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Repealed, February 8, 1999.

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Repealed, December 21, 1990.

Sec. 17-2-77. State department of social services policy

A. Services Covered by Medicare. For services covered by Medicare, the Provider must complete the Form SSA-1490, Request for Medicare Payment, or Form SSA-1491, Request for Medicare Payment—Ambulance, and submit the Medicare Claim Form directly to Connecticut General, Medicare Claim Office, 200 Pratt Street, Meriden, Connecticut 06450. Please provide the recipient's health insurance claim number, current Social Services case number and signature.

B. Acceptance of Assignment. An assignment for each bill must be accepted since the Social Services recipient has no other resources to meet medical expenses.

The Department of Social Services will not be liable for any balance between the amount billed to Medicare and the total amount allowed by Medicare.

C. Prior Authorization. There are services which ordinarily require a Prior Authorization by the Department of Social Services.

If the provider sends a Medicare claim for these services to the Connecticut General Medicare Claim Office and the claim is rejected because the individual is not covered under Medicare Part B, a prior authorization will not be required by this Department. However, these bills will be reviewed by the State Department of Social Services, Division of Health Services, for necessity of services provided and the charge for same.

D. Services Definitely Not Covered by Medicare. Claims for payment for those services which Medicare definitely does not cover, must be submitted directly to the State Department of Social Services on the Social Services Bill Form with the notation on the bill "SERVICE NOT COVERED BY MEDICARE." (For example, flu shots, hearing aids (cords, batteries), et cetera). In order to bill in this manner, it must be clearly evident to the provider that the service is definitely not covered by Medicare.

If these non-covered services require a Prior Authorization, the Provider must submit a prior authorization to the Department of Social Services prior to the submission of the Social Services Bill. The provider must note on the prior authorization form "SERVICE NOT COVERED BY MEDICARE." This will alert the Department of Social Services that it is the intent of the provider to bill the Department directly.

IMPORTANT: If the Provider is aware that the services are definitely not covered by Medicare and continues to bill Medicare directly for these particular services, the Department of Social Services will not honor the bill(s) for payment.

(Effective September 29, 1977)

Sec. 17-2-78. Billing procedures effective October 30, 1976

A. Connecticut General Medicare Claim Office—Claim and Payment Form. Connecticut General Medicare Claim Office will supply the provider with a three-part Form SSA-1490, Request for Medicare Payment, or a two-part Form SSA-1491, Request for Medicare Payment—Ambulance.

The Provider will complete the Form SSA-1490 or Form SSA-1491, and submit the original copy to Connecticut General Medicare Claim Office. The Provider should retain the copies for his files.

Connecticut General will process the original copy and send the provider a two-part Form MC-131, Medicare Payment Report, which lists payment information for each individual, including the deductible and coinsurance amounts, and remarks codes for claims partially or totally rejected. (Explanation of remarks codes are listed on the reverse side of Form MC-131, Medicare Payment Report.)

B. Department of Social Services—Payment for Deductible and Coinsurance or Claims Partially or Totally Rejected. 1. The provider must complete a Social Services bill form for each date of service, for each Social Services recipient listed on the Medicare Payment Report.

NOTE: If the Medicare Payment Report shows a rejection code and a deductible and/or coinsurance amount for the same date of service for the same recipient, two separate invoices must be completed.

2. The provider must submit the following to the Department of Social Services:
 - a. Duplicate copy of MC-131, Medicare Payment Report,

- b. Copy of SSA-1490 or SSA-1491 (for signature purposes) for only those Social Services recipients listed on the MC-131, Medicare Payment Report,
 - c. The completed Social Services bill forms for each date of service and for each Social Services recipient listed on the Medicare Payment Report.
3. Please staple corresponding material and mail directly to:

MEDICARE SECTION
 Division of Fiscal Services
 Department of Social Services
 110 Bartholomew Avenue
 Hartford, Connecticut 06115

IMPORTANT: Only Medicare/Medicaid related billing is to be mailed to the Medicare Section. All other bills should be directed to the Division of Medical Disbursements.

