16.5 CATEGORICALLY NEEDY, MANDATORY - FOR ADULTS, FAMILIES AND/OR CHILDREN

NOTE: No Categorically Needy coverage group is subject to a spenddown provision.

A. PARENTS/CARETAKER RELATIVES

Income: Parent/Caretaker Relative Medicaid Limit Assets: N/A

The Patient Protection and Affordable Care Act, enacted March 23, 2010, amended by the Health Care and Education Reconciliation Act of 2010, enacted March 30, 2010 are together referred to as the Affordable Care Act.

The Affordable Care Act simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The new Parents/Caretaker Relatives coverage group replaces the former AFDC Medicaid coverage group for parents and other caretaker relatives. AFDC methodologies for determining financial eligibility will be superseded by MAGI methodologies effective January 1, 2014.

NOTE: West Virginia received an 1115 waiver to begin using MAGI methodologies to determine eligibility for populations subject to MAGI beginning with applications submitted on or after October 1, 2013, and for any retroactive coverage months requested on applications submitted on or after October 1, 2013.

A parent or caretaker relative is eligible under this coverage group when the following requirements are met:

- The parent or caretaker relative must be living in the household with a dependent child for whom they assume primary responsibility. See Section 15.2 for the definition of a dependent child and specified caretaker relative.

- The income eligibility requirements described in Chapter 10 are met.

NOTE: If not, they are evaluated for eligibility for other coverage groups.

B. DEEMED PARENTS/CARETAKER RELATIVES MEDICAID

1. Extended Medicaid (ME S)

Income: N/A **Assets: N/A**

An AG is eligible for Extended Medicaid for 4 months when both of the following conditions are met:

- The AG lost eligibility for **Parents/Caretaker Relatives** Medicaid due to the onset of new spousal support or an increase of spousal support; and

- The AG received **Parents/Caretaker Relatives** Medicaid in any 3 or more months during the 6-month period that immediately precedes the 1st month of ineligibility for PCR Medicaid.

Recipients of Extended Medicaid are not required to cooperate with, nor are they referred to BCSE.

2. Children Covered Under Title IV-E Adoption Assistance

Income: N/A **Assets: N/A**

Families which receive Title IV-E Adoption Assistance payments from West Virginia for an adopted child, receive a medical card for the child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Adoption Assistance and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Adoption Assistance from West Virginia, medical coverage is provided as a recipient of Title IV-E Adoption Assistance. The Worker must not provide medical coverage for the child as an SSI recipient.

- When the child receives Title IV-E Adoption Assistance from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

3. Children Covered Under Title IV-E Foster Care

Income: N/A **Assets: N/A**

Persons who receive Title IV-E Foster Care payments from West Virginia for a foster child, receive a medical card for the foster child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Foster Care and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Foster Care from West Virginia, medical coverage is provided as a recipient of Title IV-E Foster Care. The Worker must not provide medical coverage for the child as an SSI recipient.

- When the child receives Title IV-E Foster Care from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

C. TRANSITIONAL MEDICAID (TM) (ME I, ME T, ME D)

Income: Phase I - N/A **Assets: N/A**
Phase II - 185% FPL

This coverage group consists of families which lose eligibility for Parents/Caretaker Relatives Medicaid because of earned income, the loss of earned income disregards. TM provides continuing medical coverage after Parents/Caretaker Relatives Medicaid eligibility ends and occurs in 2 phases as described below.

There are no application procedures for Transitional Medicaid. Instead, when an Parents/Caretaker Relatives Medicaid case becomes ineligible, the Worker must automatically determine eligibility for TM. If the case is closed in error instead of being converted to a TM case, the case must be reopened without reapplication by the client.

The periodic review letter (PRL) dates throughout this Section will vary due to adverse action deadline and non-work days. See Appendix A.

NOTE: Transitional Medicaid (TM) is not related in any way to DCA eligibility or ineligibility or the loss of WV WORKS eligibility. TM eligibility is related only to ineligibility for Parents/Caretaker Relatives Medicaid.

