Publication date: September 1999

Medicaid

OVERVIEW

What is it?

A governmental health insurance program that pays for medical services for certain low- and moderate-income people.

Who is it for?

To qualify, a child under the age of 21 must meet certain financial eligibility requirements. Adults have an additional requirement to meet—they must either be pregnant, receiving Work First payments, be an older adult (65 or older), blind or disabled.

Where are applications taken?

All local Departments of Social Services (DSS) take Medicaid applications, as do some hospitals, public health departments, community, migrant or rural health centers. Applications for children are also available by mail by calling 1-800-367-2229.

INTRODUCTION

Medicaid is a governmental health insurance program that provides assistance with medical costs to certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population.

In North Carolina, a child can qualify for Medicaid under one of six different programs. These programs generally provide the same services. The primary difference between the programs is whether other family members qualify. The programs also have different income and resource guidelines.

This chapter begins with general information about Medicaid. The Medicaid programs for children are then discussed separately. (For more information about Medicaid programs for adults, contact CARELINE, 1-800-662-7030).

1) Medicaid for Infants and Children Under Age 19 (MIC)
2) Families Receiving Work First Payments or Transitional Benefits
3) Families Who Would Have Been Eligible for Aid to Families with Dependent Children (AFDC)
4) Disabled or Blind Children
5) Medically Needy
6) Medicaid for Pregnant Women/Teens (MPW)

General Information About Medicaid

INTRODUCTION

The following information applies to all the Medicaid programs under which a child may qualify (unless noted otherwise). Requirements that are unique to a program are outlined separately in the program section.

BENEFITS/ SERVICES

Medicaid will pay for the following services:

- *Health Check.* (See Chapter 8 for description of NC Health Check program).
- *Physician services.* Also includes other professional medical services, such as podiatrists, osteopaths, chiropractors, and optometrists.
- *Clinic services.* Includes services at community, migrant or rural health centers, county health departments, and other services which are furnished by or under the direction of a physician or dentist.
- *Nurse practitioners*.
- *Inpatient and outpatient hospital care*. Includes specialty hospitals (covers inpatient care of people with pulmonary and chronic diseases).
- *Laboratory and X-ray services*.
- *Prescription drugs and insulin*.
- *Case management services.* Limited to pregnant women, children under age five with special needs (see Child Service Coordination Chapter 13), the mentally ill, chronic substance abusers, and people with HIV.
- *Mental health care*. Individualized treatment plans authorized by a psychiatrist are covered for all Medicaid recipients. Treatment in a state mental hospital is covered only for persons under age 21 (or over age 65).
- *Audiologists, occupational therapists, physical therapists, and respiratory therapists*.
- *Speech and language pathologists.* For children under age 21 only.
- *Durable medical equipment*.
- *Prosthetics and orthotics.* For children under age 21 only.
- *Eyeglasses and related services*.
- *Dental care*.
- *Hearing aids.* For children under age 21 only.
- *Home- and community-based services*. Includes: home health services, private duty nursing (in certain circumstances), and personal care services (such as assistance with dressing, feeding, household tasks, transportation and monitoring self-administered medication).
- *Community alternative programs*. More extensive services are available through the Community Alternative Program (CAP) programs, including case management, home mobility aides, respite care and more extensive personal care services. There are two CAP programs available for some disabled children: CAP-MR/DD (for children with mental retardation or developmental disabilities), or CAP/C for other medically fragile children (See Chapters on CAP/C and CAP-MR/DD programs).
- *Home infusion therapy services*.
- *Nursing home care.* Includes intermediate care facilities for the mentally retarded.
- *Family planning services*.

- *Nurse midwife services*.
- *Medically necessary transportation services and ambulance services.* Ambulance covered when other means of transportation would endanger the patient's health. Recipients who need help with transportation should notify the Department of Social Services as far in advance as possible, to enable the department to make the necessary arrangements. However, no specific advance notice is mandated.
- *Hospice care*.
- *Prepaid health plan services* (HMOs). In spring 1999, HMO coverage was available in 14 counties (Alamance, Chatham, Davidson, Durham, Forsyth, Gaston, Guilford, Harnett, Mecklenberg, Orange, Person, Rockingham, Stokes, and Wake), although more counties may offer HMO coverage in the future.

  Note: Eligible recipients in Mecklenburg County are required to join an HMO or obtain services through the CD Williams Community Health Center, recipients in other counties can choose whether or not to join an HMO.