(Effective September 29, 1977)

Sec. 17-2-79. Reserved

Sec. 17-2-80.

Repealed, August 22, 2000.

Sec. 17-2-81. Criteria for determining length of need

- 1. **Long term** - medical need may be for life, permanent or the need for a sufficient number of months which would justify purchase;
- 2. **Intermediate term** - medical need which cannot be classified as short or long term due to an inadequate prognosis;
- 3. **Short term** - medical need for a number of months but not long enough to justify purchase.

To insure proper evaluation and control by the Department it will be necessary to include the following items on a prior authorization:

- 1. Item number. (If item is not covered under contract, describe the item).
- 2. New or replacement. (If replacement, explain.)
- 3. Original request or extension. (If extension, date of original request.)
- 4. Period of use. (Enter in the number of months according to the prognosis. If for life, state.)

Items under \$50.00 will be purchased and no prior authorization is required. This will not eliminate the need for proper medical diagnosis and/or a prescription to substantiate need for same.

Note: The Department's Medical Consultant's authorization of services on durable medical equipment does not establish financial eligibility. The Medical Consultant is approving the medical need, not the price of the item. The price is determined by a fee schedule and any variance of the price must have additional justification. Authorization for the item is valid only if the recipient presents his current medical identification card on the date the item is delivered to the recipient.

All prior authorizations are submitted to the Department of Social Services, Health Services, 110 Bartholomew Avenue, Hartford, Connecticut 06115.

In an emergency situation, verbal approval may be secured. The formal request on Form W-604 must follow as soon as possible and no later than 48 hours, with the notation that verbal approval had been given and by whom.

(Effective October 11, 1977)

Sec. 17-2-82. Form W-614, bill for medical and surgical supplies

When billing for equipment, Form W-614, “Bill for Medical and Surgical Supplies” is used.

When billing for items requiring prior authorization, Form W-614 must be accompanied by the yellow copy of the authorization, Form W-604.

When billing for part of the items covered by the authorization, the authorization number should be inserted on Form W-614 in the designated area, “Authorization Number.” The yellow copy of the authorization should be attached to the bill for the last items covered by the authorization.

The vendor is responsible for having Form W-544, “Medicaid Durable Equipment Agreement” signed by the recipient. The form is attached to all bills for items over \$50.00. This is required for payment to the provider.

(Effective October 11, 1977)

Sec. 17-2-83. Fee schedule for commercial ambulance services

Revised Ambulance Rates to be Reimbursed by the Department of Social Services to Ambulance Companies for Services Rendered to Title XIX (Medicaid) Recipients.

	Base Rate	\$49.00	Note a
	Mileage	\$ 1.75	Note b
	Procedure	Not Specified	Note f
17001	Oxygen & Mask	\$10.00	
17003	Resuscitator	\$10.00	
17004	Suction Machine	\$10.00	
17005	Female Attendant	\$18.50	
17006	Waiting Time	\$25.00 per hour	Note c
17007	Waiting Time (Additional)	\$ 6.25 per one quarter hour	
17008	Cancelled Call	\$25.00	Note d
17009	Multiple Patients	Note e	By Report

Note a. Base rate shall be applicable where both the origin and destination are within one town.

Note b. Mileage to be applied from point of origin of movement to any final destination outside town in which pick-up is made. Mileage to be determined from the P.U.C.A.’s Official Mileage Docket No. 6770.

Note c. Waiting time charges apply per hour. Additional waiting time beyond the first hour will be assessed in multiples of 15 minutes at the rate of \$6.25 per quarter hour.

Note d. A charge for cancelled ambulance call will be assessed whenever such ambulance call is cancelled after an ambulance has been called for and dispatched to a home, hospital, or scene of accident.

Note e. Whenever multiple patients are carried in any one given ambulance, the base rate will be charged for each patient requiring medical attention. The other charges to be equally assessed against all patients transported are mileage, waiting time, and where applicable, female attendant.

Note f. Charges for loss of equipment used in transporting patients shall be assessed at actual cost, subject to proof of connection between loss of equipment and the transportation of patient.