NOTE: Recipients of TM are not referred to nor required to cooperate with child support activities.

NOTE: Loss of TM coverage must not affect 12 months of continuous Medicaid eligibility for the children in the AG. See Section 2.8.

NOTE: When a child loses eligibility as a Child Under Age 19 and his family is receiving Transitional Medicaid (TM), he is included in the AG, if otherwise eligible.

1. Phase I Coverage

   a. Eligibility Requirements

      In order to be eligible for Phase I coverage, all of the following conditions must be met:

      - The AG became ineligible for Parents/Caretaker Relatives Medicaid due to the amount of income from employment.

        NOTE: In determining ineligibility for Parents/Caretaker Relatives Medicaid, the Worker must consider income of the AG and any individual who would normally be included in the AG, but who has been penalized.

- The AG received Parents/Caretaker Relatives Medicaid in any 3 or more months during the 6-month period immediately preceding the 1st month of ineligibility for Parents/Caretaker RelativesMedicaid.

  NOTE: Receipt of WV WORKS or a DCA payment does not meet this requirement. It is met only by receipt of Parents/Caretaker Relatives Medicaid for at least 3 of the last 6 months.

- The AG did not receive Parents/Caretaker Relatives Medicaid fraudulently during any of the 6 months prior to the 1st month of Parents/Caretaker Relatives Medicaid ineligibility.

- The family has a dependent child who would be included in the Parents/Caretaker Relatives Medicaid AG, if the family were eligible.

* When the AG becomes ineligible for Medicaid for a combination of reasons, the Worker must determine if the amount of earned income, (or the addition of an individual with earnings who has received Parents/Caretaker Relatives Medicaid in 3 of the past 6 months), had an effect on the ineligibility. Only when this is the case is the AG eligible for TM.

* The steps below are to be followed to determine if such factors had an effect on ineligibility for Parents/Caretaker Relatives Medicaid:

* Step 1: Determine if the increase in income would have resulted in loss of Parents/Caretaker Relatives Medicaid if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in Parents/Caretaker Relatives Medicaid standards, etc.).

  If yes, the AG meets the requirement.

* If no, go to Step 2.

* Step 2: Determine if events other than the increase in income would have resulted in loss of Parents/Caretaker Relatives Medicaid if the income had stayed the same.

* If yes, the AG does not meet the requirement.

* If no, go to Step 3.

* Step 3: Determine if the AG is ineligible for Parents/ Caretaker Relatives Medicaid when all changes are considered.

* If yes, the AG meets the requirement. The increase in earnings was essential to the loss of Parents/Caretaker Relatives Medicaid eligibility. Without that increase, the AG would not have lost eligibility.

* If no, the AG is still eligible for Parents/Caretaker Relatives Medicaid.

b. Loss of Eligibility Before Expiration of Full Phase I Coverage

The following circumstances will result in case closure (after proper notice) before the expiration of the Phase I coverage:

(1) No Dependent Child

When there is no child in the home who would be eligible for Medicaid, the AG loses eligibility. Eligibility ends at the end of the 1st month in which the AG no longer includes such a child.

EXAMPLE: Last dependent child leaves the home on February 10th. The case is closed effective February. Advance notice is required.

(2) Fraud

When it is determined that Parents/Caretaker Relatives Medicaid benefits received in one or more of the 6 months prior to the start of Phase I coverage were received fraudulently, the AG is ineligible. Eligibility ends on the last day of the month when the advance notice period expires.

(3) Enrollment in Free Employer's Plan

When the person whose employment caused ineligibility for Parents/Caretaker Relatives Medicaid does not enroll or maintain enrollment in the employer's health plan, provided such coverage is free to the client, the AG becomes ineligible. Eligibility ends on the last day of the month when the advance notice period expires. Benefits are not delayed pending compliance with this requirement. The client must be allowed 30 days to prove he has taken the steps necessary to comply.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: Failure, without good cause, to return a complete PRL3 by 1st work day after the 20th of the 4th month results in ineligibility to participate in Phase II of TM, but has no effect on Phase I coverage.

c. Eligible Situations

Provided the AG meets all of the eligibility requirements in item a above, it is eligible for Phase I TM in the following situations:

- The AG was eligible for and receiving Parents/Caretaker Relatives Medicaid and the beginning of employment or payment rate had an effect on Parents/Caretaker Relatives ineligibility.

