256.9685; 256.9695*

History: *18 SR 1115*

9500.1122 DETERMINATION OF PROPERTY COST PER ADMISSION.

Subpart 1. **Minnesota and local trade area hospitals.** The department will determine the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each hospital admission in part 9500.1110, subpart 1, item D, using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost to charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in part 9500.1110, subpart 1, item D, using each hospital's base year data and recent year data from part 9500.1105, subpart 1, item A, subitem (5), according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission by program and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3), to the appropriate program and specialty group according to part 9500.1100, subparts 20a to 20g.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within each group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

Subp. 2. **Out–of–area hospitals.** The department will determine the property cost per admission by program for out–of–area hospitals according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

Subp. 3. **Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions in the base year.** The department will determine the property cost per admission by program and specialty group for Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions in the base year according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area metropolitan statistical area hospital by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total admissions for all metropolitan statistical area hospitals and round the resulting amount to whole dollars.

Subp. 4. **Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions in the base year.** The department will determine the property cost per admission by program and specialty group for Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions in the base year by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under subpart 3.

Statutory Authority: *MS S 256.9685; 256.9695*

History: *18 SR 1115*

9500.1124 DETERMINATION OF PROPERTY COST PER DAY.

Subpart 1. **Neonatal transfers.**

A. For Minnesota and local trade area hospitals, the department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a neonatal intensive care unit according to part 9500.1122, subpart 1, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area hospitals that do not have medical assistance neonatal transfer admissions in the base year, the department will determine the neonatal transfer property cost per day for admissions in the base year according to part 9500.1122, subpart 3, after substituting the term "day" for "admission."

Subp. 2. **Long–term hospitals.** For long–term hospitals, the department will determine the property cost per day for Minnesota and local trade area hospital admissions to a long–term hospital as designated by Medicare for the rate year according to subpart 1, item A, except that claims excluded in part 9500.1110, subpart 1, item B, subitems (2) and (4), will be included.

Statutory Authority: *MS S 256.9685; 256.9695*

History: *18 SR 1115*

9500.1125 [Repealed, 18 SR 1115]

9500.1126 RECAPTURE OF DEPRECIATION.

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

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

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

Statutory Authority: *MS s 256.969 subds 2,6*

History: *10 SR 227; 11 SR 1688*

9500.1128 DETERMINATION OF PAYMENT RATES.

Subpart 1. **Notification.** Minnesota and local trade area hospitals will be provided a notice of rates and relative values that are to be effective for the rate year by the preceding December 1. The payment rates shall be based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year hospital cost index.

Subp. 2. **Rate per admission.**

A. Each admission is classified to the appropriate program or specialty group and diagnostic category according to part 9500.1100, subparts 20a to 20g, and the rate per admission will be determined according to subitems (1) and (2):

(1)	Medical Assistance Rate Per Admission	=	((Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission) and multiplied by the disproportionate population adjustment
(2)	General Assistance Medical Care Rate per Admission	=	(Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment) plus the property cost per admission

B. The metabolic testing fee for newborns that is paid to the Department of Health will be added to the rate per admission for each birth until the fee is included in the base year allowable operating costs of the hospital.

C. The day outlier rates are in addition to the rate per admission and will be determined by program or specialty group as follows:

(1) The rate per day for day outliers, as classified in item A, is determined as follows:

Outlier Rate Per Day	=	Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment

(2) The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services.

D. Except for admissions subject to subpart 3, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:

Transfer Rate Per Day	=	The rate per admission in item A divided by the arithmetic mean length of stay of the diagnostic category

(1) A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission specified in item A unless that admission is a day or cost outlier.

(2) Except as applicable under subpart 4, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.

Subp. 3. **Rate per day.**

A. Admissions resulting from a transfer to a neonatal intensive care unit and classified to a diagnostic category in part 9500.1100, subpart 20f, will have rates determined according to subpart 2, item A, after substituting the word "day" for "admission."

B. Admissions or transfers to a long–term hospital as designated by Medicare for the rate year will have rates determined according to subpart 2, item A, after substituting the word "day" for "admission," without regard to relative values.

Subp. 4. **Readmissions.** An admission and readmission of the same patient to the same or a different hospital within 15 days, excluding the days of discharge and readmission, is eligible for reimbursement according to the criteria in parts 9505.0500 to 9505.0540.

Statutory Authority: *MS S 256.9685; 256.9695*

History: *18 SR 1115*

9500.1129 PAYMENT LIMITATIONS.

Subpart 1. **Charge limitation.**

A. The department will limit payment, including third party and recipient liability, for services provided by an out–of–area hospital to allowable charges for the admission.

B. Payments, in addition to third party and recipient liability, for discharges occurring during a rate year may not exceed, in aggregate, the allowable charges for the same period of time to the hospital. This limitation will exclude payments made under part 9500.1121 and Medicare crossover claims. The limitation will be calculated separately for general assistance medical care and medical assistance and separately from other services for a rehabilitation distinct part.

Subp. 2. **Transfers.** A discharging hospital is not eligible for a transfer payment for services provided to a discharged patient if the admission to the discharging hospital was not due to an emergency, as defined in part 9505.0500, subpart 11, and the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services were outside the scope of the hospital's available services and the transfer to another hospital resulted because of the patient's need for those services.

Statutory Authority: *MS S 256.9685; 256.9695*

History: *18 SR 1115*

9500.1130 PAYMENT PROCEDURES.

Subpart 1. **Submittal of claims.** Claims may not be submitted to the department until after a patient is discharged or 30 days after admission and every subsequent 30 days, whichever occurs first. A hospital that submits a claim to the department after 30 days from admission, but before discharge, shall submit a final claim after discharge.

Subp. 1a. **Payor of last resort.** A hospital may not submit a claim to the department until a final determination of the patient's eligibility for potential third party payment has been made by a hospital. Any and all available third party benefits must be exhausted prior to billing medical assistance and the third party liability amounts must be entered on the claim.

Subp. 1b. **Third party liability.** Payment for patients that are simultaneously covered by medical assistance and a third party will be determined according to a hierarchy of application as set out in items A to E.

A. Medical assistance payment for a Medicare crossover will be determined by subtracting the third party liability from the Medicare deductible and coinsurance due from the patient. A negative difference will not be implemented.

B. Medical assistance payment for a Medicare crossover whose Medicare benefits either exhaust or begin during an admission will be determined by subtracting the Medicare payment and third party liability from the medical assistance rate. A negative difference will not be implemented.

C. Medical assistance payment will not be made for an admission when either charges are paid by a third party or the hospital has an agreement to accept payment for less than charges as payment in full.

D. Medical assistance payment for an admission under item C that requires a deductible or coinsurance will be made at a level equal to the deductible or coinsurance due from the patient.

E. Medical assistance payment for a patient with any third party benefits will be determined as the lesser of the covered charges minus the third party liability, or the medical assistance rate minus the third party liability. A negative difference will not be implemented.

Subp. 1c. **Reduction of recipient resources.** Recipient resources will also be reduced from the amounts in subpart 1b.

Subp. 2. [Repealed, 18 SR 1115]

Subp. 3. [Repealed, 18 SR 1115]

Subp. 4. [Repealed, 18 SR 1115]

Subp. 5. [Repealed, 18 SR 1115]

Subp. 6. [Repealed, 18 SR 1115]

Subp. 7. [Repealed, 18 SR 1115]

Subp. 8. [Repealed, 18 SR 1115]

Subp. 9. [Repealed, 18 SR 1115]

Subp. 10. [Repealed, 18 SR 1115]

Subp. 11. [Repealed, 18 SR 1115]

Subp. 12. [Repealed, 18 SR 1115]

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 10 SR 867; 11 SR 1688; 13 SR 1689; 18 SR 1115*

9500.1135 [Repealed, 18 SR 1115]

9500.1140 APPEALS.

Subpart 1. **Scope of appeals.** A hospital may appeal a decision arising from the application of standards or methods under Minnesota Statutes, section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. The appeals procedure in subparts 2 to 6 shall apply to all appeals filed on or after August 1, 1989.

Subp. 2. **Filing of appeals.** An appeal must be received by the commissioner within the time period specified in subpart 3, 4, or 5. The appeal must include the information required in items A to D:

A. the disputed items;

B. the authority in federal or state statute or rule upon which the hospital relies for each disputed item;

C. the type of appeal in subpart 3, 4, or 5 that is applicable to each disputed item; and

D. the name and address of the person to contact regarding the appeal.

Subp. 3. **Case mix appeals.** A hospital may appeal a payment change that results from a difference in case mix between the base year and rate year. The appeal must be received by the commissioner or postmarked no later than 120 days after the end of the appealed rate year. A case mix appeal will apply to all medical assistance patients who received inpatient hospital services from the hospital and the appeal is effective for the entire rate year. The results of case mix appeals do not automatically carry forward into later rate years. Separate case mix appeals must be submitted for each rate year based on the change in the mix of cases for that particular rate year. An adjustment will be made only to the extent that the need is attributable to circumstances that are separately identified by the hospital. The hospital must demonstrate that the average acuity or length of stay of patients in each rate year appealed has increased or services have been added or discontinued according to items A to C.

A. The change must be measured by use of case mix indices derived using all federal diagnostic related groups.

B. The percentage change, in whole numbers, between the recalculated case mix indices under item A will be reduced by the change in indices as measured using diagnostic groups in part 9500.1100, subparts 20b to 20g.

C. The resulting percentage change in item B, will be multiplied by payments made for admissions occurring during the appealed rate year under part 9500.1128 reduced by property payments made under parts 9500.1129 and 9500.1130.

Subp. 4. **Medicare adjustment appeals.** To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the appeal must be received by the commissioner or postmarked not later than 60 days after the date the medical assistance determination was mailed to the hospital by the department or within 60 days of the date the Medicare determination was mailed to the hospital by Medicare, whichever is later.

Subp. 5. **Rate and payment appeals.** To appeal a payment rate or payment determination that is not a case mix or Medicare adjustment appeal, the appeal must be received by the commissioner within 60 days of the date the determination was mailed to the hospital.

Subp. 6. **Resolution of appeals.** The appeal will be heard by an administrative law judge according to parts 1400.5100 to 1400.8401 and Minnesota Statutes, sections 14.57 to 14.62, and according to the requirements of items A to D.

A. The hospital must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

B. Both overpayments and underpayments that result from the submission of appeals will be implemented.

C. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information.

D. Relative values and rates that are based on averages will not be recalculated to reflect the appeal outcome.

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 18 SR 1115*

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL JULY 29, 1985.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

M. base year admissions excluding medicare crossovers;

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

O. base year patient days excluding medicare crossovers; and

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

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

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

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

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

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

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

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

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

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

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

E. After the end of each budget year, the commissioner shall redetermine the rate per admission or rate per day, or both. The commissioner shall substitute actual pass–through costs as determined by medicare for budgeted costs in item B, subitem (2) for that year. If an adjustment indicates an overpayment to the hospital, the hospital shall pay the commissioner the overpayment within 60 days of written notification from the commissioner. If the adjustment indicates an underpayment to the hospital, the department shall pay that hospital the underpayment within 60 days of written notification from the commissioner. Interest charges will be assessed according to part 9500.1125, subpart 5.

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

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

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

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

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

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

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

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

Statutory Authority: *MS s 256.969 subds 2,6*

History: *10 SR 227; 11 SR 1688*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

N. base year admissions excluding medicare crossovers;

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

P. base year patient days excluding medicare crossovers; and

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

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

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

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

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

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

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

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

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

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

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

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

K. rate period admissions excluding medicare crossovers;

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

M. rate period patient days excluding medicare crossovers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

sion during the period from January 1, 1983, through June 30, 1983, shall be reduced by four percent.

Statutory Authority: *MS s 256.969 subds 2,6*

History: *10 SR 227; 11 SR 1688*

GENERAL ASSISTANCE

9500.1200 PURPOSE AND APPLICABILITY.

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

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

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

History: *10 SR 1715; 11 SR 134*

9500.1202 PURPOSE OF GENERAL ASSISTANCE PROGRAM.

The purposes of the general assistance program are:

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

B. to provide work readiness services to help employable and potentially employable persons prepare for and attain permanent work; and

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

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *10 SR 1715; 15 SR 1842*

9500.1204 [Repealed, 10 SR 2322]

9500.1205 [Repealed, 15 SR 1842]

9500.1206 PROGRAM DEFINITIONS.

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

Subp. 1a. **Actual availability.** "Actual availability," when used in reference to income or property, means that which is in hand or can be readily obtained for current use.

Subp. 2. **Adult child.** "Adult child" means a person aged 18 years or older who resides with at least one parent.

Subp. 3. **Advanced age.** "Advanced age" means the condition that applies to an applicant or recipient who is age 55 or older and whose work history shows a marked deterioration compared to the applicant's or recipient's work history before age 55 as indicated by decreasing occupational status, reduced hours of employment, or decreased periods of employment.

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

Subp. 4a. **Affidavit.** "Affidavit" means a written declaration made under oath before a notary public or other authorized officer.

Subp. 4b. **Appeal.** "Appeal" means a written statement from an applicant or recipient that requests a hearing or expresses dissatisfaction with a county agency decision that can be challenged under Minnesota Statutes, section 256.045 and part 9500.1211, subpart 4.

Subp. 5. **Applicant.** "Applicant" means a person who has submitted an application for general assistance to a county agency and whose application has not been approved, denied, or voluntarily withdrawn.

Subp. 5a. **Application.** "Application" means the action by which a person shows in writing a desire to receive assistance by submitting a signed and dated form prescribed by the commissioner to the county agency.

Subp. 6. **Assistance standard.** "Assistance standard" means the amount established by the commissioner under Minnesota Statutes, section 256D.01, to provide for an assistance unit's basic subsistence needs.

Subp. 6a. **Assistance unit.** "Assistance unit" means a person or group of persons who are applying for or receiving assistance and whose needs are included in the calculation of a general assistance payment.

Subp. 6b. **Authorized representative.** "Authorized representative" means a person who is authorized in writing by an applicant or recipient to act on that applicant's or recipient's behalf in matters involving general assistance or emergency general assistance, including submitting applications, making appeals, and providing or requesting information. An authorized representative may exercise the same rights and responsibilities on behalf of the person being represented as an applicant or recipient.

Subp. 7a. **Basic needs.** "Basic needs" means the minimum personal requirements of subsistence and are restricted to:

A. food;

B. clothing;

C. shelter;

D. utilities; and

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

Subp. 7b. **Budget month.** "Budget month" means the calendar month from which a county agency uses the income or circumstances of an assistance unit to determine the amount of the assistance payment for the payment month.

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

Subp. 8a. **Corrective payment.** "Corrective payment" means an assistance payment made to correct an underpayment.

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

Subp. 9a. **Countable income.** "Countable income" means gross income minus allowable exclusions, deductions, and disregards.

Subp. 9b. **County agency.** "County agency" has the meaning given in Minnesota Statutes, section 256D.02, subdivision 12.

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

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

Subp. 12a. **Documentation.** "Documentation" means a written statement or record that substantiates or validates an assertion made by a person or an action taken by a county agency.

Subp. 12b. **Earned income.** "Earned income" means compensation from lawful employment or lawful self–employment, including salaries, wages, tips, gratuities, commissions, earnings from self–employment, incentive payments from work or training programs, payments made by an employer for regularly accrued vacation or sick leave, earnings under title I of the Elementary and Secondary Education Act, employee bonuses and profit sharing, jury duty pay, picket duty pay, and profit from other lawful activities which accrues as a result of the individual's effort or labor. Earned income does not include returns from capital investment or benefits that accrue as compensation for lack of employment.

Subp. 12c. **Earned income tax credit.** "Earned income tax credit" means the payment that can be obtained by a qualified low–income person from an employer or from the United States Internal Revenue Service under United States Code, title 26, section 32.

Subp. 12d. **Emergency.** "Emergency" means a situation that causes or threatens to cause a lack of a basic need item when there are insufficient resources to provide for that need.

Subp. 12e. **Encumbrance.** "Encumbrance" means a legal claim against real or personal property that is payable upon the sale of that property.

Subp. 12f. **Equity value.** "Equity value" means the amount of equity in real or personal property owned by a person. Equity value is determined by subtracting any outstanding encumbrances from the fair market value of the real or personal property.

Subp. 12g. **Excluded time facility.** "Excluded time facility" means any hospital, sanitarium, nursing home, shelter, halfway house, foster home, semi–independent living domicile or services program, residential facility offering care, board and lodging facility, or other institution for the hospitalization or care of human beings, as defined in Minnesota Statutes, section 144.50, 144A.01, or 245A.02, subdivision 14; or a maternity home, battered women's shelter, or correctional facility.

Subp. 12h. **Fair hearing or hearing.** "Fair hearing" or "hearing" means the department evidentiary hearing conducted by an appeals referee to resolve the issues specified in part 9500.1211, subpart 4.

Subp. 12i. **Family.** "Family" has the meaning given it in Minnesota Statutes, section 256D.02, subdivision 5.

Subp. 12j. **Family assistance unit.** "Family assistance unit" means a general assistance unit that consists of one or more members of a family.

Subp. 12k. **Federal Insurance Contribution Act or FICA.** "Federal Insurance Contribution Act" or "FICA" means the federal law under United States Code, title 26, sections 3101 to 3126, that requires withholding or direct payment of income to the federal government.

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

Subp. 13a. **Filing unit.** "Filing unit" means a person or persons who reside together and whose income and value of resources must be used to determine the eligibility and benefit level of an assistance unit. The filing unit must include:

A. the applicant;

B. the applicant's spouse;

C. the applicant's family; and

D. the natural or adoptive parents of a single adult applicant or recipient and the minor children of those parents.

Subp. 14. **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.

Subp. 14a. **General assistance.** "General assistance" means the program authorized under Minnesota Statutes, sections 256D.01 to 256D.21 and parts 9500.1200 to 9500.1272. When the term general assistance is used in parts 9500.1200 to 9500.1272, it also means work readiness assistance and includes financial benefits received by persons under work readiness assistance.

Subp. 15. **Good cause.** "Good cause" means a reason for taking an action or failing to take an action that is reasonable and justified when viewed in the context of surrounding circumstances including: illness of the person, illness of another family member that requires the applicant's or recipient's presence, a family emergency, the inability to obtain transportation or adequate child care, or a conflicting obligation which has been determined by the county agency to be reasonable or justified.

Subp. 15a. **Gross income.** "Gross income" means the total amount of cash or in kind payment or benefit, whether earned or unearned, before any withholdings, deductions, or

disregards, paid to, or for the benefit of, a person, including income specified in Minnesota Statutes, section 256D.02, subdivision 8. Gross income does not include personal property previously established as a resource, subject to the limitations under part 9500.1221.

Subp. 15b. **Gross receipts.** "Gross receipts" means the money received by a self–employed person before the expenses of self–employment are deducted.

Subp. 15c. **Homestead.** "Homestead" means the house owned and occupied by a member of the filing unit as the member's dwelling place together with all contiguous land on which the house is situated and other appurtenant structures.

Subp. 15d. **Household report form.** "Household report form" means a form prescribed by the commissioner on which a recipient reports information to a county agency about income and other circumstances.

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

Subp. 16a. **In kind income.** "In kind income" means income, benefits, or payments that are provided in a form other than money or liquid assets, and which the applicant or recipient cannot legally require to be paid in cash to the applicant or recipient, including goods, produce, services, privileges, or third–party payments made on behalf of a person for whom the income is intended.

Subp. 17. **Interim assistance.** "Interim assistance" means the total amount of general assistance provided for a recipient, based on the state assistance standards and the negotiated rate provisions of part 9500.1237, subpart 7, to cover the period for which a payment of another maintenance benefit is made. The amount of general assistance considered interim assistance is limited to the total amount the monthly payments for the assistance unit would have been reduced if the other maintenance benefits had been paid at the time of their accrual. The interim assistance period begins with the month of application for general assistance or the first month of eligibility for the other maintenance benefits, whichever is later. Interim assistance does not include per diem payments made to shelters for battered women under Minnesota Statutes, section 256D.05, subdivision 3.

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

Subp. 18a. **Job Training Partnership Act.** "Job Training Partnership Act" means the Job Training Partnership Act authorized under Public Law Number 97–300 and its successor programs.

Subp. 18b. **Legal custodian.** "Legal custodian" means a person who has been granted legal custody of a minor child by a court; or, if assistance is being requested for the minor child, a person who is defined as an eligible relative caretaker of the minor child under AFDC program rules, part 9500.2440, subpart 7.

Subp. 18c. **Liquid assets or liquid resources.** "Liquid assets" or "liquid resources" means personal property in the form of cash or other financial instruments that are readily convertible to cash.

Subp. 18d. **Liquidate.** "Liquidate" means to convert real or personal property into cash or other financial instruments that are readily convertible to cash. The conversion can be by sale or by borrowing using the nonliquid real or personal property as security for a loan.

Subp. 19. [Repealed, 15 SR 1842]

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

Subp. 19b. **Lump sum.** "Lump sum" means nonrecurring income that is not excluded in part 9500.1223.

Subp. 19c. **Mandatory work readiness participant.** "Mandatory work readiness participant" means a general assistance recipient who is not exempt from work readiness under part 9500.1251.

Subp. 20. **Medical certification.** "Medical certification" means a statement about a person's illness, injury, or incapacity that is signed by a licensed physician, licensed consulting psychologist, or licensed psychologist who is qualified through professional training and experience to diagnose or certify the person's condition. For an incapacity involving a spinal subluxation condition, "medical certification" includes a statement signed by a licensed physician or a licensed chiropractor who is qualified through professional training and experience to diagnose and certify the condition.

Subp. 20a. **Medical evidence.** "Medical evidence" means records, reports, treatment notes, or other written documentation about a person's illness, injury, or impairment from a hospital, clinic, treatment facility, detoxification facility, physician, psychologist, nurse, therapist, or other mental health professional. It may also include evidence listed in a copy of the Disability Determination Rationale provided by the Social Security Administration.

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

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

Subp. 22a. **Minnesota supplemental aid or MSA.** "Minnesota supplemental aid" or "MSA" means the program established under Minnesota Statutes, sections 256D.33 to 256D.54.

Subp. 23. **Minor child.** "Minor child" means a person who is under the age of 18; or if age 18, who is a member of a family assistance unit and who is enrolled as a full–time student in an accredited high school and who is expected to graduate by age 19.

Subp. 23a. **Month.** "Month" means a calendar month.

Subp. 24. **Negotiated rate.** "Negotiated rate" means the amount a county agency will pay on behalf of recipients living in a room and board, boarding care, supervised living, or adult foster care arrangement.

Subp. 24a. **Nonrecurring income.** "Nonrecurring income" means a form of income that is:

A. received only one time or is not of a continuous nature; or

B. received in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subp. 24b. **Occupational or vocational literacy program.** "Occupational or vocational literacy program" means a program providing literacy training which emphasizes specific language and reading skills needed to perform in employment, complete employment training programs, or complete work readiness programs.

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

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

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

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

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

E. any benefits provided by the Social Security Administration under United States Code, title 42; or

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

Subp. 25a. **Overpayment.** "Overpayment" means that portion of an assistance payment which is greater than the amount for which an assistance unit is eligible, resulting from a calculation error, a client reporting error, a misapplication of existing program requirements by a county agency, or changes in payment eligibility that cannot be affected due to notification requirements.

Subp. 25b. **Parent.** "Parent" means a child's biological or adoptive parent who is legally obligated to support that child.

Subp. 25c. **Participation in a literacy program.** "Participation in a literacy program" means to receive instruction and complete assignments as part of a literacy program in accordance with the schedule or plan established by the literacy training program provider.

Subp. 25d. **Payment month.** "Payment month" means the calendar month for which the county agency issues an assistance payment.

Subp. 25e. **Permanent employment.** "Permanent employment" means suitable employment that is not, by description, of limited duration.

Subp. 25f. **Personal property.** "Personal property" means an item of value that is not real property. Personal property includes, but is not limited to, the value of a contract for deed held by a seller, assets held in trust on behalf of members of an assistance unit, cash surrender value of life insurance, value of a prepaid burial, savings account, value of stocks and bonds, and value of retirement accounts less any costs and penalties for early withdrawal.

Subp. 26. **Potentially eligible.** "Potentially eligible" means that the county agency has determined that the applicant or recipient shows circumstances which appear to meet the eligibility requirements of another maintenance benefit program.

Subp. 26a. **Principal wage earner.** "Principal wage earner" means the parent who has earned the greater amount of income in the 24 months preceding the month of application.

Subp. 26b. **Probable fraud.** "Probable fraud" means the level of evidence that, if proven as fact, will establish that assistance has been wrongfully obtained.

Subp. 26c. **Prospective budgeting.** "Prospective budgeting" means a method of determining the amount of assistance in which the budget month and payment month are the same.

Subp. 26d. **Qualified professional.** "Qualified professional" means a social worker employed by the county agency, a social worker with a master's degree in social work, a licensed consulting psychologist, a licensed psychologist, a licensed physician or psychiatrist, or a public health nurse as defined in Minnesota Statutes, section 145A.02, subdivision 18.

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

A. a nonprofit legal assistance organization;

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

C. a private attorney at law; or

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

Subp. 28a. **Real property.** "Real property" means the land itself and all buildings, structures, and improvements, or other fixtures on it, belonging or appertaining to the land, and all mines, minerals, fossils, and trees on or under it.

Subp. 28b. **Reasonable compensation.** "Reasonable compensation" means the value received in exchange for property transferred to another owner which equals or exceeds the seller's equity in the property, reduced by costs incurred in the sale.

Subp. 28c. **Recipient.** "Recipient" means an individual currently receiving, or suspended for one month from receiving, general assistance. Recipient includes any person whose needs are included in the payment to an assistance unit.

Subp. 28d. **Redetermination of eligibility.** "Redetermination of eligibility" means the process by which information is collected periodically by a county agency and used to determine a recipient's continued eligibility for assistance.

Subp. 28e. **Reside with.** "Reside with" means to share living quarters such as living rooms, bedrooms, or kitchens. Entrances, laundry rooms, and bathrooms are not considered living quarters.

Subp. 29. **Responsible relative.** "Responsible relative" means the spouse of an applicant or recipient, the parent of an applicant's or recipient's minor child if residing together as a family, the parent of a minor child who is an applicant or recipient, or the parent of an adult child who resides with the parent and is an applicant or recipient.

Subp. 29a. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of assistance an assistance unit will receive in which the payment month is the second month after the budget month.

Subp. 29b. **Social services.** "Social services" means the services included in a county's community social services plan which are administered by the county board as described under Minnesota Statutes, section 256E.03, subdivision 2.

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

Subp. 31. [Repealed, 15 SR 1842]

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

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

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

C. provides a gross weekly income equal to the federal or state minimum wage applicable to the job for 40 hours per week, or a monthly income which, after allowable exclusions, deductions, and disregards would exceed the standard of assistance for the assistance unit, whichever is less; and

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

Subp. 32a. **Suitable recipient.** "Suitable recipient" means a recipient of general assistance who is determined not to be exempt from work readiness participation under part 9500.1251, and who has been determined to be functionally illiterate by an assessment under part 9500.1259, subpart 1, item B.

Subp. 32b. **Underpayment.** "Underpayment" means an assistance payment, resulting from a calculation error, a client reporting error, or a misapplication of program requirements by a county agency, which is less than the amount for which an assistance unit is eligible.

Subp. 32c. **Unearned income.** "Unearned income" means income received by a person which does not meet the definition of earned income. Unearned income includes interest, dividends, unemployment compensation, disability insurance payments, veterans benefits, pension payments, return on capital investments, insurance payments or settlements, and severance payments.

Subp. 32d. **Vendor.** "Vendor" means a provider of goods or services.

Subp. 32e. **Vendor payment.** "Vendor payment" means a payment made by a county agency directly to a vendor.

Subp. 32f. **Verification.** "Verification" means the process a county agency must use to establish the accuracy or completeness of information from an applicant, recipient, third–party, or other source as that information relates to an assistance unit's eligibility for general assistance or the amount of a monthly assistance payment.

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

Statutory Authority: *MS s 256.05; 256D.01; 256D.04; 256D.05; 256D.051; 256D.052; 256D.06; 256D.08; 256D.09; 256D.10; 256D.101; 256D.111*

History: *9 SR 593; 10 SR 1715; 11 SR 134; 13 SR 1688; 13 SR 1735; 15 SR 1842*

9500.1208 [Repealed, 10 SR 2322]

9500.1209 [Repealed, 15 SR 1842]

9500.1210 [Repealed, 15 SR 1842]

9500.1211 APPLICANT AND RECIPIENT RIGHTS AND COUNTY AGENCY RESPONSIBILITIES TO APPLICANTS AND RECIPIENTS.

Subpart 1. **Right to information.** An applicant or recipient has the right to obtain information about the benefits, requirements, and restrictions of the general assistance program.

Subp. 2. **Right to apply.** A person has the right to apply, including the right to reapply, for general assistance. A county agency shall inform a person who inquires about financial assistance of the right to apply, shall explain how to apply, and shall mail or hand deliver an application form to the person inquiring about assistance. When a county agency ends assistance, the county agency shall inform the recipient in writing of the right to reapply.

Subp. 3. **Authorized representative.** An applicant or recipient of general assistance may designate an authorized representative to act on the applicant's or recipient's behalf. An applicant or recipient has the right to be assisted or represented by an authorized representative in the application, eligibility redetermination, fair hearing process, and any other contact with the county agency or the department.

When a county agency determines that it is necessary for a person to assist an applicant or recipient, the county agency shall designate a staff member to assist the applicant or recipient. The county agency staff member may assist the applicant or recipient to take the actions necessary to submit an application to establish the date of the application.

Upon a request from an applicant or recipient, a county agency shall provide addresses and telephone numbers of organizations that provide legal services at no cost to low–income persons.

Subp. 4. **Appeal rights.** An applicant, recipient, or former recipient has a right to request a fair hearing when aggrieved by an action or inaction of a county agency. A request for a fair hearing must be submitted in writing to the county agency or to the department. The request must be mailed within 30 days after the applicant or recipient receives written notice of the county agency's action or within 90 days when the applicant or recipient shows good cause for not submitting the request within 30 days. A former recipient who receives a notice of overpayment may appeal the action contained in the notice in the manner and within the periods described in this subpart. Issues which may be appealed are:

A. denial of the right to apply for assistance;

B. failure of a county agency to approve or deny an application within 30 days;

C. denial of an application for assistance;

D. suspension, reduction, or termination of assistance;

E. calculated amount of an overpayment and the calculated level of recoupment due to that overpayment;

F. eligibility for and calculation of a corrective payment;

G. other factors involved in the calculation of an assistance payment;

H. a change to protective, vendor, or two–party payments for recipients; and

I. the calculated amount retained by a county agency under an interim assistance authorization agreement from a retroactive benefit payment.

Subp. 5. **Rights pending hearing.** Unless otherwise specified, a county agency shall not reduce, suspend, or terminate payment when an aggrieved recipient requests a fair hear-

ing before the effective date of the action or within ten days of the mailing of the notice, whichever is later, unless the recipient requests in writing not to receive continued assistance pending a hearing decision. A county agency may increase or reduce an assistance payment while an appeal is pending when the circumstances of the recipient change and the change is not related to the issue under appeal. Assistance issued pending a fair hearing is subject to recovery when, as a result of the fair hearing, the commissioner finds that the recipient was not eligible for such assistance. This subpart shall in no way reduce any rights that the recipient may have under part 9500.1259, subpart 2.

A county agency shall reimburse appellants for reasonable and necessary expenses of attending the hearing, such as child care and transportation costs. A county agency shall reimburse appellant's witnesses and representatives for the expenses of transportation to and from the hearing.

Subp. 6. **Right to review records.** A county agency shall allow an applicant or recipient to review his or her case records that are held by the county agency and that are related to eligibility for or the assistance payment from the program, except those case records to which access is denied under Minnesota Statutes, chapter 13. A county agency shall make case records available to an applicant or recipient as soon as possible but in no event later than the fifth business day following the date of the request. When an applicant, recipient, or authorized representative asks for photocopies of material from the case record, the county agency shall provide one copy of each page at no cost.

Subp. 7. **Right to notice.** When a county agency notifies an applicant or recipient of its intention to deny an application or reduce, suspend, or terminate payment, the county agency shall specify in its notice the action it has taken or intends to take, the reason and legal authority for the action, and the right to appeal and request a fair hearing. The notice shall also inform the applicant or recipient of the conditions under which assistance will continue pending the appeal outcome, the responsibility to repay assistance if the appeal is unsuccessful, the right to be reimbursed for reasonable and necessary expenses of attending an appeal hearing, and the right to review county agency records in accordance with subpart 6.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1212 [Repealed, 15 SR 1842]

9500.1213 APPLICATION REQUIREMENTS.

Subpart 1. **Application for general assistance, county of residence.** An applicant for general assistance must apply for general assistance in the applicant's county of residence. However, a county agency must not refuse to take an application from an individual who appears to reside in another county, but must promptly forward the completed application to the county of residence. The county of residence must use the date the application was filed in the county of application as the application date.

Subp. 2. **County agency requirements.** A county agency must:

A. inform persons who inquire about cash assistance of general assistance eligibility requirements and how to apply for general assistance;

B. offer, by hand or mail, the application form prescribed by the commissioner when a person makes a written or oral inquiry;

C. inform the person that, if the person is found eligible, the county agency must use the date the application form is submitted to the county agency as the starting point for computing assistance, and that any delay in submitting an application form will reduce the amount of assistance paid for the month of application;

D. upon receipt of a signed and dated application from an applicant, the county agency must sign and date the application;

E. designate a staff member to assist the applicant to take the action necessary to submit an application if a county agency determines an applicant needs assistance in completing an application; and

F. inquire and determine at the time of initial application if the applicant has an emergency as defined in part 9500.1206, subpart 12d, and if so, determine the person's eligibility for emergency assistance under part 9500.1261.

Subp. 3. **Date of application.** The date of application is the date the county agency signs and dates the application.

Subp. 4. **Withdrawal of application.** An applicant may withdraw an application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal and inform the applicant of the agency's understanding that the applicant has withdrawn the application. If, within ten days of the date of the agency's notice, an applicant informs the county agency that the applicant does not wish to withdraw the application, the county agency must reinstate and finish processing the application.

Subp. 5. **Agency verification of information on application.** The county agency shall verify information provided by an applicant as specified in part 9500.1215.

Subp. 6. **Determination of filing unit.** When an application for general assistance is made and when the county agency redetermines the eligibility of a recipient, the county agency must determine the composition of the applicant's or recipient's filing unit. The county agency must determine the composition of a filing unit according to part 9500.1206, subpart 13a.

Subp. 7. **Processing application.** Within 30 days after receiving an application, a county agency must determine the applicant's program eligibility, approve or deny the application, inform the applicant of its decision, and issue assistance when the applicant is eligible. When an applicant establishes the inability to provide required documentation within the 30–day processing period, the county agency shall have an additional 30 days to process the application and to allow the applicant to provide the documentation. If eligibility cannot be determined by the end of the second 30–day period, the application must be denied.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1214 [Repealed, 15 SR 1842]

9500.1215 DOCUMENTING, VERIFYING, AND REVIEWING ELIGIBILITY.

Subpart 1. **Information that must be verified.** A county agency shall require an applicant or recipient to provide documentation only of information necessary to determine program eligibility and the amount of the assistance payment. Information previously verified and retained by the county agency must not be verified again unless the information no longer applies to current circumstances.

Subp. 2. **Sufficiency of documentation.** An applicant or recipient must provide documentation of the information required under subpart 4, or authorize a county agency to verify it by other means; however, the burden of providing documents for a county agency to use to verify eligibility is upon the applicant or recipient. A county agency shall help an applicant or recipient to obtain documents that the applicant or recipient does not possess and cannot obtain. When an applicant or recipient and the county agency are unable to obtain documents needed to verify information, the county agency may accept an affidavit from an applicant or recipient as sufficient documentation.

Subp. 3. **Contacting third parties.** A county agency must obtain an applicant's or recipient's written consent to request information about the applicant or recipient which is not of public record from a source other than county agencies, the department, or the United States Department of Health and Human Services. An applicant's signature on an application form shall constitute this consent for contact with the sources specified on that form. A county agency may use a single consent form to contact a group of similar sources, such as banks or insurance agencies, but the sources to be contacted must be identified by the county agency before requesting an applicant's consent. A county agency shall not provide third parties with access to information about a person's eligibility status or any other part of the case record without that person's prior written consent, except where access to specific case information is granted to agencies designated by the Minnesota Government Data Practices

Act under Minnesota Statutes, chapter 13. Information designated as confidential by the Minnesota Government Data Practices Act must only be made available to agencies granted access under that law and must not be provided to an applicant, recipient, or a third party.

Subp. 4. **Factors to be verified.** The county agency must verify the factors of program eligibility in items A to C at the time of application, when a factor of eligibility changes, and at each redetermination of eligibility.

A. A county agency must verify:

(1) the identity of each adult and child for whom assistance is requested;

(2) age, if required to establish eligibility;

(3) state residence;

(4) the basis of a claim of exemption from participation in work readiness; and

(5) the relationship of a caretaker to the child for whom application is made.

B. The county agency must verify the information in subitems (1) to (6) when that information is acknowledged by an applicant or recipient or obtained through a federally mandated verification system:

(1) receipt and amount of earned income, including gross receipts from self-employment;

(2) receipt and amount of unearned income;

(3) termination from employment;

(4) ownership and value of real property;

(5) ownership and value of personal property; and

(6) dependent care costs of an employed filing unit member at the time of application, redetermination, or a change in provider.

C. A county 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 county agency. The county 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 conditions of this item, are:

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

(2) the death of a parent or spouse;

(3) marital status;

(4) residence address; and

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

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1216 [Repealed, 15 SR 1842]

9500.1217 [Repealed, 15 SR 1842]

9500.1218 [Repealed, 15 SR 1842]

9500.1219 ASSISTANCE UNIT ELIGIBILITY.

Subpart 1. **Composition of an assistance unit.** The county agency must determine the composition of the assistance unit, as defined in part 9500.1206, subpart 6a, from eligible members of the filing unit. All members of the filing unit must be included in the assistance unit with the exception of and subject to subparts 2 to 6.

Subp. 2. **Exclusion of persons otherwise provided for by law.** Filing unit members shall not be included in an assistance unit if they meet one or more of the following conditions:

A. a filing unit member is receiving benefits under the AFDC, refugee cash assistance, SSI, or Minnesota supplemental aid programs, or has benefits paid on the member's behalf for foster care, child welfare, or subsidized adoption;

B. a filing unit member appears to be currently eligible for benefits under AFDC or refugee cash assistance, or is eligible to have benefits paid on the member's behalf for foster care, child welfare, or subsidized adoption;

C. a filing unit member has been determined to be eligible for AFDC or SSI but cannot receive benefits under those programs because the member refused or failed to comply with a requirement of those programs;

D. a filing unit member is a parent of a single adult applicant or recipient who resides with a single adult applicant together with the parents' other family members;

E. a filing unit member who is in a period of disqualification from AFDC, SSI, or general assistance due to noncompliance with a program requirement;

F. a filing unit member has, without good cause, refused or failed to comply with part 9500.1254; or

G. a filing unit member has refused to sign an interim assistance authorization agreement as required under part 9500.1251, subpart 2, items F and G.

Subp. 3. **State residence requirement.** No applicant shall be included in an assistance unit unless the applicant is a resident of Minnesota. A resident is a person living in the state with the intention of making a home here and, not for any temporary purpose, as determined by items A to E.

A. An applicant must state on a form prescribed by the commissioner that the applicant lives in the state and intends to make a home in Minnesota.

B. The county agency must verify an applicant's statement of intent to make a home in Minnesota if questionable. An applicant's statement of intent to make a home in Minnesota is questionable if:

(1) the applicant has no verified residence address in the state;

(2) the applicant provides identification indicating a residence outside the state;

(3) the applicant indicates that he or she maintains or is having maintained a residence outside the state; or

(4) the applicant is only present in the state as a resident of an excluded time facility.

C. An applicant's intent to make a home in Minnesota can be verified by:

(1) a residence address on a valid Minnesota driver's license, Minnesota identification card, or voter registration card;

(2) a rent receipt or a statement by the landlord, apartment manager, or homeowner showing that the applicant is residing at an address within the county of application;

(3) a statement by a landlord or apartment manager indicating the applicant has located housing which is affordable for the applicant;

(4) postmarked mail addressed to and received by the applicant at the applicant's address within the county;

(5) a current telephone or city directory with the applicant's residence address within the county;

(6) a written statement by an applicant's roommate verifying the applicant's residence and the date the applicant moved in. The roommate must also verify that the roommate lives in the residence by providing a copy of the roommate's mortgage statement, lease agreement, or postmarked mail addressed to and received by the roommate at that address;

(7) documentation that the applicant came to the state in response to an offer of employment;

(8) documentation that the applicant has looked for work by presenting completed job applications or documentation from employers, the local jobs service office, or temporary employment agencies;

(9) documentation that the applicant was formerly a resident of the state for at least 365 days and is returning to the state after an absence of less than 90 days; or

(10) an affidavit from a person engaged in public or private social services, legal services, law enforcement, or health services that the affiant knows the applicant, has

had personal contact with the applicant, and believes the applicant is living in the state with the intent of making Minnesota the applicant's permanent home.