Note g. There shall be no charges assessed for the transportation of non-patients as riders accompanying patients requiring ambulance service.

(Effective March 1, 1978)

Secs. 17-2-84—17-2-85.

Repealed, December 21, 1990.

Sec. 17-2-86. Ambulance and chaircar services

A. **Eligibility.** Transportation services by ambulance and chaircar for the purpose of securing medical services are available to individuals eligible for Medical Assistance (Title XIX) with the following limitations:

1. Transportation is for treatment which is medically necessary.
2. Transportation by taxi with medical assist and by taxi is medically not feasible.

3. Eligibility under medicare is first explored for individuals 65 years of age and over.

4. Prior authorization is required except in the following situations: a. Emergency Situation. A policeman or physician orders an ambulance in an emergency situation. An ambulance is called by someone other than a policeman or a physician in a situation which can later be verified by the Department as an emergency.

Note: An emergency situation is one in which it would be detrimental to the patient to be transported by means other than ambulance or chaircar for medical conditions, such as accidents, heart attacks, hemorrhage, stroke, coma, etc., which require immediate medical or surgical therapy.

(Effective October 27, 1977)

Sec. 17-2-87. Conditions which usually require transportation by ambulance

A. **Medical.** 1. Dependent on oxygen (continually).

2. Continually confined to bed (individually judged-stretcher service could be utilized).

3. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken discomfort is increased.

4. On IV.

5. After cardiac catheterization.

6. Having uncontrolled seizure disorders.

B. **Orthopedic.** 1. Total body cast.

2. Hip spica and other casts, which prevent flexion at the hip (individually judged in some cases, stretcher service could be utilized).

C. **Pediatric.** 1. In isolette (incubator).

2. Tracheostomy cases, requiring suction.

D. **Psychiatric.** 1. Needing restraints (possibly harmful to self or others).

2. Heavily sedated.

E. **Neuro-Surgical.** 1. Continually confined to bed (severe brain damage, for example).

2. Comatose.

3. After pneumonencephalogram.

F. The following do not necessarily require ambulance transport:

Routine hospital discharges and admissions.

Emergency room releases.

Persons categorized as quadriplegic, epileptic, or mentally retarded.

Patients unable to ambulate.

Patients undergoing medical procedures such as hemodialysis, chemotherapy, or brain scans, on an outpatient basis.

These persons may be safely transported by taxi or chaircar unless the seriousness of their condition renders it hazardous. In those special cases, an ambulance will be required.

(Effective October 27, 1977)

Sec. 17-2-88. Procedures

A. **Ambulance and Chaircar.** 1. Prior authorization. For ambulance and chaircar, prior authorization must indicate the name of the physician requesting the service. When verbal approval is given, the formal request must follow as soon as possible and no later than 5 days, with the notation that verbal approval has been given and by whom.

Ambulance and chaircar requests for prior authorization must be signed by a physician or other medically responsible person. If the appropriate signature does not appear on the request for prior authorization, said request will be returned unauthorized.

2. **Billing.** A bill for Medical Transportation must be accompanied by a copy of the prior authorization. A billing not accompanied by a copy of the prior authorization because the service was given on an emergency basis, will be forwarded to the Division of Health Services for review and decision regarding the emergency need for the ambulance service or the need to request additional information from the ambulance company substantiating the bill.

3. **Return Trip from Hospital - Emergency Room.** Transportation by taxicab should be used unless medically contra-indicated.

4. **Over-utilization.** Patients who over-utilize ambulance services will be identified and a medical social worker from the Bureau of Health Services will visit the patient.

(Effective October 27, 1977)

Secs. 17-2-89—17-2-94. Reserved

**Policy and Procedures Governing the Billing and
Payment for Prescription Drugs on behalf of
Title XIX (Medicaid) Recipients**

Sec. 17-2-95. Definition

1. **A.W.P. or Average Wholesale Price** means the published wholesale price listed in the "Red Book" and its subsequent monthly supplements, except that, in those cases where the current wholesale price in Connecticut is greater than the "Red Book" wholesale price, the Connecticut current wholesale price shall apply.