- The earned income of an individual who received Parents/Caretaker Relatives Medicaid in 3 of the last 6 months and who is added to the AG, has an effect on the AG's Parents/Caretaker Relatives Medicaid ineligibility.

- The case becomes ineligible for Parents/Caretaker Relatives Medicaid due to failure to report or provide verification of new earnings, provided that fraud is not indicated.

- The case becomes ineligible for 1 month only due to a temporary increase in hours worked or rate of pay.

d. Ineligible Situations

The AG is not eligible for Phase I coverage in the following situations:

- The AG becomes ineligible because of the earnings of an individual being added to the AG who has not received Parents/Caretaker Relatives Medicaid in 3 of the last 6 months.

- The AG becomes ineligible for a reason other than those found in item 1,a above.

- There is an indication, with supporting evidence, that the AG received Parents/Caretaker Relatives Medicaid fraudulently during at least 1 of the 6 months prior to the first month of Parents/Caretaker Relatives Medicaid ineligibility. The Worker must determine from the case record if a referral has been made to IFM or if an IFM decision has been rendered on any fraud claim. If there is a substantive indication that fraud was involved, the AG is not eligible for Phase I coverage.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: There is no provision to discontinue Phase I coverage due to the AG's becoming eligible for Parents/Caretaker Relatives Medicaid again. Instead, the AG is dually eligible for Parents/Caretaker Relatives Medicaid and TM. See item 3 below for the significance of dual eligibility.

e. Beginning Date of Phase I Coverage

An AG is eligible for Phase I coverage beginning the month following the last month of Parents/Caretaker Relatives Medicaid eligibility. When Parents/Caretaker Relatives Medicaid is continued beyond the month ineligibility occurs because of an agency or client error, the beginning date of TM is the 1st month after advance notice would have expired and the client should have lost eligibility**.**

f. Client's Reporting Requirements

The client is required to report his gross earnings and day care costs for the first 3 months of Phase I coverage by the 1st work day after the 20th of the 4th month. He is also required to report

the earnings and day care costs of any person in the home who is included in the Parents/Caretaker Relatives Medicaid Income Group. In addition, he must report his gross earnings and day care costs for the last 3 months of Phase I coverage by the 1st work day after the 20th of the 1st month of Phase II coverage.

eRAPIDS letter PRL3, is mailed to the client by the 3rd Friday of the 3rd month.

If the client returns the completed PRL3 form, he has met one of the eligibility requirements for Phase II coverage.

Failure to return a completed form, without good cause, by the 1st work day after the 20th of the 4th month, automatically renders the AG ineligible to participate in Phase II, after proper notice. The client must be notified of the consequences of his actions when the form is not returned by the due date without good cause or is returned but is incomplete. The client has a right to a Fair Hearing on this issue since future eligibility is involved. The Worker must not wait until the end of Phase I coverage to notify the client of his ineligibility for Phase II. The process of determining eligibility or ineligibility, based on this reporting requirement, is completed prior to the end of Phase I coverage.

The PRL3 must be filed in the case record.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

An eRAPIDS alert notifies the Worker when the form is due.

If the client provides the completed form within the 13-day notice period, this part of the eligibility requirement for Phase II is reestablished.

g. Special Agency Notification Requirements

During the 4th month of Phase I eligibility, the client is notified of the availability of Phase II coverage and what he must do to continue coverage.

2. Phase II Coverage

NOTE: When all eligibility factors for Phase II coverage are met, eligibility continues, without interruption, from Phase I to Phase II, unless the client has indicated he does not wish to continue such coverage.

a. Eligibility Requirements

In order to be eligible for Phase II coverage, all of the following conditions must be met:

- The AG received Phase I coverage for the entire 6-month Phase I period. The 6-month period includes months for which the client was dually eligible for Phase I and Parents/Caretaker Relatives Medicaid, if applicable.