D. In addition to meeting one of the requirements of item C, an applicant described by item B, subitem (2), must document that the applicant has severed the applicant's residence in another state. Documentation may include bank statements indicating the closing of accounts, a document showing cancellation or termination of a lease, or verification that real property used as the applicant's residence in another state is abandoned or for sale.

E. Notwithstanding the provisions of item C, any applicant specified in item B, subitems (2) to (4), who also indicates an intention to leave the state within 30 days of application, will be considered to be in the state for a temporary purpose and is not a resident.

Subp. 4. **Minors.** No child under the age of 18 who is not a member of a family as defined in Minnesota Statutes, section 256D.02, subdivision 5, shall be included in an assistance unit unless:

A. the child is legally emancipated;

B. the child lives with an adult who is not a family member or legal custodian with the express written consent of an agency acting in its legal capacity as a custodian of the child;

C. the child lives with an adult who is not a family member or legal custodian with the express written consent of the child's parents or legal guardian, together with the express written consent of the county agency; or

D. the child does not live with an adult but is at least 16 years of age and whose living arrangement is approved in a social services case plan for the child and includes general assistance as a component of the plan.

Subp. 5. **Refusal of suitable employment.** A person is not eligible for general assistance if, without good cause, the applicant refuses a legitimate offer of, or quits, suitable employment within 60 days before the date of application. A person who, without good cause, voluntarily quits suitable employment or refuses a legitimate offer of suitable employment while receiving general assistance shall be terminated from the general assistance program and disqualified from general assistance for two months. This subpart applies only to those applicants or recipients who are not exempt from work readiness participation requirements under part 9500.1251.

Subp. 6. **Physical presence.** The physical presence requirements for family general assistance are the same as the physical presence requirements under the AFDC program. The county agency shall not consider the needs of a family assistance unit member who is not present in the home at the time of application in the calculation of a general assistance grant unless an exception from the physical presence requirement is provided for under the AFDC program rules, part 9500.2140, subpart 5, items A to C.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1220 [Repealed, 15 SR 1842]

9500.1221 PROPERTY LIMITATIONS.

Subpart 1. **Determination of equity value of property available to assistance unit.** The county agency must determine the equity value of real and personal property available to the assistance unit. The equity value of real and personal property available to a member of the filing unit who is not included in the assistance unit, but who is a responsible relative of an assistance unit member, must be considered real and personal property available to the assistance unit.

A. When real or personal property is owned by two or more persons, the county agency shall assume that each person owns an equal share, except that either person owns the entire sum in a joint personal checking or savings account. When a person documents greater or lesser ownership, the county agency shall use that share to determine the equity value held by an applicant or recipient.

B. Real or personal property owned by an applicant or recipient is presumed legally available unless the applicant or recipient documents that the property is not legally avail-

able. When real or personal property is not legally available, its equity must not be applied against the limits in subpart 2.

C. An applicant must disclose whether the applicant transferred, within one year before the application or redetermination, real or personal property valued in excess of the property limits in subpart 2 for which reasonable compensation was not received. A recipient shall disclose all transfers of property valued in excess of the limits in subpart 2 according to the reporting requirements in part 9500.1245, subpart 5. When a transfer of real or personal property has occurred, the applicant or recipient shall comply with subitems (1) and (2) as a condition of eligibility for general assistance.

(1) The applicant or recipient who transferred the property must provide a description of the property, information necessary to determine the property's equity value, the name of the individual who received the property, and the circumstances of and reason for the transfer.

(2) If reasonable compensation for the property was not received and the property can be reasonably reacquired, or when reasonable compensation can be secured, the property is presumed legally available to the applicant or recipient.

D. A recipient may build the equity value of the recipient's real and personal property to the limits in subpart 2.

Subp. 2. **Equity value; excluded real and personal property.** The equity value of all nonexcluded real and personal property must not exceed $1,000. The county agency shall exclude the value of the real or personal property in items A to T when determining equity value.

A. The applicant's or recipient's homestead according to 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 the real property.

(2) The amount of land that can be excluded under this item 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 an applicant or recipient is sold, the county agency shall treat the cash proceeds from that sale as excluded property for a period of six months if the applicant or recipient intends to reinvest those proceeds in another home and agrees to maintain the proceeds, unused for other purposes, in a separate account.

B. One motor vehicle, not otherwise excluded, when its equity value does not exceed $1,500 exclusive of the value of special equipment for a handicapped household member. The county agency shall establish the equity value of a motor vehicle by subtracting any outstanding encumbrances from the loan value listed in the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the N.A.D.A. Official Used Car Guide, or when an applicant or recipient disputes the value listed in the guide as unreasonable given the condition of a particular vehicle, the county agency may require the applicant or recipient to document the value of the vehicle by securing a written statement from a motor vehicle dealer licensed under Minnesota Statutes, section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The N.A.D.A. Official Used Car Guide, Midwest Edition, is incorporated by reference. It is published monthly by the National Automobile Dealers Used Car Guide Company and is available through the Minitex interlibrary loan system. It is subject to frequent change.

C. The value of nonliquid real or personal property that is essential to the owner's self–support, self–care, or needed to obtain or retain suitable employment.

D. The value of nonliquid property which currently produces net earned income and is being used for the support of the assistance unit or a reasonable expectation exists that the property will be used within six months or the next income–producing season, whichever is later, to produce net earned income for the support of the assistance unit.

E. The value of real or personal property owned exclusively by the stepparent or sibling of a single adult applicant or recipient who resides with the stepparent or sibling.

F. The value of real and personal property owned exclusively by a recipient of supplemental security income or Minnesota supplemental aid.

G. The value of corrective payments but only for the month in which the payment is received and the following month.

H. Money escrowed in a separate account that is needed to pay real estate taxes or insurance and that is used for that purpose at least semiannually.

I. A mobile home used by an applicant or recipient as a home.

J. Money held in escrow by a self–employed person to cover employee FICA, employee tax withholding, sales tax withholding, employee workers' compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs that are commonly paid at least annually, but less often than monthly.

K. Income received in a budget month until the end of that month. This includes monthly general assistance payments and emergency general assistance payments.

L. The value of school loans, grants, or scholarships over the period they are intended to cover if the income from these sources is either excluded by rule or has been used in the calculation of a grant.

M. The value of personal property not otherwise specified which is commonly used by household members in day–to–day living.

N. Payments listed in part 9500.1223, subpart 2, item O, which are held in escrow for the period necessary to replace or repair the personal or real property. This period must not exceed three months.

O. One burial plot per member of a filing unit.

P. The value of a prepaid burial account, burial plan, or burial trust up to $1,000 for each member of a filing unit who is covered by that account, plan, or trust.

Q. The value of an applicant's nonliquid resources if an applicant is excluded by part 9500.1251, subpart 2, item M, because the applicant's need for assistance will not exceed 30 days.

R. The value of real and personal property in excess of the limits in this subpart if the applicant is making a good faith effort to sell the property at a reasonable price.

S. Other real or personal property specifically disregarded by federal law, state law, or federal regulation.

T. In addition to the limits specified in items A to S, an amount up to $1,000 which is accumulated in a separate account from earnings by a resident in a facility licensed under parts 9520.0500 to 9520.2500 or a resident in a supervised apartment with services funded under parts 9535.0100 to 9535.1600 for whom discharge and work are part of a treatment plan. This item applies during residency and for up to 18 additional months if the person moves to an inpatient hospital setting. The accumulated earnings, and the interest on the earnings, are to be used upon discharge from the facility. Any withdrawal before discharge must be counted as income in the month of withdrawal and treated as an available resource in the following months.

Subp. 3. **Exclusion of excess property.** If the county agency determines that an assistance unit is not eligible for general assistance due to owning property in excess of the limit in subpart 2, the county agency must inform the applicant or recipient in writing of the conditions under which excess property may be excluded.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1222 [Repealed, 15 SR 1842]

9500.1223 EXCLUDED INCOME.

Subpart 1. **Evaluation of income.** The county agency must determine income available to members of an assistance unit to determine program eligibility and the assistance amount. Income available to members of an assistance unit includes all nonexcluded income whether received by assistance unit members or filing unit members who are not members of the assistance unit when that income is deemed available to members of the assistance unit.

Subp. 2. **Excluded income of all filing unit members.** The county agency shall exclude items A to BB from the income of all filing unit members:

A. food stamps;

B. United States Department of Housing and Urban Development (HUD) refunds or rebates for excess rents charged and HUD relocation and rehabilitation funds;

C. rental security deposit refunds to the client whether paid by the client or by emergency assistance or emergency general assistance;

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

E. all Volunteers in Service to America (VISTA) payments;

F. title I loans or grants through the Minnesota Housing Finance Agency;

G. payments for basic care, difficulty of care, and clothing allowance received for providing family foster care under parts 9545.0010 to 9545.0260 or adult foster care under parts 9555.5105 to 9555.6265;

H. work and training allowances and reimbursements received through the work readiness program;

I. work and training allowances received from county agency social services programs that are not classified as wages subject to FICA withholding;

J. reimbursement for employment training received through the Job Training Partnership Act;

K. reimbursement for out–of–pocket expenses incurred while performing volunteer services, jury duty, or employment;

L. loans, whether from private, public, or governmental lending institutions, governmental agencies, and private individuals provided the filing unit member documents that the lender expects repayment. This exclusion does not include education loans on which payment is deferred;

M. state and federal income tax refunds including Minnesota property tax refunds and the earned income tax credit;

N. 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;

O. payments issued by insurance companies which are specifically designated as compensation to a member of an assistance unit for partial or total permanent loss of function or body part or insurance payments specified under Minnesota Statutes, section 256.74, subdivision 1, clause (7);

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

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

R. in kind income, as defined in part 9500.1206, subpart 16a, except for payments made for room, board, tuition, or fees by a parent on behalf of a single adult applicant who is enrolled as a full–time student in a postsecondary institution;

S. assistance payments to correct underpayments in a previous month;

T. payments to an applicant or recipient issued under part 9500.1261, 9500.2800, or 9500.2820 for emergency or special needs; however, an initial month's grant may be reduced by the amount of emergency assistance issued to cover that month's needs;

U. nonrecurring cash gifts, such as those received for holidays, birthdays, and graduations, not to exceed $30 per filing unit member in a calendar quarter;

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

W. any form of energy assistance payment made by the Low Income Home Energy Assistance Program, payments made directly to energy providers by other public and private agencies, benefits issued by energy providers when the Minnesota Department of Jobs and

Training determines that those payments qualify under Code of Federal Regulations, title 45, section 233.53, and any form of credit or rebate payment issued by energy providers;

X. the first $50 of child support received;

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. interest payments and dividends from property that is not excluded from and does not exceed the $1,000 limit under part 9500.1221, subpart 2; and

BB. income that is otherwise specifically excluded from AFDC program consideration in federal law, state law, or federal regulation.

Subp. 3. **Additional income exclusions, filing unit member who is not a member of assistance unit.** In addition to the income exclusions in subpart 2, the county agency shall exclude the following income of a filing unit member who is not a member of the assistance unit:

A. income that was excluded, disregarded, or allocated in the calculation of a public assistance grant unless the allocation was to meet the needs of persons in the general assistance unit;

B. benefits from the Retirement, Survivors, and Disability Insurance program and any income based on a disability that is received by the parent or parents of a single adult applicant or recipient;

C. income of a stepparent or of a sibling of a single adult applicant or recipient;

D. an amount equal to the standards assigned to filing unit members who are not in the general assistance unit in part 9500.1231, subpart 6, item A; and

E. child support, spousal support, or other payments to meet the needs of a person who lives outside of the household who is or could be claimed as a dependent for federal personal income tax liability or for whom payment is required by court order.

Subp. 4. **Additional income exclusions; family assistance units.** In addition to the income exclusion in subpart 2, the county agency shall exclude the following income from a family assistance unit:

A. educational grants and loans, including income from work study; and

B. income, including retroactive payments, from SSI or Minnesota supplemental aid.

Subp. 5. **Additional income exclusions, assistance unit consisting of individuals who are not members of a family.** In addition to the income exclusions in subpart 2, the county agency shall exclude the following costs from the income of filing unit members when the assistance unit consists of individuals who are not members of a family:

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

B. the cost of transportation to and from employment which is not reimbursed, based on the lesser of the actual cost, or the amount allowed for the use of a personal car in the United States Internal Revenue Code for a maximum of 100 miles per day;

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

D. the cost incurred by an applicant or paid by a recipient for uniforms, tools, and equipment which are necessary to accept or retain a job;

E. mandatory payments or deductions from pay for insurance premiums, union dues, association dues, retirement contributions, FICA, state and federal personal income tax withholding, not to exceed the amount specified in the state or federal tax withholding tables for an individual with the same income and number of dependents as the applicant or recipient;

F. other work expenses required for employment and approved by the county agency;

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

H. stipends received from the displaced homemaker services program; and

I. in addition to the $50 specified in item A, up to $150 per month from the earnings of a resident of a facility licensed under parts 9520.0500 to 9520.0690 or a resident of a supervised apartment with services funded under parts 9535.0100 to 9535.1600 for whom discharge and work are part of a treatment plan, provided that the disregarded sum is placed in a separate savings account by the resident.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1224 [Repealed, 15 SR 1842]

9500.1225 EARNED INCOME.

Subpart 1. **County agency duty to determine earned income.** The county agency must determine the total amount of earned income available to the filing unit. Earned income from self–employment must be calculated according to subpart 2. Earned income from contractual agreements must be calculated according to subpart 3. The total amount of earned income available to an individual for a month must be determined by combining the amounts of earned income calculated under subparts 2 to 4. The total amount of earned income available to an assistance unit for a month must be determined by combining the total earned income of each filing unit member.

Subp. 2. **Earned income from self–employment.** The county agency must determine the amount of earned income from self–employment by subtracting business costs from gross receipts according to items A to D.

A. Self–employment expenses must be subtracted from gross receipts except for the expenses listed in subitems (1) to (14):

(1) purchases of capital assets;

(2) payments on the principal of loans for capital assets;

(3) depreciation;

(4) amortization;

(5) the wholesale costs of items purchased, processed, or manufactured that are unsold inventory with a deduction for the costs of those items allowed at the time they are sold;

(6) transportation costs that exceed the amount allowed for use of a personal car in the United States Internal Revenue Code;

(7) the cost of transportation between the individual's home and place of employment;

(8) salaries and other employment deductions made for members of an individual's assistance unit or for individuals who live in the individual's household for whom the individual is legally responsible;

(9) monthly expenses in excess of $71 for a roomer;

(10) monthly expenses in excess of $86 for a boarder;

(11) monthly expenses in excess of $157 for a roomer–boarder;

(12) annual expenses in excess of $103 or two percent of the estimated market value on a county tax assessment form, whichever is greater, as a deduction for upkeep and repair against rental income;

(13) expenses not allowed by the United States Internal Revenue Code for self–employment income; and

(14) expenses which exceed 60 percent of gross receipts for child care performed in an individual's home unless the individual can document a higher amount. When funds are received from the quality child care program, those funds are excluded from gross receipts, and the expenses covered by those funds must not be claimed as a business expense that offsets gross receipts.

B. Except for farm income under item C, the self–employment budget period begins in the month of application for applicants and in the first month of self–employment for

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 subitems (1) to (3):

(1) The purchase cost of inventory items, including materials that are processed or manufactured, must be deducted as an expense at the time payment is received for the sale of those inventory items, processed materials, or manufactured items, regardless of when those costs are incurred or paid.

(2) Expenses to cover employee FICA, employee tax withholding, sales tax withholding, employee worker's compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs that are commonly paid at least annually, but less often than monthly, must be prorated forward as deductions from gross receipts over the period they are intended to cover, beginning with the month in which the payment for these items is made.

(3) Gross receipts from self–employment may be prorated forward to equal the period over which the expenses were incurred except that gross receipts must not be prorated over a period that exceeds 12 months. This provision applies only when gross receipts are not received monthly but expenses are incurred on an ongoing monthly basis.

C. Farm income must be annualized. Farm income is gross receipts minus operating expenses, subject to item A. Gross receipts include sales, rents, subsidies, soil conservation payments, production derived from livestock, and income from sale of home–produced foods.

D. Income from rental property must be considered self–employment earnings when the owner spends an average of 20 hours per week on maintenance or management of the property. A county agency must deduct an amount for upkeep and repairs, according to item A, subitem (11), for real estate taxes, insurance, utilities, and interest on principal payments. When an applicant or recipient lives on the rental property, the county agency must divide the expenses for upkeep, taxes, insurance, utilities, and interest by the number of rooms to determine the expense per room. The county 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 item must be subtracted from gross rental receipts.

Subp. 3. **Earned income from contractual agreements.** The county agency must prorate the amount of earned income received by individuals employed on a contractual basis over the period covered by the contract even if the payments are received over a shorter period.

Subp. 4. **Other earned income.** The county agency must consider all other forms of earned income not specifically provided for under subparts 2 and 3 to be earned income available to the individual in the month it is received.

Statutory Authority: *MS s 256D.01; 256D.03; 256D.04; 256D.05; 256D.051; 256D.06; 256D.07; 256D.08; 256D.09; 256D.111*

History: *10 SR 2322; 15 SR 1842*

9500.1226 UNEARNED INCOME.

Subpart 1. **County agency duty to determine unearned income.** The county agency must determine the total amount of unearned income available to the filing unit. The total amount of unearned income available to a filing unit for a month must be determined by combining the total unearned income of each filing unit member.

Subp. 2. [Repealed, 15 SR 1842]

Subp. 3. [Repealed, 15 SR 1842]

Subp. 4. [Repealed, 15 SR 1842]

Subp. 5. **Deductions for certain costs.** Costs incurred to secure payments of unearned income shall be deducted from unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

Subp. 6. **Payments for disability or illness.** Payments for illness or disability must be considered unearned income whether the premium payments are made wholly or in part by an employer or a recipient.

Subp. 7. **Education grants, scholarships, and loans.** Educational grants, scholarships, and loans, including assistance funded under title IV of the Higher Education Act, which are available to an assistance unit that does not contain a member of a family must be considered unearned income, together with the in kind income derived from the payment of room and board and tuition and fees paid by the parents of the student. The county agency must subtract tuition and fees, in addition to books, supplies, transportation, and miscellaneous personal expenses as indicated by the school, from the total educational grants, loans, scholarships, and in kind income. The deductions of these expenses are to be made at the time that the educational funds become available for the student's benefit, and any excess funds prorated over the remainder of the time they were intended to cover. School expenses that exceed loans, grants, and scholarships may be deducted from work study income.

Subp. 8. **Nonexcluded filing unit member income.** Income from a filing unit member who is not a member of the assistance unit which is not excluded under part 9500.1223 is deemed unearned income available to the assistance unit.

Subp. 9. **Lump sums received by filing unit.** Lump sums received by a filing unit must be considered as earned income under parts 9500.1223 and 9500.1225 or as unearned income under subparts 5 to 8. For recipients of general assistance, lump sums are considered income in the month received and a resource in the following months.

Statutory Authority: *MS s 256D.01; 256D.03; 256D.04; 256D.05; 256D.051; 256D.06; 256D.07; 256D.08; 256D.09; 256D.111*

History: *10 SR 2322; 15 SR 1842*

9500.1227 [Repealed, 15 SR 1842]

9500.1228 [Repealed, 15 SR 1842]

9500.1229 [Repealed, 15 SR 1842]

9500.1230 [Repealed, 15 SR 1842]

9500.1231 ASSISTANCE STANDARDS.

Subpart 1. **Standard, single individual.** Except as provided in subpart 2, the standard of assistance for a single adult who does not reside with his or her parents; an adult applicant or recipient who resides with his or her parents and those parents have no minor children; or an emancipated minor applicant or recipient is $203 per month. The standard in this subpart shall be increased by the same percentage as any increase in subpart 4.

Subp. 2. **Standard, individuals residing in a nursing home, negotiated rate facility, or regional treatment center.** The standard of assistance for an assistance unit composed of one individual who resides in a nursing home, negotiated rate facility, or regional treatment center is the amount established as the clothing and personal needs allowance for medical assistance recipients under Minnesota Statutes, section 256B.35, subdivision 1.

Subp. 3. **Standard, married couples without children.** The standards of assistance for a married couple without children are the same as the first and second adult standards under subpart 4. If one member of the couple is not included in the general assistance grant, the standard for the other is the second adult standard under subpart 4.

Subp. 4. **Standards, filing units with a minor child.** The county agency shall use the standards in items A to M to determine the amount of assistance for a filing unit with a minor child or children. The standard of assistance shall increase or decrease to remain equal to the equivalent AFDC standards under part 9500.2440, subpart 6:

A. first adult, $187;

B. second adult, $73;

C. first child, $250;

D. second child, $95;

E. third child, $89;

F. fourth child, $76;

G. fifth child, $76;

H. sixth child, $77;

I. seventh child, $66;

J. eighth child, $64;

K. ninth child, $55;

L. tenth child, $54; and

M. each additional child, $53.

Subp. 5. **Standard, single adult residing with parents with minor children.** A single adult applicant or recipient who resides with his or her parents who have minor children will receive a child standard from subpart 4 as though the single adult were an additional minor child added to an assistance unit composed of the parent and minor child or children.

Subp. 6. **Standard, assistance unit composed of part or all members of a family.** The county agency shall determine the assistance standard for a family assistance unit as follows:

A. The county agency shall assign standards from subpart 4 to each member of the filing unit as though each was a member of an AFDC assistance unit composed of the entire filing unit. If a member or members of a family are not to be included in the assistance unit, the county agency shall assign standards from subpart 4 to those members first and to the remaining members of the assistance unit last. Each adult in the filing unit except the first will receive a second adult standard. A minor parent family member shall be treated as provided in subitem (1) or (2).

(1) A minor parent family member who resides with his or her parent will be assigned a child standard.

(2) A minor parent family member who does not reside with his or her parent or parents shall be assigned an adult standard. If two adult standards have already been assigned to filing unit members, the minor parent will be assigned a second adult standard.

B. The county agency shall add together the standards assigned to the members of the general assistance unit in item A. That total is the standard for the assistance unit. In no case shall the standard for family members who are in the assistance unit for general assistance, when combined with the standard for family members who are not in the assistance unit, total more than the standard for the entire family if all members were in an AFDC assistance unit.

Subp. 7. **Standard applies to full month.** Except when an increase must be made in the standard of assistance applicable to an assistance unit due to the addition of a member to the assistance unit or when a recipient enters the community from a negotiated rate facility, the standard of assistance applicable to an assistance unit the first day of a payment month or at the time of application, whichever is later, applies to the assistance unit for the entire month. When a decrease must be made in the standard of assistance for an assistance unit, the decrease shall be effective in the month following the month in which the change necessitating the reduction in the standard took place.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1232 STATE PARTICIPATION.

Subpart 1. [Repealed, 15 SR 1842]

Subp. 2. [Repealed, 15 SR 1842]

Subp. 3. [Repealed, 15 SR 1842]

Subp. 4. **State participation for payment in excess of state standards.** State participation is not available for special need items or the amount of the higher county agency standard authorized under Minnesota Statutes, section 256D.03, subdivision 2a, which exceed the applicable state assistance standards.

Subp. 5. **State participation for costs of providing transportation to recipients assigned to literacy training.** State participation for the actual costs of providing transportation under part 9500.1259, subpart 1, item D, subitem (6), is 100 percent.

Statutory Authority: *MS s 256.05; 256D.01; 256D.03; 256D.04; 256D.05; 256D.051; 256D.052; 256D.06; 256D.07; 256D.08; 256D.09; 256D.111*

History: *10 SR 2322; 13 SR 1688; 13 SR 1735; 15 SR 1842*

9500.1233 FINANCIAL ELIGIBILITY TESTS.

Subpart 1. **Prospective eligibility.** A county agency shall determine whether the eligibility requirements that pertain to an assistance unit will be met prospectively for the payment month. To prospectively assess income, a county agency shall estimate the amount of income an assistance unit expects to receive in the payment month.

Subp. 2. **Termination and suspension of assistance when prospectively ineligible.** When an assistance unit is prospectively ineligible for general assistance for at least two consecutive months due to excess income, assistance must be terminated. When an assistance unit is prospectively ineligible for general assistance for only one month and is prospectively eligible the following month, assistance must continue. The income for the single month in which prospective ineligibility exists must be applied retrospectively as described in subpart 3, resulting in suspension for the corresponding payment month.

Subp. 3. **Retrospective eligibility.** After the first two months of program eligibility, a county agency must determine whether an assistance unit is prospectively eligible for the payment month. The county agency must then determine whether the assistance unit is retrospectively eligible by applying the gross income test for family assistance and the payment eligibility test to the income from the budget month. When either the gross income test for family assistance units or the payment eligibility test is not satisfied, assistance must be suspended when ineligibility exists for one month, or terminated when ineligibility exists for more than one month.

Subp. 4. **Gross income test for family assistance units.** A county agency shall apply a gross income test both prospectively and retrospectively for each month of program eligibility. A family assistance unit is not eligible when available income as determined in parts 9500.1223 to 9500.1226 equals or exceeds 185 percent of the standard of assistance for the assistance unit. The income applied against the gross income test 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. The income in items A to F must be considered in the gross income test.

A. Gross earned income from employment, before mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and disregards, unless the employment income is specifically excluded under part 9500.1223.

B. Gross earned income from self–employment, less deductions for self–employment expenses in part 9500.1225, subpart 2, but before any reductions for personal state and federal income taxes, business taxes, personal FICA, personal health and life insurance, and disregards.

C. Unearned income after allowable expenses in part 9500.1226, unless the income has been specifically excluded in part 9500.1223.

D. Gross earned income from employment as determined under item A which is received through the Job Training Partnership Act by a member of an assistance unit who is a dependent child after the child has received both Job Training Partnership Act earnings and assistance for six payment months in the same calendar year.

E. Gross earned income from employment, as determined under item A, which is received through employment other than the Job Training Partnership Act by a member of an assistance unit who is a dependent child and a full–time student after the child has received both those earnings and assistance for six payment months in the same calendar year.

F. Child support and spousal support received or anticipated to be received by an assistance unit less the first $50 of current child support.

Subp. 5. **Payment eligibility test.** Each assistance unit must pass a test of payment eligibility prospectively and retrospectively for each program month that the unit is otherwise eligible.

A. Family assistance units which have passed the gross income test, must use the income described in subpart 4 to determine payment eligibility except that:

(1) earned income of a dependent child who is a part–time or full–time student must be excluded; and

(2) the disregards as determined in part 9500.1235 must be deducted from earned income.

B. Assistance units which do not contain a member of a family must use the income determined in parts 9500.1223 to 9500.1226 to determine payment eligibility.

C. The county agency must apply the assistance unit's countable income against the assistance unit's standard. If the income is equal to or greater than the standard, the assistance unit must be denied assistance or assistance must be terminated.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1234 [Repealed, 10 SR 2322]

9500.1235 EMPLOYMENT DISREGARDS FOR EMPLOYED MEMBERS OF A FAMILY ASSISTANCE UNIT.

The county agency shall deduct the disregards in items A to D from the gross earned income of employed members of a family assistance unit.

A. A $90 work expense, whether employment is full–time or part–time, must be deducted from the gross earned income of each employed member of an assistance unit and $75 for other financially responsible household members who are excluded from the assistance unit, except that sanctioned individuals must not receive this disregard.

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 9500.1215, subpart 4, item B, subitem (6). This disregard must only be deducted from the gross income of a member of an assistance unit, and must be applied after all other disregards have been applied. 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 shall 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 the filing unit.

C. A deduction for a $30 and one–third work incentive disregard. This disregard must be allowed for each employed member of an assistance unit. The first $30 must be subtracted from the balance of gross earned income after subtracting the work expense allowed under item A. One–third of the balance must also be subtracted after allowing the $30 disregard. This disregard is limited by subitems (1) to (6).

(1) The disregard must not be deducted from the income of an applicant in the initial month when applying the payment eligibility test in part 9500.1233, subpart 5, except that an applicant who has received general assistance in any of the four months previous to the month of application and who retains eligibility for this disregard from the prior period of eligibility under subitems (2) to (5) shall be eligible for this disregard when determining payment eligibility. When an applicant satisfies the payment eligibility test in the first month, this disregard must be used to calculate the assistance payment amount for that month when the applicant is otherwise eligible to receive it.

(2) Eligibility for this disregard is limited to four payment months in subitems (3) to (5) and cannot be deducted again from the income of that member of the assistance unit until that member has not been a recipient of general assistance for a period of at least 12 consecutive payment months.

(3) The four months of eligibility for this disregard are only those payment months in which any part of the $30 and one–third work incentive is applied against income. When the four months of eligibility for this disregard are interrupted for at least one payment month before the period of eligibility is completed, the recipient is eligible for a new period

of four months, with the next subsequent month of its use considered to be the first month, except as otherwise noted in subitems (4) and (5).

(4) When this disregard is not applied because income from a recurring source results in suspension of an assistance payment, that month must not be counted as a month of the four–month period, but this interruption does not establish eligibility for a new four–month period.

(5) When employment is ended, reduced, or refused without good cause, a person shall not be eligible for any of the employment disregards under items A to D in the first month following the month in which that employment is ended, reduced, or refused. The month in which those disregards are disallowed must be counted as one of the four consecutive months in the period of eligibility for this disregard and the remaining months of eligibility must be counted in the consecutive months which immediately follow, regardless of loss of eligibility or change in employment status.

(6) Receipt of a $30 and one–third work incentive disregard of income used to calculate benefits or eligibility for the AFDC or medical assistance programs has no effect on the eligibility for the disregard for recipients of family general assistance.

D. A deduction for a $30 work incentive disregard. This disregard applies for a period of eight months to members of an assistance unit who have completed the four–month period of eligibility for the $30 and one–third work incentive disregard. This disregard is allowed beginning with the first month following the fourth month of eligibility for the $30 and one–third work incentive disregard and must be counted in consecutive months regardless of the loss of eligibility or change in employment status.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1236 [Repealed, 10 SR 2322]

9500.1237 AMOUNT OF ASSISTANCE PAYMENT.

Subpart 1. **Amount of assistance payment.** The county agency must issue an assistance payment to an assistance unit in an amount equal to the difference between the standard of assistance determined in part 9500.1231 and the assistance unit's countable income as determined in parts 9500.1223 to 9500.1226, for a whole month without separate standards for shelter, utilities, or other needs, except as provided under subparts 2 to 9.

Subp. 2. **Prorate the month of application.** When program eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all eligibility factors are met for that applicant, whichever is later. This provision must apply when an applicant loses at least one day of program eligibility.

Subp. 3. **Minimum payment for families.** When the difference between countable income and the standard of assistance for an assistance unit containing members of a family in a payment month is less than $10, an assistance payment must not be issued, but that month must be considered a month of program eligibility. When recoupment of an overpayment reduces the assistance payment, pursuant to part 9500.1243, subpart 3, and the subsequent level of payment is less than $10, the assistance payment must be made.

Subp. 4. **Persons without a verified residence address.** A county agency may make payments to eligible persons without a verified address as specified in items A to G.

A. A county agency which chooses to make payments under this subpart must notify the department of its intention to do so 30 days before implementation.

B. A county agency must apply this subpart equally to all applicants or recipients who are without a verified residence, except that this subpart must not be applied to persons who are certified as having mental illness, mental retardation or a related condition, or a family assistance unit unless requested in writing by the family assistance unit.

C. A county agency may divide the monthly assistance grant into four payments to be issued weekly for four weeks each month.

D. A county agency may determine eligibility and provide assistance on a weekly basis as specified in subitems (1) to (5).

(1) The amount of assistance issued under this item may be determined either by prorating the monthly assistance standard which applies to the individual at the time of application and at the time of weekly redetermination, or as specified in part 9500.1261.

(2) Forms required for weekly redetermination of eligibility must be approved by the department. The form must contain a statement of need by the recipient.

(3) Notwithstanding part 9500.1259, subpart 4, the county agency must notify the recipient each time weekly assistance is issued under this item that subsequent weekly assistance will not be issued unless the recipient claims need.

(4) Weekly determination of eligibility under this item must not continue beyond the first full calendar month subsequent to the month of application. Beginning with the second full calendar month, assistance may be issued as specified in item C to a recipient who has not verified a residence address but who is a resident of the state as determined by part 9500.1219, subpart 3.

(5) The provisions of this item must not be applied to any assistance unit which receives, or is expected to receive countable income within the month of application or the following month.

E. Assistance provided under items C and D may be in the form of cash or separate vouchers or vendor payments for food, shelter, or other needs.

F. Except for weekly redetermination for assistance under item D, notices must be provided to recipients under this subpart as specified by part 9500.1259, subpart 4.

G. Assistance must not continue under this subpart when the recipient has verified a residence address as specified in part 9500.1219, subpart 3, item C.

Subp. 5. **Initial payments for mandatory participants in the work readiness program.** Initial payments may be made to mandatory participants in the work readiness program as specified in items A to D.

A. The county agency must choose one of the methods described in subitems (1) and (2) to make initial payments. The county agency must use the method it chooses for all applicants, except that for family assistance units or assistance units of more than one person, the county agency must use the method described in subitem (1).

(1) The county agency may make payments to cover a period of time which begins with the date of application, or the date on which all eligibility factors have been met, whichever is later, and ending on the last day of the month in which a work readiness orientation is scheduled.

(2) The county agency may prorate an initial payment to cover only the initial certification period which begins on the date of application, or the date on which all eligibility factors have been met, whichever is later, and ending on the date on which all mandatory participants in the assistance unit must attend a scheduled orientation. This initial certification period must not exceed 30 days. If all mandatory participants in an assistance unit attend the scheduled orientation, the county agency must then issue an additional grant of assistance to cover the period beginning the day after the scheduled orientation and ending on the final day of the month. Subsequent grants of assistance must be issued according to part 9500.1237, subpart 1 or 4.

B. The county agency must inform all mandatory participants in the assistance unit that:

(1) each mandatory participant must attend an orientation within 30 days after application;

(2) a mandatory participant who fails, without good cause, to attend the required orientation will lose eligibility for assistance without further notice due to noncompliance with work readiness requirements subject to reinstatement upon a showing of good cause; and

(3) a mandatory participant who has been disqualified from work readiness may not be eligible for emergency general assistance during the period of disqualification.

C. Subsequent assistance must not be issued within 60 days from the date of the initial application to a mandatory participant whose eligibility has ended for failing, without a showing of good cause, to attend a scheduled orientation unless the person completes an

application, is determined eligible, attends an orientation, or has become exempt from work readiness participation under part 9500.1251.

D. The county may make payment under item A to persons without a verified address according to subpart 4 as long as the county agency implements the provision consistently for all applicants and recipients.

Subp. 6. **Assistance payment when need will not exceed 30 days.** For persons who are exempt from registration with the work readiness program under part 9500.1251, subpart 2, item M, the county agency shall issue a grant determined by subtracting any countable income that the applicant has received since the first of the calendar month of application and any countable income the applicant is expected to receive before the date on which the county agency has anticipated that the applicant will lose eligibility for general assistance, from his or her prorated standard of assistance. The prorated standard of assistance must be determined by comparing the number of days between the date of application or the date all eligibility factors have been met, whichever is later, and the date which the county agency has anticipated that the applicant will lose eligibility for general assistance, with a 30–day month.

Subp. 7. **Payments to facilities with negotiated rates.** In addition to any payment an individual is entitled to by comparing the individual's countable income determined by parts 9500.1223 to 9500.1226 with the standard of need specified under part 9500.1231, subpart 7, the county agency must make direct payment on behalf of an individual described under part 9500.1231, subpart 2, to a negotiated rate facility out of general assistance funds unless other funds are available. An individual who has countable income in excess of the standard specified in part 9500.1231, subpart 2, but who is otherwise eligible for general assistance, is eligible for a payment to be made to a facility on the individual's behalf. However, the initial payment to the facility must be reduced by the amount that the individual's countable income exceeds the standard applicable to the individual on the first day of the month in which the individual enters the facility. Payments for months subsequent to the month in which the individual enters the facility must be reduced by the amount the individual's countable income exceeds the standard specified by part 9500.1231, subpart 2. If the individual's countable income exceeds that standard by an amount equal to, or greater than, the facility's monthly rate, there is no eligibility under the general assistance program. The county agency may make payment to the facility either in advance each month, or upon receipt of a billing statement from the facility. Payments to the facility shall cover a period beginning on the date the county agency receives an application signed by the applicant or the date all eligibility factors have been met, or the date the individual enters the facility, whichever is later, and ending on the date the recipient leaves the facility.

Subp. 8. **Payments to shelter facilities.** In addition to any payment to which an individual may be eligible under other parts of this program or under the aid to families with dependent children program, the county agency shall make payment on behalf of that individual to a secure crisis shelter, a housing network, or other shelter facility which provides shelter services to women and their children who are being or have been assaulted by males with whom they are residing or have resided in the past. The county agency's payment to the shelter must be reduced by the amount that the individual's countable income determined by parts 9500.1223 to 9500.1226 exceeds their standard of assistance as determined by part 9500.1231. Eligibility for a shelter payment under this subpart shall not affect the individual's eligibility or benefit level for general assistance or aid to families with dependent children and there can be concurrent payments under this subpart and those programs. Eligibility for a shelter payment under this subpart begins with the date an applicant enters the shelter provided that the shelter files the applicant's completed application with the county agency within ten days of the date the applicant entered the shelter, and ends on the date the individual leaves the shelter.

Subp. 9. **Additional grants to start employment.** In addition to any other benefits to which a recipient or applicant, otherwise eligible, might be entitled under this part, the county agency may, within the limits of available appropriations, make grants necessary to enable individuals to accept bona fide offers of employment. A grant may be made for costs directly related to starting employment, including transportation costs, clothing, tools and

equipment, license or other fees, and relocation. A grant under this subpart shall not be furnished more than once in any 12–month period.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1238 [Repealed, 15 SR 1842]

9500.1239 PAYMENT PROVISIONS.

Subpart 1. **Grant issuance.** Grants of general assistance shall be issued to the recipient according to subparts 2 and 3.

Subp. 2. **Time period for issuance of assistance.** The state or county agency shall mail assistance payments to the address where the assistance unit lives, or an alternate address when approved by the county agency, within time to allow postal service delivery to occur no later than the first day of each month unless:

A. the county agency has exercised its option to issue assistance weekly under part 9500.1237, subpart 4, item C or D, in which case the county agency must provide the recipient with a schedule by which the recipient is to visit the agency to pick up the payments or notices; and

B. the state or county agency issues payments by means other than checks, in which case the payments must conform to the time limits in this subpart.

Subp. 3. **Special voucher or vendor payment provisions.** Assistance must be paid directly to a recipient, except as provided in items A to H.

A. When a county agency has determined that a voucher or vendor payment is the most effective way to resolve an emergency situation under part 9500.1261, payment shall be made by voucher or directly to a vendor.

B. When the county agency has reason to suspect that a client is drug dependent, payment shall be made as provided under part 9500.1272.

C. When the applicant or recipient has no verified residence address, payment shall be made as provided under part 9500.1237, subpart 4, item C, D, or E.

D. When the applicant or recipient requests in writing that all or part of the assistance be issued in the form of vendor payments and the county agency approves the request, payment shall be made by vendor payment.

E. When an assistance unit consists of only minor children due to the disqualification of one or both parents who have not complied with the work readiness program, payment shall be made by vendor or protective payment.

F. When a county agency has determined that a recipient has exhibited a continuing pattern of money mismanagement, payment shall be made by vendor or protective payment. A continuing pattern of money mismanagement exists when a recipient has received a total of two or more grants of emergency assistance within an 18–month period. For the purposes of this provision, grants of emergency assistance are payments made under part 9500.1261 or 9500.2820 or emergency payments from county funds. In order to be counted for this provision, the emergencies for which grants were issued must have resulted from the recipient's failure to use available resources for the payment of basic need items. The county agency must review the use of protective or vendor payments under this item at each redetermination of eligibility.

G. When a county agency has established a negotiated rate with providers of room and board, boarding care, supervised living, or adult foster care, payment shall be made by vendor payment.

H. When an applicant or recipient resides in a shelter facility as defined in Minnesota Statutes, section 256D.05, subdivision 3, payment shall be made by vendor payment.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1240 [Repealed, 15 SR 1842]

9500.1242 [Repealed, 15 SR 1842]

9500.1243 BUDGETING.

Subpart 1. **Prospective budgeting.** A county agency shall use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received general assistance for at least one payment month preceding the first month of payment under a current application, subject to items A to E.