Adults who receive services may be subject to some limitations in frequency or duration of visits (for example, adults can only receive six prescriptions per month or 24 doctors visits per year unless life-threatening circumstances exist). In addition, some adult Medicaid recipients are required to make a small payment—called a copayment—for some of their health services. The service limitations and copayment requirements do not apply to medical services provided to children under age 21.

APPLICATIONS

An individual or family can apply for Medicaid at the local Department of Social Services offices. Some hospitals, public health departments, and community, rural and migrant health centers also have DSS workers available to take applications. There is a two-page Medicaid application for children who are applying for Medicaid (NC Health Check) or the new NC Health Choice program (see Chapter 9 for more information about the NC Health Choice program). *Families can call 1-800-367-2229, to find the nearest place to get an application, or to receive an application by mail.*

Certain children automatically receive Medicaid, so a separate Medicaid application is not needed: children in families receiving Work First payments, and children who are found eligible for SSI. Other children must file a separate application. Applicants have a right to apply for Medicaid on the same day they seek assistance. DSS must determine eligibility within 45 days of the date of application. However, DSS has 90 days to determine eligibility if the child is applying for Medicaid on the basis of being disabled and is not already receiving SSI.

Applicants can apply for ongoing ("prospective") Medicaid coverage and/or retroactive coverage. Prospective coverage is available to cover medical bills for the current month and the following five month period. Retroactive coverage is available to cover medical expenses for one, two or three months prior to the date of application. In most program categories, a child who is determined to be eligible for prospective coverage will continue to receive insurance coverage for 12 months.

Recipients who lose eligibility for one program category may still be eligible under another Medicaid program. DSS is supposed to automatically "redetermine" Medicaid eligibility for any individual who becomes ineligible to see if he/she is eligible under another program.

ELIGIBILITY REQUIREMENTS

Personal Eligibility Requirements

To qualify for Medicaid, an applicant must:

- Be a US citizen or eligible immigrant (see below). Undocumented immigrants and other immigrants ineligible for full Medicaid coverage may still receive coverage for emergency care (which includes labor and delivery);
- Be a resident of North Carolina;
- Have a Social Security number, or have applied for one;
- Provide verification of any health insurance coverage;
- Assign to the state the right to payment for health care from any third parties;
- Not be in a public institution. This does not apply to children under age 21 or older adults age 65 or older who are receiving inpatient psychiatric services, or people age 21-65 who are in the medical/surgical unit of a state mental hospital; and
- Not be receiving Medicaid through any other source (for example, in another county or state).

Citizenship/Immigration Status

Citizens are eligible for assistance under the Medicaid program if they meet other programmatic rules. Most immigrants are ineligible for Medicaid, although they can receive Medicaid for emergency medical services. However, legal permanent residents (LPR) are eligible for assistance if admitted on or before August 22, 1996. If the person was admitted after August 22, 1996, he/she is ineligible for five years from the date of entry (unless he/she meets one of the exceptions listed below).

The five year ban on receiving assistance does not apply to certain lawful permanent residents including:

- *Refugees, Asylees, persons granted withholding of deportation, Cuban/Haitian entrants, and Amerasians* can obtain benefits immediately but can only receive assistance for their first five years.
- *Veterans/active duty service members and their spouses and unmarried children under 21* can obtain benefits immediately, and continue to receive these benefits as long as they meet the programmatic rules.
- *Immigrants who are receiving SSI* can continue to receive Medicaid for as long as they continue to receive SSI.

Note: A child who is a US citizen is always eligible for these benefits, regardless of the immigration status of the parents.

Income Eligibility

The income of the person applying for Medicaid will always be counted in determining Medicaid eligibility, but not all income is "countable." Medicaid does not count certain income, including but not limited to things such as:

- SSI,
- Earned Income Tax Credit payments,
- The earned income of a child who is a full-time or part-time student,
- Income that is unpredictable (such as occasional yard work or baby-sitting),
- Foster care payments,
- $50 child support or military allotment per month,
- Loans,
- In-kind shelter and utility contributions, and
- HUD Section 8 benefits.

In addition, Medicaid applicants are allowed certain income exemptions, disregards and deductions. Each Medicaid category has slightly different rules about income exemptions. Please see sections on specific Medicaid programs for information unique to that program.

Income must be verified by copying a source document, such as a paycheck stub, or statement from the employer.