- The client completed and returned, in a timely manner, the PRL3 sent to him, or had good cause for not returning it. The form is considered to be returned in a timely manner when it is received within the advance notice period.

- The family has a dependent child who would be eligible for Parents/Caretaker Relatives Medicaid.

- The earned income amount meets the financial test as described in Chapter 10. For Phase II coverage, information from the PRL3 is used. Information from the PRL3 determines eligibility for months 7 – 12 of Phase II TM coverage. Information from the PRL8 determines continued eligibility for months 9 – 12 of Phase II and the PRL9 determines eligibility for month 12 of TM.

- The client continues to have earnings, unless the lack of earnings is due to involuntary loss of employment, illness, or unless good cause is established.

- The client applies for and maintains enrollment in his employer's health plan, provided such coverage is free to the client

b. Beginning Date of Phase II Coverage

An AG is eligible for Phase II coverage beginning the 1st month immediately after Phase I coverage ends. When Phase II coverage

is, in error, not begun in the correct month, coverage begins upon discovery of the error and is backdated to the date coverage should have begun. In no instance is Phase II coverage extended beyond 6 months past the end of Phase I coverage.

c. Client's Reporting Requirements

The client is required to report his gross earnings, the gross earnings of other Income Group adults in the home, and actual out-of-pocket day care costs. This information is used to determine financial eligibility for Phase II coverage. The PRL3 is mailed by the 3rd Friday of the 3rd month and must be completed and returned by the 1st work day after the 20th of the 4th month, unless the client establishes good cause.

The PRL8 is mailed by the 3rd Friday of the 6th month and the completed form is due by the 1st work day after the 20th of the 7th month. The PRL9 is mailed by the 3rd Friday of the 9th month and the completed form is due by the 1st work day after the 20th of the 10th month. All PRL forms must be returned by the due date, unless the client establishes good cause.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

The PRL forms must be filed in the case record. An eRAPIDS alert notifies the Worker that the forms are due.

d. Automatic Termination of TM

The data system will automatically terminate TM eligibility at the end of 8th month if the PRL8 is not returned by the due date.

eRAPIDS will automatically terminate TM at the end of the 11th month if the PRL9 is not returned by the due date.

At the end of the TM Phase II, the data system will automatically terminate coverage.

NOTE: When TM eligibility ends for any reason other than expiration of the time period, the Worker must evaluate eligibility of the AG for all other Medicaid coverage groups.

3. Return To Parents/Caretaker Relatives Medicaid, Phases I and II

If an AG returns to Parents/Caretaker Relatives Medicaid during Phase I or Phase II, but otherwise meets the requirements for TM, the AG is dually eligible for Parents/Caretaker Relatives Medicaid and TM. If the AG again becomes ineligible for Parents/Caretaker Relatives Medicaid, Worker action depends upon the case circumstances at the time of the subsequent case closure as follows.

a. Otherwise Eligible for TM

If the AG meets all of the eligibility requirements found in item 1,a above, the family is eligible for a new TM period, beginning with Phase I for 6 months and continuing through Phase II, if the Phase II requirements are met.

b. Not Otherwise Eligible for TM

When either of the two following conditions are met at the time of the subsequent case closure, the AG is eligible only for the remainder of the original TM period.

- The AG loses eligibility for a reason not related to employment; or

- The AG loses eligibility for a reason related to employment, but does not meet the requirement of having received Parents/Caretaker Relatives Medicaid in 3 of the preceding 6 months.

EXAMPLE: An Parents/Caretaker Relatives Medicaid AG becomes ineligible when the parent obtains full-time employment. The family receives TM for 7 months, from March through September, but returns to Parents/Caretaker Relatives Medicaid for 2 months, October and November. At the time the parent's job starts again, at the end of November, he has no longer received Parents/Caretaker Relatives Medicaid in 3 of the 6 months prior to ineligibility. One of the eligibility requirements for TM is no longer met. However, because the AG was dually eligible for TM and Parents/Caretaker Relatives Medicaid, TM coverage continues for December, January and February.