2. **E.A.C. (Estimated Acquisition Cost)** means the Department of Social Services' closest estimate of the price generally and currently paid by providers for a prescribed drug.

3. **Nonlegend drugs** mean those drugs which do not require a prescription to be purchased and which are commonly referred to as over the counter drugs (OTC drugs).

4. **Usual and Customary Charge to the "General Public"** means the charge which will be made for the particular prescription by the provider to the patient group accounting for the largest number of Non-Medicaid prescriptions. In determining such charge, all charges made to third party payors and special discounts offered to an individual such as a senior citizen will be excluded.

(Effective September 26, 1978)

Sec. 17-2-96. Generic prescribing of drugs and quantities thereof

The department may pay for accepted methods of diagnosis and treatments, but will not pay for anything of an unproven, experimental or research nature.

(Effective September 26, 1978)

Sec. 17-2-97. Charge

1. When the more commonly used generic drugs are prescribed, average prices of such generic drugs as determined by the department will apply as to the charge to the state—not prices applicable to trade names. This will apply to the more commonly prescribed drugs such as: chloral hydrate, penicillin—G, penicillin—VK, tetracycline, ampicillin, meprobamate, reserpine, prednisone, propoxyphene and its compounds, hydrochlorothiazide, etc.

2. Except as provided in sec. 17-2-99A, the charge for prescriptions shall be based on the average wholesale price per 100, pint or package, as indicated in the Red Book, plus the applicable professional fee, or the E.A.C. plus the applicable professional fee, or the usual and customary charge to the general public whichever is lower; the use of the foregoing price determination methods shall be as follows:

A. For the most frequently proscribed legend drugs, reimbursement shall be made on the basis of an estimated acquisition cost or AWP which shall be the price generally and currently paid by providers and which shall be determined by the department of social services, plus the applicable professional fee, or the usual and customary charge to the general public by the provider, whichever is lower.

Following final determination of the E.A.C. prices for the most frequently prescribed drugs, a list shall be compiled by the department showing the name of the drug, the procedure code for the drug and its E.A.C. price. Such lists shall be distributed to all pharmacy providers.

B. For all legend drugs for which an E.A.C. price has not been determined, reimbursement shall be made on the basis of the average wholesale price per 100, pint or package as indicated in the Red Book or their respective continuing supplements plus the applicable professional fee, or the usual and customary charge to the general public by the provider whichever is lower. In those cases where the current wholesale price in Connecticut is greater than the Red Book or AWP (e.g. controlled drugs) the Connecticut current wholesale price shall apply.

C. For nonlegend drugs (OTC drugs) reimbursement shall be based on the usual and customary over the counter price. For any nonlegend drug prescribed in less than the standard package, reimbursement shall be made for the full standard package size closest to the quantity ordered. The list of items in sec. 17-2-98 represents by category, those products which are reimbursable.

(Effective September 26, 1978)

Sec. 17-2-98.

Repealed, March 3, 1981.

Secs. 17-2-98a—17-2-101.

Repealed, January 31, 1991.

Sec. 17-2-102. Reserved

Sec. 17-2-103.

Repealed, February 17, 1982.

Secs. 17-2-104—17-2-113.

Repealed, April 2, 1985.

Secs. 17-2-114—17-2-117.

Repealed, May 2, 1983.

Sec. 17-2-118.

Repealed, December 21, 1990.

Sec. 17-2-119. Services requiring prior authorization

a. **Contact Lenses.** When such lenses provide better management of a visual or ocular condition that can be achieved with spectacle lenses — for unilateral aphakia, (after second eye is operated a spectacle, lenticular “regular” cataract Rx will be supplied instead of additional contact lenses), keratoconus, corneal transplant, and anisometropia.

Soft lenses will not be provided unless necessary for treatment of corneal disease.
(Effective November 28, 1977)

Secs. 17-2-120—17-2-122.

Repealed, May 2, 1983.

**Establishment of a Pilot Program of Shelter Services
for Victims of Household Abuse**

Secs. 17-2-123—17-2-128.

Repealed, August 28, 1981.

Sec. 17-2-129. Reserved

Sec. 17-2-130.