A. Income received or anticipated in the first month of program eligibility must be applied against the need of the first month. Income received or anticipated in the second month must be applied against the need of the second month.

B. When the assistance payment for any part of the first two months is based on anticipated income, an initial assistance payment amount must be determined based on information available at the time the initial assistance payment is made. When the amount of actual countable income is different than the anticipated countable income which was budgeted to determine the assistance payment for the first two months, the assistance unit is liable for an overpayment or is eligible for a corrective payment for the difference between anticipated and actual countable income for those two months.

C. The assistance payment for the first two months of program eligibility must be determined by budgeting both recurring and nonrecurring income for those two months.

D. An assistance unit shall have the assistance payment amount determined prospectively according to items A to C if the assistance unit:

(1) has had assistance suspended for a month as provided by part 9500.1233, subpart 2; and

(2) has experienced a recurring change of at least $50 in net income, exclusive of the disregards in part 9500.1235, items B and C, in the month preceding the month of suspension or in the month of suspension.

E. An individual who enters a facility with a negotiated rate or a shelter facility described in Minnesota Statutes, section 256D.05, subdivision 3, shall have an assistance payment determined prospectively from the date the individual entered the facility. Any income, including grants of public assistance, received by the individual before entering the facility must only be applied against the assistance unit's standard specified under part 9500.1231, subpart 2, and not against the payment to the facility as specified in part 9500.1237, subparts 7 and 8. Any assistance payments made to the individual beginning two months after the month the individual leaves the facility must be determined retrospectively according to subpart 2.

Subp. 2. **Retrospective budgeting.** Retrospective budgeting must be used to calculate the monthly assistance payment amount after the payment for the first two months has been made under subpart 1. Retrospective budgeting is subject to items A and B.

A. Retrospective budgeting is used to determine the amount of the assistance payment in the first two months of program eligibility when:

(1) an assistance unit applies for general assistance for the same month for which general assistance has been terminated, the interruption in eligibility is less than one payment month, and the general assistance payment for the immediately preceding month was determined retrospectively; or

(2) a person applies to be added to an assistance unit, that assistance unit has received general assistance for at least two preceding months, and that person has been receiving general assistance for at least two months as a member of another assistance unit.

B. Income received in the budget month by an assistance unit and by a filing unit member who is not included in the assistance unit must be applied against the standard of assistance to determine the assistance payment to be issued for the payment month, except as provided in subitems (1) to (4).

(1) When a source of income ends before the third payment month, that income is not considered in calculation of the assistance payment for the third payment month. When a source of income ends before the fourth payment month, that income is not considered when determining the assistance payment for the fourth payment month.

(2) When a member of a filing unit leaves the household of the assistance unit, the income of that member is not budgeted retrospectively for any full payment month in

which that household member does not live with that household and is not included in the filing unit.

(3) When a child is removed from an assistance unit because the child is no longer a dependent, the income of that child is not budgeted retrospectively for payment months in which that child is not included in the assistance unit.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subp. 3. **Recoupment of overpayments.** When a recipient receives an overpayment, the overpayment must be recouped or recovered under the conditions of this part even when the overpayment is due to agency error or to other circumstances outside the person's responsibility or control, according to items A to D.

A. When a county agency discovers that a person has received an overpayment for one or more months, the county agency shall notify that person of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the person's right to appeal recoupment of the overpayment.

B. When an assistance unit is eligible for assistance, the county agency shall recoup an overpayment by reducing one or more monthly assistance payments until the overpayment is repaid. The amount of repayment deducted from a monthly assistance payment shall be three percent of the assistance unit standard of assistance for the payment month.

C. A county agency shall not initiate efforts to recover overpayments from a person no longer on assistance unless the amount of overpayment is greater than $35 or overpayment was due to fraud.

D. This subpart shall not be applied to nonfamily assistance units until the MAXIS automated eligibility system is implemented on a statewide basis.

Subp. 4. **Correction of underpayments.** A county agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment or by issuing a separate payment to a current recipient. When an underpayment occurs in a payment month specified in subpart 1, and is not identified until the next payment month or later, that underpayment must first be subtracted from any overpayment balance before issuing the corrective payment. An underpayment for a current payment month must not be applied against an overpayment balance and payment must be issued within seven calendar days after the underpayment is identified.

Subp. 5. **Prohibition against use of general assistance grant to recover overpayment from other maintenance programs.** Subparts 3 and 4 apply only to overpayments or underpayments of assistance from the general assistance program. A county agency may not recover an overpayment by another maintenance benefit program from a general assistance grant.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1244 [Repealed, 10 SR 2322]

9500.1245 APPLICANT AND RECIPIENT RESPONSIBILITIES.

Subpart 1. **Applicant reporting requirements.** An applicant shall provide information about circumstances that affect the applicant's program eligibility or the assistance payment. The applicant shall provide the information on an application form and supplemental forms. An applicant shall report any changes in those circumstances under subpart 5 while the application is pending.

Subp. 2. **Responsibility to inquire.** An applicant or recipient who does not know or who is unsure whether a change in circumstances will affect program eligibility or assistance payments shall contact the county agency for information about whether or not to report the change.

Subp. 3. **Household report forms.** An assistance unit with a member who has earned income or a recent work history, and an assistance unit that has income allocated to it from a filing unit member 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. To be complete, a household report form must be signed and dated 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 by the eighth calendar day of the month following the reporting period covered by the form, or, if the eighth calendar day of the month falls on a weekend or holiday, 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.

Subp. 4. **Late household report forms.** When a household report form is late or incomplete, items A, B, or C apply.

A. When a complete household report form is not received by a county agency before the last ten days of the month in which the form is due, the county 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.

B. When a recipient submits an incomplete household report form before the last ten days of the month in which it is due, a county agency's ten–day notice of termination of assistance for failure to provide a complete household report form is invalid unless the county agency has returned the incomplete form on or before the ten–day notice deadline.

C. If a complete household report form is received by the county agency within a calendar month after the month in which assistance was received, 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 county agency. However, no assistance shall be paid for the period beginning with the first day of the month after the month in which the report was due and ending with the date the report was received by the county agency.

Subp. 5. **Changes which must be reported.** Recipients shall report the changes or anticipated changes specified in items A to K within ten days after the date they occur, within ten days after the date the recipient learns that the change will occur, at the time of the periodic redetermination under subpart 6, or within eight calendar days after a reporting period as in subpart 3, whichever occurs first. A recipient shall report other changes at the time of the periodic redetermination of eligibility under subpart 6 or at the end of a reporting period under subpart 3 as applicable. A recipient shall make these reports in writing or in person to the county agency. Changes in circumstances which must be reported within ten days must also be reported on the household report form for the reporting period in which those changes occurred. Within ten days, a recipient must report changes in:

A. initial employment;

B. the initial receipt of unearned income;

C. a recurring change of more than $50 per month of net earned or unearned income;

D. the receipt of a lump sum;

E. an increase in resources;

F. a change in the physical or mental status of a recipient who is exempt from work readiness registration due to the physical or mental condition;

G. the marriage or divorce of an assistance unit member;

H. a change in the household composition including departures from and returns to the home of filing unit members, or the birth or death of a member of the filing unit;

I. a change in the address or living quarters of an assistance unit;

J. the sale, purchase, or other transfer of property; and

K. a change in school attendance of a child over 15 years of age or an adult member of an assistance unit.

Subp. 6. **Redetermination of eligibility.** Except as provided in items A to C, a county agency must redetermine eligibility of a recipient once each year. A recipient must complete forms prescribed by the commissioner and required for redetermination of eligibility.

A. A county agency that has opted to provide assistance on a weekly basis to persons without a verified residence address may redetermine eligibility each week. In redetermining eligibility, the county agency must use the form in part 9500.1237, subpart 4, item D, subitem (2). The form must include a claim of need by the recipient.

B. A county agency must redetermine eligibility when a recipient who has been disqualified from receiving cash assistance due to noncompliance with a program provision requests assistance after the expiration of the disqualification period.

C. A county agency may redetermine the eligibility of a recipient when a change that affects program eligibility is reported to the county agency.

Subp. 7. **Other maintenance benefits.** An applicant or recipient must apply, according to part 9500.1254, for other maintenance benefits that the county agency has determined the applicant or recipient is potentially eligible for. An applicant or recipient who fails or refuses to take the actions specified by the county agency according to part 9500.1254 must be terminated from general assistance and remains ineligible for assistance until the applicant or recipient takes the actions specified by the county agency under this subpart.

Subp. 8. **Work readiness program.** Any applicant or recipient who is not exempt from work readiness under part 9500.1251 must participate in the work readiness program under part 9500.1259, according to items A and B.

A. A mandatory work readiness participant meets the work readiness participation requirements if the mandatory participant:

(1) cooperates with the county agency in all aspects of the work readiness program;

(2) accepts any suitable employment, including employment offered through the Job Training Partnership Act, Minnesota Employment and Economic Development Act, and other employment and training options;

(3) does not voluntarily quit or refuse suitable employment without good cause; and

(4) participates in work readiness activities assigned by the county agency, including completing the specific tasks or assigned duties that were identified by the county agency in the notice required under part 9500.1259, subpart 1, item E, subitem (1).

B. Mandatory participants who fail, without good cause, to meet the work readiness participation requirements shall be terminated from assistance and disqualified from work readiness according to subitems (1) and (2).

(1) For the first instance of noncompliance, without good cause, in a six-month period beginning with the completion of the work readiness orientation, the county agency shall notify the participant of the particular action or actions that the participant must take, by a date certain, to achieve compliance and avoid termination of assistance. A mandatory participant's failure to take the required actions by the specified date will result in the removal, both prospectively and retrospectively, of that individual's needs from the calculation of a grant for the assistance unit. The period of disqualification for those persons is one month.

(2) For any subsequent instance of noncompliance, without good cause, in a six-month period beginning with the date of any previous instance, the mandatory participant may not take corrective action to avoid removal from assistance and disqualification. If the effective date of a termination under this subitem is within six months of the end of a previous disqualification, the period of disqualification is two months.

Subp. 9. **Persons exempt from work readiness, voluntary participation.** An applicant or recipient of general assistance who is exempt from mandatory participation in work readiness may volunteer to participate in work readiness.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1246 [Repealed, 15 SR 1842]

9500.1248 DETERMINATION OF COUNTY OF FINANCIAL RESPONSIBILITY.

Subpart 1. [Repealed, 15 SR 1842]

Subp. 2. [Repealed, 15 SR 1842]

Subp. 3. **Determination of county of financial responsibility.** The county of financial responsibility shall be determined according to Minnesota Statutes, chapter 256G.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *10 SR 1715; 15 SR 1842*

9500.1249 [Repealed, 10 SR 2322]

9500.1250 LOCAL AGENCY REPORTS.

The county agencies shall collect and report information necessary to administer, monitor, and evaluate the general assistance program, including work requirements.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *10 SR 1715; 15 SR 1842*

9500.1251 WORK READINESS REQUIREMENT AND EXEMPTIONS.

Subpart 1. **Work readiness participation required.** To receive a grant of general assistance, an individual must be a registrant with the work readiness program or must be exempt from registration by the county under subpart 2. A "registrant" is an individual, otherwise eligible for assistance, whose exemption status under subpart 2 has been assessed by the county agency and who does not qualify for an exemption, or who has qualified for an exemption and has voluntarily requested to participate in the work readiness program. An individual who is otherwise exempt under subpart 2, items F and G, who has been requested by the county agency to sign an interim assistance authorization agreement, and who refuses or fails to sign the agreement, shall not be allowed to register for work readiness and therefore cannot receive a grant.

Subp. 2. **Exemption from work readiness.** An applicant or recipient is exempt from work readiness requirements if:

A. The applicant or recipient suffers from a permanent or temporary injury, or incapacity that is medically certified and that prevents the applicant or recipient from obtaining or retaining suitable employment for at least 30 days and, if a rehabilitation plan is specified in the medical certification, the applicant or recipient is following the rehabilitation plan. An applicant or recipient is exempt under this item only for the period of illness, injury, or incapacity.

B. The applicant or recipient is needed at home on a substantially continuous basis because a member of the applicant's or recipient's household requires care due to age, or a medically certified illness, injury, or incapacity. The medical certification of illness, injury, or incapacity must state that the individual requiring care is unable to care for himself or herself. The applicant or recipient must verify that no other household member is able to provide the care.

C. The applicant or recipient is residing in a facility licensed under Minnesota Statutes, chapter 245A, and certified under Minnesota Statutes, chapter 144, for purposes of physical or mental health rehabilitation or a chemical dependency domiciliary facility. Residence in the facility must be due to illness or incapacity and must be based on a plan developed or approved by the director of the county agency.

D. The applicant or recipient resides in a shelter facility for battered women as described in Minnesota Statutes, section 256D.05, subdivision 3.

E. The applicant or recipient does not meet the condition in item A or C but is diagnosed by a qualified professional as having mental retardation or mental illness and that condition prevents the applicant or recipient from obtaining or retaining employment.

F. The applicant or recipient has an application pending for the social security disability program or the supplemental security income program and the applicant or recipient

has, upon the request of the county agency, signed an interim assistance authorization agreement. An applicant or recipient whose previous application for social security benefits was based solely on a condition other than chemical dependency or mental illness who does not request a reconsideration of an initial denial by the social security administration is only exempt under this item if the new application is made for social security benefits based on a different disability or a new application is made that alleges new or aggravated symptoms of the original disability.

G. The applicant or recipient has appealed the denial of an application for social security disability or SSI benefits or the termination of social security disability benefits or SSI benefits and the appeal is pending. The applicant or recipient must produce medical evidence in support of a request for reconsideration of a denial of an initial application within 60 days of the initial denial. An applicant or recipient of general assistance under this item must sign an interim assistance authorization agreement upon the request of the county agency. A county agency shall not approve a new application for a recipient whose general assistance has been terminated for failure to provide medical evidence in support of the appeal of an application denied by social security until such medical evidence is produced.

H. The applicant or recipient is unable to obtain or retain employment due to advanced age as defined in part 9500.1206, subpart 3.

I. The applicant or recipient is medically certified as being learning disabled. "Learning disabled" means the applicant or recipient has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. The disability must severely limit the applicant or recipient in obtaining, performing, or maintaining suitable employment. Learning disabled does not include learning problems that are primarily the result of visual, hearing, or motor handicaps; mental retardation; emotional disturbance; or due to environmental, cultural, or economic disadvantage.

J. The applicant or recipient is under the age of 19 and is a full–time student in a secondary institution.

K. The applicant or recipient is under the age of 16.

L. The applicant or recipient is in the last trimester of pregnancy.

M. The applicant shows circumstances that indicate the need for general assistance will not exceed 30 days because of impending employment, an impending move to another state, or anticipated income, provided that the applicant has not received general assistance under that condition for at least 60 days.

N. The applicant or recipient is involved with protective or court–ordered services that prevent the applicant or recipient from working at least four hours per day.

O. The applicant's or recipient's homestead is more than two hours round–trip from any potential suitable employment, exclusive of time needed to transport the applicant's or recipient's children to and from child care.

P. The recipient or applicant is a parent, who is not otherwise exempt, in an assistance unit which contains a child under the age of six if there is no suitable child care available at no cost to the family which is not reimbursed, or greater than the disregard provided by part 9500.1235, item B. If there are two parents in an assistance unit who are not otherwise exempt under this subpart, the parent who is not the principle wage earner as defined in part 9500.1206, subpart 26a, is exempt. If, in a two–parent assistance unit, there are no earnings, or if the earnings of both parents are the same, the applicant must designate the principal wage earner, and that designation must not change as long as assistance continues without interruption. "Suitable child care at no cost to the family," as described above, can include a parent in the filing unit who is not in the assistance unit so long as that parent is not a current participant in an AFDC work program or is not otherwise available for child care.

Q. The applicant or recipient, not otherwise exempt under items A to P, has been assessed by a qualified professional or vocational specialist as not being likely to obtain permanent employment and:

(1) the applicant or recipient has been referred to, and has not refused or failed without good cause to participate in, any available, accredited remedial or skills training program designed to address barriers to the person's employment; or

(2) the applicant or recipient has been referred to another maintenance benefit for which the applicant or recipient is potentially eligible in accordance with the provisions of part 9500.1254.

Subp. 3. **Assessment of exemption status.** The assessment by the qualified professional or vocational specialist must consider the person's age, physical and mental health, education, trainability, prior work experience, and local market.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1252 [Repealed, 15 SR 1842]

9500.1254 REFERRAL TO OTHER MAINTENANCE BENEFIT PROGRAMS.

Subpart 1. **Screening requirement.** The county agency must determine the potential eligibility of each general assistance applicant or recipient for other maintenance benefits as follows:

A. The county agency must determine an applicant's potential eligibility for other maintenance benefits when application for general assistance is made.

B. The county agency must determine a recipient's potential eligibility for other maintenance benefits at the recipient's semiannual redetermination of eligibility for general assistance. The county agency must also determine a recipient's potential eligibility for other maintenance benefits whenever it determines that changes in the recipient's circumstances, including eligibility for medical assistance, indicate potential eligibility for other maintenance benefits.

C. If the county agency determines that the applicant or recipient is potentially eligible for other maintenance benefits, the county agency must document its determination on forms prescribed by the commissioner and must retain the forms in the county agency case record for the applicant or recipient.

Subp. 2. **Informing and referral requirement.** When the county agency determines that the applicant or recipient is potentially eligible for other maintenance benefits, the county agency shall refer the applicant or recipient to the other maintenance benefit program on a form prescribed by the commissioner by informing the applicant or recipient orally and in writing of the following:

A. that the applicant or recipient must apply for the other maintenance benefit program, according to subpart 4, item A;

B. that the applicant or recipient must execute an interim assistance authorization agreement, according to subpart 4, item D;

C. that the applicant or recipient must comply with all procedures necessary to determine eligibility or ineligibility for the other maintenance benefits according to subpart 4, item C;

D. that the applicant or recipient must authorize the county agency and the qualified provider, when one is chosen, to exchange relevant data concerning the applicant's or recipient's eligibility with the other maintenance benefit program office, according to subpart 4, item B;

E. the estimated amount of benefits the applicant or recipient may be eligible to receive under the other maintenance benefit program, if known;

F. the address at which the applicant or recipient shall apply for the other maintenance benefit program;

G. general instructions regarding how to apply for the other maintenance benefit program;

H. that the applicant or recipient may elect to receive special services to assist in applying for SSI benefits, according to part 9500.1256, subpart 1, and that the applicant or recipient has a right to choose to receive special services from a qualified provider;

I. notice of the actions which the county agency must take, according to subpart 5, if the applicant or recipient fails to comply with the requirements under subpart 4, items A to D; and

J. notice of the applicant's or recipient's right to appeal a determination of ineligibility for general assistance due to noncompliance with subpart 4, items A to D.

Subp. 3. **Special referral provisions.** When the county agency determines that the applicant or recipient is potentially eligible for another maintenance benefit program, the county agency shall refer the applicant or recipient to a chosen qualified provider and the other maintenance benefit program according to items A and B:

A. If the applicant or recipient is determined to be potentially eligible for maintenance benefits from SSI, the county agency shall:

(1) offer to provide special services to the applicant or recipient according to part 9500.1256, subpart 1, to assist in applying for and obtaining SSI;

(2) furnish the applicant or recipient with a list of qualified providers with whom the county agency has contracted to provide special services to applicants or recipients or who have asked to be included on the list;

(3) notify the Social Security Administration's local office of the applicant's or recipient's potential eligibility for SSI on the date of referral so that the earliest potential date of eligibility for SSI can be established; and

(4) if the applicant or recipient elects at any time to receive the special services specified in part 9500.1256, subpart 1, from a qualified provider other than the county agency, the county agency shall refer the applicant or recipient to the chosen provider. If the county agency has not contracted with the chosen provider, the county agency must enter into a contract with that qualified provider to provide special services to applicants or recipients who apply for SSI benefits.

B. If the county agency determines that an applicant or recipient is potentially eligible for another maintenance benefit program, and the applicant or recipient has previously applied for and been found ineligible for that other maintenance benefit program, the applicant or recipient shall not be required to appeal from that decision or to reapply for that other maintenance benefit program unless one of the following conditions is met:

(1) the county agency determines that the applicant's or recipient's health or circumstances have changed and the change may result in eligibility for that other maintenance benefit program; or

(2) the eligibility requirements or procedures of the other maintenance benefit program have changed and the change may result in the applicant or recipient being found eligible for that other maintenance benefit program.

Subp. 4. **Requirements upon referral for other maintenance benefits.** When the county agency refers an applicant or recipient to another maintenance benefit program as provided under subpart 2, the applicant or recipient shall do the following:

A. The applicant or recipient shall apply for those benefits within 30 days of the date of referral. If the recipient has not provided the county agency with verification of an application for those benefits within 30 days of the date of referral, the county agency must contact the other maintenance benefit program county office to determine if the recipient has applied for benefits. If the county office of the other maintenance benefit program verifies that the recipient has applied for those benefits, the recipient shall be deemed to have met the requirement of applying for other maintenance benefits. If the county office of the other maintenance benefit program verifies that the recipient has not applied for those benefits, the local agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

B. The applicant or recipient shall, within 30 days of the date of referral, provide informed written consent and authorization for the county agency or a qualified provider, if one is chosen, to exchange data concerning the applicant or recipient with the other maintenance benefit program county office. The data exchanged must be relevant to a determination of the applicant's or recipient's eligibility or ineligibility for benefits from the other program.

For purposes of exchanging private or confidential data about a person for whom a qualified provider has contracted to provide special services, a qualified provider other than the county agency shall not be considered part of the welfare system under Minnesota Statutes, section 13.46, subdivision 1.

If the county agency determines that the recipient has not given informed written consent and authorization for the county agency or a qualified provider to exchange data concerning eligibility or ineligibility for the other maintenance benefit program within the prescribed 30 days, the county agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

C. A recipient shall comply with all procedures necessary to determine eligibility or ineligibility for the other maintenance benefit program.

If the county agency determines that the recipient has not complied with the procedures necessary to determine eligibility or ineligibility for other maintenance benefits, the county agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

D. An applicant or recipient shall execute an interim assistance authorization agreement with the county agency within 30 days of the date of referral.

If the recipient fails to execute an interim assistance authorization agreement within the 30 days prescribed, the county agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

Subp. 5. **Ineligibility.** This subpart governs termination of general assistance eligibility for a recipient who fails, without good cause, to comply with the requirements of subpart 4.

A. Upon determining that a recipient has failed, without good cause, to comply with the requirements of subpart 4, the county agency shall mail or give the recipient notification of termination from general assistance. The county agency shall hand deliver or mail the written notice to the recipient at least 30 days before reducing, suspending, or terminating the recipient's monthly general assistance payment. The notice must be on a form prescribed by the commissioner and must:

(1) list the requirements with which the county agency believes the recipient has not complied and inform the recipient that the recipient must comply with the requirements to avoid or end a period of ineligibility;

(2) inform the recipient that the recipient will be terminated from general assistance if the recipient fails to comply with the listed requirements, specify the date that the recipient's general assistance will be terminated if the recipient does not comply, and explain the recipient's right to appeal the action according to subpart 6;

(3) offer assistance to resolve the circumstances or concerns which prevent the recipient from complying with the requirements of subpart 4; and

(4) inform the recipient of the continued availability of special services provided under part 9500.1256, subpart 1.

B. If the recipient complies with the requirements specified in the notice in item A before the termination date stated in the notice, a period of ineligibility must not be imposed.

C. A recipient who fails to comply with the requirements specified in the notice in item A before the termination date stated in the notice is ineligible for general assistance. The period of ineligibility begins on the date specified in the notice and continues until the person fulfills the requirements of subpart 4. The period of ineligibility always begins on the first day of a calendar month. If the ineligible person subsequently applies for general assistance, the application must be denied unless the requirements of subpart 4 have been met.

D. If the person is determined to be ineligible under item C, the assistance standard applicable to the person's assistance unit must be based on the number of remaining eligible members of the assistance unit.

Subp. 6. **Appeals.** A recipient to whom the county agency has given or mailed a notice of termination according to subpart 5 may appeal the determination by submitting a written request for a hearing according to Minnesota Statutes, section 256.045. If the recipient files a written request for an appeal on or before the first day of the period of ineligibility under subpart 5, item C, the recipient shall continue to receive general assistance while the appeal is pending, provided that the recipient is otherwise eligible for general assistance.

Subp. 7. **Reimbursement for interim assistance.** A county agency must seek reimbursement for the interim assistance provided to a person who has executed an interim assistance authorization agreement under subpart 4, item D, when the person receives a retroac-

tive payment of other maintenance benefits unless reimbursement is prohibited under federal or state law. Reimbursement for interim assistance and special services provided to an SSI applicant or recipient is governed by part 9500.1256, subpart 2.

The county agency must request reimbursement for interim assistance from the person receiving other retroactive maintenance benefits, except for SSI, or in those instances where the state or county agency has rights of subrogation under Minnesota Statutes, section 256.03. If a request for reimbursement under this subpart is denied, the county agency may institute a civil action to recover the interim assistance based on the interim assistance authorization agreement. The county agency must take no action other than a civil action to recover the interim assistance.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *10 SR 1715; 15 SR 1842*

9500.1256 SPECIAL SERVICES FOR SSI APPLICANTS.

Subpart 1. **Special services.** A recipient who is referred to SSI according to part 9500.1254, subparts 2 and 3, item B, may elect to receive special services to assist the recipient in obtaining SSI benefits. Special services for which reimbursement for fees, costs, or disbursements may be claimed under subpart 2 or 3 are limited to the following:

A. explaining to or counseling the applicant or recipient about the application procedures and benefits available through the SSI program;

B. assisting the applicant or recipient in completing the application for SSI and arranging appointments related to application for SSI;

C. assisting the applicant or recipient in assessing his or her disability in relation to SSI eligibility, and identifying probable issues that may arise during the SSI eligibility determination process;

D. providing the applicant or recipient with medical or vocational evidence, social history, or expert testimony currently available to substantiate the presence and severity of the applicant's or recipient's blindness or disability;

E. assisting the applicant or recipient in obtaining and using medical or vocational evidence, social history, or expert testimony and in cooperating with the Social Security Administration and its agents, procedures, and requirements;

F. assisting the applicant or recipient with necessary transportation;

G. preparing for and representing the applicant or recipient at interviews, hearings, or appeals related to application for SSI or appeal of the Social Security Administration's determination of ineligibility for SSI;

H. the county agency's preparation of a contractual agreement with a qualified provider chosen by the applicant or recipient; and

I. providing other services to assist the applicant or recipient to establish eligibility for SSI benefits.

Subp. 2. **Reimbursement for interim assistance and special services.** A county agency must be reimbursed for providing interim assistance and special services to an SSI applicant or recipient in the following manner:

A. Upon receiving the initial SSI payment for a person who has executed an interim assistance authorization agreement as specified in part 9500.1254, subpart 4, item D, the county agency may recover the amount of interim assistance provided. After recovering the interim assistance from the initial SSI payment, the county agency shall pay the remainder to the person or to a representative payee identified by the Social Security Administration within ten days of receiving the initial SSI payment. From the amount of interim assistance recovered, the county agency:

(1) shall retain the county's share of the interim assistance provided;

(2) may retain, subject to subpart 3, item E, 25 percent as an advocacy incentive for providing the special services specified in subpart 1, items A to D; and

(3) may retain from the remainder, subject to subpart 3, item E, reimbursement for actual reasonable fees, costs, and disbursements related to appeals and litigation and provision of special services under subpart 1.

B. The county agency may not seek reimbursement from the applicant or recipient for the fees, costs, or disbursements of providing special services except as provided in item A.

C. The balance of the amount of interim assistance that is not retained by the county agency pursuant to item A or paid to another qualified provider under subpart 3 must be credited to the state as an advance payment to the county agency for the state's share of the next month's general assistance grants.

D. The county agency must document the fees, costs, and disbursements which it incurs in providing the special services to claim reimbursement. The county agency shall be reimbursed under item A, subitem (3), only for the direct costs of providing special services.

Subp. 3. **Reimbursement to qualified providers under contract with the county agency to provide special services.** Qualified providers under contract with the county agency to provide special services to general assistance applicants or recipients shall be reimbursed from the amount of interim assistance recovered by the county agency under subpart 2 in the following manner:

A. To receive reimbursement for the fees, costs, and disbursements related to appeals and litigation and the provision of special services as provided in subpart 1, the qualified provider shall enter into a contract with the county and provide one or more of the special services specified in subpart 1.

The contract must be on a form prescribed by the commissioner except that the county agency may add to or modify the form without changing the substance of the contract in order to meet standard contracting procedures established by the county board.

B. The county agency must reimburse a qualified provider under contract with the county agency for the provider's reasonable actual fees, costs, and disbursements, including medical reports and expert testimony related to appeals, litigation, and providing special services to an applicant or recipient according to the following:

(1) a qualified provider shall not be reimbursed by the county agency for any fees, costs, or disbursements unless the applicant or recipient has requested the services, the county agency has referred the applicant or recipient to the qualified provider, and the county agency has received the initial SSI payment for the recipient served;

(2) the qualified provider shall be reimbursed by the county agency for fees related to the provision of special services at the rate determined by the qualified provider, but not to exceed $75 per hour of service; and

(3) when a qualified provider requests reimbursement from the county agency for fees, costs, or disbursements related to services provided, the qualified provider shall document the total number of hours of services provided to the applicant or recipient and provide a record of its costs and disbursements.

C. A qualified provider under contract to provide special services must comply with the following:

(1) a qualified provider shall not require prepayment of any fees, costs, or disbursements from the applicant or recipient; and

(2) a qualified provider shall not seek reimbursement from the applicant or recipient for fees related to the provision of special services. If a qualified provider intends to seek reimbursement for costs and disbursements from an applicant or recipient in the event the applicant or recipient is determined to be ineligible for SSI and the qualified provider therefore will not be fully reimbursed by the county agency, the qualified provider must so inform the applicant or recipient and obtain the applicant's or recipient's written consent before providing the special services. The qualified provider must also inform the applicant or recipient that he or she may receive the special services from the county agency without cost to the applicant or recipient.

D. The total reimbursement for special services made by the county agency to all qualified providers must not exceed the amount of interim assistance retained by the county agency as specified in subpart 2, item A, subitems (2) and (3), unless the excess is expressly authorized by the county agency and paid for exclusively with county agency funds.

E. If more than one qualified provider provides special services to an applicant or recipient, and the amount of interim assistance retained by the county agency will not fully

reimburse all qualified providers, the reimbursement to each qualified provider for fees, costs, and disbursements shall be calculated by multiplying the total amount of funds available to the county agency as specified in subpart 2, item A, subitems (2) and (3), including any excess funds authorized by the county agency under item D, by the qualified provider's reimbursement percentage. The qualified provider's reimbursement percentage shall be determined by dividing the number of hours spent by each qualified provider who provided special services by the total number of hours spent by the county agency and all other qualified providers under contract with the county agency who have provided special services to the applicant or recipient.

F. If the county agency and one or more other qualified providers provide special services to an applicant or recipient, and the amount of interim assistance recovered by the county agency under subpart 2, item A, subitems (2) and (3), exceeds the amount necessary to fully reimburse the qualified providers for fees, costs, and disbursements, the county agency may retain the excess to the extent allowed under subpart 2, item A, subitem (2).

G. The county agency shall reimburse a qualified provider for fees, costs, and disbursements for special services provided during the six–month period before the applicant or recipient was referred to the qualified provider, unless general contracting procedures of the particular county prohibit this payment. The provider's fees, costs, or disbursements for special services provided before the person's application for general assistance may be reimbursed only if funds remain after reimbursement for special services provided to the person after the person made application for general assistance.

H. The county agency and another qualified provider may contract to jointly provide the special services specified in subpart 1.

Subp. 4. **Termination of special services and contracts.** Special services and contracts must be terminated in the following manner:

A. If an applicant or recipient requests in writing that the county agency terminate the special services agreement with a qualified provider, the special services agreement for that applicant or recipient must be terminated, and the county agency shall mail written notice of the termination to the qualified provider. The notice must include a copy of the applicant's or recipient's written request for termination of the special services agreement. Termination of the agreement is effective three days after the date when the notice is mailed. The qualified provider shall not be reimbursed for fees, costs, or disbursements for special services provided to an applicant or recipient after the effective date of termination.

B. If a qualified provider decides to stop providing special services to an applicant or recipient, the qualified provider shall give or mail the following information to the applicant or recipient and, if the qualified provider is not the county agency, to the county agency:

(1) the status of the applicant's or recipient's application for SSI benefits;

(2) any deadlines that must be met regarding the applicant's or recipient's application for SSI benefits;

(3) the right of the applicant or recipient to choose another qualified provider, and the county agency's obligation to enter into a contract with a new qualified provider to provide the special services specified if the applicant or recipient chooses a qualified provider other than the county agency; and

(4) that a list of qualified providers may be obtained from the county agency.

Termination of the contract is effective three days after the date the provider gives or mails the information required in subitems (1) to (4) to the client.

C. If a qualified provider fails to perform all or part of the terms of the contract with the county agency, the county agency may terminate the contract with the provider. The county agency shall terminate the contract and mail written notice to the qualified provider and to the recipients served by the qualified provider. The notice must specify the county agency's grounds for terminating the contract. Termination of the contract is effective three days after the notice is mailed to the qualified provider. The county agency shall also give the recipient a list of other qualified providers who have contracted with the county agency to provide the special services specified in subpart 1 or who have asked to be included on the

list. The qualified provider shall not be reimbursed for fees, costs, or disbursements related to special services provided after the effective date of termination.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *10 SR 1715; 15 SR 1842*

9500.1257 [Repealed, 15 SR 1842]

GENERAL ASSISTANCE ELIGIBILITY

9500.1258 [Repealed, 15 SR 1842]

9500.1259 COUNTY AGENCY RESPONSIBILITIES.

Subpart 1. **Work readiness program.** The county agency must provide a work readiness program for mandatory and voluntary participants according to items A to F.

A. The county agency's work readiness program must include an orientation to the work readiness program which must be offered at least monthly.

B. The county agency must assess each participant's literacy; ability to communicate in the English language; eligibility for displaced homemaker services under Minnesota Statutes, section 268.96; educational history; occupational assets; barriers to employment; and exemption status from work readiness participation. When assessing a participant's literacy, the county agency must determine whether the participant is functionally illiterate. For the purpose of this item, "functionally illiterate" means the participant is unable to read at or above the eighth grade level. A county agency shall determine if the participant is functionally illiterate according to subitems (1) and (2).

(1) The county agency may determine that the participant is functionally illiterate based on personal observations or information in the participant's case file.

(2) If the participant is not determined to be functionally illiterate as provided in subitem (1), but the county agency believes that the participant may be functionally illiterate, or if the participant asserts or presents evidence that the participant may be functionally illiterate, the county agency shall offer the participant an opportunity to take a standardized literacy test approved by the commissioner. The test must be offered in the county at no expense to the participant. The county agency shall either administer the test or make arrangements for the test. If the participant attains a score lower than the eighth grade, the participant shall be considered functionally illiterate.

C. The county agency must prepare an employability development plan for each participant in work readiness. The employability development plan must address the participant's barriers to employment; estimate the length of time it will take for the participant to obtain employment; and specify steps necessary for the participant to overcome any barriers to employment identified in item B. Barriers to employment shall be addressed in the following order:

(1) A participant who is assessed by an English as a second language specialist, vocational specialist, or the county agency as being unable to communicate in the English language must participate in an English language program, if available.

(2) A participant who is determined to be functionally illiterate under item B must participate in an occupational or vocational literacy program, if available.

(3) A participant who has not completed secondary education must participate in a secondary school program or GED program, if available and appropriate.

(4) A participant who has none of the barriers specified in subitems (1) to (3) but who has no work experience must participate in job seeking skills training and a job search program.

(5) A participant who has none of the barriers specified in subitems (1) to (3) and who has a work history must participate in a job search program.

The employability development plan may include referral to available training programs and work experience programs designed to prepare the participant for permanent employment or to education and training activities. A participant in a work experience program

shall not perform work ordinarily performed by a regular public employee. The employability development plan must address the participant's barriers to employment, and may, in addition, require the participant to engage in job search or other work readiness activities so long as the combination of requirements does not exceed 32 hours per week or place any requirement upon a participant that interferes with employment which the county agency has determined can lead to self–sufficiency.

D. For those participants who are considered to be functionally illiterate under item B, the county agency must:

(1) assess existing reading level, learning disabilities, reading potential, and vocational or occupational interests of the participant;

(2) assign suitable participants to openings in occupational and vocational literacy programs;

(3) if no openings are available in occupational or vocational literacy programs, assign suitable participants to openings in literacy training programs;

(4) reassign to another literacy program any participant who does not complete an assigned program and who wishes to try another program;

(5) within the limits of funds available, contract with technical institutes or other groups who have literacy instructors trained in occupational literacy methods to provide literacy training sessions so that eligible participants will have the opportunity to attend training;

(6) provide transportation to enable participants to participate in literacy training. The state shall reimburse the county agency for the costs of providing this transportation; and

(7) make every effort to ensure that child care is available as needed by participants who are pursuing literacy training; however, no participant shall be disqualified for noncompliance with the literacy training requirement of work readiness if child care is not made available.

E. The county agency shall provide notices to work readiness participants as provided in subitems (1) to (6).

(1) The county agency shall provide, at the time of registration and each 30 days after that, in advance, a clear written description of the specified tasks and assigned duties the participant must complete to receive work readiness pay. The county agency shall provide notice that the participant will be terminated from the work readiness program unless the participant completes the specified tasks and assigned duties, or shows good cause for failure to do so. The county agency shall provide notice of the disqualification that will be imposed on the participant for failure to comply with part 9500.1245, subpart 8, item B.

(2) The county agency shall provide notice to a participant within three days of determination that the participant has failed to comply with work readiness requirements as specified in part 9500.1245, subpart 8, item A.

(3) For the first instance of noncompliance in a six–month period, beginning on the date of the participant's orientation or the end of the previous disqualification, whichever is later, the county agency's notice:

(a) must allow at least five working days, after the mailing or hand delivery of the notice, for the participant to take specific corrective action which can realistically be done before the date assistance is scheduled to be paid;

(b) must advise the participant that the participant may request and have a conference with the county agency to discuss the notice; and

(c) must advise the participant that failure to take corrective action by the effective date of the termination notice in subitem (5) will result in termination of assistance and disqualification from program eligibility for one month.

(4) For a second or subsequent instance of noncompliance within a six–month period, beginning on the date of the participant's orientation or the end of the previous disqualification, whichever is later, the county agency's notice of its determination of noncompliance:

(a) must be mailed or hand delivered to the participant before the date assistance is scheduled to be paid; and

(b) must advise the participant that the participant may request and have a conference with the county agency to discuss the notice. The applicable period of disqualification under this subitem is two months.

(5) The county agency shall mail or hand deliver notice of termination concurrently with the notice of noncompliance specified in subitems (3) and (4) only after assessing the participant's exemption status from work readiness participation under part 9500.1251, subpart 2, items A to Q, using the information contained in the recipient's case file. The notice of termination must state that the recipient is not exempt from registration and must indicate the applicable period of disqualification. The advance notice requirements of this item are the same as those of subitems (3) and (4).

(6) The county agency shall assign a schedule by which a participant who has failed to provide the agency with a mailing address must visit the county agency to pick up any notices. Those notices must be deemed delivered on the date of the participant's next scheduled visit to the county agency.

F. The county agency may subcontract any or all of the duties prescribed in items A to D and E, subitem (1). The contract does not relieve the county agency of its primary responsibility in the instance of a default of any provision by a subcontractor.

Subp. 2. **Appeals.** The participant may appeal a proposed termination of benefits until five days after the effective date specified in the notice and continue benefits otherwise due, pending the outcome of the appeal. Appeals from proposed terminations of benefits of participants must be heard within 30 days from the date that the appeal was filed.

Subp. 3. **Information about other programs.** A county agency must inform an applicant or recipient about other programs administered by the county agency for which, from the county agency's knowledge of the person's situation, the person may be eligible.

Subp. 4. **Notices.** The county agency shall mail or hand deliver a notice to a recipient no later than ten days before the effective date of the action except as provided in items A to C. A recipient who has failed to provide the county agency with a mailing address must be assigned a schedule by which the recipient is to visit the agency to pick up any notices. Notices will be deemed to have been delivered on the date of the recipient's next scheduled visit to the county agency.

A. A county agency shall mail a notice to a recipient no later than five days before the effective date of the action when the county agency has factual information which requires an action to reduce, suspend, or terminate assistance based on probable fraud.