Resource Eligibility

Children who receive Medicaid under the Medicaid for Infants and Children program (MIC) category are not subject to a resource or assets test. However, children who are seeking assistance through another program category must meet certain resource limitations. In these instances, an applicant may only have a limited amount of resources to be found eligible for Medicaid.

Note: It is important not to transfer away excess assets in order to qualify for Medicaid. Some people who attempt to qualify for Medicaid by getting rid of excess resources may be disqualified from receiving Medicaid for a certain period of time.

As with income, certain resources are not "countable" in determining Medicaid eligibility. Assets that do not count towards the resource limits include, but are not limited to:

- The person's homesite (the principal place of residence, including the lot on which it sits, and, in some Medicaid programs, some additional contiguous property);
- Personal effects and household goods;
- One essential motor vehicle (used to retain employment or to get to the doctor at least four times a year, or one that is specially equipped for the disabled);
- Partial interests in real property, such as life estates, remainder interests that cannot be sold, and interests held with others as tenants-in-common;
- Income-producing real property, such as rental property, or land that is rented out for farming (the Medicaid program has special rules to determine if the property is producing enough income to be exempt from the resource consideration).

NUMBERS SERVED

The Medicaid program served 1,197,173 individuals in FY 1998. Medicaid is an entitlement program, so all eligible individuals are served.

APPEAL RIGHTS

Medicaid applicants or recipients have a right to appeal any decision by the county DSS that involves the granting, denying, terminating, or modifying of assistance, or the failure of the county DSS to act within a reasonable time. Generally, the person has 60 days to request a hearing on an adverse decision. The 60-day deadline is calculated from the date the notice of the decision is mailed. If the person is already receiving Medicaid, he or she can request that benefits be continued until the first appeal is completed. Coverage will continue in these instances only if the person requests continued benefits within 10 days of the date of the notice.

All Medicaid appeals, except those involving disability, are first heard by a local DSS official. Individuals who disagree with the decision of the local DSS official can appeal to the decision to the NC Department of Health and Human Services (DHHS). Individuals have 15 days to file the state-level appeal; the 15 days is counted from the date the local official's decision was mailed. These second-level appeals (and cases involving disability determinations) will be heard before a state hearing officer. Individuals who are dissatisfied with the DHHS decision may appeal to Superior Court by filing a petition for judicial review. The petition for judicial review must be filed within 30 days of the time the individual receives the notice of the DHHS decision.

Anyone wishing to file such a petition would be wise to seek the services of an attorney before engaging in such a process. Free legal representation may be available for low-income families. See Chapter 32.

FINANCING

The Medicaid program is financed jointly among the federal, state and local governments. In general, the federal government pays approximately 63% of medical or service costs, the state pays approximately 31%, and counties pay the remaining 6%. The federal match rate is adjusted slightly each federal fiscal year. Administrative costs are split differently, with the federal government paying 50% of most administrative costs, and the state/county paying the remaining 50% (depending on whether the costs are incurred at the state or county level). In SFY 1998, the program spent the following amounts:

Federal:	$3,048,333,192
State:	$1,515,711,083
County:	$267,677,380
Total:	$4,831,721,654

ADMINISTRATION

Medicaid is administered on the federal level by the Health Care Financing Administration (HCFA) of the US Department of Health and Human Services. The program is administered on the state level by the Division of Medical Assistance (DMA) of the NC Department of Health and Human Services, and locally through the county Departments of Social Services (DSS).

SOURCES OF LAW

Federal statute:	42 USC 1396 *et. seq.*
Federal regulations:	42 CFR 430 *et. seq.*
State statutes:	NCGS 108A-54 *et. seq.*
State regulations:	10 NCAC Chapters 26 and 50
	State Medicaid policy manuals (available at every county DSS)

FOR MORE INFORMATION

Division of Medical Assistance
NC Department of Health and Human Services
1985 Umstead Dr.
PO Box 29529
Raleigh, NC 27626-0529
(919) 733-7160

DHHS also has a toll-free number for Medicaid information and referral. Call CARE-LINE at 1-800-662-7030.

There is a special toll-free number for information about the Medicaid for Pregnant Women program. Call 1-800-FOR-BABY, 1-800-367-2229.

1. Medicaid for Infants and Children Under Age 19 (MIC)

INTRODUCTION

Children under 19 may be eligible for Medicaid if they meet certain income requirements. Under this program, only the children—not their parents or caretaker relatives—are eligible for Medicaid coverage. Children need not reside with their parent(s) or with caretaker relatives in order to qualify for this program.