D. CHILDREN UNDER AGE 19

Income:	Children < 1	158% FPL	Assets:	N/A
	Children 1-5	141% FPL		
	Children 6 – 19	108% FPL		

The Affordable Care Act simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The new Children Under Age 19 coverage group combines prior coverage for children under the AFDC group, Qualified Child and Poverty-Level Children coverage groups into one group. Eligibility will be determined using MAGI methodologies beginning January 1, 2014.

NOTE: West Virginia received an 1115 waiver to begin using MAGI methodologies to determine eligibility for populations subject to MAGI beginning with applications submitted on or after October 1, 2013, and for any retroactive coverage months requested on applications submitted on or after October 1, 2013.

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child under the age of 19 is eligible for Medicaid coverage in the Children Under 19 group when all of the following conditions are met:

- The child is not eligible for SSI Medicaid.
- The child is under age 19, regardless of school attendance or course completion date.
- The income eligibility requirements described in Chapter 10 are met.

E. PREGNANT WOMEN

Income: 158% FPL Assets: N/A

The Affordable Care Act simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The new Pregnant Women coverage group combines existing categorically needy groups Poverty-Level Pregnant Woman and Deemed Poverty-Level Pregnant Woman into one coverage group. Eligibility will be determined using MAGI methodologies beginning January 1, 2014.

NOTE: West Virginia received an 1115 waiver to begin using MAGI methodologies to determine eligibility for populations subject to MAGI beginning with applications submitted on or after October 1, 2013, and for any retroactive coverage months requested on applications submitted on or after October 1, 2013.

1. General Requirements

   A pregnant woman is eligible for Medicaid coverage in the Pregnant Woman group when the income eligibility requirements described in Chapter 10 are met. Changes in income after eligibility has been established have no effect on continuing eligibility.

2. Postpartum Coverage

   This coverage applies only to the mother, not the child. The child may be covered as a Continuously Eligible Newborn.

   A woman who received coverage as a pregnant woman while living in another state or who is a recipient of postpartum coverage from another state is not eligible for postpartum coverage in WV, unless she is determined eligible for Pregnant Woman coverage in WV.

   A woman continues to be eligible for Medicaid for 60 days postpartum, and the remaining days of the month in which the 60th day falls, provided that during the pregnancy or within 3 months of the end of the pregnancy, the woman met all of the following requirements:

   - She applied for Medicaid (any coverage group)
   - She was eligible for Medicaid (any coverage group)
   - She received Medicaid services (any covered service, not limited to pregnancy services).

   NOTE: The postpartum period begins with the child's date of birth. In some instances, the postpartum period extends into the third calendar month after the month of birth to assure the recipient receives proper notice.

   EXAMPLE: A woman with a pregnancy due date of August 7, 2009 reports on September 9, 2009 that her child was born on July 28, 2009. The redetermination date remains October 2009 to assure she receives proper notice of her scheduled eligibility redetermination. This also assures proper closure notice if she fails to complete the eligibility redetermination.

If the mother is determined, after the end of the pregnancy, to have been eligible in a month prior to the end of the pregnancy, she is eligible for postpartum coverage. This is true even if income increases above the income eligibility limits in any month after she is determined eligible.

NOTE: Postpartum coverage is required if the pregnancy ends in a live birth, miscarriage, abortion, or if the child is stillborn.

The last day of pregnancy is counted as day one of the 60-day postpartum period, and a redetermination is completed in the 2nd month of the postpartum period. If eligible for other Medicaid, or WV CHIP, that coverage must not begin until expiration of the postpartum period.

If no review takes place, Medicaid coverage will automatically close after the adverse notice period.

NOTE: A Pregnant Woman is not referred nor required to cooperate with child support activities while pregnant nor during the postpartum period.

NOTE: A Pregnant Woman cannot have Medicaid terminated or denied for failure to cooperate with QC until the end of the postpartum period. After the postpartum period the sanction is applied, even if she qualifies under another coverage group.