B. A county agency must mail or hand deliver a notice to a recipient no later than the effective date of the action when:

(1) the county agency receives a recipient's household report form which includes facts that require payment reduction, suspension, or termination and which contains the recipient's signed acknowledgment that this information will be used to determine program eligibility or the assistance payment amount;

(2) the county agency verifies the death of a recipient or the payee;

(3) the county agency receives a signed statement from a recipient that assistance is no longer wanted;

(4) the county 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 the recipient understands the consequences of providing that information;

(5) the county agency verifies that a member of an assistance unit has been approved to receive assistance by another county or state; or

(6) the county agency cannot locate a payee's whereabouts and mail from the local agency has been returned by the post office showing that the post office has no forwarding address.

C. Whenever any provision of this subpart conflicts with any special notice requirements of another part, those special notice provisions shall prevail.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1260 [Repealed, 15 SR 1842]

9500.1261 EMERGENCY ASSISTANCE.

Subpart 1. **Emergency assistance.** A county agency shall make grants of general assistance for emergency situations to eligible individuals, married couples, or families whether residents or nonresidents of the state. The emergency assistance grant may be in excess of the standard amounts for eligible individuals, married couples, or families under part 9500.1231.

Subp. 2. **Emergency situation.** An emergency situation is a situation in which an assistance unit is without, or will lose within 30 days after application, a basic need item as defined in part 9500.1206, subpart 7a.

A. The emergency situation must require immediate financial assistance.

B. The financial assistance required by the emergency must be temporary and must not exceed 30 days subsequent to the date of application. Assistance must be paid for needs that accrue before the 30–day period when it is necessary to resolve emergencies arising or continuing during the 30–day period subject to subpart 4.

Subp. 3. **Eligible persons.** Eligible individuals, married couples, or families are those:

A. who are not current recipients of AFDC, other than a one–person assistance unit consisting of a pregnant woman;

B. who are not recipients under or eligible for the program of emergency assistance under AFDC in the month of application for emergency general assistance;

C. whose resources are not adequate to resolve the emergency situation. For the purpose of this part, "resources" means any funds or services which can actually be available to the applicant or recipient or any member of the filing unit before the loss of a basic need item. Resources include available income without exclusion or disregard, and any resource otherwise excluded under part 9500.1221, subpart 2, which could be liquidated before the loss of a basic need item, so long as the terms of any borrowing cannot be reasonably expected to place the borrower in another emergency situation within three months including the month of application;

D. who have not, without good cause, used more than 50 percent of available income and liquid resources for purposes other than basic needs during the 60 days before application. This item does not apply to individuals who are chemically dependent, mentally ill, or mentally retarded; or

E. who are not in a period of disqualification from work readiness if that disqualification has caused the emergency situation unless the emergency situation directly affects other assistance unit members who are not in a period of disqualification.

Subp. 4. **Payment provisions.** When the county agency has determined that an applicant has an emergency situation and is eligible for emergency general assistance, the county agency must resolve the emergency in the most cost–effective manner. Resolution of the emergency situation in a cost–effective manner shall be governed by items A to H.

A. An emergency general assistance payment is not cost–effective if the applicant's anticipated income together with the grant of emergency general assistance will not be sufficient to cover the applicant's basic needs for the three–month period beginning with the month of application, and another emergency situation can reasonably be anticipated within the two months after the month of the grant of emergency general assistance.

B. When alternative solutions to the emergency situation are available, the most cost–effective solution is the solution which will require an expenditure of emergency general assistance funds which is at least 25 percent less than the emergency general assistance expenditure required to maintain the applicant or recipient in his or her current situation. The county agency has no duty to provide alternative solutions, but must have a reasonable basis

to believe that alternative solutions exist. A county agency must not deny assistance because of the determination that the applicant's anticipated income will not cover continued payment of shelter and utility costs when no alternative solution is identified by either the applicant or the county agency.

C. In determining the cost–effectiveness of an emergency general assistance payment, the county agency must not consider a period of time greater than three months including the month of application for emergency general assistance.

D. When the county agency has determined that the emergency situation has resulted from the applicant's mismanagement of money, the county agency may include vendor payment of future needs as part of a cost–effective solution subject to review at each redetermination of eligibility.

E. Emergency grants for food must not exceed the amount the assistance unit would receive under the United States Department of Agriculture's Thrifty Food Plan.

F. Emergency grants for clothing must not exceed the cost of necessary clothing for assistance unit members considering the season of application.

G. Emergency grants for shelter, exclusive of moving expenses or deposits, must not exceed an amount equal to four times the assistance unit's monthly assistance standard. For the purposes of this item, the amount of a single individual's monthly assistance standard is the amount specified in part 9500.1231, subpart 1. A county agency may receive state participation for payments in excess of the limits of this item if the county agency has documented that no shelter is available within the limits of this item which is cost effective as governed by items A to C.

H. Grants for emergency general assistance must be in the form of vouchers or vendor payments unless the county agency determines that a cash grant will better meet the need of the emergency situation.

Subp. 5. **Assistance for transportation.** Notwithstanding subpart 2, grants may be issued under the emergency general assistance program for an applicant's immediate need for transportation in the following situations:

A. the need for assistance will not exceed 30 days and the transportation is required to accept a bona fide offer of suitable employment; or

B. the transportation is requested by the applicant to return to a residence maintained by or for the applicant.

Subp. 6. **Excess grants, county agency payment responsibility.** A county agency may issue emergency assistance grants that exceed the limitations in subpart 4 if the county agency does not include the additional costs on its claim for state aid reimbursement.

Statutory Authority: *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 1842*

9500.1262 [Repealed, 15 SR 1842]

9500.1264 [Repealed, 15 SR 1842]

9500.1266 [Repealed, 15 SR 1842]

9500.1268 [Repealed, 15 SR 1842]

9500.1270 [Repealed, 15 SR 1842]

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 9500.1261. 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 Minnesota 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.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

History: *15 SR 120; 15 SR 1842*

9500.1300 [Repealed, 15 SR 1842]

9500.1302 [Repealed, 15 SR 1842]

9500.1304 [Repealed, 15 SR 1842]

9500.1306 [Repealed, 15 SR 1842]

9500.1308 [Repealed, 15 SR 1842]

9500.1310 [Repealed, 15 SR 1842]

9500.1312 [Repealed, 15 SR 1842]

9500.1314 [Repealed, 15 SR 1842]

9500.1316 [Repealed, 15 SR 1842]

9500.1318 [Repealed, 15 SR 1842]

ADMINISTRATION OF THE PREPAID MEDICAL ASSISTANCE PROGRAM

9500.1450 INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.1450 to 9500.1464 govern administration of the prepaid medical assistance program (PMAP) 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 adopted under them, governing the administration of the title XIX program and PMAP 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 prepaid medical assistance program.

Subp. 3. **Geographic area.** PMAP shall be operated in the counties of Dakota, Hennepin, and Itasca and other geographical areas designated by the commissioner. If the geographic area is expanded beyond Dakota, Hennepin, and Itasca counties, participating counties in the expanded area shall receive at least 180 days notice from the commissioner before implementation of PMAP and shall be governed by parts 9500.1450 to 9500.1464.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

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. [Repealed, 16 SR 1086]

Subp. 2a. **Appeal.** "Appeal" means an enrollee's written request for a hearing, filed with the commissioner according to Minnesota Statutes, section 256.045, related to the delivery of health services or participation in a health plan.

Subp. 2b. **Authorization.** "Authorization" means a participating provider's written referral for health services provided by a nonparticipating provider. Authorization includes an admission request by a participating provider, on behalf of a PMAP enrollee, following the established health plan admission procedures for inpatient health services.

Subp. 2c. **Authorized representative.** "Authorized representative" means a person authorized in writing by a PMAP consumer to act on the PMAP consumer's behalf in matters involving the prepaid medical assistance program.

Subp. 3. [Repealed, 16 SR 1086]

Subp. 4. **Capitation.** "Capitation" means a method of payment for health services that involves a monthly per person rate paid on a prospective basis to a health plan.

Subp. 4a. **Case management.** "Case management" means a method of providing health care in which the health plan coordinates the provision of health services to an enrollee.

Subp. 4b. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's designated representative.

Subp. 4c. **Complaint.** "Complaint" means an enrollee's written or oral communication to a health plan expressing dissatisfaction with the provision of health services. The subject of the complaint may include, but is not limited to, the scope of covered services, quality of care, or administrative operations.

Subp. 5. [Repealed, 16 SR 1086]

Subp. 6. **Department.** "Department" means the Department of Human Services.

Subp. 7. **Enrollee.** "Enrollee" means a PMAP consumer who is enrolled in a health plan.

Subp. 7a. **Health plan.** "Health plan" means an organization contracting with the state to provide medical assistance health services to enrollees in exchange for a monthly capitation payment.

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.0625.

Subp. 9. **Insolvency.** "Insolvency" means the condition in which a health plan is financially unable to meet the financial and health care service delivery obligations in the contract between the department and the 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. [Repealed, 16 SR 1086]

Subp. 12. [Repealed, 16 SR 1086]

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 a category of eligibility for the medical assistance program, the eligibility standards for which are in parts 9505.0010 to 9505.0150 and Minnesota Statutes, section 256B.055.

Subp. 14a. **Multiple health plan model.** "Multiple health plan model" means a health services delivery system that allows PMAP consumers to enroll in one of two or more health plans.

Subp. 14b. **Nonparticipating provider.** "Nonparticipating provider" means a provider who is not employed by or under contract with a health plan to provide health services.

Subp. 14c. **Ombudsperson.** "Ombudsperson" means an individual designated by the commissioner under Minnesota Statutes, section 256B.031, subdivision 6, to advocate for PMAP consumers and enrollees and to assist them in obtaining necessary health services.

Subp. 14d. **Open enrollment.** "Open enrollment" means the annual 30–day period during which PMAP enrollees in a multiple health plan model may change to another health plan.

Subp. 14e. **Participating provider.** "Participating provider" means a provider who is employed by or under contract with a health plan to provide health services.

Subp. 14f. **Personal care assistant.** "Personal care assistant" means a provider of personal care services prescribed by a physician, supervised by a registered nurse, and provided to a medical assistance recipient under Minnesota Statutes, section 256B.0627. A personal care assistant must not be the recipient's spouse, legal guardian, or parent if the recipient is a minor child.

Subp. 14g. **Personal care services.** "Personal care services" has the meaning given it in Minnesota Statutes, section 256B.0627, subdivision 4.

Subp. 14h. **Prepaid medical assistance program or PMAP.** "Prepaid medical assistance program" or "PMAP" means the prepaid medical assistance program authorized under Minnesota Statutes, section 256B.69.

Subp. 14i. **PMAP consumer.** "PMAP consumer" means a medical assistance recipient who is selected to participate in PMAP.

Subp. 14j. **Prepayment coordinator.** "Prepayment coordinator" means the individual designated by the local agency under Minnesota Statutes, section 256B.031, subdivision 9.

Subp. 14k. **Primary care provider health plan model.** "Primary care provider health plan model" means a health services delivery system that allows PMAP consumers to select a primary care physician and primary care dentist from a list of physicians and dentists under contract with the state or a county to provide health services to PMAP consumers.

Subp. 15. **Provider.** "Provider" means a person or entity providing health services.

Subp. 16. **Rate cell.** "Rate cell" means a grouping of recipients by demographic characteristics, established by the commissioner for use in determining capitation rates. The following are deemed to be demographic characteristics: a recipient's age, sex, medicare status, basis of medical assistance eligibility, county of residence, and residence in a long–term care facility.

Subp. 16a. **Rate cell year.** "Rate cell year" means the period beginning on the date of enrollment in the health plan and ending on the date of the annual eligibility review or the date of enrollment in a new plan, whichever occurs sooner, and thereafter the 12–month period between eligibility reviews during which an enrollee's rate cell assignment is fixed.

Subp. 17. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for the medical assistance program.

Subp. 17a. **Spend–down.** "Spend–down" means the process by which a person who has income in excess of the medical assistance income standard becomes eligible for medical assistance by incurring health services expenses, other than nursing home facility per diem charges, that are not covered by a liable third party and that reduce the excess income to zero.

Subp. 17b. **State institution.** "State institution" means all regional treatment centers as defined in Minnesota Statutes, section 245.0312, and all state operated facilities as defined in Minnesota Statutes, section 252.50.

Subp. 18. [Repealed, 16 SR 1086]

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.

Subpart 1. **Medical assistance eligibility required for PMAP participation.** Only persons who have been determined eligible for medical assistance under parts 9505.0010 to 9505.0150 shall be eligible to participate in the prepaid medical assistance program.

Subp. 2. **Medical assistance categories ineligible for PMAP.** A person who belongs to a category listed in items A to N is ineligible to enroll in a health plan under the prepaid medical assistance program:

A. a person who is eligible for medical assistance on a spend–down basis as defined in part 9500.1451, subpart 17a;

B. a person who is currently receiving the services of a personal care assistant, or PMAP 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;

D. a person who is receiving benefits under the Refugee Assistance Program, established at United States Code, title 8, section 1522(e);

E. a person who is eligible for medical assistance through an adoption subsidy;

F. a person who is determined eligible for medical assistance due to blindness or disability as certified by the Social Security Administration or the state medical review team, unless the recipient is 65 years of age or older;

G. a person who is eligible for medical assistance but currently has private health insurance coverage through a health maintenance organization licensed under Minnesota Statutes, chapter 62D;

H. a person who resides in Itasca county but who lives near the county border and who chooses to use a primary care provider located in a neighboring county;

I. a person who is a qualified medicare beneficiary, as defined in United States Code, title 42, section 1396(d), who is not otherwise eligible for medical assistance;

J. a person who is terminally ill as defined under part 9505.0297, subpart 2, item N, and who, at the time of notification of mandatory enrollment in PMAP, has a permanent relationship with a primary physician who is not part of any PMAP health plan;

K. a person who is in foster placement;

L. a child who prior to enrollment in a health plan is determined to be in need of protection under Minnesota Statutes, sections 626.556 to 626.5561, is identified to the state by the county social service agency, and is receiving medical assistance covered services through a provider who is not a participating provider in PMAP;

M. a child who prior to enrollment in a health plan is determined to be severely emotionally disturbed under Minnesota Statutes, sections 245.487 to 245.4887, and is:

(1) coded as severely emotionally disturbed on the Minnesota welfare information system;

(2) receiving county mental health case management services; and

(3) under the primary care of a mental health professional as defined in Minnesota Statutes, section 245.4871, subdivision 27, who is not a participating provider in PMAP; or

N. a person who, at the time of notification of mandatory enrollment in PMAP:

(1) has a communicable disease;

(2) the prognosis of the communicable disease is terminal illness, however, for the purpose of this subitem, "terminal illness" may exceed six months;

(3) the person's primary physician is not a participating provider in any PMAP health plan; and

(4) the physician certifies that disruption of the existing physician–patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

Subp. 3. **Exclusions during phase–in period.** The 65 percent of medical assistance eligible persons in Hennepin county who were not randomly selected to participate in the former medical assistance prepaid demonstration project because they served as a control group must participate in PMAP. Hennepin county may temporarily exclude individuals' participation in PMAP in order to provide an orderly phase–in period for new enrollees. The phase–in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Counties participating in the prepaid medical assistance program for the first time after June 30, 1991, may temporarily exclude PMAP consumers from participation in PMAP in order to provide an orderly phase–in period for new enrollees. The phase–in period must be

completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Subp. 4. **Elective enrollment.** An individual categorically excluded from PMAP under subpart 2, item G, may enroll in PMAP on an elective basis if the private health insurance health plan is the same as the health plan the consumer will select under PMAP.

Individuals categorically excluded from PMAP under subpart 2, items K, L, and M, may enroll in the prepaid medical assistance program on an elective basis.

Program requirements are the same for elective and mandatory PMAP enrollees under Minnesota Statutes, section 256B.69.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1453 MANDATORY PARTICIPATION; FREE CHOICE OF HEALTH PLAN.

Subpart 1. **Local agency enrollment of PMAP consumers.** Each local agency shall enroll recipients to participate as PMAP consumers in the prepaid medical assistance program. Health services may be provided to PMAP consumers under a multiple health plan model or a primary care provider health plan model.

Subp. 2. **Counties using a multiple health plan model, choice.** In a county that uses a multiple health plan model, the local agency shall notify each PMAP consumer, in writing, of the health plan choices available. The PMAP consumer shall be given 30 days after receiving the notification to select a health plan and to inform the local agency of the health plan choice. If a PMAP consumer fails to select a health plan within 30 days, the local agency must randomly assign the PMAP consumer to a health plan at the end of the 30–day period. The commissioner shall notify each PMAP consumer in writing before the effective date of enrollment, of the health plan in which the PMAP consumer will be enrolled.

Subp. 3. **Counties using primary care provider health plan model, provider choice.** In a county that uses a primary care provider health plan model, the local agency shall notify each PMAP consumer, in writing, of the primary care physicians and dentists available. The PMAP consumer shall be given 30 days after receiving the notification to select a primary care physician and dentist and to inform the local agency of the choice. If a PMAP consumer fails to select a primary care physician or dentist within 30 days, the local agency must randomly assign the PMAP consumer to a primary care physician and dentist at the end of the 30–day period. The local agency shall notify each PMAP consumer in writing of the assigned primary care physician or dentist before the effective date of enrollment.

Subp. 4. **Designation of prepayment coordinator.** To carry out its responsibilities under this part, each local agency shall designate a prepayment coordinator. The prepayment coordinator shall perform the duties set forth under Minnesota Statutes, section 256B.031, subdivision 9. The commissioner shall monitor the tasks performed by the prepayment coordinator.

Subp. 5. **Enrollment period in counties using a multiple health plan model; change.** In a county that uses a multiple health plan model, a PMAP consumer shall be enrolled in a health plan for up to one year from the date of enrollment but shall have the right to change to another health plan once within the first year of initial enrollment in PMAP. In addition, when a PMAP consumer is enrolled in a health plan whose participation in PMAP is subsequently terminated for any reason, the PMAP consumer shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. An enrollee shall also have the opportunity to change to another health plan during the annual 30–day open enrollment period. The local agency shall notify enrollees of the opportunity to change to another health plan before the start of each annual open enrollment period.

Subp. 6. **Enrollment period in counties using primary care provider health plan model; change.** In a county that uses a primary care provider health plan model, an enrollee shall select a primary care physician or dentist for a period up to one year from the date of enrollment but shall have the right to select a new primary care physician or dentist during the first year of initial enrollment. An enrollee shall also have the opportunity to change primary

care physicians and dentists on an annual basis. The local agency shall notify an enrollee of this change option.

Subp. 7. **Enrollment changes without a hearing, substantial travel time.** An enrollee in a multiple health plan model may change a health plan and an enrollee in a primary care provider health plan model may change a primary care provider without a hearing if the travel time to the enrollee's primary care provider is over 30 minutes from the enrollee's residence. The county shall notify the commissioner, in writing, prior to making a change under this subpart.

Subp. 8. **Enrollment changes without a hearing when agency error.** Upon an enrollee's request, the county shall change an enrollee's health plan or primary care physician or dentist without a hearing when the enrollee's health plan or primary care physician or dentist choice was incorrectly designated due to local agency error.

The county shall notify the commissioner, in writing, prior to making a change under this subpart.

Subp. 9. **Authorized representative.** A PMAP consumer may designate an authorized representative to act on the PMAP consumer's behalf in matters involving the PMAP.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1454 RECORDS.

A health plan shall maintain fiscal and medical records as required in part 9505.0205. A local agency shall comply with part 9505.0135 and maintain a list showing the enrollment choices of recipients who participate in the PMAP.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1455 THIRD–PARTY LIABILITY.

To the extent required under Minnesota Statutes, section 62A.046 and part 9505.0070, the health plan shall coordinate benefits for or recover the cost of medical care provided to its enrollees who have private health care or Medicare coverage. Coordination of benefits includes paying applicable copayment or deductibles on behalf of an enrollee.

The health plan must comply with the claims settlement requirements under Minnesota Statutes, section 256B.69, subdivision 6, paragraph (b).

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

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*

9500.1457 SERVICES COVERED BY PMAP.

Subpart 1. **In general.** Services currently available under the medical assistance program in Minnesota Statutes, section 256B.0625 and parts 9505.0170 to 9505.0475 are covered under PMAP. Chemical dependency services provided under this part must fully comply with the requirements of parts 9530.4100 to 9530.6655. The following services are not covered:

A. case management services for serious and persistent mental illness as defined in Minnesota Statutes, section 256B.0625, subdivision 20;

B. nursing home facility per diem services as defined in Minnesota Statutes, section 256B.0625, subdivision 2, and parts 9549.0010 to 9549.0080; and

C. services provided under home–based and community–based waivers authorized under United States Code, title 42, section 1396.

Subp. 2. **Additional services.** A health plan may provide services in addition to those available under the medical assistance program.

Subp. 3. **Prior authorization of services.** A health plan shall be exempt from the requirements of Minnesota Statutes, chapter 256B, parts 9505.0170 to 9505.0475 and 9505.5000 to 9505.5030, that require prior authorization before providing health services to an enrollee.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1458 DATA PRIVACY.

Under Minnesota Statutes, section 13.46, subdivisions 1 and 2, a health plan under contract with the department is considered an agent of the department and shall have access to information on its enrollees to the extent necessary to carry out its responsibilities under the contract. The health plan must comply with Minnesota Statutes, chapter 13, the Minnesota Government Data Practices Act.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1459 CAPITATION POLICIES.

Subpart 1. **Rates.** On or before the tenth day of each month, the commissioner shall prepay each health plan the capitation rates specified in the contract between the health plan and the state. The capitation rates shall be developed in accordance with Minnesota Statutes, section 256B.69. The capitation rates established under this part, the rate methodology and the contracts with the health plan shall be made available to the public upon request. The rates established must be less than the average per capita fee–for–service medical assistance costs for an actuarially equivalent population.

Subp. 2. [Repealed, 16 SR 1086]

Subp. 3. [Repealed, 16 SR 1086]

Subp. 4. [Repealed, 16 SR 1086]

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1460 ADDITIONAL REQUIREMENTS.

Subpart 1. **Health plan requirements.** An organization that seeks to participate as a health plan under the PMAP shall meet the criteria in subparts 2 to 17.

Subp. 2. **Medical assistance populations covered.** A health plan may choose to serve the medical assistance population defined in part 9500.1452 or the aged medical assistance population exclusively.

Subp. 3. **Services provided.** A health plan shall provide its enrollees all health services eligible for medical assistance payment under Minnesota Statutes, section 256B.0625, and parts 9505.0170 to 9505.0475 except for services excluded in part 9500.1457, subpart 1, items A to C.

Subp. 4. **Prohibition against copayments.** A health plan shall not charge its enrollees for any health service eligible for medical assistance payment under parts 9505.0170 to 9505.0475 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 health plan may choose to organize itself as either a profit or not–for–profit organization.

Subp. 6. **Contractual arrangements.** A health plan shall contract with providers as necessary to meet the health service needs of its enrollees. Before contracting with the state, and on an annual basis after contracting with the state, the health plan shall give the commissioner a current list of the names and locations of the providers under contract with the health plan. These subcontracts shall be submitted to the commissioner upon request. The commissioner shall require a health plan to terminate a subcontract under the following conditions:

A. the subcontractor is terminated as a medical assistance provider under the provisions of parts 9505.2160 to 9505.2245;

B. the commissioner finds through the quality assurance review process contained in subpart 17 that the quality of services provided by the subcontractor is deficient in meeting

the department's quality assurance standards and the subcontractor has failed to take action to correct the area of deficiency within 60 days; or

C. the subcontractor has failed to comply with the Department of Health licensure standards under Minnesota Statutes, chapter 62D.

Subp. 7. **Enrollment capacity.** A health plan shall accept all PMAP consumers who choose or are assigned to the health plan, regardless of the PMAP consumers' health conditions, if the PMAP consumers are from the medical assistance category or categories and the geographic area or areas specified in the contract between the health plan and the state. The commissioner shall limit the number of enrollees in the health plan upon the issuance of a contract termination notice under subpart 12.

Subp. 8. **Financial capacity.** A health plan shall demonstrate its financial risk capacity through a reserve fund or other mechanism agreed upon by the providers within the health plan in the contract with the department. A health plan 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 health plan must have a plan approved by the commissioner for transferring its enrollees to other sources of health services if the health plan becomes insolvent.

Subp. 10. **Limited number of contracts.** The commissioner may limit the number of health plan contracts in effect under PMAP.

Subp. 11. **Liability for payment for unauthorized services.** Except for emergency health services under Minnesota Statutes, section 256B.0625, subdivision 4, or unless otherwise specified in contract, a health plan shall not be liable for payment for unauthorized health services rendered by a nonparticipating provider. The department is not liable for payment for health services rendered by a nonparticipating provider.

Subp. 11a. **Liability for payment for authorized services rendered by a nonparticipating provider.** When a health plan or participating provider authorizes services for out–of–plan care, the health plan shall reimburse the nonparticipating provider for the out–of–plan care. The health plan is not required to reimburse the nonparticipating provider more than the comparable medical assistance fee for service rate, unless another rate is otherwise required by law. A nonparticipating provider shall not bill the PMAP enrollee for any portion of the cost of the authorized service.

Subp. 12. **Termination of participation as a health plan.** The state may terminate a contract upon 90 days' written notice to the health plan. When the state issues a contract termination notice, the health plan must notify its enrollees in writing at least 60 days before the termination.

Subp. 13. **Financial requirements placed on health plan.** Each health plan shall be accountable to the commissioner for the fiscal management of the health services it provides enrollees. The state and the health plan's enrollees shall be held harmless for the payment of obligations incurred by a health plan if the health plan or a participating provider becomes insolvent and if the state has made the payments due the health plan under part 9500.1459.

Subp. 14. **Required educational and enrollee materials.** When contracting with the state, a health plan must provide to the commissioner 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 PMAP consumers shall be disseminated without the commissioner's prior approval.

When a person enrolls in the health plan, the health plan shall provide each enrollee with a certificate of coverage, a health plan identification card, a listing of plan providers, and a description of the health plan's complaint and appeal procedure.

According to Minnesota Statutes, section 256.016, any educational materials, new enrollee information, complaint and appeal information, or other enrollee materials must be understandable to a person who reads at the seventh grade level as determined by the Flesch readability scale index defined in Minnesota Statutes, section 72C.09.

Subp. 15. **Required case management system.** A health plan shall implement a system of case management in which an enrollee's individual medical needs are assessed to determine the appropriate plan of care. The individual plan of care shall be developed, implemented, evaluated, monitored, revised, and coordinated with other health care providers, as appropriate and necessary.

Subp. 16. **Required submission of information.** The contract between the state and the health plan shall specify the information the health plan shall submit to the commissioner and the Health Care Financing Administration, and the form in which the information shall be submitted. The information submitted must enable the commissioner to make the calculations required under part 9500.1459 and to carry out the requirements of parts 9505.2160 to 9505.2245 and the Health Care Financing Administration. A health plan shall make the required information available to the commissioner at times specified in the contract or, if the commissioner requires additional information for the purposes in this subpart, within 30 days of the date of the commissioner's written request for the additional information.

Subp. 17. **Required quality assurance system.** Each health plan shall have an internal quality assurance system in operation that meets the requirements of title XIX of the Social Security Act. This quality assurance system shall encompass an ongoing review of:

A. use of services;

B. case review of all problem cases and a random sample of all cases, including review of medical records and an assessment of medical care provided in each case;

C. enrollee complaints and the disposition of the complaints; and

D. enrollee satisfaction, as monitored through an annual survey.

Based on the results of the review, the health plan shall develop an appropriate corrective action plan and monitor the effectiveness of the corrective action or actions taken.

The health plan shall permit the commissioner and United States Department of Health and Human Services or their agents to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under its contract with the commissioner. If the commissioner or Department of Health and Human Services finds that the quality of services offered by the health plan is deficient in any area, and, after giving the health plan at least 60 days in which to correct the deficiency, the health plan has failed to take action to correct the area of deficiency, the commissioner shall withhold all or part of the health plan's capitation premiums until the deficiency identified under subpart 6 is corrected to the satisfaction of the commissioner or the Department of Health and Human Services.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1462 SECOND MEDICAL OPINION.

A health plan must indicate in the certificate of coverage that enrollees have a right to a second medical opinion according to items A to C.

A. A health plan must provide, at its expense, a second medical opinion within the health plan upon enrollee request.

B. According to Minnesota Statutes, section 62D.103, a health plan is required to provide a second medical opinion by a qualified nonparticipating provider when it determines that an enrollee's chemical dependency or mental health problem does not require structured treatment.

C. According to Minnesota Statutes, section 256.045, subdivision 3a, paragraph (b), a health plan must provide, at its expense, a second medical opinion by a participating provider or nonparticipating provider when ordered by a state human services referee.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1463 COMPLAINT AND APPEAL PROCEDURES.

Subpart 1. [Repealed, 16 SR 1086]

Subp. 2. [Repealed, 16 SR 1086]

Subp. 3. **Health plan complaint procedure.** A health plan shall have a written procedure for reviewing enrollee complaints. This complaint procedure must be approved by the

commissioner. The complaint procedure must include both an informal process, in which a determination is made within ten calendar days after the date a health plan receives a verbal complaint, and a formal process to handle written complaints. The formal process shall provide for an impartial hearing containing the elements in items A to E.

A. A person or persons with authority to resolve the case shall be designated to hear the complaint.

B. The enrollee has the right to be represented at the hearing by a representative of his or her choice, including legal counsel.

C. The enrollee and the health plan may call witnesses to provide relevant testimony.

D. A determination shall be made and written notice of the decision shall be issued to the enrollee within 30 days after the date the written complaint is received by the health plan. The written notice shall include notice of the enrollee's right to appeal to the state.

E. The health plan must notify the ombudsperson within three working days after any written complaint is filed by a PMAP enrollee.

Each health plan shall provide its enrollees with a written description of the health plan's complaint procedure and the state's appeal procedure at the time of enrollment. The written description shall clearly state that exhaustion of the health plan's complaint procedure is not required before appealing to the state. The health plan's complaint procedure and revisions to the complaint procedure must be approved by the commissioner. Approved revisions in the health plan's complaint procedure must be communicated, in writing, to its enrollees at least two weeks before the revisions are implemented.

Subp. 4. **Health plan notice requirements.** When a health plan denies, reduces, or terminates a health service, it must notify the enrollee or the enrollee's authorized representative in writing of the right to file a complaint or appeal according to Minnesota Statutes, section 256.045, subdivision 3. The notice must explain:

A. the right to a second opinion within the plan;

B. how to file a complaint;

C. how to file a state appeal, including the name and telephone number of the state ombudsperson;

D. the circumstances under which health services may be continued pending an appeal; and

E. the right to request an expedited hearing under Minnesota Statutes, section 256.045, subdivision 3a, paragraph (c).

For purposes of this subpart, a health plan does not include the treating physician, second opinion physician, or other treating health care professional whether employed by, or contracting with, the health plan.

Subp. 5. **State appeal procedure.** An enrollee may appeal the refusal to change a health plan or primary care provider under part 9500.1453, subparts 7 and 8, a health plan's or participating provider's denial, delay, reduction, or termination of health services or a health plan's resolution of a complaint or any other ruling of a prepaid health plan by submitting a written request for a hearing as provided in Minnesota Statutes, section 256.045, subdivision 3. The enrollee may request an expedited hearing by contacting the appeals referee or ombudsperson. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner. An enrollee is not required to exhaust the health plan's complaint system before filing a state appeal. An enrollee may request the assistance of the ombudsperson or other persons in the appeal process.

Subp. 6. **Services pending state appeal or resolution of complaint.** If an enrollee files a written complaint with the health plan or appeals in writing to the state under Minnesota Statutes, section 256.045, on or before the tenth day after the decision is communicated to the enrollee by the health plan to reduce, suspend, or terminate services the enrollee had been receiving on an ongoing basis, or before the date of the proposed action, whichever is later, and the treating plan physician or another plan physician has ordered the services at the present level and is authorized by the contract with the health plan to order the services, the health plan must continue to provide services at a level equal to the level ordered by the plan physi-

cian until written resolution of the complaint is made by the health plan or a decision on the appeal is made by the human services referee. If the resolution is adverse, in whole or part, to the enrollee, the enrollee must be notified of the right to a state appeal. If the enrollee appeals a health plan's written resolution within ten days after it is issued, or before the date of the proposed action, whichever is later, services must be continued pending a decision by the human services referee. A resolution is made or issued on the date it is mailed or the date postmarked, whichever is later. For the purposes of this subpart, "plan physician," where appropriate, includes a plan dentist, mental health professional, chiropractor, or osteopath, nurse practitioner, or nurse midwife.

Subp. 7. **State ombudsperson.** The commissioner shall designate a state ombudsperson to help enrollees resolve health plan service related problems. Upon an enrollee's request, the ombudsperson shall investigate the enrollee's case and when appropriate attempt to resolve the problem in an informal manner by serving as an intermediary between the enrollee and the health plan. If the enrollee requests appeal information, or if the ombudsperson believes that an informal resolution is not feasible or is unable to obtain a resolution of the problem, the ombudsperson shall explain to the enrollee what his or her complaint and appeal options are, how to file a complaint or appeal, how the complaint or appeal process works and assist the enrollee in presenting the enrollee's case to the appeals referee, when requested. The ombudsperson must be available to help the enrollee file a written complaint or appeal request. The ombudsperson must notify the appropriate health plan of a state appeal within three working days after the state appeal is filed.

Subp. 8. **Record keeping and reporting requirements.** The health plan must maintain a record of all written complaints from enrollees, actions taken in response to those complaints, and the final disposition of the complaints. The health plan must report this information to the commissioner on a semiannual basis.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086*

9500.1464 SURVEILLANCE AND UTILIZATION REVIEW.

The provisions of parts 9505.2160 to 9505.2245 apply to MAPDP.

Statutory Authority: *MS s 256B.69*

History: *11 SR 1107*

COMMISSIONER'S CONSENT TO PATERNITY SUIT SETTLEMENTS

9500.1650 APPLICABILITY.

Parts 9500.1650 to 9500.1663 govern the procedures and the standards applicable to the way in which the commissioner decides, as a party under Minnesota Statutes, section 257.60, whether to agree to a particular lump sum settlement or compromise agreement in a paternity action under Minnesota Statutes, sections 257.51 to 257.74. Parts 9500.1650 to 9500.1663 apply equally to lump sum settlements and compromise agreements proposed as part of a maternity suit under Minnesota Statutes, section 257.71.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1655 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9500.1650 to 9500.1663, the following terms have the meanings given to them in this part.

Subp. 2. **Admission of paternity.** "Admission of paternity" means a written acknowledgment by a male that he is the biological father of a child.

Subp. 3. **Aid to families with dependent children or AFDC.** "Aid to families with dependent children" or "AFDC" means the program authorized by title IV–A of the Social Security Act to provide financial assistance services to needy families with dependent children.

Subp. 4. **Alleged father.** "Alleged father" means a male alleged to be the biological father of a child.

Subp. 5. **Blood test.** "Blood test" means a test using blood group identification of a mother, child, and alleged father that is used to predict the probability or exclude the possibility that the alleged father is the biological father of the child.

Subp. 6. **Child.** "Child" means an individual under age 18 whose parental relationship with the alleged father is being determined and whose legal rights and privileges are at issue.

Subp. 7. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 8. **Compromise agreement.** "Compromise agreement" has the meaning given it by Minnesota Statutes, section 257.64, subdivision 1, clause (b).

Subp. 9. **Costs.** "Costs" has the meaning given it under Minnesota Statutes, section 257.69.

Subp. 10. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 11. **Depository.** "Depository" means a person or organization entrusted to safekeep a father's or an alleged father's lump sum settlement or compromise agreement payments and to make periodic payments of the money on behalf of the child.

Subp. 12. **Guardian ad litem.** "Guardian ad litem" means the person designated by the court to represent the interests of a child in a paternity suit, according to Minnesota Statutes, section 257.60.

Subp. 13. **Income.** "Income" has the meaning given it under Minnesota Statutes, section 518.54, subdivision 6.

Subp. 14. **Interest rate.** "Interest rate" means the rate of interest used to calculate the present value of periodic payments a father is required to pay and is equal to the current market rate of interest on a United States Treasury obligation using as its maturity date the child's 18th birthdate.

Subp. 15. **Liability for past support.** "Liability for past support" means the financial obligation of the noncustodial parent to reimburse the local child support enforcement agency for all or a portion of past expenses furnished on behalf of a child under Minnesota Statutes, sections 257.66 and 257.67.

Subp. 16. **Local IV-D agency.** "Local IV-D agency" means the county or multicounty agency that is authorized under Minnesota Statutes, section 393.07, to administer the child support enforcement program under the requirements of title IV-D of the Social Security Act, United States Code, title 42, sections 651 to 658, 660, 664, 666, 667, 1302, 1396(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

Subp. 17. **Lump sum settlement.** "Lump sum settlement" means a single payment to satisfy the remaining obligations of a noncustodial parent for support of the parent's minor child.

Subp. 18. **Medical support.** "Medical support" has the meaning given it under Minnesota Statutes, section 518.171.

Subp. 19. **Mother.** "Mother" means a woman who was not married to her child's father when the child was born or when the child was conceived.

Subp. 20. **Office of Child Support Enforcement.** "Office of Child Support Enforcement" means the office within the department that administers the child support enforcement program for the purposes of locating absent parents, establishing paternity, and establishing and enforcing orders for support under the requirements of title IV-D of the Social Security Act, United States Code, title 42, sections 651 to 658, 660, 664, 666, 667, 1302, 1396(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

Subp. 21. **Party.** "Party" means a person as defined in Minnesota Statutes, sections 257.57 and 257.60, who is involved in a paternity suit.

Subp. 22. **Paternity suit.** "Paternity suit" means a legal action brought to establish that a man is the biological father of a child and has legally enforceable duties and responsibilities in regard to that child.

Subp. 23. **Periodic payments.** "Periodic payments" means payments of support on a schedule established by the court under Minnesota Statutes, section 518.551, subdivision 5.

Subp. 24. **Present value.** "Present value" means the current monetary worth of future periodic payments. The formula used to determine present value is $An = V\ 1-(1+i)^{-n}/i$ where:

"An" means present value of the periodic payments,

"V" means value of the periodic payments,

"n" means number of periodic payments, and

"i" means interest rate.

Subp. 25. **Reimbursement.** "Reimbursement" means payment of a sum for public funds expended for the care and support of a child under Minnesota Statutes, sections 256.87; 257.66, subdivisions 3 and 4; 257.69; and 393.07, subdivision 9.

Subp. 26. **Support.** "Support" has the meaning given to "support money" under Minnesota Statutes, section 518.54, subdivision 4.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1656 CONSENT BY COMMISSIONER TO A COMPROMISE AGREEMENT.

The commissioner shall not consent to a compromise agreement.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1657 COMMISSIONER'S CONSENT TO A LUMP SUM SETTLEMENT.

The commissioner shall consider each proposed lump sum settlement that is submitted to the commissioner. If a submitted proposed lump sum settlement does not comply with parts 9500.1650 to 9500.1663, the commissioner shall not consent to the proposed lump sum settlement.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1658 STANDARDS USED BY COMMISSIONER TO DETERMINE WHETHER TO CONSENT TO A PROPOSED LUMP SUM SETTLEMENT.

Subpart 1. **Standards.** The commissioner shall consent to a proposed lump sum settlement only if the conditions of subparts 2 to 6 are met.

Subp. 2. **Admission of paternity.** The alleged father must admit paternity and either waive blood tests or the results of blood tests indicate a likelihood of more than 92 percent that the alleged father is the biological father of the child.

Subp. 3. **Comparison of proposed lump sum settlement to present value of periodic payments.** The proposed lump sum settlement must be equal to or greater than the present value of periodic payments.

Subp. 4. **Liability for past support and costs.** A provision must be made for a partial or full reimbursement consisting of the alleged father's liability for past support and costs. The alleged father's liability for past support and costs includes:

A. all or a proportion of the amount of assistance furnished the child during the two years immediately preceding the start of the paternity action under Minnesota Statutes, section 257.66, subdivision 4;

B. expenses of the mother's pregnancy and confinement under Minnesota Statutes, section 257.66, subdivision 3; and

C. all or a proportion of costs and fees detailed under Minnesota Statutes, section 257.69, subdivision 2.

If a reimbursement is to be made through payments to the local IV-D agency, provisions for income withholding shall be included in the proposed lump sum settlement agreement under Minnesota Statutes, section 518.611.