Repealed, May 11, 1998.

Secs. 17-2-131—17-2-139.

Repealed, December 21, 1990.

**Title XIX (Medicaid) Recipient's Personal Allowance in a nursing facility,
intermediate care facility for the mentally retarded (ICF/MR),
Chronic Disease Facility or Mental Health Facility**

Sec. 17-2-140. Definitions

A. Patient's Personal Allowance. The Patient's Personal Allowance (PPA) is the amount of money that patients who are recipients of Medical Assistance in Long-Term Care Facilities have accumulated from the amount allowed each month from his or her income for personal needs, as determined by section 17b-272 of the Connecticut General Statutes.

B. Long-Term Care Facility. Long-Term Care Facilities include licensed nursing facilities, ICF/MR, Chronic Disease Facilities and Mental Health Facilities.

(Effective June 30, 1978; amended October 1, 2001)

Sec. 17-2-141. Purpose of patient's personal allowance policy

The purpose of the Patient's Personal Allowance (PPA) Policy is to establish standards and accounting controls for PPA when the Long-Term Care Facility acts as trustee for publicly-aided patients who are residents of the Long-Term Care Facility. In terms of this section, publicly-aided patients are those recipients who participate in the Medical Assistance Program through residence in a licensed nursing facility, ICF/MR, Chronic Disease Facility or Mental Health Facility. Items and services that may be charged to the patient's personal allowance are described in 42 CFR 483.10(c)(8)(ii), as amended from time to time.

(Effective June 30, 1978; amended October 1, 2001)

Sec. 17-2-142. Patient's authorization for facility to manage funds

When a facility assumes responsibility for funds for a patient receiving Medical Assistance, there must be a statement on file signed by the patient, his guardian, conservator or legally liable relative authorizing the facility to manage the personal funds. No nursing home shall use or cause to be used for any purpose the personal funds of any patient admitted to a Long-Term Care Facility unless written consent has been obtained from the patient or from a legally liable relative, conservator or guardian.

Consent by a patient shall not be effective unless co-signed by a legally liable relative or guardian if the patient has been determined by a physician to be mentally incapable of understanding and no conservator has been appointed.

A facility may request written authorization from a competent patient of an alternative plan of control of his personal funds if he should become incompetent. A Power-of-Attorney designating a relative or other responsible person may be an acceptable plan for assuming responsibility for the funds. The "other responsible person" shall not be an employee of the facility or in any way related to an employee of the facility.

(Effective June 30, 1978)

Sec. 17-2-143. The PPA accounting system-responsibilities of facility

A. Relative, Guardian or Conservator Handles the PPA. 1. If a relative, guardian or conservator receives the patient's resource or Supplemental Security Income (SSI) check and keeps the PPA to manage for the patient, the facility is not required to keep any records.

2. If the facility receives the resource or SSI check and remits the PPA to a relative, guardian or conservator, the facility shall obtain a signature from the person receiving funds and record the dates and amounts received. This must be done in the Disbursements Register. If the facility mails checks to the relative, guardian, or conservator, the cancelled checks are acceptable in lieu of a signature. A signed receipt is also acceptable in lieu of a signature. Records must be kept of all these transactions.

B. Patient Handles His/Her Own Money. When a Long-Term Care Facility delivers the entire \$25.00 PPA lump-sum amount to the patient, the facility must obtain a signature from the patient for receipt of the money, along with the date and amount received. This must be done in the Disbursements Register or a petty cash receipt slip, or via a check endorsed by the patient. The facility need keep no additional records since it is the patient who is managing his/her own funds.

C. Facility as Trustee for Funds. When the facility acts as trustee of the PPA, the facility shall follow the accounting procedures listed below.

1. **The Banking System.** The facility may elect to have individual bank accounts for patients, utilizing bank books, or it may establish a single aggregate trust account or it may have a combination of these two types of accounts. If an aggregate trust account is used, the account shall be clearly entitled as such and the facility owner or administrator shall be at least one of the designated trustees. The trustee account shall be entirely separate at all times from any facility business account. The trustee account need not be interest bearing, but if it is, interest shall accrue for the patients in an equitable manner.