ELIGIBILITY

Income Eligibility

Income eligibility is determined by the family's countable income, family size and the child's age. Certain deductions from gross income are allowed in determining the family's countable income. These include:

- Any Earned Income Tax Credit (EITC) included in wages;
- Work-related expenses of $90 per wage earner;
- Child care or adult day care expenses, limited to $200 for each child under age two and $175 for others;
- Alimony or child support paid to someone outside the household; and
- Needs of any minor children who are not in the family (up to certain maximums).

If the family's countable income exceeds the amounts listed below, the child is not eligible for this program (although may still be eligible under another program category). These income guidelines are revised each April. The following are the guidelines in effect from April 1, 1999 to March 31, 2000.

Family Size	Children < age 1 (at/below 185% FPG)	Children ages 1-5 (at/below 185% FPG)	Children ages 6-18 (at/below 185% FPG)
1	$1,271	$ 914	$ 687
2	1,706	1,226	922
3	2,140	1,539	1,157
4	2,575	1,851	1,392
5	3,010	2,164	1,627
6	3,445	2,477	1,862
7	3,879	2,789	2,097
8	4,314	3,102	2,332
Each additional person	add $435	add $313	add $236

Resource Eligibility

There is no resource limit for children under age 19.

2. Medicaid for Families Receiving Work First Payments or Transitional Medicaid Benefits

Medicaid coverage for families is available automatically for families receiving Work First payments (in "standard" counties, see Work First Chapter 1). In order to qualify, a family with dependent children must also meet strict work, income and resource eligibility criteria. The major advantage to this program category is that both the children and parents or caretaker relatives can receive assistance. Also, no application is required, as the children automatically receive Medicaid when they are also part of a family receiving Work First payments.

Twelve months of transitional Medicaid benefits are available to families who lose Work First cash payments due to the earnings of a parent or a caretaker relative. Beginning October 1, 1999, families will be eligible for 24 months of transitional Medicaid benefits. To qualify, families must have received assistance during at least three of the six months prior to having their cash assistance benefits terminated.

3. Medicaid for Families who would have Qualified under North Carolina's Former Aid to Families with Dependent Children (AFDC) Program

INTRODUCTION

Medicaid coverage for families with dependent children is also available to families with children under age 21 who have been deprived of the support of one or both parents because of death, absence from the home, physical or mental incapacity, or the unemployment or underemployment of the parent who is the principal wage earner. Families who do not qualify for Work First payments, for example, because the family fails to participate in the work programs, or after the two year time limit expires, may nonetheless still qualify for Medicaid under the old AFDC program requirements. In order to qualify, a family with dependent children must file a separate application and must meet strict income and resource eligibility criteria. The chief advantage of this program category is that both the children and parents or caretaker relatives can receive assistance, in contrast to the program for Children under Age 19 where only the children can receive assistance.

ELIGIBILITY

Personal Eligibility

The general personal eligibility rules set out in the General Information section are applicable both to a child and to caretaker relatives. However, additional personal eligibility rules are also applicable to each:

To be eligible as a caretaker, the person must:

- Be living with and caring for a child under age 19 (including unborn children) who is deprived of the support of at least one parent due to death, absence from the home, incapacity or unemployment;
- Be either the child's parent or a specified relative (such as a grandparent, aunt, or uncle who is related by blood, marriage or adoption);

- Cooperate with the local Child Support Enforcement Agency in establishing paternity and medical support for all dependent children in the family; and
- Meet financial need requirements.

To be eligible as a child, a person must:

- Be under age 21; and
- Meet financial need requirements.

Income Eligibility

Certain deductions from gross income are allowed in determining a family's countable income. These include:

- Any Earned Income Tax Credit included in wages;
- Work-related expenses of $90 per wage earner;
- Child care or adult day care expenses, limited to $200 for each child under age two and $175 for others;
- Alimony or child support paid to someone outside the household; and
- Needs of any minor children who are not in the family (up to certain maximums).

To be eligible for Medicaid under this program category, the family's countable monthly income may not exceed the following amounts:

Family Size	Monthly Income Limit
1	$362
2	472
3	544
4	594
5	648
6	698
7	746
8	772

Resource Eligibility

Families cannot have more than $1,000 in countable resources, regardless of the size of the family. In this program the homesite exclusion is defined as a house and lot in a city or a house and one acre of land in rural areas.