Subp. 5. **Protection over lump sum settlement amount.** A plan to invest the lump sum settlement to meet the child's future needs and to prevent rapid depletion of the lump sum

settlement must be made part of the lump sum settlement. The plan to invest the lump sum settlement must include:

A. an agreement to deposit the lump sum settlement amount in an interest bearing account with a rate of interest based on a United States Treasury obligation that matures on the date of the child's 18th birthday;

B. provisions for making periodic payments to the child until the child is 18 years of age;

C. provisions for making the periodic payments under item B to the public agency, if the child receives AFDC or becomes eligible to receive AFDC and rights to support are assigned under Minnesota Statutes, section 256.74, subdivision 5;

D. the name of the depository that will hold and disburse the lump sum settlement under this subpart;

E. the name of the person or agency designated to make decisions on managing the lump sum settlement account; and

F. the amounts charged by the depository for the costs of administering the lump sum settlement account.

Subp. 6. **Medical benefits.** The lump sum settlement must provide for maintenance of health and dental insurance for the child under Minnesota Statutes, section 518.171.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1659 CONTENTS OF PROPOSED LUMP SUM SETTLEMENT AGREEMENT.

A proposed lump sum settlement must include:

A. the names and addresses of the parties to the paternity suit;

B. a statement indicating whether there has been an admission of paternity;

C. the amount of reimbursement agreed to be paid to the local IV–D agency and the method by which payments will be made as required under part 9500.1658, subpart 4;

D. the amount of the proposed lump sum settlement;

E. a plan for distributing the lump sum settlement amount on behalf of the child under part 9500.1658, subpart 5;

F. a written statement showing compliance with part 9500.1658, subpart 6, by the responsible parent; and

G. a signature line for each of the parties and the guardian ad litem.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1660 DOCUMENTS THAT MUST ACCOMPANY A PROPOSED LUMP SUM SETTLEMENT AGREEMENT.

The documents in items A to G must accompany the proposed lump sum settlement submitted to the commissioner:

A. the statement of blood test results or a statement that blood tests were waived by the alleged father;

B. a statement of the reasons a lump sum settlement is proposed rather than periodic payments;

C. a copy of the alleged father's affidavit of earnings, income, and resources, including real and personal property;

D. the mathematical calculation used to make the computation required under part 9500.1658, subpart 3;

E. an itemization of amounts previously expended by each public agency as support on behalf of the child, including dates and amounts of AFDC expended, pregnancy and confinement expenses, costs of blood tests, filing fees, service of process fees, and county attorney's fees;

F. a written statement showing how the plan for reimbursement of the alleged father's liability for support and costs owed to the local IV–D agency was derived; and

G. a written, signed statement from the guardian ad litem that indicates how the proposed lump sum settlement is in the best interest of the child.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1661 TIME FOR SUBMISSION OF PROPOSAL.

The proposed lump sum settlement agreement under part 9500.1659 and documents required under part 9500.1660 must be submitted to the Office of Child Support Enforcement for review at least 30 days before the date scheduled for the court hearing on the proposed lump sum settlement. If the 30–day period is not complied with, parties must not presume that the commissioner has consented to the proposed lump sum settlement unless a written statement to that effect is made by the commissioner and submitted to the parties.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1662 REVIEW PROCESS.

On receipt of a proposed lump sum settlement, the commissioner shall review the submitted proposal and documents for compliance with parts 9500.1650 to 9500.1663. If the commissioner consents to the proposal, the commissioner will sign the proposal and return it to the submitting party. If the commissioner does not consent to the proposal, the commissioner will send a letter to the submitting party indicating the reasons for not consenting to the proposal. The commissioner will send copies of either response to the court of jurisdiction. The commissioner will also send copies of either response to the other parties and guardian ad litem if addresses for those parties are provided by the submitting party.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

9500.1663 NOTIFICATION OF FINAL DISPOSITION.

If the lump sum settlement or compromise agreement is approved by the court, a copy of the final order must be provided to the commissioner within 30 days of the date of the court order. If the submitted agreement is not approved by the court, the commissioner must be notified in writing of any other disposition made regarding the paternity suit. The parties other than the commissioner must agree between themselves as to the party responsible for notification to the commissioner in accordance with this part.

Statutory Authority: *MS s 257.60*

History: *11 SR 957*

CHILD SUPPORT INCENTIVE AWARDS

9500.1800 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1810 to 9500.1821, the following terms have the meanings given them.

Subp. 2. **AFDC collections.** "AFDC collections" means money paid by an individual to a county IV–D agency to satisfy an assignment of support obligation under Code of Federal Regulations, title 45, section 232.11, or United States Code, title 42, section 671(a)(17).

Subp. 3. **Collections.** "Collections" means AFDC collections and non–AFDC collections.

Subp. 4. **County IV–D agency.** "County IV–D agency" means the county agency responsible for child support enforcement to whom collections are paid.

Subp. 5. **County IV–D costs.** "County IV–D costs" means the expenditures reported quarterly by a county IV–D agency to the department for the operation of the county child support enforcement program minus amounts reported for fees, interest collected, and recovered costs.

Subp. 6. **County IV–D agency quarterly incentive award.** "County IV–D agency quarterly incentive award" means the amount of money determined quarterly by the depart-

ment to reimburse the county for a portion of its contribution toward AFDC assistance payments.

Subp. 7. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 8. **Dollar amount.** "Dollar amount" means the amount of money calculated according to part 9500.1811 which is used to determine a county IV–D agency's quarterly incentive award under parts 9500.1815 and 9500.1820.

Subp. 9. **Federal fiscal year or FFY.** "Federal fiscal year" or "FFY" means the period from October 1 of each year through September 30 of the next year.

Subp. 10. **Fees.** "Fees" means money paid by individuals to a county IV–D agency for child support enforcement services.

Subp. 11. **Interest collected.** "Interest collected" means the money collected by a county IV–D agency from the obligor which represents a charge for a late payment and which is calculated as a percent of the money owed by the obligor for a certain time period.

Subp. 12. **Non–AFDC collections.** "Non–AFDC collections" means the money paid by individuals to a county IV–D agency to satisfy support obligations which have not been assigned under Code of Federal Regulations, title 45, section 232.11, and United States Code, title 42, section 671(a)(17).

Subp. 13. **Quarter.** "Quarter" means one–fourth of the federal fiscal year with the following starting and ending dates:

A. October 1 through December 31;

B. January 1 through March 31;

C. April 1 through June 30; and

D. July 1 through September 30.

Subp. 14. **Ratio.** "Ratio" means the quotient of the total of a county IV–D agency's collections for a quarter divided by the total of that county IV–D agency's county IV–D costs less optional subtractions from county IV–D costs for that quarter. This total is then truncated at one decimal place.

Subp. 15. **Recovered costs.** "Recovered costs" means a refund paid by an individual or a governmental agency to a county IV–D agency for county IV–D costs.

Subp. 16. **State's quarterly incentive award.** "State's quarterly incentive award" means the grant award issued quarterly by the federal government to the department to reimburse the county for a portion of its share of AFDC assistance payments.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1805 PURPOSE AND EFFECT.

Subpart 1. **Purpose.** The purpose of parts 9500.1800 to 9500.1821 is to encourage county IV–D agencies to make maximum child support collections in a cost effective manner through a financial incentive to counties according to Code of Federal Regulations, title 45, sections 302.55 and 303.52.

Under parts 9500.1800 to 9500.1821, county IV–D agencies are rewarded proportionately more as their collections increase and their costs decrease.

The reward the county IV–D agencies receive is in the form of money a county would otherwise have to pay as its portion of aid to families with dependent children assistance payments.

Subp. 2. **Effect.** Parts 9500.1800 to 9500.1821 apply to all Minnesota county human services or welfare departments. Effective October 1, 1985, the state will receive incentive payments from the federal government which will be passed through to the counties.

The extent to which a county IV–D agency is making maximum child support collections in a cost effective manner is measured by determining ratios of collections to costs for each county.

Ratios are translated into a percent and then into a dollar amount subject to certain limitations. Each county's proportionate share of the state's quarterly incentive award is then

determined with adjustments to quarterly estimates made at the end of each federal fiscal year.

Parts 9500.1820 and 9500.1821 provide for an alternative award determination and redetermination formula for the first two years of the new award system to allow time for the less effective and efficient counties to improve ratios to the point that they may earn higher incentive awards under the new system.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1810 RATIO DETERMINATION.

Subpart 1. **Time frame.** The department shall use the county IV–D costs and collections reported by a county IV–D agency to the department in a quarter to determine the ratio for that quarter.

Subp. 2. **Collections credited to the county IV–D agency that makes collections on behalf of another Minnesota county IV–D agency.** Each county IV–D agency shall identify collections made on behalf of another Minnesota county IV–D agency and shall credit those collections only to the county IV–D agency that makes the collection.

Subp. 3. **Optional subtractions from county IV–D costs.** At the option of the county IV–D agency, certain costs incurred and reported to the department in determining paternity may be subtracted from county IV–D costs. These costs are costs incurred for:

A. drawing and shipping blood;

B. testing and retesting blood; and

C. human leucocyte antigen (HLA) testing.

Subp. 4. **Separate ratios.** The department shall determine separate ratios for AFDC and non–AFDC collections.

Subp. 5. **Ratio to percent.** Based on ratios determined under subparts 1 to 4, the department shall use the following schedule to determine the corresponding percent of a county IV–D agency's collections to be used in determining each county IV–D agency's dollar amounts under part 9500.1811.

Ratio		Percent
.1	or less	3.0
at least .2		3.5
.4		4.0
.6		4.5
.8		5.0
1.0		5.5
1.2		6.0
1.4		6.5
1.6		7.0
1.8		7.5
2.0		8.0
2.2		8.5
2.4		9.0
2.6		9.5
2.8	or more	10.0

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1811 QUARTERLY DETERMINATION OF DOLLAR AMOUNTS.

The department shall determine a county IV–D agency's quarterly AFDC dollar amount by multiplying the county's AFDC collections by the percent determined under part 9500.1810, subpart 5. The department shall determine a county IV–D agency's quarterly

non–AFDC dollar amount by multiplying the county's non–AFDC collections by the percent determined under part 9500.1810, subpart 5.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1812 LIMIT ON QUARTERLY DETERMINATION OF DOLLAR AMOUNT OF NON–AFDC COLLECTIONS.

The department shall limit each quarterly determination of the dollar amount of non–AFDC collections for each county IV–D agency as determined under part 9500.1811, to a percentage of its quarterly AFDC dollar amount as follows:

A. up to 100 percent in FFY 1986 and FFY 1987;

B. up to 105 percent in FFY 1988;

C. up to 110 percent in FFY 1989; and

D. up to 115 percent in FFY 1990 and thereafter.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1815 DISTRIBUTION FORMULA.

The department shall determine each county IV–D agency's share of the state's quarterly incentive award for AFDC collections and each county IV–D agency's share of the state's quarterly incentive award for non–AFDC collections according to the formula in items A to F. Within 45 working days after the end of the quarter, the department shall inform each county IV–D agency of the determinations. The department shall add the AFDC and non–AFDC determinations for each county and pay the total amount to that county.

A. Add all county IV–D agency quarterly AFDC dollar amounts as determined in part 9500.1811.

B. Divide the state's quarterly AFDC incentive award by the total obtained in item A.

C. Multiply the quotient obtained in item B by each county IV–D agency's quarterly AFDC dollar amount as determined under part 9500.1811.

D. The product obtained in item C is the county IV–D agency's quarterly AFDC incentive award.

E. To determine a county IV–D agency's quarterly non–AFDC incentive award, the department shall follow the steps in items A to C except that it shall use the county IV–D agency's quarterly non–AFDC dollar amounts in item A instead of AFDC dollar amounts, subject to the limitations of part 9500.1812.

F. The county IV–D agency's quarterly incentive awards determined in items D and E are subject to the determinations in parts 9500.1817 to 9500.1821.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1817 ADJUSTMENTS.

Within 30 working days after the department receives the state's quarterly incentive award for the last quarter of the federal fiscal year that adjusts the estimated federal quarterly incentive awards received by the state to the actual incentive award earned by the state under Code of Federal Regulations, title 45, section 303.52(c)(3), the department shall notify each county IV–D agency of any increase or decrease in the county IV–D agency's next quarterly incentive award. This increase or decrease must be added to or subtracted from the state's quarterly incentive award for the next quarter as determined in part 9500.1815.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1820 FEDERAL FISCAL YEAR 1986 AND 1987 ALTERNATIVE INCENTIVE AWARD DETERMINATION.

For federal fiscal years 1986 and 1987, the department shall determine the yearly incentive awards for county IV–D agencies according to items A to H.

A. Determine each county IV–D agency's yearly incentive award according to United States Code, title 42, section 658 as effective for federal fiscal year 1985.

B. Multiply each of the amounts determined in item A by 0.80.

C. Multiply each of the amounts in item A by 0.81.

D. Determine an incentive award for each county according to part 9500.1817.

E. Designate as a county IV–D agency's incentive award the higher of the results obtained under items B and D.

F. Identify those county IV–D agency incentive awards from item E whose corresponding incentive award under item B is higher than the result obtained under item D.

G. Identify those county IV–D agency incentive awards from item E whose corresponding incentive award in item D is higher than in item C.

H. If a county IV–D agency's incentive award is not in item F or G, then the incentive award is the determination made in item B.

I. No further determinations are necessary if all incentive awards are included in item F.

J. All incentive awards must be redetermined according to part 9500.1821 if one or more incentive awards are included in item G.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

9500.1821 REDETERMINATION OF INCENTIVE AWARDS FOR FEDERAL FISCAL YEARS 1986 AND 1987.

When directed by part 9500.1820, item J, the department shall make the following redeterminations.

A. Add the incentive awards identified under part 9500.1820, items F and H. This amount equals 80 percent of what the incentive award would be if determined under the incentive award system in effect for federal fiscal year 1985.

B. Add the incentive awards identified under part 9500.1820, item G.

C. Add the totals obtained in items A and B.

D. Subtract the total obtained in item C from the state's yearly incentive award.

E. Divide the result, without regard to sign, obtained in item D by the total obtained in item B.

F. Multiply the quotient obtained in item E by each county IV–D agency's incentive award included from item B.

G. Add the products in item F.

H. Item G is the redetermination adjustment to be subtracted from those counties identified in item B.

I. To apply the redetermination adjustment for those counties of item A, subtract their award from part 9500.1817 from the total identified in item A. This is the amount that is to be paid to the counties.

Statutory Authority: *MS s 256.01 subd 2*

History: *10 SR 1298*

ADMINISTRATION OF AID TO FAMILIES WITH DEPENDENT CHILDREN

9500.2000 SCOPE.

Parts 9500.2000 to 9500.2880 govern the administration of the aid to families with dependent children program in Minnesota. The aid to families with dependent children program provides financial assistance to qualifying families, according to assistance payment standards authorized in Minnesota law, to help them provide their children with a reasonable subsistence compatible with decency and health. Parts 9500.2000 to 9500.2880 must be read in conjunction with Minnesota Statutes, chapter 256; title IV of the Social Security Act; and Code of Federal Regulations, title 45.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2020 ADMINISTRATION.

Subpart 1. **Compliance with state and federal law.** The commissioner shall cooperate with the federal government in order to qualify for federal financial participation in the aid to families with dependent children program. Changes to the aid to families with dependent children program required by state or federal law or by court order supersede parts 9500.2000 to 9500.2880. The changes are effective on the date specified in bulletins or manuals issued by the commissioner to a local agency.

Subp. 2. **Administrative relationships.** The aid to families with dependent children program is administered by local agencies under the supervision of the commissioner.

The commissioner shall supervise the aid to families with dependent children program on a statewide basis so that local agencies comply with the standards of the program.

A local agency shall provide fair and equal treatment to an applicant or recipient according to statewide policies. The commissioner is authorized to direct a local agency to correct a policy or practice that conflicts with statewide program requirements. A local agency shall comply with procedures and forms prescribed by the commissioner of human services in bulletins and manuals to assure conformance with parts 9500.2000 to 9500.2880.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2060 DEFINITIONS.

Subpart 1. **Applicability.** The terms used in parts 9500.2000 to 9500.2880 have the meanings given them in subparts 2 to 154 unless otherwise indicated.

Subp. 2. **Absent parent.** "Absent parent" means the parent of a dependent child who does not live in the child's home.

Subp. 3. **Actual availability.** "Actual availability," when used in reference to income or property, is that which is in hand or which can be readily obtained for current use.

Subp. 4. **Affidavit.** "Affidavit" means a written declaration made under oath before a notary public or other authorized officer.

Subp. 5. **Agency error.** "Agency error" means an error that results in an overpayment which is not caused by an applicant's or recipient's failure to provide adequate, correct, or timely information about income, property, or other circumstances.

Subp. 6. **Aid to families with dependent children or AFDC.** "Aid to families with dependent children" or "AFDC" means the program authorized under title IV–A to provide financial assistance and social services to needy families with dependent children.

Subp. 7. **AFDC family allowance.** "AFDC family allowance" means the standardized Minnesota need and assistance payment schedule for assistance units of various compositions. An assistance unit's net income is subtracted from the AFDC family allowance to determine the amount of that assistance unit's monthly assistance payment.

Subp. 8. **AFDC housing allowance.** "AFDC housing allowance" means those payments authorized under Minnesota Statutes, section 256.879 and described in part 9500.2800, subpart 2.

Subp. 9. **AFDC unit.** "AFDC unit" means the organizational entity within a local agency which is responsible for determining program eligibility and the amount of assistance payment.

Subp. 10. **Appeal.** "Appeal" means a written statement from an applicant or recipient which requests a hearing or expresses dissatisfaction with a local agency decision that can be challenged under Minnesota Statutes, section 256.045 and part 9500.2740, subpart 8.

Subp. 11. **Applicant.** "Applicant" means a person for whom an application has been submitted to a local agency, and whose application has not been approved, denied, nor voluntarily withdrawn.

Subp. 12. **Application.** "Application" means the action by which a person shows in writing a desire to receive assistance by submitting a signed and dated form prescribed by the commissioner to the local agency.

Subp. 13. **Assignment of support.** "Assignment of support" means the transfer of a person's right to support to a local agency.

Subp. 14. **Assistance.** "Assistance" means a financial benefit received from the aid to families with dependent children program.

Subp. 15. **Assistance unit.** "Assistance unit" means a group of persons who are applying for or receiving assistance and whose needs are included in the assistance payment issued under Minnesota Statutes, sections 256.72 to 256.87.

Subp. 16. **Authorized representative.** "Authorized representative" means a person who is authorized in writing by an applicant or recipient to act on that applicant's or recipient's behalf in matters involving AFDC or emergency assistance, including submitting applications, making appeals, and providing or requesting information. An authorized representative may exercise the same rights and responsibilities on behalf of the person being represented as an applicant or recipient.

Subp. 17. **Basic needs.** "Basic needs" means food, clothing, shelter, utilities, personal hygiene items, and other subsistence items.

Subp. 18. **Blood related.** "Blood related" means a person who is related by birth rather than by marriage or adoption.

Subp. 19. **Budget month.** "Budget month" means the calendar month from which a local agency uses the income or circumstances of an assistance unit to determine the amount of the assistance payment for the payment month.

Subp. 20. **Care.** "Care" means regular and ongoing supervision and provision of services such as feeding, dressing, and cleaning.

Subp. 21. **Caretaker.** "Caretaker" means a person listed in part 9500.2440, subpart 7 who lives with and provides care to a dependent child.

Subp. 22. **Case record.** "Case record" means the eligibility file of a particular assistance unit.

Subp. 23. **Children standard.** "Children standard" means the portion of the AFDC family allowance so named in part 9500.2440, subpart 5, item A.

Subp. 24. **Child support enforcement unit.** "Child support enforcement unit" means the organizational entity within a county which is responsible for establishing paternity and collecting support according to Title IV–D of the Social Security Act.

Subp. 25. **Child support pass through.** "Child support pass through" means the payment authorized under Code of Federal Regulations, title 45, section 302.51(b)(1).

Subp. 26. **Child welfare funds.** "Child welfare funds" means funds issued under Title IV–B.

Subp. 27. **Civil judgment.** "Civil judgment" means a money judgment rendered by a court of competent jurisdiction.

Subp. 28. **Client error.** "Client error" means an error that results in an overpayment which is due to an applicant's or recipient's failure to provide adequate, correct, or timely information concerning income, property, or other circumstances or a recipient's choice to continue assistance while an appeal is pending.

Subp. 29. **Commissioner.** "Commissioner" means the commissioner of the department or the commissioner's designee.

Subp. 30. **Community Social Services Act.** "Community Social Services Act" means the system of planning for and providing community social services authorized under Minnesota Statutes, chapter 256E.

Subp. 31. **Community work experience program.** "Community work experience program" means the program authorized under Code of Federal Regulations, title 45, part 238.

Subp. 32. **Corrective payment.** "Corrective payment" means an assistance payment which is made to correct an underpayment.

Subp. 33. **Cost effective.** "Cost effective" refers to a result that is economical in terms of the goods and services received for the money spent, given feasible alternatives, or a result in which the cost is less than the value of the benefit received.

Subp. 34. **County board.** "County board" means the board of commissioners in each county established under Minnesota Statutes, chapter 393.

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

Subp. 36. **County of residence.** "County of residence" means the county providing AFDC administrative services to an applicant or recipient.

Subp. 37. **Date of application.** "Date of application" means the date on which a local agency receives a person's application.

Subp. 38. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 39. **Dependent child.** "Dependent child" means a child who is living in the home of a parent or other caretaker, who is deprived of the support or care of a parent as specified in parts 9500.2180 to 9500.2300, who is in financial need according to part 9500.2480, and who meets one of the conditions in items A 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.

Subp. 40. **Deregistration from WIN.** "Deregistration from WIN" means the action taken through the WIN program by the Minnesota Department of Jobs and Training to remove a person from that program.

Subp. 41. **Disregard.** "Disregard" means a deduction from income as authorized under the Code of Federal Regulations, title 45, part 233.

Subp. 42. **Documentation.** "Documentation" means a written statement or record which substantiates or validates an assertion made by a person or an action taken by a local agency. "Primary documentation" means evidence that independently establishes a fact and that is provided by a public or private institution or organization having an official responsibility to establish that fact. "Alternative documentation" means evidence, including declarations, that supports the existence of a fact and that is provided by an individual or institution who has no official responsibility to establish that fact.

Subp. 43. **Early and periodic screening, diagnosis, and treatment or EPSDT.** "Early and periodic screening, diagnosis, and treatment" or "EPSDT" means the program authorized under Title XIX and which operates under parts 9505.1500 to 9505.1690.

Subp. 44. **Earned income.** "Earned income" means compensation from legal employment or legal self employment, including salaries, wages, tips, gratuities, commissions, net profits from self employment, earned income tax credits, incentive payments from work or training programs except those excluded in part 9500.2380, subpart 2, payments made by an employer for regularly accrued vacation or sick leave, and profit from other legal activity earned by an applicant's or recipient's effort or labor. Earned income does not include returns from capital investment or benefits that accrue as compensation or reward for service or for lack of employment.

Subp. 45. **Earned income tax credit.** "Earned income tax credit" means the payment which can be obtained by a qualified low income person from an employer or from the United States Internal Revenue Service under provisions of United States Code, title 26, section 32, as amended through December 31, 1985.

Subp. 46. **Emancipated minor.** "Emancipated minor" means a person under the age of 18 years who has been married, is on active duty in the uniformed services of the United States, or who has been emancipated by a court of competent jurisdiction.

Subp. 47. **Emergency.** "Emergency" means a situation that causes, or threatens to cause, a lack of a basic need item and the lack of resources to provide for that need.

Subp. 48. **Emergency assistance.** "Emergency assistance" means assistance and services funded under Title IV–A, authorized under Minnesota Statutes, section 256.871 and Code of Federal Regulations, title 45, section 233.120, and governed by part 9500.2820.

Subp. 49. **Encumbrance.** "Encumbrance" means a legal claim against real or personal property that is payable upon the sale of that property.

Subp. 50. **Equity value.** "Equity value" means the amount of equity in real or personal property owned by a person. Equity value is determined by subtracting any outstanding encumbrances from the fair market value.

Subp. 51. **Fair hearing or hearing.** "Fair hearing" or "hearing" means the department evidentiary hearing conducted by an appeals referee to determine whether an applicant or recipient is eligible for assistance or has received an incorrect amount of assistance.

Subp. 52. **Fair market value.** "Fair market value" means the price that an item of a particular make, model, size, material, or condition would sell for on the open market in the particular geographic area.

Subp. 53. **Federal and state AFDC participation.** "Federal and state AFDC participation" means the federal and state aid to a local agency for AFDC expenditures as specified under Code of Federal Regulations, title 45, part 237, and Minnesota Statutes, sections 256.82 and 256.871, subdivision 6.

Subp. 54. **Federal Insurance Contributions Act or FICA.** "Federal Insurance Contributions Act" or "FICA" means the federal law under United States Code, title 26, sections 3101 to 3126, that requires withholding or direct payment from earned income.

Subp. 55. **Financially responsible household members.** "Financially responsible household members" means spouses, parents of dependent children and minor caretakers, legal guardians of minor caretakers, and stepparents of dependent children to the extent authorized by federal and state law.

Subp. 56. **Filing unit.** "Filing unit" means a dependent child, any blood related and adoptive minor siblings, and any biological and adoptive parents who live in the same household.

Subp. 57. **First adult standard.** "First adult standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item B.

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

Subp. 59. **GED.** "GED" means the general educational development certification issued by the Minnesota Board of Education as an equivalent to a secondary school diploma under part 3500.3100, subpart 4.

Subp. 60. **General assistance.** "General assistance" means the financial aid program authorized under Minnesota Statutes, chapter 256D.

Subp. 61. **General assistance medical care.** "General assistance medical care" means the program defined under Minnesota Statutes, section 256D.02, subdivision 4a.

Subp. 62. **Good cause.** "Good cause" means, generally, the circumstances, including those specified in parts 9500.2700, subparts 6, item C; 8, item B; 12; and 19; and 9500.2740, subpart 8, which are allowed to excuse a person's failure to comply with specified requirements or to meet specific conditions of eligibility.

Subp. 63. **Gross income.** "Gross income" means income, except for in kind income, before any withholdings, deductions, disregards, or exclusions. When earnings are from self–employment, gross income is the difference between gross receipts and allowable expenses as provided in part 9500.2380, subpart 5.

Subp. 64. **Gross receipts.** "Gross receipts" means the money received by a business before the expenses of the business are deducted.

Subp. 65. **Guidance.** "Guidance" means regular and ongoing services provided to a dependent child, including supervision, training, discipline, and help with schoolwork.

Subp. 66. **Home.** "Home" means the primary place of residence used by a person as the base for day to day living and does not include locations used as maildrops.

Subp. 67. **Homestead.** "Homestead" means the real property used by a person as his or her home, as defined in Minnesota Statutes, section 256.73, subdivision 2, clause (1).

Subp. 68. **Household.** "Household" means a group of persons who live together.

Subp. 69. **Household report form.** "Household report form" means a form prescribed by the commissioner which an applicant or recipient uses to report information to a local

agency about income and other circumstances according to part 9500.2700, subparts 5 to 7. The household report form is incorporated by reference. It is available at the State Law Library, 25 Constitution Avenue, Saint Paul, Minnesota 55155. It is subject to frequent change.

Subp. 70. **Incapacity.** "Incapacity" means the presence of a temporarily or permanently debilitating physical or mental condition which is expected to continue for a minimum of 30 days, and which reduces or eliminates the ability of a person to hold substantial gainful employment or which substantially reduces or eliminates a person's ability to care for his or her children with whom he or she lives. A person who has had disability status conferred by the Social Security Administration meets the definition of incapacity.

Subp. 71. **Income.** "Income" means cash or in kind benefit, whether earned or unearned, received by or available to an applicant or recipient and not established as an asset under part 9500.2340.

Subp. 72. **In kind income.** "In kind income" means income, benefits, or payments which are provided in a form other than money or liquid asset, including the forms of goods, produce, services, privileges, or payments made on behalf of a person by a third party.

Subp. 73. **Inquiry.** "Inquiry" means a communication to a local agency through mail, telephone, or in person, by which a parent, caretaker of minor children, or authorized representative requests information about AFDC or emergency assistance. The local agency shall also treat as an inquiry any communication in which a person requesting assistance offers information about his or her family's circumstances which indicates that eligibility for AFDC or emergency assistance may exist.

Subp. 74. **Job Training Partnership Act.** "Job Training Partnership Act" means the act authorized under Public Law Number 97–300 and its successor programs.

Subp. 75. **Joint legal custody.** "Joint legal custody" means a court ordered arrangement under which both parents have equal rights and responsibilities, including the right to participate in major decisions determining the child's upbringing, including education, health care, and religious training.

Subp. 76. **Joint physical custody.** "Joint physical custody"means an arrangement under which the routine daily care and control of a child is divided between both parents.

Subp. 77. **Legal availability.** "Legal availability" means a person's right under the law to secure, possess, dispose of, or control income or property.

Subp. 78. **Legal guardian.** "Legal guardian" means a person or persons designated by a court to assume, on a temporary or permanent basis, those rights and responsibilities for a child that would otherwise be assigned to a parent.

Subp. 79. **Licensed adoption agency.** "Licensed adoption agency" means a public or private agency which is licensed to place children for adoption under Minnesota Statutes, sections 259.21 to 259.49.

Subp. 80. **Licensed physician.** "Licensed physician" means a person who is licensed to provide medical services within the scope of his or her profession under Minnesota Statutes, chapter 147.

Subp. 81. **Licensed psychologist.** "Licensed psychologist" means a person who is licensed or certified to act in that capacity under Minnesota Statutes, sections 148.88 to 148.98.

Subp. 82. **Local agency.** "Local agency" means a county or multicounty agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7, and 393.07, subdivision 2, to administer AFDC.

Subp. 83. **Lockout.** "Lockout" means an action taken by an employer to refuse entry of an employee due to a labor dispute which is in progress at the worksite.

Subp. 84. **Low income home energy assistance program or LIHEAP.** "Low–income home energy assistance program" or "LIHEAP" means the program authorized under United States Code, title 42, sections 8621 to 8629 and administered by the Minnesota Department of Jobs and Training.

Subp. 85. **Lump sum.** "Lump sum" means nonrecurring income which is not excluded in part 9500.2380, subpart 2.

Subp. 86. **Maildrop.** "Maildrop" means an address or post office box which does not represent the actual home of the addressee and is used primarily for the receipt of mail or the establishment of AFDC eligibility.

Subp. 87. **Mandatory registrant.** "Mandatory registrant" means a person who is required to register for WIN, employment, or other employment activities as a condition of AFDC eligibility under part 9500.2700, subpart 16.

Subp. 88. **Medical assistance.** "Medical assistance" means the program established under title XIX and Minnesota Statutes, chapter 256B.

Subp. 89. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

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

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

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

Subp. 91. **Net income.** "Net income" means the countable income remaining after allowable deductions, disregards, and exclusions have been subtracted from gross income.

Subp. 92. **Nonrecurring income.** "Nonrecurring income" means a form of income which:

A. is received only one time or is not of a continuous nature; or

B. is received in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subp. 93. **Non–WIN county.** "Non–WIN county" means a county which does not operate a WIN program within its boundaries.

Subp. 94. **Occupational Safety and Health Administration.** "Occupational Safety and Health Administration" means that organizational part of the United States Department of Labor.

Subp. 95. **Overpayment.** "Overpayment" means an assistance payment, resulting from a calculation error, a client reporting error, a misapplication of existing program requirements by a local agency, or changes in payment eligibility that cannot be effected due to notification requirements in part 9500.2740, subpart 7, which is greater than the amount for which an assistance unit is eligible.

Subp. 96. **Parent.** "Parent" means a child's biological or adoptive parent who is legally obligated to support that child.

Subp. 97. **Payee.** "Payee" means a person to whom an assistance payment is made.

Subp. 98. **Payment eligibility test.** "Payment eligibility test" means an eligibility test applied to income after the gross income test is satisfied.

Subp. 99. **Payment month.** "Payment month" means the calendar month for which assistance is paid.

Subp. 100. **Personal property.** "Personal property" means an item of value which is not real property, including the value of a contract for deed held by a seller, assets held in trust on behalf of members of an assistance unit, cash surrender value of life insurance, value of a prepaid burial, savings account, value of stocks and bonds, and value of retirement accounts.

Subp. 101. **Principal wage earner.** "Principal wage earner" means the parent who has earned the greater amount of income in the 24 months preceding application for assistance, subject to the conditions in part 9500.2300.

Subp. 102. **Probable fraud.** "Probable fraud" means the level of evidence that, if proven as fact, will establish that assistance has been wrongfully obtained.

Subp. 103. **Program.** "Program" means the aid to families with dependent children program.

Subp. 104. **Prospective.** "Prospective" means anticipating conditions in a future period, normally the following month.

Subp. 105. **Prospective budgeting.** "Prospective budgeting" means a method of determining the amount of assistance in which the budget month and payment month are the same.

Subp. 106. **Protective payee.** "Protective payee" means a person other than the caretaker of an assistance unit who receives the monthly assistance payment on behalf of an assis-

tance unit and is responsible to provide for the basic needs of the assistance unit to the extent of that payment.

Subp. 107. **Protective payment.** "Protective payment" means the assistance payment made to a protective payee.

Subp. 108. **Quality child care program.** "Quality child care program" means the program authorized under Code of Federal Regulations, title 7, part 226.

Subp. 109. **Quality control review process.** "Quality control review process" means the review process required under Code of Federal Regulations, title 45, sections 205.40 to 205.44.

Subp. 110. **Quarter of work.** "Quarter of work" means a calendar quarter in which a principal wage earner meets the qualifications of part 9500.2300, item G.

Subp. 111. **Real property.** "Real property" means the land itself and all buildings, structures, and improvements, or other fixtures on it, belonging or appertaining to the land, and all mines, minerals, fossils, and trees on or under it.

Subp. 112. **Reasonable compensation.** "Reasonable compensation" means the value received in exchange for property transferred to another owner which equals or exceeds the seller's equity in the property, reduced by costs incurred in the sale.

Subp. 113. **Recipient.** "Recipient" means a person who is currently receiving assistance. A person who 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.

Subp. 114. **Recoupment.** "Recoupment" means the actions taken by a local agency to reduce one or more monthly assistance payments in order to reclaim the value of overpayments, according to part 9500.2620, items C and D.

Subp. 115. **Recovery.** "Recovery" means actions taken by a local agency to reclaim the value of overpayments through voluntary repayment, recoupment from the assistance payment, or court actions.

Subp. 116. **Recurring income.** "Recurring income" means a form of income which:

A. is received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

B. is from the same source or of the same type that is received and budgeted in a prospective month and is received in one or both of the first two retrospective months.

Subp. 117. **Redetermination of eligibility.** "Redetermination of eligibility" means the process by which information is collected periodically by a local agency and used to determine a recipient's continued eligibility for AFDC.

Subp. 118. [Repealed, 15 SR 117]

Subp. 119. **Retrospective.** "Retrospective" means looking back on conditions in a past month.

Subp. 120. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of assistance in which the payment month is the second month after the budget month.

Subp. 121. **Second adult standard.** "Second adult standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item C.

Subp. 122. **Secondary school.** "Secondary school" means a school which is accredited by the Minnesota Department of Education as a secondary school under Minnesota Statutes, section 120.05, subdivision 2 or equivalent level technical college or an educational program which provides a GED.

Subp. 123. **Settlement.** "Settlement" means a resolution of financial responsibility by the commissioner when there is a dispute between or among local agencies concerning which county is financially responsible for a person's assistance.

Subp. 124. **Social Security Act.** "Social Security Act" means the act authorized under United States Code, title 42, sections 301 to 1399.

Subp. 125. **Social Security Administration.** "Social Security Administration" means that organizational part of the United States Department of Health and Human Services.

Subp. 126. **Social services.** "Social services" means the services included in a county's community social services plan which are administered by the county board as described under Minnesota Statutes, section 256E.03, subdivision 2.

Subp. 127. **Special adult standard.** "Special adult standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item E.

Subp. 128. **Special child standard.** "Special child standard" means the portion of the AFDC family allowance so named and described in part 9500.2440, subpart 5, item D.

Subp. 129. **State medical review team.** "State medical review team" means the person or group of persons designated by the commissioner to determine incapacity under part 9500.2220.

Subp. 130. **Statewide administration.** "Statewide administration" means the administration of uniform program standards throughout Minnesota.

Subp. 131. **Strike.** "Strike" means the action by employees defined under Minnesota Statutes, section 179.01.

Subp. 132. **Substantial gainful employment.** "Substantial gainful employment" means employment which averages at least 30 hours per week on a monthly basis and which is compensated at the level of the federal minimum wage or at the minimum standard for that employment in a geographic area, whichever is greater.

Subp. 133. **Supplemental security income.** "Supplemental security income" means the program authorized under title XVI of the Social Security Act.

Subp. 134. **Support.** "Support" means the provision of financial assistance, exclusive of payments in kind, by an absent parent to a caretaker or a local agency. Support includes the payments made to or on behalf of an eligible child or payments made to or on behalf of the caretaker.

Subp. 135. **Title IV–A.** "Title IV–A" means that part of the Social Security Act.

Subp. 136. **Title IV–B.** "Title IV–B" means that part of the Social Security Act.

Subp. 137. **Title IV–E.** "Title IV–E" means that part of the Social Security Act.

Subp. 138. **Title XIX.** "Title XIX" means that part of the Social Security Act.

Subp. 139. **Title XX.** "Title XX" means that part of the Social Security Act.

Subp. 140. **Two party payment.** "Two party payment" means an assistance payment issued by a local agency to a caretaker and another person jointly so that neither party can liquidate the payment without the signature of the other party.

Subp. 141. **Underpayment.** "Underpayment" means an assistance payment, resulting from a calculation error, a client reporting error, or a misapplication of program requirements by a local agency, which is less than the amount for which an assistance unit is eligible.

Subp. 142. **Unearned income.** "Unearned income" means income received by a person which does not meet the definition of earned income. Unearned income includes interest, dividends, unemployment compensation, disability insurance payments, veterans benefits, pension payments, return on capital investment, insurance payments or settlements, and severance payments.

Subp. 143. **Unemployment compensation.** "Unemployment compensation" means the insurance benefit paid to an unemployed worker under Minnesota Statutes, sections 268.03 to 268.231.

Subp. 144. **Uniformed services.** "Uniformed services" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, and National Oceanographic and Atmosphere Administration.

Subp. 145. **Unsubsidized employment.** "Unsubsidized employment" means employment under which the wage or salary is paid exclusively from private funds of the employer

without sharing or direct incentive payments from the WIN, community work experience, Job Training Partnership Act, or similar governmental work experience program.

Subp. 146. **Vendor.** "Vendor" means a provider of goods or services.

Subp. 147. **Vendor payment.** "Vendor payment" means a payment made by a local agency directly to a vendor.

Subp. 148. **Verification.** "Verification" means the process a local agency uses to establish the accuracy or completeness of information from an applicant, a recipient, a third party, or other source as that information relates to program eligibility or the assistance payment.

Subp. 149. **Water and sewer system.** "Water and sewer system" means the fixed structures required to provide water to and to dispose of sewage from a home. The water and sewer system includes the interior plumbing of a house, exterior water and sewer mains, drainage fields, cisterns, cesspools, wells, and pumps.

Subp. 150. **Welfare fraud.** "Welfare fraud" means those actions through which assistance is wrongfully obtained and which are actionable as theft under Minnesota Statutes, section 256.98.

Subp. 151. **Willfully or intentionally.** "Willfully" or "intentionally" means knowing or having reason to know the consequences of one's action or failure to act.

Subp. 152. **Work incentive program or WIN.** "Work incentive program" or "WIN" means the program authorized under title IV–C of the Social Security Act and administered by the Minnesota Department of Jobs and Training.

Subp. 153. **Work study program.** "Work study program" means a program operated or approved by a secondary school which allows a student to earn academic credit by working for a public or private sector employer.

Subp. 154. **Wrongfully obtaining assistance.** "Wrongfully obtaining assistance" means:

A. the action of an applicant or recipient to willfully or intentionally withhold, conceal, or misrepresent information which results in a household's receipt of assistance in excess of the amount for which it is eligible under the program and the eligibility basis claimed by the applicant or recipient;

B. the receipt of real or personal property by a person without providing reasonable compensation and for the known purpose of creating another person's eligibility for assistance; or

C. the action of a person to conspire with or knowingly aid or abet another person to wrongfully obtain assistance.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; L 1987 c 258 s 12, c 403 art 3 s 96; 15 SR 117; L 1989 c 246 s 2*

9500.2100 APPLICATION FOR ASSISTANCE.

Subpart 1. **Where to apply.** A person who wishes to apply for assistance shall apply at the local agency in the county in which that person lives.

Subp. 2. **Local agency responsibility to provide information.** A local agency shall inform a person who inquires about the program's eligibility requirements and how to apply for AFDC. A local agency shall offer the person brochures developed or approved by the commissioner that describe how to apply for AFDC.

Subp. 3. **Application form and accompanying advisory.** A local agency shall offer, by hand or mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the local agency shall inform the person that, if the person is found eligible, the local agency must use the date the application form was submitted to the local agency as the starting point for computing assistance, and that any delay in submitting an application form will reduce the amount paid for the month of application. A local agency shall inform a person that the person may submit an application before an interview appointment. A local agency shall log inquiries for information about assistance. Logs must contain the name of the person making the inquiry, the date of inquiry, the name of the local agency staff member who receives the inquiry, and the content of the inquiry.