F. ADULT GROUP

Income: 133% FPL Assets: N/A

The Patient Protection and Affordable Care Act, enacted March 23, 2010, amended by the Health Care and Education Reconciliation Act of 2010, enacted March 30, 2010, are together referred to as the Affordable Care Act. The Affordable Care Act established a new categorically mandatory coverage group known as “the Adult Group.” Eligibility for this group will be determined using MAGI methodologies established in Section 10.8.

The Department must begin accepting applications and determining eligibility using MAGI methodologies for the Adult Group on or after October 1, 2013. However, coverage in the Adult Group cannot begin prior to January 1, 2014.

Effective January 1, 2014 Medicaid coverage will be provided in the Adult Group to individuals age 19 or older and under age 65 who meet the following requirements:

They are not eligible for another categorically mandatory Medicaid coverage group:

- SSI
- Deemed SSI
- Parents/Caretaker Relatives
- Pregnant Women
- Children Under Age 19
- Former Foster Children

- They are not entitled to or enrolled in Medicare Part A or B.

- The income eligibility requirements described in Chapter 10 are met.

NOTE: Parents or other caretaker relatives living with a dependent child under the age of 19 are not eligible for Medicaid in the Adult Group unless the child is receiving benefits under Medicaid, CHIP, or otherwise is enrolled in minimum essential health coverage (MEC). See Section 10.1 for definition.

NOTE: If a woman indicates at application that she is pregnant she is not eligible to be included in the Adult Group; she must be evaluated for the Pregnant Women coverage group. If a woman currently receiving Medicaid in the Adult Group later reports a pregnancy to the Department, she should be enrolled in the Pregnant Women coverage group. However, there is no requirement for a woman to report her pregnancy to the Department.

G. FORMER WV FOSTER CHILDREN

Income: N/A Assets: N/A

The Affordable Care Act established a new categorically mandatory coverage group called the WV Former Foster Children group. The Department must begin accepting applications and determining eligibility for Former WV Foster Children on or after October 1, 2013. However, coverage in the Former WV Foster Children Group cannot begin prior to January 1, 2014.

Effective January 1, 2014 Medicaid coverage will be provided in the WV Former Foster Children group to individuals who meet the following requirements:

- Are under 26 years of age;
- Are not eligible for another categorically mandatory coverage group:
  - SSI
  - Deemed SSI
  - Parents/Caretaker Relatives
  - Pregnant Women
  - Children Under Age 19
- Were in foster care under the responsibility of the State of West Virginia;
- Receiving Medicaid on the date of attaining 18 years of age, or the date they aged out of foster care, up to age 21.

There is no income or asset test for the WV Former Foster Children coverage group.

NOTE: Individuals eligible for both the WV Former Foster Children group and the Adult Group must be enrolled in the WV Former Foster Children group.

H. CATEGORICALLY NEEDY (MN) CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN),

NOTE: See Section 16.8,A for Medically Needy CEN coverage.

Income: N/A **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

A Continuously Eligible Newborn Child (CEN) (birth - 12 months) is eligible for Medicaid until he reaches age 1, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- A Medicaid application was made, or considered to have been made, and approved. The application may be made up to 3 months after the child's birth. If the child's mother was eligible for and receiving Medicaid from West Virginia in the month the child was born, an application is considered to have been made for the child.

- The child resides continuously in West Virginia during the entire CEN period. If the child leaves WV and returns, CEN coverage cannot be reinstated.

  NOTE: Under SSI, a child born to an institutionalized woman is eligible on the date of birth only. Eligibility under all other Medicaid coverage groups must be explored immediately for these children.

CEN's must <u>not</u> be required to live with a specified relative, and there is no income or asset test for such children. Enumeration requirements are not to be applied.

NOTE: There is no requirement that the CEN be evaluated for the Children Under Age 19 group. He must remain a CEN until he reaches age 1, as long as all CEN eligibility requirements are met.

DUE TO DELETION OF MANUAL MATERIAL

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