4. Medicaid for Disabled or Blind Children

INTRODUCTION

Medicaid is available automatically to disabled children receiving SSI payments. No application is needed. Medicaid is also available to children who were receiving SSI prior to August 22, 1996, but who later lost benefits because of changes in the eligibility requirements. These children should receive Medicaid benefits automatically, without the

need to fill out a new application. Children who are not receiving SSI, but who meet the SSI disability requirements may also receive Medicaid, but will need to file a separate Medicaid application. Children who are applying on the basis of blindness must also fill out a separate Medicaid application. The application procedures are essentially the same as outlined above in the General Information section; however, DSS has 90 days (instead of the usual 45 days) to make an eligibility determination if the child's disability status is at issue.

ELIGIBILITY

Personal Eligibility

- *Disability:* To qualify as a disabled child, the child must have a severe mental or physical impairment that has lasted or is expected to last a minimum of twelve months, or which is expected to result in death (see SSI Chapter 3).

- *Blindness:* To qualify as a blind child, the child must have corrected visual acuity of 20/200 in the better eye or worse, or tunnel vision.

Income Eligibility

Children with disabilities will automatically receive Medicaid if they receive SSI. A child who does not receive SSI, but who meets the SSI disability standard, may still qualify for Medicaid. These children are eligible if their family income is equal to or less than 100% of the federal poverty guidelines.

Note: These children would also be eligible under the Medicaid program for Infants and Children. The MIC program has higher income guidelines for younger children, and has no resource tests. The health care coverage is the same for both programs, so most disabled children who are not receiving SSI would be better off applying under the MIC program.

To be eligible for SSI, a child can have no more than $500 per month in countable income. The child's income plus certain income deemed from his/her parent(s) is considered in the income calculations. The SSI income limits change January 1st of each year.

As in other program categories, there are certain allowable deductions from gross income. Countable income is determined by subtracting the first $65 of earned income plus half of the remaining earned income from either the parent's or child's gross income. In addition, each budget unit is allowed a $20 standard deduction.

To determine the amount of the parent(s) income that is considered available to the child, the Department of Social Services will look at the parent's countable income (after allowable deductions listed above), and then subtract the following:

- An amount equal to the SSI income limits for the parent(s). (The 1999 SSI income limits are $500 for an individual, and $751/month for a couple); and
- An amount equal to one-half of the SSI payment level for each ineligible child (i.e., $250 for each ineligible child).

Any remaining income is “deemed” available to the child.

Resource Eligibility

Disabled children who apply for Medicaid under this program can have countable resources of $2,000. The child's homesite, plus all contiguous property is excluded from the resource calculation.

5. Medically Needy

INTRODUCTION

North Carolina also provides Medicaid coverage to "medically needy" individuals and families. A child or family who cannot qualify under other program requirements because of excess income may still qualify for Medicaid under the medically needy program. In general, a child or family qualifies as "medically needy" because of large medical expenses. To qualify as medically needy, the child or family must incur and be responsible for paying medical bills equaling the difference between their countable income and the medically needy income limits (see below). This difference is called a deductible or "spend-down."

Children with large medical bills can apply separately for Medicaid for themselves or as a family unit under the medically needy Medicaid program. The size of the spend-down or deductible will be calculated according to the family's income and number of people to be covered.

ELIGIBILITY

Personal Eligibility

To qualify under the medically needy Medicaid program, the child or family must meet the same personal eligibility requirements of the other Medicaid programs. Thus, if a child applies separately, the child must meet the personal eligibility requirements of the Medicaid program for infants and children under age 19, or for disabled children. If the whole family is applying under the medically needy program, then the family must meet the personal eligibility requirements of the Work First or former AFDC program (see preceding sections).

Income Eligibility

Children or families who cannot qualify for other programs because of excess income may still be able to qualify for Medicaid under the medically needy program with a deductible. The child or family's countable income is compared to the medically needy income limits and the difference is the monthly deductible or "spend-down."

Family Size	Medically Needy Monthly Income Limit
1	$242
2	317
3	367
4	400
5	433
6	467
7	500
8	525

Thus, for example, a family of four with a countable monthly income of $800 has a $400 deductible or "spend-down" ($800 countable income - $400 medically needy monthly income limit = $400). If the family wants ongoing Medicaid coverage, the amount of the deductible is calculated on a six-month prospective basis. In the example outline above, the family would have to incur $2,400 in medical bills ($400 deductible x 6 months = $2,400). After the family meets the deductible, Medicaid will pay medical bills for covered services for the remaining of the six-month period.