To apply for assistance, a person shall submit an application form to a local agency. Upon receipt of an application, a local agency shall stamp the date of receipt on the face of the application.

An applicant may withdraw his or her application at any time by giving written or oral notice to the local agency. The local agency shall issue a written notice confirming the withdrawal. The notice must inform the applicant of the local agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a local agency in writing that he or she does not wish to withdraw the application, the local agency shall reinstate the application and finish processing the application.

Subp. 4. **Assessment of and issuance for initial needs.** When a person inquires about assistance, a local agency shall ask the person if immediate or emergency needs exist. When a person has emergency needs, the local agency shall determine that person's eligibility for emergency assistance unless the person's needs can be met through other sources or by promptly processing an application for monthly assistance.

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.

Subp. 5. **Verification of information on application.** A local agency shall verify information provided by an applicant as specified in part 9500.2420.

Subp. 6. **Processing application.** Upon receiving an application, a local agency shall determine the applicant's program eligibility, approve or deny the application, inform the applicant of its decision according to part 9500.2740, subpart 5, and issue assistance when the applicant is eligible. When a local agency is unable to process an application within 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.

Subp. 7. **Invalid reason for delay.** A local agency shall neither delay a decision on program eligibility nor delay issuing assistance:

A. by treating the 45–day processing period as a waiting period, except as provided in part 9500.2300, item E;

B. by delaying approval or issuance of assistance pending the decision of the county board;

C. by delaying issuance of initial assistance checks more than seven calendar days to accommodate the county's check issuance schedule;

D. for remaining family members when WIN registration requirements in part 9500.2700, subpart 16 have not been met by a mandatory registrant, unless that registrant is a nonexempt principal wage earner; or

E. by awaiting the result of a referral to a local agency in another county when the county receiving the application does not believe it is the county of financial responsibility.

Subp. 8. **Changes in residence during application.** The requirements of subparts 6 and 7 apply without regard to the length of time that an applicant remains, or intends to remain, a resident of the county in which application is made. When an applicant leaves the county where application was made but remains in the state, part 9500.2880 applies, and the local agency may request additional information from the applicant about changes in circumstances related to the move.

Subp. 9. **Additional applications.** Until a local agency issues notice of approval or denial, additional applications submitted by an applicant are void. However, an application for monthly assistance and an application for emergency assistance may exist concurrently. More than one application for monthly assistance or emergency assistance may exist concurrently when the local agency decisions on one or more earlier applications have been ap-

pealed 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 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2140 BASIC ELIGIBILITY REQUIREMENTS.

Subpart 1. **Citizenship.** To be eligible for AFDC, a member of an assistance unit must be a citizen of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien otherwise permanently residing in the United States under color of law.

Subp. 2. **Minnesota residence.** Minnesota residence is an eligibility requirement for AFDC. A person who enters Minnesota from another state and receives assistance from that state must not be considered a Minnesota resident until the last month in which that state issues an assistance payment. Minnesota residence is established according to the provisions in items A to E.

A. A person who lives in Minnesota and who entered Minnesota with a job commitment or to seek employment in Minnesota, whether or not that person is currently employed, is considered a resident of Minnesota. Neither a length of prior 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.

C. A person who lives in vehicles or other temporary places, including transient facilities, is a resident of Minnesota when that person is physically present in Minnesota on an ongoing basis and meets the requirements of item A or B.

D. A person placed in Minnesota by another state under Minnesota Statutes, section 257.40 or a juvenile who enters Minnesota from another state under Minnesota Statutes, section 260.51 shall not be considered a resident of Minnesota. A person placed in another state by Minnesota under Minnesota Statutes, section 257.40 or a juvenile who enters another state from Minnesota under Minnesota Statutes, section 260.51 shall maintain Minnesota residence.

E. Subitems (1) to (3) constitute loss of Minnesota residence for purposes of the program:

(1) an absence from Minnesota for more than one month, except as allowed under subpart 5;

(2) an absence involving either the establishment of a residence outside of Minnesota or the abandonment of the Minnesota home; or

(3) an assertion of residence in another state in order to receive assistance.

Subp. 3. **Deprivation as eligibility factor.** To be eligible for AFDC, a dependent child must be deprived of parental support or care under part 9500.2180, 9500.2220, 9500.2260, or 9500.2300 due to the death, incapacity, or continued absence from the home of a parent or the unemployment of the parent who is the principal wage earner.

Subp. 4. **Dependent child.** An assistance unit shall include at least one dependent child, except that program eligibility may exist for a woman beginning with her seventh month of

pregnancy and for the parents or a caretaker relative of a dependent child receiving supplemental security income with no other children in the home.

Subp. 5. **Physical presence.** To be eligible for AFDC, a dependent child and a caretaker must live together except as provided in items A to C.

A. The physical presence requirement is met when a child is required to live away from the caretaker's home to meet the need for educational curricula that cannot be met by, but is approved by, the local public school district, the home is maintained for the child's return during periodic school vacations, and the caretaker continues to maintain responsibility for the support and care of the child.

B. The physical presence requirement is met when an applicant caretaker or applicant child is away from the home due to illness or hospitalization when the home is maintained for the return of the absent family member, the absence is not expected to last more than six months beyond the month of departure, and the conditions of subitem (1), (2), or (3) apply:

(1) when the child and caretaker lived together immediately prior to the absence, the caretaker continues to maintain responsibility for the support and care of the child, and the absence is reported at the time of application;

(2) when the pregnant mother is hospitalized or out of the home due to the pregnancy; or

(3) when the newborn child and mother are hospitalized at the time of birth.

C. The absence of a caretaker or child does not affect eligibility for the month of departure when he or she received assistance for that month and lived together immediately prior to the absence. Eligibility also exists in the following month when the absence ends on or before the tenth day of that month. A temporary absence of a caretaker or a child which continues beyond the month of departure must not affect eligibility when the home is maintained for the return of the absent family member, the caretaker continues to maintain responsibility for the support and care of the dependent child, and when one of subitems (1) to (7) apply:

(1) when a recipient caretaker or recipient child is absent due to illness or hospitalization, and the absence is expected to last no more than six months beyond the month of departure;

(2) when a recipient child is out of the home due to 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.

Subp. 6. **Ineligibility of labor dispute participants.** An assistance unit is ineligible for any month in which a caretaker parent participates in a strike on the last day of that month.

Participation in a strike on the last day of the month by any other member of the assistance unit renders only that member ineligible. A person is considered to be "participating" in a strike if he or she, with others, actually refuses to provide services to his or her employer. A person who is unable to work due to a lockout by his or her employer, or because a labor dispute among other parties has reduced or eliminated demand for the person's services, is not considered on strike.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2180 DEATH OF PARENT.

The death of one or both parents constitutes deprivation of parental support or care. To be eligible for AFDC, a dependent child must live with a person who is a caretaker, as defined under part 9500.2440, subpart 7, and must meet the income and resource limitations of the program.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2220 INCAPACITY OF PARENT.

Subpart 1. **Requirements for disclosure of medical and social information.** The applicant or recipient is responsible for proving his or her incapacity. An applicant or recipient who claims incapacity shall provide supporting medical evidence to a local agency when the local agency requires that evidence to determine initial and ongoing program eligibility. When medical evidence, by itself, does not prove incapacity, a local agency shall request social information to supplement the medical evidence. The applicant or recipient shall provide the names of licensed physicians or licensed psychologists who have information relevant to their incapacity. The applicant or recipient shall provide the local agency with materials he or she has which are relevant to his or her incapacity.

Subp. 2. **Referral to state medical review team.** When a local agency cannot determine incapacity from the medical evidence and social information, the local agency shall submit the evidence and information to the commissioner so that the state medical review team can decide whether incapacity exists. The applicant or recipient and the local agency shall provide the state medical review team with additional information it requires to determine incapacity. The state medical review team's decision is binding on the local agency.

Subp. 3. **Changes in circumstances.** A local agency shall review any reported changes in circumstances for continued program eligibility based on incapacity.

A. When an incapacitated parent resumes or begins employment of less than 100 hours per month or which pays less than the federal minimum wage, the local agency shall continue to treat the parent as incapacitated for the period granted under the most recent determination of incapacity. At the end of that period, the local agency shall evaluate the parent's employment and current medical evidence and social information to determine whether the incapacitated parent can perform substantial gainful employment.

B. A recipient is no longer eligible under this part when medical evidence or social information documents that the recipient can resume substantial gainful employment or care of a dependent child, or when the recipient begins substantial gainful employment. Before ending assistance under this item, the local agency shall allow the recipient an opportunity to demonstrate another basis of AFDC eligibility.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2260 CONTINUED ABSENCE OF PARENT.

Subpart 1. **Continued absence.** Continued absence of a parent exists when a parent lives out of the home of the dependent child and the absence interrupts or ends the absent parent's support, care, or guidance of that child. There is no minimum time period used to establish absence of a parent. The absence may be permanent or temporary, and a temporary absence may be of a known or indefinite duration. When support payments made on behalf of a dependent child are less than the AFDC family allowance standard for a dependent child,

the child is considered deprived of parental support for purposes of determining continued absence. Two exceptions apply when program eligibility based on continued parental absence is determined.

A. A child is not eligible when a parent is absent solely by reason of active duty in the uniformed services of the United States. The absence must be presumed to be solely because of uniformed service duty when the parent had been living in the home immediately prior to entering active duty, no subsequent divorce or legal separation has been filed, and the parent who is in the home cannot document a reason for the absence other than, or in addition to, the active duty.

B. A child is eligible when a parent is a convicted offender but is permitted to live at home while serving a court–imposed sentence by performing unpaid public work or unpaid community service during the workday. Provision must not be made for the offender's needs in computing the amount of the assistance payment described in parts 9500.2440, 9500.2600, and 9500.2620.

Subp. 2. **Visitation.** Regular or sporadic visitation by an absent parent does not, by itself, constitute the provision of care or guidance as defined in part 9500.2060. When an absent parent is present in the child's home so often that a local agency questions whether absence exists, the issue shall be resolved by determining whether the absent parent lives in the home of the child.

Subp. 3. **Evidence of home.** Evidence of a home includes: the amount of time spent there as opposed to other residences; where the majority of personal belongings are kept; the address given to a current employer; the address given for current school registration; the mailing address for government benefits which require mailing to the current address; the address recently used to apply for credit; the address for service of legal documents; the address given to creditors or utility companies as a current address; vehicle registration, driver's license, or post office address which has been changed since the absence; and the frequency, type, and length of absences. A local agency shall evaluate each applicable item of evidence together with other items when determining the home, and a local agency must consider all circumstances together to determine whether continued absence exists. A maildrop does not constitute evidence of a home.

Subp. 4. **Shared custody.** This subpart applies to court ordered and noncourt ordered custody arrangements. The language of a court order that specifies joint legal or physical custody must not, in and of itself, preclude a determination that a parent is absent. Absence must be determined based on the actual facts of the absence and according to the provisions of this part.

A. When a dependent child spends time in each of the parents' homes within a payment month, the child's home shall be considered the home in which the majority of the child's time is spent. When this time is exactly equal within a payment month, or when the parents alternately live in the child's home within a payment month, the child's home shall be with that parent who is applying for AFDC, unless the child's needs for the full payment month have already been met through the provision of assistance to the other parent for that month.

B. When the physical custody of a dependent child alternates between parents for periods of at least one payment month, each parent shall be eligible for assistance for any full payment months the child's home is with that parent, except under the conditions in item C.

C. When a dependent child's home is with one parent for the majority of time in each month for at least nine consecutive calendar months, and that child visits or vacations with the other parent under the provisions of part 9500.2140, subpart 5, item C, subitem (4), the child's home shall remain with the first parent even when the stay with the second parent is for all or the majority of the months in the period of the temporary absence.

Subp. 5. **Special circumstances.** A child is considered deprived of the support, care, or guidance of a parent when:

A. paternity has not been established under law;

B. a child has been adopted by a single parent; or

C. a child is born from artificial insemination to an unmarried mother.

Subp. 6. **Substitute parent.** The determination of whether a child is deprived of parental care or support due to the absence of the parent from the child's home must be made only in relation to the child's parent. Under this requirement, the presence of a substitute parent or another person in the household must not be a reason for denying or ending assistance.

Subp. 7. **Return of parent to child's home.** When an absent parent returns to live with the child and the other parent, financial need exists, and application is made under another basis of eligibility, the local agency shall continue assistance payment until that application is approved, withdrawn, or denied, when:

A. application is made during the month of the absent parent's return; or

B. the return of the absent parent is reported timely according to part 9500.2700, subpart 7, and application is made within ten calendar days from the date the report of the return is received by the local agency.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2300 UNEMPLOYED PARENT.

To be considered an unemployed parent, a parent must meet the requirements in items A to I.

A. The parent's family is in need according to the provisions of parts 9500.2000 to 9500.2740.

B. The parent's unemployment is not the result of participation in a labor dispute.

C. The parent is employed less than 100 hours per month. The parent may exceed that standard for a particular month when employment is intermittent and the excess hours of employment are of a temporary nature as evidenced by the fact that the hours of employment were under the 100–hour standard for the prior two months and are expected to be under the standard for the next month.

D. The parent has not quit or refused a bona fide offer of employment or training for employment in the last 30 days unless the termination or refusal was for good cause as provided under part 9500.2700, subpart 19.

E. The parent has not been fully employed during the 30–day period preceding the receipt of assistance on the basis of unemployed parent.

(1) When employment is less than 100 hours in the month employment is lost but was 100 or more hours in the preceding month, the last day of the preceding month must be considered the last day of full employment.

(2) When employment is 100 hours or more in the month employment is lost, the day employment is lost must be considered the last day of full employment.

(3) Program eligibility must be established as of the date of application, the 31st day following the last day of full employment, or the day all other eligibility factors are met, whichever is later.

F. The parent shall be:

(1) registered with WIN or qualified for an exemption from WIN. When the parent is an exempt principal wage earner, the other parent, unless exempt, shall satisfy the registration and cooperation requirements of WIN; or

(2) registered with the local job service office when the county does not operate a WIN program.

G. The parent shall have:

(1) received or been qualified to receive unemployment compensation during the year prior to the month of the original application for assistance, or shall have been qualified to receive compensation if the work performed had been covered by unemployment compensation; or

(2) worked at least six quarters during any 13 calendar quarter period ending within one year prior to the date of the original application for assistance and earned the equivalent of not less than $50 per quarter during this period. Compensation for this work may be:

(a) in United States dollars or in a foreign currency that purchases goods and services equal to or exceeding $50 in United States currency; or

(b) in the form of food, shelter, personal items, medical care, and services of a fair market value equal to or exceeding $50 if purchased in the county of residence.

Work performed includes the labor or services rendered to an employer or through self-employment that was necessary to secure that compensation.

Cooperation in the WIN program or a community work experience program qualifies as a quarter of work under this item.

H. The parent shall be the principal wage earner, having earned the greater of the two parents' incomes, except for income received in kind, during the 24 months immediately preceding the month of application for assistance under this part. When there are no earnings or when earnings are identical for each parent, the applicant may designate the principal wage earner, and that designation must not be transferred after program eligibility is determined as long as assistance continues without interruption.

I. The parent shall apply for unemployment compensation benefits when the circumstances which cause loss of employment and the duration of and compensation for that employment indicate eligibility for those benefits. When that application establishes eligibility, the parent shall also comply with the requirements necessary to receive unemployment compensation benefits.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2340 PROPERTY LIMITATIONS.

Subpart 1. **General provisions of property ownership.** A local agency shall apply the provisions of items A to D to real and personal property. A local agency shall use the equity value of legally available real and personal property, except property excluded in subparts 2 and 3, to determine whether an applicant or recipient is eligible for assistance.

A. When real or personal property is jointly owned by two or more persons, the local agency shall assume that each person owns an equal share, except that either person owns the entire sum of a joint personal checking or savings account. When the owners document greater or smaller ownership, the local agency shall use that greater or smaller share to determine the equity value held by an applicant or recipient. Other types of ownership must be evaluated according to law.

B. Real or personal property owned by an applicant or a recipient must be presumed legally available unless the applicant or recipient documents that the property is not legally available to him or her. When real or personal property is not legally available, its equity must not be applied against the limits of subparts 2 and 3.

C. An applicant shall disclose whether he or she has transferred real or personal property valued in excess of the property limits in subparts 2 and 3 for which reasonable compensation was not received within one year prior to application. A recipient shall disclose all transfers of property valued in excess of these limits according to the reporting requirements in part 9500.2700, subpart 7. When a transfer of real or personal property without reasonable compensation has occurred, subitems (1) and (2) apply.

(1) The person who transferred the property shall provide the property's description, information needed to determine the property's equity value, the names of persons who received the property, and the circumstances of and reasons for the transfer.

(2) When the transferred property can be reasonably reacquired, or when reasonable compensation can be secured, the property is presumed legally available to the applicant or recipient.

D. A recipient may build the equity value of the recipient's real and personal property to the limits in subparts 2 and 3.

Subp. 2. **Real property limitations.** Ownership of real property by an applicant or recipient is subject to the limitations in items A and B.

A. A local agency shall exclude the homestead of an applicant or recipient, according to the provisions in subitems (1) to (3).

(1) An applicant or recipient who is purchasing real property through a contract for deed and using that property as a home is considered the owner of real property.

(2) The total amount of land that can be excluded under this subpart is limited to 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.

B. The equity value of real property which is not excluded under item A and which is legally available must be applied against the limits in subpart 3. When the equity value of the real property exceeds the limits under subpart 3, the applicant or recipient may qualify to receive nine months of assistance when he or she makes a good faith effort to sell the property and signs a legally binding agreement to repay the amount of assistance issued during that nine months. When the property is sold during the nine months, the assistance unit receives assistance for the month the property is sold, and the net proceeds are less than the amount of assistance issued, the amount which must be repaid shall be the net proceeds from that sale. When the property is sold after the nine–month period, or in a month when assistance is not received by the assistance unit, the full amount of assistance received during the nine–month period must be considered an overpayment and is subject to recovery.

Subp. 3. **Other property limitations.** The equity value of all nonexcluded real and personal property must not exceed $1,000. To determine whether the value of an item of real or personal property is to be counted, a local agency shall exclude the value of real and personal property listed in items A to P:

A. One motor vehicle, when its equity value does not exceed $1,500 exclusive of the value of special equipment for a handicapped household member. To establish the equity value of a vehicle, a local agency shall subtract any outstanding encumbrances from the loan value listed in the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. The N.A.D.A. Official Used Car Guide, Midwest Edition, is incorporated by reference. It is published monthly by the National Automobile Dealers Used Car Guide Company and is available through the minitex interlibrary loan system. It is subject to frequent change. When a vehicle is not listed in the guidebook, or when the applicant or recipient disputes the value listed in the guidebook as unreasonable given the condition of the particular vehicle, the local agency may require the applicant or recipient to document the value by securing a written statement from a motor vehicle dealer licensed under Minnesota Statutes, section 168.27 stating the amount that the dealer would pay to purchase the vehicle. The local agency shall reimburse the applicant or recipient for the cost of a written statement that documents a lower value.

B. The value of personal property needed to produce earned income, including tools, implements, farm animals, and inventory, 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.

C. The value of real and personal property owned by a recipient of supplemental security income or Minnesota supplemental aid.

D. The value of real and personal property owned by a parent of a minor caretaker, a stepparent, or a legal guardian, when those persons are not applying for AFDC and are not required to apply for AFDC under part 9500.2440.

E. The value of corrective payments and the AFDC housing allowance, but only for the month in which the payment is received and for the following month.

F. A mobile home used by an applicant or recipient as his or her home.

G. Money escrowed in a separate account which is needed to pay real estate taxes or insurance and which is used for this purpose at least semiannually.

H. Money held in escrow under part 9500.2380, subpart 7, item B, by a self–employed person, when the money is used for those purposes at least annually.

I. Monthly assistance and emergency assistance payments issued for the current month's need.

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

K. The value of school loans, grants, or scholarships over the period they are intended to cover.

L. The value of personal property not otherwise specified which is commonly used by household members in day–to–day living.

M. Payments listed in part 9500.2380, subpart 2, item J, which are held in escrow for the period necessary to replace or repair the personal or real property. This period must not exceed three months.

N. One burial plot per member of an assistance unit.

O. The value of a prepaid burial account, burial plan, or burial trust up to $1,000 for each member of an assistance unit who is covered by that account, plan, or trust.

P. Other real or personal property specifically disregarded by federal law, state law, or federal regulation.

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 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2380 INCOME.

Subpart 1. **Evaluation of income.** To determine program eligibility and the assistance payment amount, a local agency shall evaluate income received by members of an assistance unit, or by other persons whose income is considered available to an assistance unit under parts 9500.2440, 9500.2500, subparts 4 and 5, and 9500.2760. All payments, unless specifically excluded in subpart 2, must be counted as income.

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

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

B. work and training allowances, incentive payments, and reimbursements received through WIN;

C. work and training allowances received from local agency social services programs;

D. reimbursements for employment training received through the Job Training Partnership Act;

E. reimbursement for out–of–pocket expenses incurred while performing volunteer services, jury duty, or employment;

F. 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.

Subp. 3. **Distribution of income.** Income must be attributed to the person who earns it or to the beneficiary of the income according to items A to E.

A. Income may be allocated from spouse to spouse and from parents to children under age 21, according to parts 9500.2500, subpart 5 and 9500.2600, when the person to whom income is allocated is in financial need according to the standards of the AFDC family allowance table under part 9500.2440 and when that person lives with the dependent child who is applying for or receiving assistance.

B. Funds distributed from a trust, whether from the principal holdings or sale of trust property or from the interest and other earnings of the trust holdings, must be considered income when the income is legally available to an applicant or recipient. Trusts are presumed legally available unless an applicant or recipient can document that the trust is not legally available.

C. Income from jointly owned property must be divided equally among the property owners unless the terms of ownership provide for a different distribution of equity.

D. Income of the sponsors of certain aliens must be considered income to the aliens according to Code of Federal Regulations, title 45, section 233.51.

E. Except as provided under part 9500.2500, subpart 4, item G, deductions are not allowed from the gross income of a financially responsible household member or by the members of an assistance unit to meet a current or prior debt.

Subp. 4. **Earned income.** Earned income is treated according to items A to C.

A. Sick leave and vacation payments issued as a result of earned or accrued leave time are earned income.

B. Earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time.

C. The earned income tax credit, whether received from an employer or from the federal government, is earned income. An applicant or recipient who is eligible for the earned income tax credit is required to apply for it. An applicant or recipient may choose to apply for the credit either when the applicant or recipient files an income tax return for the year in which the applicant or recipient was eligible or in advance through his or her employer.

Subp. 5. **Self–employment earnings.** A local agency shall determine gross earned income from self–employment by subtracting business costs from gross receipts according to subparts 6 to 9.

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

A. purchases of capital assets;

B. payments on the principal of loans for capital assets;

C. depreciation;

D. amortization;

E. the wholesale costs of items purchased, processed, or manufactured which are unsold inventory with a deduction for the costs of those items allowed at the time they are sold;

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

G. costs, in any amount, for mileage between applicant or recipient's home and his or her place of employment;

H. salaries and other employment deductions made for members of an assistance unit or persons who live in the household for whom an employer is legally responsible;

I. monthly expenses in excess of $71 for each roomer;

J. monthly expenses in excess of $86 for each boarder;

K. monthly expenses in excess of $157 for each roomer–boarder;

L. annual expenses in excess of $103 or two percent of the estimated market value on a county tax assessment form, whichever is greater, as a deduction for upkeep and repair against rental income;

M. expenses not allowed by either the United States Internal Revenue Code for self–employment income or the Code of Federal Regulations, title 45, section 233.20(a)(6)(v)(B); and

N. expenses which exceed 60 percent of gross receipts for child care performed in a recipient's home unless the recipient can document a higher amount. When funds are received from the quality child care program, those funds are excluded from gross receipts, and the expenses covered by those funds must not be claimed as a business expense which offsets gross receipts.

Subp. 7. **Self–employment budget period.** 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.

A. The purchase cost of inventory items, including materials which are processed or manufactured, must be deducted as an expense at the time payment is received for the sale of those inventory items, processed materials, or manufactured items, regardless of when those costs are incurred or paid.

B. Expenses to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs which are commonly paid at least annually, but less often than monthly, must be prorated forward as deductions from gross re-

ceipts over the period they are intended to cover, beginning with the month in which the payment for these items is made.

C. Gross receipts from self–employment may be prorated forward to equal the period of time over which the expenses were incurred except that gross receipts must not be prorated over a period which exceeds 12 months. This provision applies only when gross receipts are not received monthly but expenses are incurred on an ongoing monthly basis.

Subp. 8. **Farm income.** Farm income is the difference between gross receipts and operating expenses, subject to subpart 6. Gross receipts include sales, rents, subsidies, soil conservation payments, production derived from livestock, and income from sale of home–produced foods. Farm income must be annualized.

Subp. 9. **Rental income.** Income from rental property must be considered self–employment earnings when 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.

Subp. 10. **Unearned income.** Unearned income is treated according to items A and B.

A. An amount must be deducted for costs necessary to secure payments of unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

B. Payments for illness or disability, except for those payments described as earned income in subpart 4, item A, must be considered unearned income whether the premium payments are made wholly or in part by an employer or by a recipient.

Subp. 11. **Lump sums.** Lump sums received by an assistance unit must be considered earned income under subparts 4 to 9 or unearned income according to subpart 10. Lump sums received by a parent excluded from an assistance unit, by a child excluded from an assistance unit due to a WIN sanction, or a member of an assistance unit must be applied to meet both current and future need of the assistance unit according to part 9500.2560. When a lump sum is received by a stepparent, a parent or legal guardian of a minor caretaker, or a legal guardian, and this person is not included in the assistance unit, the lump sum must be counted as income only in the budget month.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2420 DOCUMENTING, VERIFYING, AND REVIEWING ELIGIBILITY.

Subpart 1. **Information that must be verified.** A local agency shall only require a person to document the information necessary to determine program eligibility and the amount of the assistance payment. Information previously verified and retained by a local agency must not be verified again unless the verification no longer applies to current circumstances.

Subp. 2. **Sufficiency of documentation.** A person shall document the information required under subpart 4 or authorize a local agency to verify it. The burden of providing documents for a local agency to use to verify eligibility is upon the applicant or recipient. A local agency shall help an applicant or recipient to obtain documents which the applicant or recipient does not possess and cannot obtain. When a person and the local agency are unable to obtain primary or alternate documents needed to verify information, a local agency shall accept affidavits from an applicant or recipient as sufficient documentation. Information previously verified and retained by a local agency must not be verified again unless the verification no longer applies to current circumstances.

Subp. 3. **Contacting third parties.** A local agency must not request information about an applicant or recipient which is not of public record from a source other than local agencies, the department, or the United States Department of Health and Human Services without the

person's prior written consent. An applicant's signature on an application form shall constitute this consent for contact with the sources specified on that form. A local agency may use a single consent form to contact a group of similar sources, such as banks or insurance agencies, but the sources to be contacted must be identified by the local agency prior to requesting an applicant's consent. A local agency shall not provide third parties with access to information about a person's eligibility status or any other part of the case record without that person's prior written consent, except where access to specific case information is granted to agencies designated by the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13. Information designated as confidential by the Minnesota Government Data Practices Act must only be made available to agencies granted access under that law and must not be provided to an applicant, recipient, nor a third party.

Subp. 4. **Factors to be verified.** A local agency shall verify factors of program eligibility at the time of application, when a factor of eligibility changes, and at each redetermination of eligibility under subpart 5.

A. A local agency shall verify:

(1) the social security number of each adult and child applying for assistance;

(2) 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.

Subp. 5. **Redetermination of eligibility; frequency.** A periodic redetermination of eligibility of a recipient must occur at least annually when the recipient provides a monthly household report form or is in a low error category identified through an error–prone profile developed by the commissioner and approved by the United States Secretary of Health and Human Services; a periodic redetermination of eligibility of all other recipients must occur semiannually, or more frequently for recipients in a high error category identified through an error–prone profile developed by the commissioner. One face–to–face redetermination of eligibility of each recipient must occur every 12 months. A local agency shall redetermine the eligibility of a recipient when a recipient household has changed its county of residence. A local agency may redetermine the eligibility of a recipient when a change which affects program eligibility is reported to the local agency.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2440 FAMILY COMPOSITION AND ASSISTANCE STANDARDS.

Subpart 1. **Requirement to use standards.** A local agency shall determine who is a member of an assistance unit according to subparts 2 to 4. A local agency shall determine the amount of the AFDC family allowance which applies to the size and composition of an assistance unit according to subparts 5 and 6. Payment eligibility and the amount of the assistance payment must be determined by applying the assistance unit's income against the AFDC family allowance standard, according to parts 9500.2380 to 9500.2620.

Subp. 2. **Filing unit composition.** When an application for assistance is made for a dependent child, that child and all blood related and adoptive minor siblings of that child, 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.

Subp. 3. **Assistance unit composition.** An assistance unit is a group of individuals who are applying for or receiving assistance and whose needs are included in the assistance payment under part 9500.2620. Eligible members of a filing unit who are required by federal law to apply for AFDC must be included in a single assistance unit. Members of separate filing units who live together must be included in a single assistance unit when:

A. one caretaker makes application for separate filing units; and

B. two caretakers, who are currently married to each other, make application for separate filing units.

Subp. 4. **Multiple assistance units.** When there is more than one filing unit living together, eligibility for the assistance payment must be determined separately for each filing unit except as provided in subpart 3.

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

A. The children standard must be used for an assistance unit member who is a dependent child or who is a minor caretaker who lives with either parent.

B. The first adult standard must be used for the first eligible adult caretaker and for the first eligible minor caretaker who is emancipated or who lives apart from both parents.

C. The second adult standard must be used for an additional eligible parent caretaker when one parent caretaker is eligible for the first adult standard.

D. The special child standard must be used for an assistance unit that contains no adult because a parent or parents are excluded from an assistance unit either because of fail-

ure 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.

E. The special adult standard must be used for an assistance unit that contains only one adult and no dependent child when eligibility exists under part 9500.2140, subpart 4.

Subp. 6. **AFDC family allowance table.** The following table represents the standards in effect on July 1, 1986.

Children Standard		Adult Standards	
Number of Eligible Children	Monthly Standard Of Need	Eligible Adults	Monthly Standard Of Need
1	$250	first adult standard	$187
2	345	second adult standard	73
3	434		
4	510		
5	586		
6	663		
7	729		
8	793		
9	848		
10	902		
over 10	add 53 per additional child		
Special Standard for one child	337	Special Standard for one adult	250

Subp. 7. **Persons who may be caretakers.** To be eligible to receive assistance, a dependent child must live with a person who is authorized to be a caretaker under this subpart. A caretaker's eligibility to be included in an assistance unit is subject to subparts 2 and 3, and other eligibility conditions in parts 9500.2140 to 9500.2700. When parental rights to a child have been terminated, the termination must not prevent a person in items A to D, except a parent whose rights were specifically terminated, from being the child's caretaker. A person who may be a caretaker of a dependent child is:

A. a relative of at least half–blood, including a first cousin, a nephew or niece, or a person of preceding generations who are identified by prefixes of grand, great, or great–great;

B. a stepparent or stepsibling;

C. a relationship listed in items A and B when a person has been legally adopted; and

D. a spouse of a person listed in items A to C or a former spouse of that person when marriage has ended by death or divorce.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2480 DETERMINATION OF AFDC ELIGIBILITY AND ASSISTANCE PAYMENT.

A local agency must determine program eligibility prospectively for a payment month based on its best estimate of income and the circumstances which will exist in the payment month. Except as described in part 9500.2520, subparts 1 and 2, when prospective eligibility

exists, a local agency must calculate the amount of the assistance payment using retrospective budgeting. To determine program eligibility and the assistance payment amount, a local agency must apply gross earned income and unearned income, described in part 9500.2380, subparts 4 to 11, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under part 9500.2500, subpart 4. This income must be applied to the AFDC family allowance, described in part 9500.2440, subpart 6, subject to the provisions in parts 9500.2500 to 9500.2620. Income received in a calendar month and not otherwise excluded under part 9500.2380, subpart 2, must be applied to the needs of an assistance unit.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2500 AFDC ELIGIBILITY TESTS.

Subpart 1. **Prospective eligibility.** A local agency shall determine whether the eligibility requirements that pertain to an assistance unit, including those in parts 9500.2140 to 9500.2380, will be met prospectively for the payment month. To prospectively assess income, a local agency shall estimate the amount of income an assistance unit expects to receive in the payment month and shall apply the gross income test in subpart 4 and the payment eligibility test in subpart 5.

Subp. 2. **When to terminate.** When an assistance unit is prospectively ineligible for AFDC for at least two consecutive months, assistance must end.

When an assistance unit is 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.

Subp. 3. **Retrospective eligibility.** After the first two months of program eligibility, a local agency must determine whether an assistance unit is prospectively eligible for the payment month and then determine whether the assistance unit is retrospectively eligible by applying the gross income test and the payment eligibility test to the income from the budget month. When either the gross income test or the payment eligibility test is not satisfied, assistance must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subp. 4. **Gross income test.** A local agency shall apply a gross income test both prospectively and retrospectively for each month of program eligibility. An assistance unit is not eligible when income equals or exceeds 185 percent of the AFDC family allowance for the assistance unit. The income applied against the gross income test must include the income of a parent in the filing unit even when that parent is not included in the assistance unit. It must include the earned and unearned income of an eligible relative who seeks to be included in the assistance unit. It must include the unearned income of a dependent child who seeks to be included in the assistance unit. It must include the gross earned income of a dependent child in the assistance unit who is not a full–time student and whose income is from a source other than the Job Training Partnership Act. It must also include the earned or unearned income of a dependent child who is a member of the filing unit but is excluded from the assistance unit because of failure to register or cooperate with WIN. The income in items A to G must be considered in the gross income test:

A. Gross earned income from employment, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, the disregards in part 9500.2580, and the allocations in part 9500.2600, unless the employment income is specifically excluded under part 9500.2380, subpart 2.

B. Gross earned income from self–employment less deductions for self–employment expenses in part 9500.2380, subpart 6 but prior to any reductions for personal or busi-

ness state and federal income taxes, personal FICA, personal health and life insurance, the disregards in part 9500.2580, and the allocations in part 9500.2600.

C. Unearned income after deductions for allowable expenses in part 9500.2380, subpart 10, but prior to the allocations in part 9500.2600, unless the income has been specifically excluded in part 9500.2380, subpart 2.

D. Gross earned income from employment as determined under item A which is received through the Job Training Partnership Act by a member of an assistance unit who is a dependent child after the child has received both Job Training Partnership Act earnings and assistance for six payment months in the same calendar year.

E. Gross earned income from employment as determined under item A which is received through employment other than the Job Training Partnership Act by a member of an assistance unit who is a dependent child and a full–time student after the child has received both those earnings and assistance for six payment months in the same calendar year.

F. Child support and spousal support received or anticipated to be received by an assistance unit less the first $50 of current child support.

G. Income as determined under items A to C of a stepparent, a parent of a minor caretaker, and a legal guardian of a minor caretaker who lives in the household and is not in the assistance unit. Subitems (1) to (6) must be deducted from this income:

(1) child or spousal support paid to a person who lives outside of the household;

(2) payments to meet the need of another person who lives outside of the household and who is or could be claimed as a dependent for federal personal income tax liability;

(3) $75 for work 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.

Subp. 5. **Payment eligibility test.** When an assistance unit satisfies the gross income test, a local agency shall apply the payment eligibility test prospectively and retrospectively for each month of program eligibility to determine whether the assistance unit is eligible to receive assistance. The income described in subpart 4 must be used to determine payment eligibility except that:

A. earned income of a dependent child who is a part– or full–time student must be excluded;

B. disregards in part 9500.2580 must be deducted from earned income; and

C. allocations in part 9500.2600 must be deducted from earned income after the deductions in item B are deducted, and from unearned income of a member of the assistance unit who has financial responsibility for an ineligible member of the household in part 9500.2600.

Income that remains after making the adjustments described in items A, B, and C is considered the net income of the assistance unit and must be applied dollar for dollar against the AFDC family allowance to determine payment eligibility.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2520 CALCULATING PAYMENTS.

Subpart 1. **Prospective budgeting.** A local agency shall use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in Minnesota for at least one payment month preceding the first month of payment under a current application.

Subp. 2. **Limitations on prospective budgeting.** The requirements of subpart 1 are subject to items A to E.

A. Income received or anticipated in the first month of program eligibility must be applied against the need of the first month. Income received or anticipated in the second month must be applied against the need of the second month.

B. When assistance payment for any part of the first two months is based on anticipated income, an initial assistance payment amount must be determined based on information available at the time the initial assistance payment is made. When the amount of actual net income is different than the anticipated net income budgeted to determine the assistance payment for the first two months, the assistance unit is liable for an overpayment or is eligible for a corrective payment for the difference between anticipated and actual net income for those two months.

C. The assistance payment for the first two months of program eligibility must be determined by budgeting both recurring and nonrecurring income for those two months.

D. Child support income received or anticipated to be received by an assistance unit must be budgeted to determine the assistance payment amount from the month of application through the month in which program eligibility is determined and assistance is authorized. Child support income which has been budgeted to determine the assistance payment in the initial two months is considered nonrecurring income. An assistance unit shall forward the payment of child support to the child support enforcement unit of the local agency for the months which follow the month in which assistance is authorized.

E. An assistance unit who has had assistance suspended for a month as provided by part 9500.2500, subpart 2, and who has experienced a recurring change of at least $50 in net income, exclusive of the disregards in part 9500.2580, items C and D, in the month preceding the month of suspension or in the month of suspension shall have the assistance payment amount determined prospectively according to items A to D and subpart 1.

Subp. 3. **Retrospective budgeting.** Retrospective budgeting must be used to calculate the monthly assistance payment amount after the payment for the first two months has been made under the provisions of subparts 1 and 2.

Subp. 4. **Limitations on retrospective budgeting.** The requirements of subpart 3 are subject to the limitations of items A and B.

A. Retrospective budgeting is used to determine the amount of the assistance payment in the first two months of program eligibility in the situations described in subitems (1) and (2):

(1) When an assistance unit applies for AFDC for the same month for which assistance has been terminated, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in Minnesota, and the assistance payment for the immediately preceding month was determined retrospectively.

(2) When a person applies to be added to an assistance unit, that assistance unit has received assistance in Minnesota for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

B. Income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit must be applied against the AFDC family allowance to determine the assistance payment to be issued for the payment month, except as provided in subitems (1) to (4).

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When a child is removed from an assistance unit because he or she is no longer a dependent child, the income of that child is not budgeted retrospectively for payment months in which that child is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against his or her own needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2560 LUMP SUM PAYMENTS.

Subpart 1. **Budgeting lump sum payments.** When a recipient receives a lump sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to items A to E.

A. A lump sum received during the first two months prospective budgeting is used to determine payment must be combined with other earned or unearned income received in that month and budgeted in the payment month in which it is received.

B. A lump sum received after the first two months of program eligibility must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

C. When a lump sum, combined with other income according to items A and B, is less than the AFDC family allowance for the applicable payment month, the assistance payment is reduced according to the amount of the combined net income. When the combined income is greater than the AFDC family allowance, the combined income must be divided by the AFDC family allowance for the payment month to determine the period over which the lump sum must be budgeted.

(1) When the combined income is greater than the AFDC family allowance for one month and less than the AFDC family allowance for two months, eligibility does not exist in the month the lump sum is received under item A and assistance must be suspended in the first payment month under item B. The excess, and other income which must be budgeted in the month following the month of ineligibility or suspension, must be deducted from the AFDC family allowance for the second payment month.

(2) When the combined income is equal to or greater than the AFDC family allowance for two or more months, each member of the assistance unit, at the time the lump sum payment was received, shall be ineligible for the determined number of months beginning with the first payment month in which the lump sum is budgeted.

D. When a lump sum is received by an assistance unit or member of an assistance unit in a state other than Minnesota, the period of ineligibility determined by another state does not apply.

E. When a member of an ineligible assistance unit under item C, subitem (2), applies for AFDC for a child who was not a member of the ineligible assistance unit in the budget month in which the lump sum was received, program eligibility may exist for that child as an assistance unit, and only the current income and resources of a financially responsible household member must be considered to determine eligibility and the amount of the assistance payment for that child.

Subp. 2. **Reducing the period of ineligibility.** When an assistance unit is determined ineligible under subpart 1, item C, and reapplies for AFDC before the period of ineligibility ends, a local agency shall redetermine the period of ineligibility after the first payment month by deducting items A to E from the combined income for the initial month in which the lump sum was received:

A. The amount of verified medical payments paid by the assistance unit during the period of ineligibility that, if eligibility for medical assistance had existed, would have been covered by medical assistance.

B. The amount the AFDC family allowance increased during the period of ineligibility.

C. The amount paid by the assistance unit during the period of ineligibility to cover a cost that would otherwise qualify for emergency assistance under part 9500.2820.

D. An amount documented as stolen.

E. An amount that is unavailable because a member of the assistance unit left the household with that amount and has not returned. The month in which that person returns, and any subsequent months, are months of ineligibility according to the period determined in subpart 1, item C.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2580 EMPLOYMENT DISREGARDS.

A local agency shall deduct the disregards in items A to D from gross earned income as defined in part 9500.2380:

A. A $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).

(1) The disregard must not be deducted from the income of an applicant in the initial month when applying the payment eligibility test in part 9500.2500, subpart 5, except that an applicant who has received assistance in Minnesota within four months of the most recent application and who retains eligibility for this disregard from the prior period of eligibility under subitems (2) to (6) shall be eligible for this disregard when determining payment eligibility. When an applicant satisfies the payment eligibility test in the first month, this disregard must be used to calculate the assistance payment amount for that month when the applicant is otherwise eligible to receive it.

(2) Eligibility for this disregard is limited to the four payment months in subitems (3) to (6) and cannot be deducted again from the income of that member of the assistance unit until he or she has not been a recipient in Minnesota for a period of at least 12 consecutive payment months.

(3) The four months of eligibility for this disregard are only those payment months in which any part of the $30 and one–third work incentive is applied against income. When the four months of eligibility for this disregard are interrupted for at least one payment month before the period of eligibility is completed, eligibility for the entire four months must be reestablished, with the next subsequent month of its use considered to be the first month, except as otherwise noted in subitems (4) to (6).

(4) When this disregard is not applied because income from a recurring source results in suspension of an assistance payment, that month must not be counted as a month of the four–month period, but this interruption does not establish eligibility for a new four–month period.

(5) When employment is ended, reduced, or refused without good cause according to part 9500.2700, subpart 19, a person shall not be eligible for any of the employment disregards under items A to D in the first month following the month in which that employment is ended, reduced, or refused. The month in which those disregards are disallowed must be counted as one of the four consecutive months in the period of eligibility for this disregard and the remaining months of eligibility must be counted in the consecutive months which immediately follow, regardless of loss of eligibility or change in employment status.

(6) When a recipient loses all disregards under this part due to late reporting, according to part 9500.2700, subpart 5, item A, the month in which those disregards are disallowed must be considered as one of the four consecutive months in the period of eligibility for this disregard.

D. A deduction for a $30 work incentive disregard. This disregard applies for a period of eight months to members of an assistance unit who have completed the four–month period of eligibility for the $30 and one–third work incentive disregard. This disregard is allowed beginning with the first month following the fourth month of eligibility for the $30 and one–third work incentive disregard and must be counted in consecutive months regardless of the loss of eligibility or change in employment status.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2600 ALLOCATION FOR UNMET NEED OF OTHER HOUSEHOLD MEMBERS.

An allocation of income must be allowed to meet the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caretaker is financially responsible who also lives with the caretaker. An allocation must be made from the caretaker's income to meet the need of an ineligible or excluded spouse up to the amount allowed in the second adult standard. An allocation must be made from the caretaker's income to meet the need of an ineligible or excluded child. That allocation must be made in an amount up to the difference between the payment standard allowed for the assistance unit and the payment standard allowed when that excluded or ineligible child is included in the assistance unit. These allocations must be deducted from the caretaker's net earned income after the deductions under part 9500.2580 have been made and from unearned income subject to items A to C.

A. Income of a dependent child in the assistance unit must not be allocated to meet the need of a person who is not a member of the assistance unit, including the child's parent, even when that parent is the payee of the child's income.

B. Income of an assistance unit must not be allocated to meet the need of a member of the household who elects to receive general assistance.

C. Income of an assistance unit must not be allocated to meet the need of a person sanctioned for failure to cooperate with child support requirements under part 9500.2700, subpart 11, a person required to register with WIN under part 9500.2700, subpart 15, or a person sanctioned for failure to cooperate with WIN under part 9500.2700, subpart 18.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2620 AMOUNT OF ASSISTANCE PAYMENT.

The amount of an assistance payment must be equal to the difference between the AFDC family allowance described in part 9500.2440, subpart 6 and net income, except for items A to F.

A. When program eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision must apply when an applicant loses at least one day of program eligibility.

B. When the difference between net income and the AFDC family allowance in a payment month is less than $10, an assistance payment must not be issued, but that month must be considered a month of program eligibility.

C. Overpayments to an assistance unit identified by a local agency or by a court order prior to October 1, 1981, must be recouped by deducting an amount from the assistance payment. This amount must be equal to one–half of the work incentive disregards described in part 9500.2580, items C and D for each payment month a member of the assistance unit is eligible for those disregards.

D. Overpayments to an assistance unit identified by a local agency on or after October 1, 1981, must be recouped according to part 9500.2640, subpart 4.

E. When recoupment reduces the assistance payment, as in items C and D, and the subsequent level of payment is less than $10, the assistance payment must be made, and the limitations in item B must not apply.

F. An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2640 CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.

Subpart 1. **Scope of overpayment.** When a current or former recipient receives an overpayment, the overpayment must be recouped or recovered under the conditions of this part even when the overpayment is due to agency error or to other circumstances outside the person's responsibility or control.

Subp. 2. **Notice of overpayment.** When a local agency discovers that a person has received an overpayment for one or more months, the local agency shall notify that person of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the person's right to appeal. No limit applies to the period in which the local agency is required to recoup or recover the overpayment. A local agency shall recoup or recover an overpayment according to the provisions of subparts 3 and 4.

Subp. 3. **Recovering overpayments from former recipient.** A local agency shall initiate efforts to recover overpayments paid to a person no longer on assistance. A person who is a member of an assistance unit at the time an overpayment occurs is jointly and individually liable for its repayment. The local agency shall request repayment from each former member of the assistance unit who is 18 years of age or older at the time eligibility for assistance ends. When an agreement for repayment is not completed within six months or when there is a default on an agreement for repayment after six months, the local agency shall initiate recovery under Minnesota Statutes, chapter 270A or section 541.05. When a person has been convicted of fraud under Minnesota Statutes, section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment balance is less than $35, and is not the result of a fraud conviction under Minnesota Statutes, section 256.98, the local agency shall not seek recovery under this subpart. The local agency shall retain information about all overpayments regardless of the amount. When a member of that assistance unit reapplies for assistance, the remaining balance must be recouped under subpart 4.

Subp. 4. **Recouping overpayments from current recipient.** 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.

Subp. 6. **Scope of underpayments.** A local agency shall issue a corrective payment for underpayments identified after September 30, 1981, made to a current recipient or to a person who would be a current recipient if an agency or client error causing the underpayment had not occurred. Issuance of corrective payments must occur according to the provisions of subparts 7 and 8.

Subp. 7. **Identifying the underpayment.** An underpayment may be identified by a local agency, by a current recipient, by a former recipient, or by a person who would be a recipient except for agency or client error.

Subp. 8. **Issuing corrective payments.** A local agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment or by issuing a separate payment to a current recipient, or by reducing an existing overpayment balance. When an underpayment occurs in a payment month and is not identified until the next payment month or later, that underpayment must first be subtracted from any overpayment balance before issuing the corrective payment. An underpayment for a current payment month must not be applied against an overpayment balance and payment must be issued within seven calendar days after the underpayment is identified.

Subp. 9. **Appeals.** A person may appeal an underpayment, an overpayment, and the amount by which an assistance payment will be reduced to recoup the overpayment under part 9500.2740, subpart 8. Appeal of each issue must be timely under Minnesota Statutes, section 256.045. When an appeal based on the notice issued under subpart 2 is not timely, the fact or the amount of that overpayment must not be considered as a part of a later appeal, including an appeal of a reduction of an assistance payment to recoup that overpayment.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2680 PAYMENT PROVISIONS.

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

A. A local agency shall mail assistance payment checks to the address where a caretaker lives unless the local agency approves an alternate arrangement.

B. A local agency shall mail monthly assistance payment checks within time to allow postal service delivery to occur no later than the first day of each month. Monthly assistance payment checks must be dated the first day of the month.

C. A local agency shall issue replacement checks promptly, but no later than seven calendar days after the provisions of Minnesota Statutes, section 471.415 have been met.

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:

A. When the needs of a caretaker are not included in the assistance unit's assistance payment because the caretaker is under sanction for noncooperation with WIN under part 9500.2700, subpart 18. In this case, the assistance payment must be issued by protective or vendor payment in accordance with the Code of Federal Regulations, title 45, sections 224.51(b)(1) and 234.60(a)(12).

B. When the needs of a caretaker are not included in the assistance unit's assistance payment because the caretaker has failed or refused to cooperate with child support enforcement according to part 9500.2700, subpart 11. In this case, the assistance payment must be issued by protective or vendor payment in accordance with Code of Federal Regulations, title 45, section 234.60(a)(13).

C. When a local agency determines that a vendor or two–party payment is the most effective way to resolve an emergency situation under part 9500.2820.

D. When a caretaker makes a written request asking that the local agency issue part or all of the assistance payment by protective, vendor, or two–party payments. The caretaker may withdraw this request in writing at any time.

E. When a caretaker has exhibited a continuing pattern of mismanaging funds under the conditions specified in Code of Federal Regulations, title 45, section 234.60(a)(2).

(1) The director of a local agency must approve a proposal for protective, vendor, or two–party payment for money mismanagement. During the time a protective, vendor, or two–party payment is being made, the local agency shall provide services designed to alleviate the causes of the mismanagement in accordance with Code of Federal Regulations, title 45, section 234.60(a)(8).

(2) The continuing need for and method of payment must be documented and reviewed every 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 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2700 APPLICANT AND RECIPIENT RESPONSIBILITIES.

Subpart 1. **Applicant reporting requirements.** An applicant shall provide information on an application form and supplemental forms about his or her circumstances which affect program eligibility or the assistance payment. An applicant shall report any changes in those circumstances under subpart 7 while the application is pending. When an applicant does not accurately report information on an application, both an overpayment and a referral for a fraud investigation under part 9500.2780, subpart 2 may result. When an applicant does not provide information or documentation, the receipt of the assistance payment may be delayed or the application may be denied depending on the type of information required and its effect on eligibility.

Subp. 2. **Requirement to apply for other benefits.** An applicant or recipient shall apply for benefits from other programs for which they are potentially eligible and which would, if received, offset assistance payments. Failure without good cause to complete application for these benefits must result in denial or termination of assistance. Good cause for failure to apply for these benefits is allowed when circumstances beyond the control of the applicant or recipient prevent him or her from making application.

Subp. 3. **Responsibility to inquire.** An applicant or recipient who does not know or is unsure whether a given change in circumstances will affect his or her program eligibility or assistance payment shall contact the local agency for information.

Subp. 4. **Recipient's redetermination of eligibility form.** A recipient shall complete forms prescribed by the commissioner which are required for redetermination of eligibility according to part 9500.2420, subpart 5.

Subp. 5. **Household reports.** Each 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.

A. When a recipient submits an incomplete household report form before the last working day of the month on which a ten–day notice of termination of assistance can be is-

sued for failure to provide a complete household report form, the local agency shall return the incomplete form on or before the ten–day notice deadline or any ten–day notice of termination which is issued due to the incomplete household report form must be invalid.

B. When a complete household report form is not received by a local agency before the last ten days of the month in which the form is due, the local agency shall send notice of proposed termination of assistance. When a recipient submits an incomplete form on or after the date the notice of proposed termination has been sent, the termination is valid unless the recipient submits a complete form before the end of the month. 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.

Subp. 7. **Changes which must be reported.** A recipient shall report the changes or anticipated changes specified in items A to M within ten days of the date they occur, within ten days of the date the recipient learns that the change will occur, at the time of the periodic redetermination of eligibility under part 9500.2420, subpart 5, or within eight calendar days of a reporting period as in subpart 5, whichever occurs first. A recipient shall report other changes at the time of the periodic redetermination of eligibility under part 9500.2420, subpart 5 or at the end of a reporting period under subpart 5 as applicable. A recipient shall make these reports in writing or in person to the local agency. When a local agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under items A to M had not occurred, the local agency shall determine whether a timely notice under part 9500.2740, subpart 7 could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under part 9500.2640. Changes in circumstances which must be reported within ten days must also be reported on the household report form for the reporting period in which those changes occurred. Within ten days, a recipient must report changes in:

A. initial employment;

B. the initial receipt of unearned income;

C. a recurring change of more than $50 per month of net earned or unearned income;

D. the receipt of a lump sum;

E. an increase in resources which may cause the assistance unit to exceed AFDC resource limits;

F. a change in the physical or mental status of an incapacitated parent;

G. a change in the employment status of an unemployed parent;

H. a change in the status of an absent parent, change in the household composition, including departures from and returns to the home of assistance unit members and financially responsible persons, or a change in the custody of a dependent child;

I. the marriage or divorce of an assistance unit member;

J. the death of a parent or a dependent child;

K. a change in address or living quarters of the assistance unit;

L. the sale, purchase, or other transfer of property; and

M. a change in school attendance of a dependent child over 15 years of age or an adult member of an assistance unit.

Subp. 8. **Requirement to cooperate with quality control review.** To receive assistance, a recipient shall cooperate with the department's quality control review process by providing information that will verify program and assistance payment eligibility upon the request of the department or the local agency.

A. Cooperation in the quality control review process includes both participating in a personal interview with a quality control staff person at a mutually acceptable time and location and assisting the quality control staff person to get the verifications necessary to establish program and assistance payment eligibility for the month of the redetermination of eligibility when those verifications do not duplicate what already exists in the local agency case record and when getting them does not cause the recipient to incur an expense.

B. When a recipient does not cooperate with the quality control review process and does not have good cause for not cooperating, a local agency must end assistance. The assistance unit shall remain ineligible until they cooperate with the quality control review process or until the last day of the annual period for reporting quality control cases to the federal government, whichever occurs first. A recipient shall have good cause under this subpart only when he or she does not cooperate because of mental or physical disability or illness of such severity and duration that he or she cannot participate within the period that is allotted to complete the quality control review process.

Subp. 9. **Requirement to provide social security numbers.** To receive assistance, 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.

Subp. 10. **Cooperation with child support enforcement.** When the basis of program eligibility for a dependent child is continued absence under part 9500.2260, the caretaker of that child shall cooperate with the efforts of the local agency to collect child and spousal support.

A. A caretaker shall assign the right to collect past due, current, and future support to the local agency. Signing an application form satisfies this requirement under Minnesota Statutes, section 256.74, subdivision 5. The assignment of support ends with the last day of the last month in which a dependent child receives assistance. When assistance ends, a local agency has the right to any unpaid support for the period in which assistance was received.

B. A caretaker shall provide information known to them about an absent parent and requested by either the AFDC unit or the child support enforcement unit, which is required to establish paternity or secure support for the dependent child, unless the caretaker has good cause for refusing to cooperate under subpart 12.

C. When the paternity of a dependent child is not established under law, a caretaker shall cooperate with the child support enforcement unit to determine and establish the child's paternity unless the caretaker has good cause for noncooperation under subpart 12.

D. A caretaker shall forward to the local agency all support he or she receives during the period the assignment of support is in effect according to item A. Support received by a caretaker, and not forwarded to the local agency, must be repaid to the child support enforcement unit for any month following the month in which initial eligibility is determined, except as provided under subpart 11, item B, subitem (3).

Subp. 11. **Refusal to cooperate with support requirements.** Failure by a caretaker to satisfy any of the requirements of subpart 10 constitutes refusal to cooperate, and the sanctions under item B apply.

A. The AFDC unit of a local agency shall determine whether a caretaker has refused to cooperate within the meaning of subpart 10. Before making this determination, the AFDC unit shall:

(1) allow the child support enforcement unit to review and comment on the findings and basis for the proposed determination of noncooperation;

(2) consider any recommendations from the child support enforcement unit; and

(3) allow the child support enforcement unit to appear at a hearing under part 9500.2740, subparts 8 to 10, which results from an appeal of a local agency action involving cooperation with child support enforcement under subpart 10.

B. Determinations of refusal to cooperate shall have the following effects.

(1) A parent caretaker who refuses to cooperate must not be included in an assistance unit. Payments for the remaining members of the assistance unit are subject to the conditions of part 9500.2680, subpart 2, item B.

(2) A caretaker who is not a parent of a dependent child in an assistance unit may choose to remove that child from the assistance unit or to have his or her own needs removed from the assistance unit, unless otherwise required by federal or state law. When a caretaker chooses to remove his or her own needs, assistance payments for the remaining members of the assistance unit are subject to the conditions of part 9500.2680, subpart 2, item B.

(3) Direct support retained by a caretaker must be counted as unearned income when determining the amount of the assistance payment.

Subp. 12. **Good cause exemption from cooperating with support requirements.** Before requiring a caretaker to cooperate, a local agency shall notify an applicant that he or she may claim a good cause exemption from cooperating with the requirements in subpart 10, items B to D, under the conditions specified in Code of Federal Regulations, title 45, sections 232.12 and 232.40 to 232.49 at the time of application or at any subsequent time. When a caretaker submits a good cause claim in writing, action related to child support enforcement must stop. The caretaker shall submit evidence of a good cause claim to the local agency within 20 days of submitting the claim.

A. Good cause exists when a caretaker documents that:

(1) a dependent child for whom child support enforcement is sought was conceived as the result of incest or rape;

(2) legal proceedings for the adoption of a dependent child are pending before a court of competent jurisdiction; or

(3) a parent caretaker is receiving services from a licensed adoption agency to determine whether to keep the child or relinquish the child for adoption, and the services have not been provided for longer than three months.

B. Good cause exists when a caretaker documents that his or her cooperation would not be in the best interest of the dependent child because the cooperation could result in:

(1) physical harm to the child;

(2) emotional impairment of the child which would substantially affect the child's functioning; or

(3) physical harm to or emotional impairment of the caretaker which would substantially affect the caretaker's functioning and reduce the caretaker's ability to adequately care for the child.

C. When an applicant or recipient has difficulty obtaining evidence, the local agency shall help him or her obtain it. When a local agency requires additional evidence to make a determination on the claim for good cause, the local agency shall notify the caretaker that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

D. A local agency shall determine whether good cause exists based on the weight of the evidence.

E. Once a local agency determines that good cause exists for a caretaker, the exemption from cooperating under subpart 10, items B and C must remain in effect for the period the dependent child remains eligible under that application, except for subitems (1) to (4).

(1) A good cause exemption allowed because a child was conceived as the result of incest or rape must continue until a subsequent acknowledgment of paternity or an application for adoption by a second parent is submitted for that child.

(2) A good cause exemption allowed because of adoption proceedings must be issued for a fixed period of time based on the expected time required to complete adoption proceedings. The exemption must be extended when the required time is longer than was anticipated and must stop when adoption proceedings are discontinued or completed.

(3) A good cause exemption allowed because of adoption counseling must last no more than three months from the time the counseling began.

(4) A good cause exemption must be allowed under subsequent applications and redeterminations of eligibility without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under item B must end when the factors which led to allowing the exemption have changed.

F. A good cause exemption which has been allowed by a local agency for a caretaker must be honored by the local agency in the county of residence when the caretaker moves into that county, until the factors which led to allowing the exemption change.

G. When a local agency denies a claim for a good cause exemption, the local agency shall require the caretaker to submit additional evidence in support of a later claim for a good cause exemption before the local agency stops acting to enforce child support under this subpart.

H. Following a determination that a caretaker has good cause for refusing to cooperate, a local agency shall take no further action to enforce child support until the good cause exemption ends according to item E.

Subp. 13. [Repealed, 12 SR 2787]

Subp. 14. [Repealed, 12 SR 2787]

Subp. 15. [Repealed, 12 SR 2787]

Subp. 16. [Repealed, 12 SR 2787]

Subp. 17. [Repealed, 12 SR 2787]

Subp. 18. [Repealed, 12 SR 2787]

Subp. 19. [Repealed, 12 SR 2787]

Statutory Authority: *MS s 256.01 subd 4; 256.736 subd 7; 256.851; 256.871 subd 7*

History: *11 SR 212; 14 SR 2988; 15 SR 117*

9500.2720 DEFINITIONS.

Subpart 1. **Applicability.** The terms used in parts 9500.2720 to 9500.2730 have the meanings given them in this part and in part 9500.2060 unless otherwise indicated.

Subp. 2. **Employability plan.** "Employability plan" means a plan written for a registrant by an employment and training provider in consultation with the registrant that defines the registrant's employment and training goals and outlines the training, education, and support services the registrant needs to achieve these goals.

Subp. 3. **Employment search.** "Employment search" means the program authorized under the Code of Federal Regulations, title 45, part 240, which provides AFDC recipients with training and assistance in finding and securing regular, unsubsidized employment.

Subp. 4. **Employment and training services.** "Employment and training services" means programs, activities, and services as defined in Minnesota Statutes, section 256.736, subdivision 1a, paragraph (d).

Subp. 5. **Employment and training service provider or service provider.** "Employment and training service provider" or "service provider" means a provider certified by the commissioner of jobs and training under Minnesota Statutes, section 268.0122, subdivision 3, to deliver employment and training services.

Subp. 6. **Priority caretaker.** "Priority caretaker" means a caretaker who:

A. is under age 21;

B. has not graduated from high school or received a general equivalency diploma; or

C. has received AFDC for 24 or more months out of the last 36 consecutive calendar months.

Statutory Authority: *MS s 256.736 subd 7*

History: *12 SR 2787*

9500.2722 ORIENTATION REQUIREMENT.

Subpart. 1. **Local agency responsibilities.** Each local agency shall:

A. provide or contract with another entity to provide orientation to AFDC caretakers residing in the local agency's jurisdiction who are required to attend orientation under subpart 2; and

B. provide or pay the reasonable cost of child care and transportation needed to enable a caretaker to attend orientation. A local agency is not required to pay child care costs that exceed limits established by the local agency under Minnesota Statutes, section 268.91, subdivision 8.

Subp. 2. **Mandatory participants.** A recipient shall attend an orientation session if the recipient is:

A. a caretaker who is a principal wage earner in an assistance unit whose eligibility is based on the unemployment of a parent under part 9500.2300;

B. a priority caretaker; or

C. a caretaker who is determined eligible for AFDC on or after July 1, 1988, and who has not attended an orientation within the previous 12 calendar months.

Subp. 3. **Orientation content.** Orientation must consist of a presentation that tells a recipient of the identity, location, and phone number of available employment and training services, and support services relevant to the recipient's circumstances. Orientation must encourage recipients to view AFDC as a temporary program providing grants and services to clients who set goals and develop strategies for supporting their families without AFDC assistance. The content of orientation must not imply that a recipient's eligibility for AFDC is time limited. The presentation must also inform recipients of the headstart program and encourage caretakers to have their children screened for enrollment in the program where appropriate.

Subp. 4. **Orientation format.** Videotaped presentations may be used, but orientation must include the opportunity for face–to–face interaction between the recipient and staff of the local agency or the entity providing orientation.

Subp. 5. **Good cause for failure to attend orientation.** Good cause for failure to attend orientation exists when a recipient cannot attend because of:

A. illness or injury of the recipient;

B. illness or injury of a member of the recipient's family that requires the recipient's care during the hours when orientation is offered;

C. an inability to obtain the necessary child care or transportation;

D. employment, school, or employment and training service obligations that are scheduled during the hours when orientation is offered and that cannot be changed to allow participation in orientation;

E. a judicial proceeding that requires the recipient's presence in court during the hours when orientation is scheduled; or

F. a nonmedical emergency that requires the recipient's presence at a different location during the hours when orientation is scheduled. "Emergency" under this item means a sudden, unexpected occurrence or situation of a serious or urgent nature that requires immediate action.

Subp. 6. **Notice to mandatory participants.** Except as provided in subpart 7, the local agency shall provide written notice of the orientation requirement to a recipient required to

attend orientation under subpart 2. The notice must tell the recipient the time, date, and location of the orientation that the recipient is scheduled to attend, the consequences of failing to attend on the scheduled date, and the recipient's appeal rights in part 9500.2740, subparts 8 to 10. The notice must be mailed or delivered to the recipient at least ten days before the recipient's scheduled orientation date.

Subp. 7. **Voluntary early participation in orientation.** If the local agency and the applicant or recipient agree, orientation may be provided before issuance of the notice under subpart 6. If the applicant or recipient fails to attend orientation on the agreed upon date, the local agency shall schedule the recipient for orientation under subpart 8 and issue a notice under subpart 6.

Subp. 8. **Timing of orientation.** A recipient required to attend orientation under subpart 2 must attend orientation on the date scheduled by the local agency under this subpart unless the recipient has good cause for not attending on that date or the local agency and recipient agree on a different date. The local agency must schedule a recipient required to attend orientation under subpart 2, item A or B, for an orientation session to be held before January 1, 1989. The local agency must schedule a recipient required to attend orientation under subpart 2, item C, for an orientation session to be held within 60 days after the local agency mails the recipient's notice of eligibility.

Subp. 9. **Sanctions for failure to attend orientation.** If a recipient who is required to attend orientation under subpart 2 fails, without good cause, to attend orientation on a scheduled or agreed upon date after issuance of the notice required under subpart 6, the recipient must be sanctioned under items A and B. Before imposing sanctions under item A or B, the local agency must provide the notice required under part 9500.2740, subpart 6.

A. When a recipient fails for the first time to attend an orientation session, the local agency shall issue a maximum of 50 percent of the next monthly payment to which the assistance unit is entitled in the form of a vendor or protective payment. The local agency shall schedule the recipient for another orientation session to be held during the payment month for which the sanction under this item is imposed and shall notify the recipient of the date, time, and location of the session under subpart 6.

B. When a recipient fails for the second time to attend an orientation session, the local agency shall issue 100 percent of the next monthly payment to which the assistance unit is entitled in the form of a vendor or protective payment. The local agency's notice of sanction under this item must include an offer to schedule the recipient for an orientation session. If the recipient contacts the local agency and asks to be scheduled for orientation, the local agency must schedule the recipient's orientation to be held within 30 days of the request. The sanction under this item ends when the recipient attends the orientation. The local agency shall then issue to the recipient any remaining benefits being held for vendor or protective payments.

C. When a vendor payment is required under item A or B, the local agency may continue payments to the caretaker to the extent that no vendor is available.

Statutory Authority: *MS s 256.736 subd 7*

History: *12 SR 2787*

9500.2724 GENERAL EMPLOYMENT AND TRAINING REQUIREMENTS.

Subpart 1. **Registration and referral for employment and training services.** Except for registration with the local job service office under part 9500.2300, item F, or subpart 2 of this part, completion of the AFDC application form automatically registers the applicant for WIN and for other mandatory employment and training services that require registration. The local agency shall refer to the local WIN office recipients residing in WIN counties who are not exempt from mandatory WIN registration under part 9500.2726, subpart 1. The local agency shall refer to the local job service office recipients who are principal wage earners residing in non–WIN counties whose program eligibility is based on the unemployment of a parent under part 9500.2300.

Subp. 2. **Mandatory employment and training participation.** Recipients shall participate in WIN if required under part 9500.2726, subpart 1, in employment search if required under part 9500.2728, subpart 1, and in CWEP if required under parts 9505.1050 to

9505.1065 [Emergency]. A principal wage earner who resides in a non–WIN county and whose program eligibility is based on the unemployment of a parent under part 9500.2300 must be currently registered with the local job service office. If an applicant or recipient does not comply with this requirement, the person's entire assistance unit shall be ineligible.

Statutory Authority: *MS s 256.736 subd 7*

History: *12 SR 2787*

9500.2726 WIN REQUIREMENTS.

Subpart 1. **Participation in WIN.** A recipient living in a WIN county, regardless of the recipient's basis of program eligibility under parts 9500.2180 to 9500.2300, shall cooperate with the local WIN office as a condition of AFDC eligibility unless the local agency determines that the applicant or recipient is exempt. A recipient who is exempt from mandatory WIN registrant status is:

A. A child under the age of 16.

B. A student who is at least 16 but less than 18 years of age and meets the conditions of part 9500.2060, subpart 58, item A, B, C, or F.

C. A person who is 18 years of age and meets the conditions of part 9500.2060, subpart 39, items B and C.

D. A person who, for up to 90 consecutive days, is ill or injured to the extent that the illness or injury temporarily prevents participation in training or employment. Determination of an exemption under this item must be made by the AFDC unit and may be allowed without medical documentation when the illness or injury is evident. An exemption for an illness or injury that extends for 90 days or more must be documented by medical evidence described in item E.

E. A person who, for at least 90 consecutive days, is physically or mentally incapacitated when the incapacitating factors, by themselves or with the person's age, prevent participation in training or employment. The incapacity must be documented by medical evidence. The medical evidence must include a prognosis and diagnosis of the impairment from at least one licensed physician or licensed psychologist. The local agency shall give the applicant or recipient voluntary referral to the Minnesota Department of Vocational Rehabilitation upon determination of the exemption.

F. A person 65 years of age or older.

G. A person whose round trip commuting time from the person's residence to the local WIN office is more than two hours by the means of transportation available to the recipient and exclusive of the time needed to transport children to and from child care.

H. A person needed in the home to care for a physically or mentally incapacitated person living in the household. The incapacity and the need for care must be documented by medical evidence from a licensed physician or licensed psychologist.

I. A parent or caretaker of a child under age six who is providing full–time care for that child. A person who is anticipated to be absent from the child for an average of at least 30 hours per week during the current and following month, exclusive of absences related to providing care for the child, does not qualify for this exemption.

J. A person who is currently employed in unsubsidized employment that is expected to last at least 30 days and that provides a monthly average of at least 30 hours of employment per week.

K. A parent who is not a principal wage earner but who is in an assistance unit whose program eligibility is based on the unemployment of a parent, provided the principal wage earner in the assistance unit is not exempt under the other items of this subpart and is cooperating with WIN.

L. A person, who after applying for AFDC, volunteered to participate under the Volunteers in Service to America (VISTA) program as provided by United States Code, title 42, sections 4951 to 4959 as amended through December 31, 1987.

M. A pregnant woman when the pregnancy has entered the third trimester.

N. A person employed under a work supplement program established under the Code of Federal Regulations, title 45, part 239.

Subp. 2. **Good cause for noncooperation with WIN.** A recipient who has good cause for not cooperating with WIN shall not be sanctioned. Good cause for not cooperating with WIN must be determined under the Code of Federal Regulations, title 45, section 224.34.

Subp. 3. **Determination of noncooperation.** The WIN office shall determine whether a WIN registrant has, without good cause, failed to cooperate with WIN. The WIN office shall notify the local agency of a deregistration action taken against a registrant for noncooperation. When notified of deregistration, the local agency shall sanction the recipient under part 9500.2730, beginning with the first payment month following deregistration in which notification and appeal rights under part 9500.2740, subparts 5 to 10, allow application of those sanctions.

Statutory Authority: *MS s 256.736 subd 7*

History: *12 SR 2787*

9500.2728 EMPLOYMENT SEARCH REQUIREMENTS.

Subpart 1. **Participation in employment search.** Each local agency shall provide a mandatory employment search program for recipients whose participation is mandatory under item A. A local agency may provide a voluntary employment search program for recipients who are not required to participate under item A. The employment search program must be administered in accordance with items A to C.

A. A caretaker who is the principal wage earner in an assistance unit whose program eligibility is based on the unemployment of a parent under part 9500.2300 must participate in employment search as a condition of AFDC eligibility unless:

(1) the caretaker is exempt from WIN participation under part 9500.2726, subpart 1, items A to F or H to N;

(2) the caretaker is currently participating in another employment and training service which can reasonably be expected to improve the recipient's ability to obtain and keep employment;

(3) the caretaker's employability plan specifies other activities that conflict with participation in employment search; or

(4) the caretaker cannot secure employment because of an inability to communicate in the English language as determined by the local agency, a specialist in English as a second language, or a vocational specialist as defined in part 9500.1206, subpart 33, and the recipient is attending a program in English as a second language, if available.

B. In the third month after determining that a recipient is required to participate in employment search, the local agency shall refer the recipient to the employment search service provider and inform the recipient of the consequences of failure to participate and of the recipient's appeal rights.

C. The employment search service provider shall specify the number of weeks and hours that a recipient must participate in employment search. The service provider shall not require a recipient to participate in employment search for more than eight weeks in any 12 consecutive calendar months and for more than 32 hours during any week.

D. A WIN registrant who is suspended from WIN and referred to the employment search program by the local WIN office is not exempt from the employment search program under item A, subitem (2).

Subp. 2. **Offers of employment.** A recipient who is the principal wage earner in an assistance unit whose program eligibility is based on the unemployment of a parent under 9500.2300 must, as a condition of AFDC eligibility, accept any bona fide offer of employment made by an employer.

Subp. 3. **Good cause for refusing or terminating employment or failing to comply with employment search requirements.** A recipient who fails to participate in employment search required under subpart 1 or accept employment as required under subpart 2 shall not be sanctioned if the recipient has good cause for the failure. Good cause shall be determined by applying the conditions in items A to I.

A. Good cause exists when a job or employment search is not suited to the physical or mental capacity of the person or when it will have an adverse effect on that person's physi-

cal or mental health. Evidence from a licensed physician or licensed psychologist must document a claim under this item.

B. Good cause exists when the round trip commuting time from a person's residence to the employment search or job site is more than two hours by available means of transportation, exclusive of the time to transport children to and from child care.

C. Good cause exists when licensed child care is required but not available.

D. Good cause exists when the work or employment search site is unsafe under health and safety standards established by the Occupational Safety and Health Administration and the Minnesota Department of Jobs and Training.

E. Good cause exists when a person documents discrimination at the job or employment search site on the basis of age, sex, race, religion, or place of national origin.

F. Good cause exists when the hourly gross employment earnings are less than the federal or state minimum wage for that type of employment, whichever applies.

G. Good cause exists when the gross monthly employment earnings are less than 185 percent of the AFDC family allowance for the recipient's assistance unit.

H. Good cause exists when the job that is offered is vacant due to a strike, lockout, or other bona fide labor dispute.

I. Good cause exists when the recipient incurs unreimbursed out of pocket expenses to participate in employment search.

Subp. 4. **Determination of failure to accept employment or participate in employment search.** The employment search service provider shall determine whether a recipient has failed, without good cause, to comply with employment search requirements under subpart 1 or accept employment as required under subpart 2. If the employment search or employment offer is provided through WIN, the WIN office shall make the determination. If the service provider determines that a recipient has failed, without good cause, to comply with the participation or employment requirements of subpart 1 or 2, the provider shall notify the recipient under subpart 5.

Subp. 5. **Notice of failure to participate or accept employment.** If a service provider determines under subpart 4 that a recipient has failed, without good cause, to participate in employment search or accept employment as required, the provider shall mail a written notice of its determination to the recipient at the recipient's last known mailing address. The notice shall provide a detailed explanation of the reasons for the determination, the consequences of failure to participate or accept employment, the actions the service provider believes are necessary for the recipient to comply with the employment and training requirements, the right to request a conciliation conference within 15 days after the date the notice is mailed, and the right to request a hearing under part 9500.2740, subpart 8.

Subp. 6. **Conciliation conference.** A service provider shall, according to its contract with the local agency, provide a conciliation conference to recipients who request a conference within 15 days after the notice under subpart 5 is mailed. The conciliation conference must be conducted according to items A to D.

A. If a recipient requests a conciliation conference, the service provider shall provide the conference within 30 days after receiving the recipient's written request for a conference. The service provider shall notify the recipient of the conference date at least ten days before the date of the conference.

B. The local agency shall reimburse the recipient for the recipient's reasonable and necessary child care and transportation expenses incurred as a result of the recipient's attendance of the conciliation conference.

C. The service provider shall hold the conciliation conference during regular working hours at the service provider's office. If the service provider and the recipient agree, the conciliation conference may be conducted over the telephone.

D. If a conciliation conference is not requested or if the dispute is not resolved at the conference, the service provider shall provide to the local agency and to the recipient written notification of its determination that the recipient failed or refused without good cause to participate in employment search or accept employment.

Subp. 7. **Final determination before sanction.** When WIN does not sanction a recipient for failure to accept employment assigned by WIN or participate in an employment and

training service provided through WIN, a local agency shall not apply sanctions for the same failure. The local agency shall make a final determination of whether the recipient has failed, without good cause, to accept employment that has not been assigned by WIN or to participate in employment search program that has not been provided through WIN. Upon final determination of failure to participate or accept employment, the local agency shall apply the sanctions under part 9500.2730.

Statutory Authority: *MS s 256.736 subd 7*

History: *12 SR 2787*

9500.2730 SANCTIONS FOR FAILURE TO PARTICIPATE IN A MANDATORY EMPLOYMENT AND TRAINING SERVICE OR ACCEPT EMPLOYMENT.

Subpart 1. **Notice.** If a local agency is notified of WIN deregistration under part 9500.2726, subpart 3, or if a local agency determines under part 9500.2728, subpart 7, that a recipient has failed, without good cause, to participate in employment search or accept employment, the local agency shall notify the recipient that the local agency will impose the sanctions of subpart 2, beginning with the first payment month following deregistration or noncompliance in which notification and appeal rights under part 9500.2740, subparts 5 to 10, allow application of those sanctions.

Subp. 2. **Sanctions.** The following sanctions apply to recipients who do not comply with WIN, employment search, or employment requirements:

A. When a recipient is also the principal wage earner under part 9500.2300, the entire assistance unit is ineligible for three payment months for the first failure to comply or for six payment months for later failures to comply. When, during the period of sanction, the principal wage earner leaves the home or when either parent becomes incapacitated and eligibility is established under parts 9500.2180 to 9500.2260, the sanction period ends for the remaining members of the assistance unit.

B. When a recipient in an assistance unit that qualifies under part 9500.2300 is the parent who is not the principal wage earner, or when the recipient is a parent caretaker in an assistance unit that qualifies under part 9500.2180, 9500.2220, or 9500.2260, the parent caretaker shall be removed from the assistance unit. The parent caretaker shall be ineligible for a period of three payment months for the first failure to comply or for six payment months for later failures to comply. Protective or vendor payments shall be issued for the needs of the remaining members of the assistance unit under part 9500.2680, subpart 2, item A until the period of the sanction ends or the recipient who is under sanction is no longer a member of the assistance unit.

C. When a recipient who is under sanction is a caretaker relative other than a parent or is one of several dependent children, that person must be removed from the assistance unit for three payment months for the first failure to comply or for six payment months for subsequent failures to comply. When the recipient is the only dependent child in the assistance unit, the assistance unit shall be ineligible for AFDC for three payment months following the first occasion of noncompliance or for six payment months following later occasions of noncompliance.

Statutory Authority: *MS s 256.736 subd 7*

History: *12 SR 2787*

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

Subpart 1. **Right to information.** An applicant or recipient has the right to obtain information about the benefits, requirements, and restrictions of AFDC.

Subp. 2. **Right to apply.** A person has the right to apply, including the right to reapply, for AFDC. A local agency shall inform a person who inquires about AFDC of his or her right to apply, shall explain how to apply, and shall offer a brochure about the program. When a local agency ends assistance, the local agency shall inform the recipient in writing of the right to reapply. When a report is received that indicates a loss of basis of eligibility under parts 9500.2180, 9500.2220, 9500.2260, or 9500.2300, the local agency shall notify the caretaker of other possible bases of eligibility, the need to file an addendum or a new application and the time limit for meeting that requirement.

Subp. 3. **Information about other programs.** A local agency shall inform an applicant or recipient about other programs administered by the local agency for which, from its knowledge of the person's situation, the person may be eligible. A local agency shall display, in a public place, brochures provided by the commissioner describing the medical assistance, general assistance, general assistance medical care, emergency assistance, food stamp, and Minnesota supplemental aid programs.

Subp. 4. **Right to authorized representative.** An applicant or recipient has the right to designate an authorized representative to act in his or her behalf. An applicant or recipient has the right to be assisted or represented by an authorized representative in the application, eligibility redetermination, fair hearing process, and any other contacts with the local agency or the department.

When a local agency determines that it is necessary for a person to assist an applicant or recipient, the local agency shall designate a staff member to assist him or her. The local agency staff member may assist the applicant or recipient to take the actions necessary to submit an application to establish the date of the application.

Upon a request from an applicant or recipient, a local agency shall provide addresses and telephone numbers of organizations that provide legal services at no cost to low income persons.

Subp. 5. **Right of applicant to notice.** A local agency shall notify an applicant of the disposition of his or her application. The notice must be in writing and on forms prescribed by the commissioner. The local agency must mail the notice to the last known mailing address provided by the applicant. When an application is denied, the local agency must notify the applicant in writing of the reasons for the denial, of the right to appeal, and of the right to reapply for assistance.