Alternatively, families can request that the Medicaid coverage be retroactive—that is, that outlined above, the family would have to incur $2,400 in medical bills ($400 deductible x 6 months = $2,400). After a family meets the deductible, Medicaid will pay the medical bills for covered services for the remaining six-month period. Alternatively, families can request that the Medicaid coverage be retroactive - that is, that Medicaid cover medical bills incurred in the one-, two-, or three-month period prior to applying. The amount of the deductible would be calculated accordingly.

Note: The family need not actually pay the medical bills in order to qualify. They are, however, responsible for paying those medical bills. Medical bills that will be paid by a third party (such as an insurance company) cannot be applied to the deductible. Medical bills that a family incurs to cover the cost of health insurance, medical services or products can be used in meeting a deductible.

Resource Eligibility

For families who qualify under "medically needy" requirements, the following resource limits will usually apply:

Family Size	Medically Needy Resource Limits
1	$1,500
2	2,250
3	2,350
Each additional person	add $100 (up to a maximum of $3,050)

In the medically needy program, the homesite exclusion is defined as a house and lot in a city or a house and one acre of land in rural areas, plus up to $12,000 worth of contiguous property.

Disabled children who apply for Medicaid under the medically needy program have higher resource limits. A child under the medically needy program for disabled children can have countable resources of $2,000. The child's homesite plus all contiguous property is excluded from the resource calculation.

6. Medicaid for Pregnant Women (MPW) or "Baby Love"

INTRODUCTION

A pregnant woman/minor whose countable income is not more than 185% of the federal poverty guidelines is eligible for Medicaid for Pregnant Women as soon as her pregnancy is medically verifiable. This program is also known as the "Baby Love" program. For pregnant minors, only the income of the minor (not her parents) will be counted in determining eligibility. There is no resource test in this program. Medicaid coverage will continue throughout the pregnancy and for a certain length of time after the pregnancy ends. In general, pregnant women/minors receive Medicaid coverage until the end of the month which contains the 60th day after the pregnancy ends. Coverage will continue for the full eligibility period, even if her personal finances improve and she no longer meets the income guidelines.

BENEFITS/ SERVICES

Pregnant women who qualify for Medicaid under the Medicaid for Pregnant Women program are eligible for pregnancy-related services only. Treatment of other conditions, such as pregnancy induced diabetes, that might complicate the pregnancy are also covered. Pregnant women may also qualify under the Work First or the former Families with Dependent Children programs. If they qualify under these latter programs, they are eligible for the full range of Medicaid benefits.

APPLICATIONS

Eligibility for Medicaid under this program can be determined "presumptively"—that is, staff at health departments, hospitals, or clinics can "presume" that a woman or minor will be eligible for this coverage based on medical verification of the pregnancy and a verbal declaration by the applicant of her family (or in the case of a minor, her own) income. If it appears that she will be eligible, coverage will begin immediately. Coverage while a woman/minor is "presumptively eligible" is limited to ambulatory prenatal care.

In order to continue coverage, the applicant must file a formal application with the Department of Social Services by the last working day of the month following the "presumptive eligibility" determination. The final determination of eligibility will be made within 45 days of application.

ELIGIBILITY

Personal Eligibility

A woman meets the personal eligibility requirements once her pregnancy is medically verified.

Income Eligibility

Pregnant women/minors must have a family income of not more than 185% of the federal poverty guidelines to qualify for assistance (see above in the Medicaid program for infants and children section). Only the income of the pregnant woman and her spouse, if any, will be counted. In order to encourage pregnant minors (teens or younger children) to obtain necessary prenatal care, the income of a pregnant minor's parents is not counted. However, cash given to the minor by a parent will count as income.

Eligibility is determined based on the number of people in the family. The family includes the pregnant woman, her unborn child(ren), the spouse, and any other children residing with the family. However, if the family qualifies, only the pregnant woman or minor receives coverage.

Families are entitled to certain deductions from gross income. These include:

- Any Earned Income Tax Credit included in wages;
- Work-related expenses of $90 per wage earner;
- Child care or adult day care expenses, limited to $200 for each child under age two and $175 for others;
- Alimony or child support paid to someone outside the household; and
- Needs of any minor children who are not in the family (up to certain maximums).

After subtracting the allowable deductions, the countable income of the family must be no more than 185% of the federal poverty guidelines.

Resource Eligibility

There is no resource test in this program.