Subp. 6. **Right of recipient to notice.** A local agency shall give a recipient written notice of payment reductions, suspensions, terminations, or changes in the use of protective, vendor, or two–party payments. The notice must be on forms prescribed or approved by the commissioner and must be mailed to the last known mailing address provided by the recipient. The local agency shall state on the notice the action it intends to take, the reasons for the action, the recipient's right to appeal the action, the conditions under which assistance can be continued pending an appeal decision, and the related consequences of the action, such as the loss of eligibility for medical assistance.

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

A. A local agency shall mail a notice to a recipient no later than ten days before the effective date of the action, except as provided in items B and C.

B. A local agency shall mail a notice to a recipient no later than five days prior to the effective date of the action when the local agency has factual information which requires an action to reduce, suspend, or terminate assistance, and this action is based on probable fraud.

C. A local agency shall mail a notice to a recipient no later than the effective date of the action when:

(1) the local agency receives a recipient's monthly household report form which includes facts that require payment reduction, suspension, or termination and which contains the recipient's signed acknowledgment that he or she understands that this information will be used to determine program eligibility or the assistance payment amount;

(2) the local agency verifies the death of a recipient or the payee;

(3) the local agency receives a signed statement from a recipient that assistance is no longer wanted;

(4) the local agency receives a signed statement from a recipient that provides information which requires the termination or reduction of assistance, and the recipient shows in that statement that he or she understands the consequences of providing that information;

(5) the local agency verifies that a recipient is hospitalized and does not qualify under part 9500.2140, subpart 5, item C, subitem (1);

(6) the local agency verifies that a recipient has entered a state hospital or a licensed residential facility for medical or psychological treatment or rehabilitation;

(7) the local agency verifies that a member of an assistance unit has been approved to receive assistance by another county or state;

(8) the local agency verifies that a member of an assistance unit has been placed in foster care, except as specified in part 9500.2140, subpart 5, item C, subitem (2); or

(9) the local agency cannot locate a caretaker's whereabouts and mail from the local agency has been returned by the post office showing that the post office has no forwarding address.

Subp. 8. **Appeal rights.** An applicant, recipient, or former recipient has a right to request a fair hearing when aggrieved by an action or by inaction of a local agency. Requests for fair hearings must be submitted in writing to a local agency or to the department. These requests must be mailed within 30 days after an applicant or recipient receives written notice of the local agency's action or within 90 days when an applicant or recipient shows good cause for not submitting the request within 30 days. A former recipient who receives a notice of overpayment may appeal the action contained in the notice in the manner and within the periods described in this subpart. Issues which may be appealed are:

A. a denial of the right to apply for assistance;

B. the failure of a local agency to promptly approve or deny an application;

C. a denial of an application for assistance;

D. a suspension, reduction, or termination of assistance;

E. the calculated amount of an overpayment and the calculated level of recoupment due to that overpayment;

F. the eligibility for and calculation of a corrective payment;

G. other factors involved in the calculation of an assistance payment; and

H. the use of protective, vendor, or two–party payments.

Subp. 9. **Rights pending hearing.** A local agency shall not reduce, suspend, or terminate payment when an aggrieved recipient requests a fair hearing prior to the effective date of the action or within ten days of the mailing of the notice, whichever is later, unless the recipient requests in writing not to receive continued assistance pending a hearing decision. A local agency may increase or reduce an assistance payment while an appeal is pending when the circumstances of the recipient change and are not related to the issue under appeal. Assistance issued pending a fair hearing is subject to recovery under part 9500.2640, subpart 3 when, as a result of the fair hearing, the commissioner finds that the recipient was not eligible for the assistance. The commissioner's order is binding on a local agency and shall be implemented subject to Minnesota Statutes, section 256.045, subdivision 7. No additional notice is required to enforce the commissioner's order.

A local agency shall reimburse appellants for reasonable and necessary expenses of their attendance at the hearing, such as child care and transportation costs and for the transportation expenses of the appellant's witnesses and representatives to and from the hearing.

Subp. 10. **Hearings.** Fair hearings shall be conducted at a reasonable time, date, and place by an impartial referee employed by the department. An applicant, recipient, or former recipient may introduce new or additional evidence relevant to the issues on appeal. Recommendations of an appeals referee and decisions of the commissioner are based on evidence introduced at the hearing and are not limited to a review of the propriety of a local agency action.

Subp. 11. **Right to review records.** A local agency shall allow an applicant or recipient to review his or her own case records that are held by a local agency and which are related to eligibility for or the assistance payment from the program, except those case records to which access is denied under Minnesota Statutes, chapter 13. A local agency shall make case records available to an applicant or recipient as soon as possible but in no event later than the fifth business day following the date of the request. When an applicant, recipient, or authorized representative asks for photocopies of material from the case record, the local agency shall provide one copy of each page at no cost.

Subp. 12. **Right to manage affairs.** An applicant or recipient has the right to manage his or her financial affairs, except as provided in part 9500.2680, subpart 2. A local agency

shall not restrict the use of an assistance payment except as specified in parts 9500.2680, subpart 2, 9500.2800, and 9500.2820.

Subp. 13. **Right to protection.** Under the circumstances defined in this subpart, a local agency shall refer an applicant or recipient to the social services unit of the local agency. Neither a referral for social services nor an applicant's or recipient's cooperation with the referral is a condition of eligibility for continued assistance. Referral must be made according to items A and B.

A. Referral must be made when a minor caretaker does not live with his or her parent, 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.

B. Referral must be made when a local agency staff member has reason to believe that neglect, physical abuse, or sexual abuse exists as defined under Minnesota Statutes, section 626.556, subdivision 2 or 626.557, subdivision 2. The local agency shall also fulfill the requirements for reporting to proper authorities when the conditions in Minnesota Statutes, section 626.556, subdivision 3 or 626.557, subdivision 3 exist.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2760 SUPPORT FROM PARENTS OF MINOR CARETAKERS LIVING APART.

Subpart 1. **General provisions.** A parent who lives outside the home of a dependent child who is an unemancipated minor caretaker of an assistance unit is financially responsible for that minor caretaker unless the parent is a recipient of assistance, supplemental security income, Minnesota supplemental aid, medical assistance, general assistance, or general assistance medical care, and a court order does not otherwise provide a support obligation.

Subp. 2. **Amount of support payment.** The amount of support to be paid by a parent, except a parent specified in subpart 4, must be determined according to items A to F.

A. A minor caretaker shall provide information required by the local agency to identify the whereabouts of his or her absent parent.

B. A local agency shall notify an absent parent of his or her legal responsibility to support a minor caretaker and shall request that the absent parent provide the following:

(1) the amount of the parent's earned and unearned income for the previous tax year;

(2) the amount of the parent's earned and unearned income for the current month;

(3) the number and names of dependents who are claimed or could be claimed by the parent on federal income tax forms;

(4) the amount of annual medical bills paid by the parent;

(5) the amount of annual housing costs paid by the parent;

(6) the costs for utilities and repairs to the home which are paid by the parent; and

(7) the amount of annual educational costs for family members paid by the parent.

C. When a parent of a minor caretaker does not provide the information requested under item B, the local agency shall refer the matter to the county attorney. Assistance to the minor caretaker must not be denied, delayed, reduced, or ended because of the lack of cooperation of the minor caretaker's parent.

D. When the information requested under item B is received by a local agency, the local agency shall compare the parent's income against the following scale using the conditions and procedures specified in item E.

Size of Family	Annual Cost of Living (ACL)
1	$ 7,466
2	12,084
3	17,380
4	20,774
5	23,891

Twenty percent of the ACL for a family of five must be added for each additional family member.

E. The parent's income is the parent's earned income plus unearned income, determined by the methods in part 9500.2500, subpart 4, items A to C. To determine family size, each person claimed or who could be claimed by a parent as a dependent on federal income tax forms, exclusive of the minor caretaker, must be included. A deduction from income must be allowed for the amount that medical, educational, and housing costs together exceed 30 percent of the parent's income. When the amount of income, after the allowable deduction, exceeds the annual income level in item D, a parent is liable to pay one third of the excess for the annual support of the minor caretaker. These payments must be paid monthly to the minor caretaker or to the local agency on behalf of the minor caretaker.

F. A local agency shall notify the parents of the minor caretaker that they are liable for the amount of support determined by the local agency as specified in item E. When the support payment is received by the minor caretaker, it must be treated as unearned income of the assistance unit. When the support payment is not received, or a lesser amount is received in any payment month, the local agency shall refer the matter to the county attorney.

Subp. 3. **Reviews.** A local agency shall review financial responsibility every 12 months until minor caretakers reach the age of 18 or are otherwise emancipated. The local agency shall promptly review the required amount of payment when a parent reports a change in circumstances.

Subp. 4. **Parents under court order for support.** A parent who is required under an existing court order issued under some other authority in state or federal law to pay child support for a minor caretaker is subject to the conditions of that order in lieu of the requirements and contribution levels of subpart 2.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2780 WRONGFULLY OBTAINED ASSISTANCE.

Subpart 1. **Applicability to other laws.** This part outlines procedures that apply to AFDC which anticipate their use in combination with established civil and criminal procedures and law.

Subp. 2. **Responsibility of local agency to act.** In response to welfare fraud allegations received by a local agency, the local agency shall take any or all of the actions in items A to C.

A. A local agency shall refer cases of suspected welfare fraud to the person or unit designated by the county board for investigation of welfare fraud.

B. A local agency shall issue notice under the provisions of part 9500.2740, subpart 7 to reduce or end assistance when the local agency receives facts which show that an assistance unit is not eligible for assistance or for the amount of assistance currently being received.

C. A local agency shall refer cases of probable welfare fraud to the county attorney.

Subp. 3. **Continued program eligibility.** A local agency shall issue assistance when current program eligibility exists even when welfare fraud was proven for an earlier period or is currently under investigation, subject to subpart 2.

Subp. 4. **Recoupment and recovery of wrongfully obtained assistance.** A local agency shall recoup or attempt recovery of wrongfully obtained assistance. The amount recouped or recovered must not be more than the amount wrongfully obtained unless it is based

on a court judgment. A local agency shall recoup wrongfully obtained assistance according to the procedures in part 9500.2620, items C and D until the full amount of wrongfully obtained assistance is repaid, seek voluntary repayment, or initiate civil court proceedings to recover any unrepaid balance of the wrongfully obtained assistance.

Subp. 5. **Reporting requirement.** A local agency shall gather and report statistical data required by the commissioner on local agency activities to prevent welfare fraud.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

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

Subpart 1. **Payment of funeral and cemetery charges.** A local agency shall pay expenses incurred, up to a maximum of $370, for the funeral of a person who was a recipient at the time of death, and who is survived by members of the AFDC assistance unit who remain eligible for AFDC. In addition to these expenses, the local agency shall pay the actual cemetery charges. The local agency shall not pay for funeral expenses or cemetery charges when relatives of the deceased recipient, who had a legal responsibility to support the deceased recipient, are able to pay the expenses according to Minnesota Statutes, section 256.935. When donations from third parties or payments from other sources, including payments from prepaid burials or insurance, are conditioned on use for specific items such as a cemetery lot, interment, transportation of the body, or a religious service, the local agency must not apply these donations or payments against other items which the local agency must otherwise provide under this subpart. Amounts paid by a local agency for funeral expenses or cemetery charges under this subpart are reimbursable by the commissioner and recoverable from the estate according to Minnesota Statutes, section 256.935, subdivision 1. To determine the sufficiency of an estate to pay for funeral expenses, the local agency shall consider the nature and marketability of the assets of the estate.

Subp. 2. **Procedures for payment of AFDC housing allowance.** A recipient is eligible to receive an AFDC housing allowance under Minnesota Statutes, section 256.879 to replace a portion of his or her housing costs attributable to the payment of local property tax. The commissioner shall pay the AFDC housing allowance to a recipient who applies for a Minnesota property tax refund credit under Minnesota Statutes, chapter 290A. The commissioner must not direct payment of the AFDC housing allowance to a recipient who has already received a Minnesota property tax refund credit for the same tax year. The AFDC housing allowance is subject to reduction as an offset against any outstanding state tax liabilities.

Subp. 3. **State appropriation for special needs.** Payments for special need items, as defined and conditioned in subparts 4 to 9, must be paid to a recipient subject to the amount appropriated by the Minnesota legislature. Each quarter, the commissioner shall 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.

Subp. 4. **Relationship between special needs and emergency assistance.** When a person is eligible for an item to be provided from both special need and emergency assistance funds, the local agency shall provide the item through special need funds when these funds are available.

Subp. 5. **Requests for special need funds.** When a local agency receives a request for items which are covered as a special need, the local agency shall provide the recipient with the information in subpart 3, item A; shall inform the recipient that a written request must be made; and may require the recipient to document need for the item. When payment is delayed due to lack of special need funds, or when payment is denied for any reason, the local agency shall notify the recipient in writing of the delay or denial.

Subp. 6. **Household furnishings and appliances.** Items A to S specify the items and special need payment amounts for repair or replacement of household furnishings and appliances:

A. infant layette, $35;

B. infant or child car seat, $35;

C. crib and mattress, $49;

D. high chair, $16;

E. cooking stove or range, $80;

F. refrigerator, $93;

G. water heater, $186;

H. bed:

(1) twin size (complete), $72;

(2) mattress or box spring (only), $27;

(3) frame, $18;

I. bed:

(1) full size (complete), $116;

(2) mattress or box spring (only), $49;

(3) frame, $18;

J. bedding (includes blanket, pillow and case, sheets), $20;

K. chest of drawers, $26;

L. lamp, $13;

M. washing machine, $93;

N. kitchen table, $24;

O. kitchen chair, $10;

P. couch, $74;

Q. living room chair, $24;

R. living room table, $10; and

S. clothes dryer, $93.

A recipient must not receive a special need payment for the same item more than once in a three–year period unless the payment is for repair of the item or the item needs replacement because of damage, theft, normal wear and tear, or loss. Abandonment of items during a move or change in living quarters when the recipient has failed to make reasonable attempts

to retake possession does not constitute loss for this purpose. When the cost of an item is greater than the special need maximum payment, a recipient must document that he or she has other available resources which can be combined with the amount payable from special needs funds to pay for the item. A credit arrangement with the vendor which provides for immediate possession of the item satisfies this requirement, but layaway arrangements which delay the possession of an item until a recipient makes an additional payment do not. A local agency shall make payment for home furnishings and appliances by direct payment to a recipient, unless the recipient requests vendor payment or the recipient's monthly assistance payment is subject to the conditions of Code of Federal Regulations, title 45, section 234.60(a)(2). When a local agency approves a two–party or vendor payment for an item to resolve an emergency under part 9500.2820 and the quarterly special need fund appropriation becomes available before the bill for that payment is received by the local agency, payment must be made according to the conditions of the original approval for payment.

Subp. 7. **Home repairs.** A local agency shall pay for repairs to the roof, foundation, wiring, heating system, chimney, and water and sewer system of a home which is owned and lived in by a recipient. Special need payments for these repairs are conditioned by items A to E.

A. The recipient shall document and the local agency shall verify the need for and method of repair.

B. The payment must be cost effective in relation to the overall condition of the home and in relation to the cost and availability of alternative housing.

C. A recipient must have no other resources for payment. To determine whether a recipient has available resources, the local agency must consider the immediacy of the need for the repair and the likelihood that the recipient may qualify for other programs or secure other resources to cover part or all of the funds needed for the cost of the repair.

D. A recipient shall provide the local agency with one vendor's estimate for the repair. The local agency may require up to two additional estimates when it determines the first is excessive. Any charge for an estimate authorized or required by a local agency must be paid from the appropriation under subpart 3. When one or more estimate is received, a local agency shall approve payment for the estimate which is most cost effective. When a recipient requests vendor payment under item E, a local agency shall condition payment on a written agreement with the vendor and shall not issue payment until it determines that the home repair is satisfactorily completed.

E. A local agency shall make payment for home repairs directly to a recipient unless the recipient requests vendor payment or the recipient's monthly assistance payment is subject to the conditions of Code of Federal Regulations, title 45, section 234.60(a)(2). When a local agency approves a two–party or vendor payment for a home repair to resolve an emergency under part 9500.2820 and the quarterly special need funds appropriation is received by the local agency before the bill for that payment, payment must be made according to the conditions of the original approval for payment.

Subp. 8. **Special diets.** A local agency shall make special need payments to a recipient for the costs of the diets specified in item A. These diets or dietary items must be prescribed by a licensed physician. When these costs are paid by a program other than AFDC, AFDC special need payment must not be made.

A. Payment amounts must be determined as percentages of the allotment for a one person household under the thrifty food plan. The payment amounts are revised annually and published in general notices in the Federal Register. The types of diets that may be paid for, and the percentages of the thrifty food plan which must be used to determine payment amounts, are identified in subitems (1) to (11):

(1) high protein diet (at least 80 grams daily), 25 percent of thrifty food plan;

(2) controlled protein diet (40–60 grams and requires special products), 100 percent of thrifty food plan;

(3) controlled protein diet (less than 40 grams and requires special products), 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten free diet, 25 percent of thrifty food plan;

(8) lactose free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan;

(11) ketogenic diet, 25 percent of thrifty food plan.

B. Payment must be issued directly to a recipient as a part of the monthly assistance payment or as a separate monthly payment. Continuing need for the diet must be verified no less often than at each redetermination of eligibility. The local agency shall not require a recipient to document his or her actual expenditures for the dietary items.

Subp. 9. **Verification and preauthorization requirements.** Payments made under subparts 6 to 8 must be made only when a recipient's need for the item is verified by the local agency. A local agency may require prior authorization as a condition of payment, but when the need for a special need item occurs at a time outside of the local agency's business hours, this requirement is satisfied when a recipient contacts the local agency on the next working day to request authorization.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2820 EMERGENCY ASSISTANCE.

Subpart 1. **Applicability.** This part governs the administration of the emergency assistance program funded under title IV–A for needy families with children. This part identifies circumstances under which assistance or services must be provided, conditions of eligibility for that assistance or those services, and the conditions under which the department and a local agency shall administer the program to be consistent with federal requirements for statewide administration and equal access to program benefits by recipients and persons who are not recipients.

Subp. 2. **Definitions.** The terms used in this part have the meanings given to them in items A to O.

A. "Applicant" means a person for whom an application for assistance has been filed with a local agency.

B. "Assistance" means a financial benefit received from the emergency assistance program.

C. "Available resources" means an applicant's property that is liquid or can be liquidated within the time necessary to avoid or promptly alleviate destitution, together with income and public funds for which an applicant is eligible.

D. "Balloon payment" means an amount of money required to be paid on a specific date according to the terms of a contract for deed or mortgage loan agreement and that exceeds the monthly contract for deed or mortgage payment.

E. "Basic need items" means subsistence items necessary for life and health, including food, safe drinking water, habitable shelter, clothing, medical care; the companion items necessary to assure these needs, including heating fuel, electricity, essential household appliances and furnishings; caregiving services to children and incapacitated adults; transportation, equipment, or other expenses necessary for employment; transportation necessary for medical care; and other goods or services necessary to protect a child's health or safety.

F. "Child" means a person who is under the age of 21 years who lives with a caretaker.

G. "Destitution" means the lack of a basic need item and the lack of resources to provide for that need.

H. "Emergency" means a situation or set of circumstances that causes or threatens to cause destitution to a child.

I. "Family" means the persons who are part of the same household with a child. When the caretaker applying for a child is a parent, the term "family" includes that child, siblings or stepsiblings under the age of 21, and the other parent or stepparent of that child. When the caretaker applying for a child is not a parent, the term "family" includes that child,

the eligible relative caretaker of that child, the spouse of that caretaker, and any other children under the age of 21 for whom that caretaker or spouse would qualify as an eligible relative under part 9500.2440, subpart 7.

J. "Family budgeting services" means services which help an applicant or recipient to develop the ability to use its available income and resources to improve his or her financial stability and provide himself or herself with basic need items.

K. "Habitable shelter" means housing that meets the health or safety standards provided under local ordinance, state or federal law, and any specific criteria established by a licensed physician as necessary to the life or health of a child.

L. "Program" means the program of emergency assistance for needy families with children under the age of 21 years.

M. "Threatened destitution" means the destitution that will result in the future unless action is taken.

N. "Utility budget period" means the month of application and the continuous 11–month period immediately preceding that month or a shorter period when an applicant has had no responsibility to pay for utility service for any month of the last 12 months. Unpaid utility bills covering a period of time in excess of 12 months must be divided into two or more utility budget periods.

O. "Utility costs" means charges incurred by an applicant for the provision of electrical, gas, wood, heating fuel, and municipal water and sewer service.

Subp. 3. **Statement of purpose.** The purposes of the program are to avoid and to prevent the destitution of children. The program does so by providing assistance to resolve an emergency and by providing services that reduce the risk of recurrence of destitution.

Subp. 4. **Inquiries.** A local agency shall offer, by hand or mail, an application form and an informational brochure provided by the department as soon as a person makes a written or oral inquiry about the program. A local agency shall offer an application form and brochure on the same day the inquiry is received by the local agency. 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.

Subp. 5. **Application.** Any family with a child may apply for assistance. At that time, a local agency shall explain to an applicant the program's eligibility requirements, the limitation of annual eligibility, the extent of the program's coverage, other programs provided by the local agency or known by the local agency to be applicable to the family's circumstances, the availability of expedited issuance of food stamps for eligible persons, and the rights and responsibilities of an applicant for and recipient of assistance.

Subp. 6. **Forms.** A person must submit to a local agency a signed and dated application for emergency assistance on forms prescribed by the commissioner.

Subp. 7. **Interview.** A local agency shall conduct a personal interview with an applicant after receipt of an application for assistance. When the circumstances of an applicant show destitution is imminent or already present, a local agency shall offer to conduct a personal interview on the same day the application is received to determine the applicant's eligibility. In all other cases, the local agency shall conduct a personal interview within a time that does not inhibit the local agency's ability to provide assistance in time to prevent destitution.

Subp. 8. **Processing application.** An application must be processed in a manner that considers the immediacy and severity of the destitution. A local agency shall help an applicant complete the verification process in time to prevent destitution. Verification must be made promptly and must be done by telephone when necessary to avoid destitution. When documentation from a third party is not secured in time, an affidavit from an applicant must be accepted. A local agency shall designate at least one staff person to authorize immediate issuance of assistance. A local agency shall not delay issuance of assistance to get formal action from the county board.

Subp. 9. **Notice of eligibility.** A local agency shall notify an applicant in writing on a form prescribed by the commissioner of its determination of his or her eligibility for assistance. The local agency shall mail or deliver the notice to the applicant within one week of the date the application was submitted unless the applicant is informed in writing within that time of the reason for the delay.

Subp. 10. **Eligibility.** A local agency shall issue assistance to a family, including a migrant family, that meets the conditions of items A to D:

A. the family must have a child under the age of 21 years who is or, within six months prior to application, has been living with the caretaker;

B. the family must have an emergency;

C. the family's available resources must not be sufficient to resolve the emergency; and

D. the emergency must not exist because a caretaker or child age 16 or over refused employment or training for employment without good cause as defined in part 9500.2700, subpart 19.

Subp. 11. **Covered emergencies.** Assistance must be authorized when a child lacks or is threatened with the loss of basic need items.

A. Emergency need may be caused by eviction, condemnation, cancellation of a contract for deed, mortgage foreclosure, or other relocation; return from residential treatment, long–term hospitalization, incarceration or other separations of a child from the caretaker; civil disorders or strikes; fire, flood, storm, or other natural disaster; or loss or theft of funds.

B. Assistance may be authorized for:

(1) shelter or shelter deposit;

(2) moving expenses;

(3) storage costs necessary to recover property described in part 9500.2800, subpart 6;

(4) necessary household furnishings described in part 9500.2800, subpart 6;

(5) necessary household appliances described in part 9500.2800, subpart 6;

(6) necessary home repairs described in part 9500.2800, subpart 7;

(7) utility service or utility hookup;

(8) clothing;

(9) food;

(10) safe drinking water;

(11) necessary medical care;

(12) necessary dependent care;

(13) transportation, equipment, or other expenses necessary for employment, subject to subpart 13;

(14) transportation necessary for medical care; or

(15) other items necessary for the health or safety of a child.

Subp. 12. **Limitations.** The limitations of the program are listed in items A to G.

A. A local agency shall issue assistance to a family during only one 30–day period in a consecutive 12–month period. A local agency shall issue assistance for needs that accrue before that 30–day period only when it is necessary to resolve emergencies arising or continuing during the 30–day period of eligibility. When emergency needs continue, a local agency may issue assistance for up to 30 days beyond the initial 30–day period of eligibility but only when assistance is authorized during the initial period.

B. A local agency must not issue assistance when uncashed AFDC checks are lost or stolen. Instead, the lost or stolen AFDC checks must be replaced under part 9500.2680, subpart 1, item C.

C. A local agency shall limit assistance for household furnishings and appliances according to part 9500.2800, subpart 6.

D. A local agency shall limit assistance for home repairs according to part 9500.2800, subpart 7.

E. A local agency shall issue assistance for storage costs that are cost effective in relation to the value of the materials in storage and to other alternatives for resolving the emergency.

F. A local agency must not deny an application for assistance because a recipient does not choose to request that future monthly AFDC payments be paid through protective,

vendor, or two–party payments. When a local agency determines mismanagement of a monthly AFDC payment has occurred under part 9500.2680, subpart 2, item E, the local agency must proceed with protective, vendor, or two–party payments under that provision.

G. A local agency may deny assistance to prevent eviction from rented or leased shelter of an otherwise eligible applicant when the local agency determines that an applicant's anticipated income will not cover continued payment of shelter and utility expenses, subject to the conditions in subitems (1) to (3).

(1) A local agency must not deny assistance when an applicant can document that he or she is unable to locate habitable shelter, unless the local agency can document that one or more habitable shelters are available in the community that will result in at least a 20 percent reduction in monthly expense for shelter and utilities and that this shelter will be cost effective for the applicant. When considering cost effectiveness for an applicant, a local agency shall evaluate the appropriateness of the alternative shelter in terms of size in relation to the number of family members, location in relation to special needs of the child, and other factors which would be likely to arise due to the disruption of the move.

(2) When no alternative shelter is identified by either the applicant or the local agency, the local agency must not deny assistance because of the determination that the applicant's anticipated income will not cover continued payment of shelter and utility costs. The local agency shall issue assistance in the amount needed to prevent the eviction.

(3) When alternative living shelter is identified, the local agency shall issue assistance for moving expenses as provided in subpart 18, item D.

Subp. 13. **Issuance of payment.** A local agency shall determine the most effective method of payment to resolve the emergency. Payment may be made either by direct cash payment to an applicant or by vendor or two–party payment. When assistance is issued for employment–related expenses under subpart 11, item B, subitem (13), issuance is limited to an interest–free loan of up to $100.

Subp. 14. **Available services.** Services allowed under the program are listed in items A to D.

A. A local agency may offer family budgeting services to persons who inquire about the program. Family budgeting services may be provided by local agency staff, including social services staff, or a local agency may contract with qualified persons or agencies to provide the services. When a local agency uses its own staff, administrative costs may be attributed to the program as a part of the local agency's cost allocation process, or the local agency may choose to use its own funds. When a local agency contracts with persons or agencies outside the local agency, the costs are considered program expenditures in the same manner as other program expenditures made on behalf of persons who apply for assistance.

B. A local agency may negotiate on behalf of an applicant with vendors or creditors at the applicant's request or under the conditions of subpart 16, item D.

C. A local agency may provide protective payee or vendor payment services at the request of a recipient for monthly AFDC payments.

D. A local agency may assist an applicant by coordinating local agency financial assistance programs with public or private resources which exist in the community.

Subp. 15. **Termination of utility service.** Assistance payments must be made when an otherwise eligible family has had a termination or is threatened with a termination of municipal water and sewer service, electric, gas, or heating fuel service, or lacks wood when that is the heating source, subject to the conditions of items A and B.

A. A local agency must not issue assistance unless the local agency receives confirmation from a utility provider that assistance combined with payment by the applicant will continue or restore the utility service.

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

C. When an applicant pays the amounts specified in item B, a local agency shall issue assistance as follows:

Amounts Paid By The Program

Percent of total utility consumption cost paid by applicant prior to issuance of assistance	Percent of the unpaid balance which will be paid by the program	Percent of the unpaid balance which must be paid by the applicant
less than 10 percent	70 percent	30 percent
at least 10 percent and less than 20 percent	76 percent	24 percent
at least 20 percent and less than 30 percent	82 percent	18 percent
at least 30 percent and less than 40 percent	88 percent	12 percent
at least 40 percent and less than 50 percent	94 percent	6 percent
50 percent or more	100 percent	0 percent

D. When a utility provider does not offer a repayment plan to the applicant and the applicant does not have sufficient current funds which, when combined with the assistance, will allow for the continuation or restoration of utility service, a local agency may negotiate with the utility provider on behalf of the applicant. When a utility provider does not withdraw the proposed termination of service, the local agency shall assist the family in seeking alternate arrangements for utility service.

E. The provisions in items A to D must not be construed to prevent the issuance of assistance when a local agency must take immediate and temporary action necessary to protect the life or health of a child.

Subp. 17. **Mortgage and contract for deed arrearages.** A local agency shall issue assistance for mortgage or contract for deed arrearages on behalf of an otherwise eligible applicant according to items A to H.

A. Assistance for arrearages must be issued only when a home is owned, occupied, and maintained by the applicant.

B. Assistance for arrearages must be issued only when no subsequent foreclosure action is expected within the 12 months following the issuance. To make this determination, a local agency shall consider the anticipated mortgage costs over the 12–month period together with the applicant's anticipated income and other circumstances which would affect the applicant's ability to prevent foreclosures during that period.

C. Assistance for arrearages must be issued only when an applicant has been refused refinancing through a bank or other lending institution and the amount payable, when combined with any payments made by the applicant, will be accepted by the creditor as full payment of the arrearage.

D. Costs paid by a family which are counted toward the payment requirements in item E are principal and interest payments on mortgages or contracts for deed, balloon payments, homeowner insurance payments, rental payments for shelter, mobile home lot rental payments, and tax or special assessment payments related to the homestead. Costs paid which are not counted include rental deposits, and down payments and closing costs related to the sale or purchase of real property.

E. To be eligible for assistance for the costs in item D which are outstanding at the time of foreclosure, an applicant must have paid at least 30 percent of the family's gross income toward these costs in the month of application and the 11–month period immediately preceding the month of application. When an applicant has received assistance on or after October 1, 1986, for a prior foreclosure action, the applicant must have paid at least 40 percent of the family's gross income toward these costs in the month of application and the 11–month period immediately preceding the month of application.

F. When an applicant is eligible under item E, a local agency shall issue assistance for outstanding costs up to a maximum of four times the AFDC family allowance for a family of the size and composition of the family applying for assistance.

G. Payments made under item F constitute a debt owed to the county and the state, but only when the person's interest in the property is sold. A local agency shall file a lien against the property and shall notify the applicant, at the time of application for payment of the arrearage payment, that a lien will be filed.

H. When a local agency determines that an applicant is ineligible for assistance for arrearage payment, but is otherwise eligible for assistance, the local agency shall assist the family with relocation according to subpart 18.

Subp. 18. **Moving expenses.** A local agency shall issue assistance for expenses incurred when a family must move to a different shelter according to items A to D.

A. Moving expenses include the cost to transport personal property belonging to a family, the cost for utility connection, and the cost for securing different shelter.

B. Moving expenses must be paid only when the local agency determines that a move is cost effective.

C. Moving expenses must be paid at the request of an applicant, but only when destitution or threatened destitution exists.

D. Moving expenses must be paid when a local agency denies assistance to prevent an eviction because the local agency has determined that an applicant's anticipated income will not cover continued payment of shelter and utility costs in the applicant's current shelter under subpart 12, item G.

Subp. 19. **Right to appeal.** An applicant shall have the right to appeal a local agency's action or failure to act with reasonable promptness on an application for assistance.

A. A local agency shall inform an applicant in writing of the right to appeal and the procedures to follow in filing an appeal. Within two working days after receiving a written request for an appeal, the local agency shall forward the written request and an agency appeal summary to the appeals office of the department.

B. The appeals office shall schedule a hearing on the earliest available date and, following the hearing, shall promptly forward the decision of the referee to the commissioner.

C. The commissioner shall issue a written order within five working days of receipt of the referee's decision, shall immediately inform the parties of the outcome of the decision by telephone, and shall mail the written decision to the parties no later than the second working day following the date of the commissioner's decision.

Statutory Authority: *MS s 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*

9500.2860 RELATIONSHIP TO OTHER PROGRAMS.

Subpart 1. **Medical assistance; applicants.** An applicant may qualify to receive retroactive medical assistance benefits for up to three months before the month of application. An applicant shall provide information about health insurance and other medical coverage held by or available to the applicant, including pending lawsuits or claims for medical costs. An applicant who is a policyholder of health insurance shall assign to the department any rights to policy benefits he or she has during the period of medical assistance eligibility. When an applicant refuses to assign the rights to the department, the caretaker's program eligibility is unaffected, but the caretaker is ineligible for medical assistance. An application is used to determine retroactive medical assistance eligibility and to establish current eligibility for medical assistance, according to items A and B.

A. When a person applies for AFDC, the local agency shall inform the applicant of the existence of retroactive medical assistance and shall determine eligibility for retroactive medical assistance when the applicant requests it.

B. When a local agency approves an AFDC application, the effective date of medical assistance eligibility must be the first day of the month in which program eligibility begins, unless eligibility existed for medical assistance under item A. When a local agency denies an AFDC application and medical assistance is requested, the local agency must accept a medical assistance application. The local agency shall use the date of application for AFDC as the date of application for medical assistance or general assistance medical care.

Subp. 2. **Medical assistance; recipients.** A recipient shall receive medical assistance according to items A to F.

A. A local agency shall reimburse or issue direct payment to a recipient for transportation costs for medical care from medical assistance administrative funds.

B. A local agency must not recover amounts for ineligible medical assistance claims or payments from the monthly assistance payment.

C. A recipient shall inform the local agency of injuries for which a third–party payor may be liable for payment of medical costs.

D. A local agency shall allow a recipient eligibility for medical assistance for months during which monthly assistance payments are suspended due to increased earned income or for months where no monthly assistance payments are issued due to the $10 minimum issuance limitation specified in part 9500.2620, item B.

E. A local agency shall determine eligibility for medical assistance according to subpart 3, item A, when assistance is suspended for a reason other than that in item D.

F. A local agency shall offer services through the EPSDT program on behalf of each applicant or recipient who is less than 21 years of age, subject to parts 9505.1500 to 9505.1690.

Subp. 3. **Medical assistance; terminations of assistance.** A local agency shall continue medical assistance when assistance ends according to items A to C.

A. When assistance ends solely due to the increased earned income, increased hours of employment of a member of an assistance unit, or increased child support, medical assistance eligibility must be continued for four months from the month in which program eligibility ends.

B. When assistance ends solely because a member of an assistance unit is no longer eligible for the work incentive disregard under part 9500.2580, item C or D, medical assistance must continue for the assistance unit for nine months from the month in which program eligibility ends. When at the end of that nine–month period, the assistance unit would be eligible for assistance except for the loss of the work incentive disregard under part 9500.2580, item C or D, medical assistance must continue for up to three additional months.

C. When assistance is ended due to applying the income from stepparents, grandparents, or siblings to the need of an assistance unit, the local agency shall provide the recipient with an AFDC termination notice that allows one month of medical assistance after assistance ends. To continue eligibility for medical assistance beyond the one month, eligibility must be established under parts 9500.0750 to 9500.1080 and the application supplied with the AFDC termination notice must be returned to the local agency within ten days of the date assistance ends.

Subp. 4. **Social services.** An AFDC unit staff member shall refer a recipient for social services that are offered in the county of financial responsibility according to the criteria which is established by that local agency under the Community Social Services Act. A payment issued from title XX, child welfare funds, or county funds in a payment month must not restrict program eligibility or reduce the monthly assistance payment for that recipient.

Subp. 5. **Concurrent eligibility.** A local agency shall not count an applicant or recipient as a member of more than one assistance unit in a given payment month except as provided in items A to C.

A. An applicant who receives assistance in a state other than Minnesota may be eligible in the first month of application at Minnesota payment standards. An assistance payment from another state must be considered unearned income when determining the assistance payment issued under the Minnesota program.

B. A recipient who is a member of an assistance unit in Minnesota is eligible to be included in a second assistance unit in the first full month that the recipient lives with a second assistance unit or from the date of application to include those persons, whichever is later. The assistance payment issued to and kept by the first assistance unit must be considered an overpayment and must be recouped or recovered from the first assistance unit.

C. An applicant who has his or her needs met through foster care under title IV–E for the first part of an application month is eligible to receive assistance for the remaining part of the month in which the applicant returns home. Title IV–E payments and assistance payments must be considered prorated payments rather than a duplication of AFDC need.

Subp. 6. **Other income maintenance programs.** An applicant or recipient is not eligible to receive general assistance medical care, general assistance, or Minnesota supplemental aid in the same payment month except for items A to C.

A. A general assistance recipient who applies for AFDC may be eligible for both assistance and general assistance in the months that the application for AFDC is pending. General assistance payment must be considered unearned income in determining AFDC eligibility. When a general assistance payment is issued to a battered women's shelter for an applicant or recipient, that payment must not be applied against AFDC need.

B. An applicant or recipient who is eligible for both AFDC and Minnesota supplemental aid may choose to receive benefits through either program.

C. An applicant who is receiving general assistance medical care at the time of application may continue to receive general assistance medical care until AFDC eligibility is established. Services received by applicants while they are eligible for both general assistance medical care and medical assistance must be paid under medical assistance.

Statutory Authority: *MS s 256.01 subd 4; 256.871 subd 7*

History: *11 SR 212*

9500.2880 COUNTY OF RESPONSIBILITY POLICIES AND DISPUTES.

Subpart 1. **Determining the county of financial responsibility.** The county of financial responsibility is the county in which a dependent child lives on the date the application is signed, unless subpart 4 applies. The county in which a woman with no children lives on the date the application is signed under part 9500.2140, subpart 4 is the county of financial responsibility unless subpart 4 applies. When more than one county is financially responsible for the members of an assistance unit, 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.

A. When a recipient moves from one county to another, eligibility for assistance is not affected unless eligibility factors are affected in the move. A local agency must not require a recipient to reestablish program eligibility as a new applicant for assistance solely because a recipient moves. A local agency shall not require reapplication nor apply the program eligibility criteria which govern only initial applications, except as described under item B, subitem (3).

B. The requirements in subitems (1) to (3) apply when a recipient moves from one county to another.

(1) When a recipient informs the local agency in the current county of residence of a planned move, the local agency in that county shall forward to the local agency in the county of planned residence the information from the case record which the county of planned residence needs to redetermine eligibility and to determine the amount of the assistance payment. Within 30 calendar days of the recipient's move, the new county of residence shall interview the recipient and take action to increase, reduce, suspend, or end assistance due to changes in the recipient's circumstances which affect either program eligibility or the amount of the assistance payment.

(2) When a recipient informs the new county of residence that he or she has entered the county as a current recipient, the new county shall obtain from the county from which the recipient moved the information from the case record that it needs to redetermine eligibility and determine the amount of the assistance payment. Within 30 calendar days, the local agency in the new county shall interview the recipient and take action to increase, reduce, suspend, or end assistance due to changes in the recipient's circumstances which affect either program eligibility or the amount of the assistance payment.

(3) When a recipient does not inform either county that the move has occurred before the mailing of the next assistance payment and when the whereabouts of a recipient are unknown, the county of financial responsibility shall end assistance. When a recipient reapplies in another county within 30 calendar days of termination and is eligible, assistance is considered to be uninterrupted for the determination of the county of financial responsibility for members of the assistance unit. This payment must be issued by the county of financial responsibility until the recipient has lived in the new county for two full calendar months.

C. When an applicant moves from one county to another while the application is pending, the county where application first occurred is the county of financial responsibility until the applicant has lived in the new county for two full calendar months, unless the applicant's move is covered under subpart 4.

Subp. 3. **Responsibility for incorrect assistance payments.** A county of residence, when different from the county of financial responsibility, will be charged by the commissioner for the value of incorrect assistance payments and medical assistance paid to or on behalf of a person who was not eligible to receive that amount. Incorrect payments include payments to an ineligible person or family resulting from decisions, failures to act, miscalculations, or overdue redeterminations of eligibility. However, financial responsibility does not accrue for a county when the redetermination of eligibility is overdue at the time the referral is received by the county of residence or when the county of financial responsibility does not act on the recommendation of the county of residence.

When federal or state law requires that medical assistance continue after assistance ends, the provisions of this subpart also govern financial responsibility for the extended medical assistance.

Subp. 4. **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 256.01 subd 4; 256.851; 256.871 subd 7*

History: *11 SR 212; 15 SR 117*