Additional Stipulation: a. Designated trustee updated for sale of facility or change of personnel. b. Interest division in an equitable manner should be spelled out in detail; i.e., mathematical method. c. Survivorship accounts are prohibited.

2. **The Accounting System.** a. Regardless of whether or not a patient's personal allowance is deposited into an individual bank account, or an aggregate PPA trustee account, or some combination, there must be an accounting system maintained which reflects the activity into and out of the bank account. The accounting system, at a minimum, should consist of the following:

1. Receipts Register or acceptable equivalent
2. Patient's Ledger - control card with subsidiary ledger cards (individual patient accounts)
3. Disbursement Vouchers

b. The bank account statements and the patient’s ledger shall be in agreement and reconcilable at any point in time. All bank statements and cancelled checks of the trust account shall be kept in the facility for at least three years.

c. All of the personal fund portion of checks or cash received on behalf of the patient shall be deposited into the trustee or bank book account in a timely manner which shall be no later than two weeks after the receipt of the money by the facility.

d. Each patient for whom the facility manages funds shall have an individual recording in the Receipts Register or its acceptable equivalent and all disbursements (cash or check) shall be charged directly to the patient’s account.

e. All disbursements made on the patient’s behalf (check or cash) shall have an accompanying voucher. All vouchers shall be maintained on file for a period of at least three years to allow for audits of individual patient accounts. These invoices should be kept in individual envelopes or folders with the patient’s name on the outside. If cash or a check is disbursed for a number of patients at once, such as an aggregate amount for a hairdresser, barber or newspapers, the invoices submitted by these service people may be kept in an “aggregate” folder in lieu of filing into each individual patient’s folder.

The facility may, if it elects, utilize in lieu of individual patient folders, a continuous sequence file of invoices as long as it adheres to a date or reference number from the invoice to the disbursements register.

f. All cash receipts and disbursements shall be recorded in the related registers as follows:

Cash Receipts

- (1) Date (of entry)
- (2) Patient
- (3) Patient A/C No.
- (4) Amount

Cash Disbursements

- (1) Date
- (2) Check No.
- (3) Payee
- (4) Amount
- (5) Patient A/C to be changed
- (6) Specific item

Patient’s Ledger-Subsidiary Accounts

- (1) Date (of entry)
- (2) Specific item (i.e., cigarette, shoes, not the words “misc.” or “personal needs”)
- (3) Amount
- (4) A copy of the patient’s signature is kept on file and all disbursements are made by check or if in cash, they are verified by a voucher signed by the patient and charged directly to the patient’s account.
- (5) Persons working with the facility receiving cash from patients for services rendered will sign a voucher for filing in the business office.
- (6) Invoice number or date

g. Patient’s ledger records shall be posted once a month.

h. Cash shall be available to patients in the form of actual cash or a check no less than ten hours a week and no less than three days a week. The patients shall be fully informed of the time when they may receive their money.

i. All money disbursed on behalf of a patient shall be within guidelines of Social Services Department guidelines and consistent with that patient’s needs and desires.

j. If money is disbursed to a patient by means of a check, or if the patient signs petty cash vouchers, these are acceptable in lieu of a signature in the register.

k. When cash is disbursed to a patient there is no need to itemize other than “cash to patient” if not in excess of \$1.00.

3. Petty Cash in the Facility. The facility may, if it chooses, maintain a petty cash fund in order to make direct cash distributions to patients. The facility must *not* keep on hand an amount which exceeds more than five dollars (\$5.00) per patient or 5 times the number of patients for whom the facility handles funds; however, two hundred and fifty dollars (\$250.00) is allowable regardless of the

number of patients. The facility is responsible to ensure the safekeeping of this money and must repay the patients for any money which cannot be accounted for accurately via the general ledger or which has been lost through theft in the facility.

4. The Distribution of Cash at a Second Point in the Facility. If the facility elects to distribute cash at a point other than the business office, and if it is not convenient that the required records be brought to that point, disbursement vouchers must be maintained at this point.

5. Availability of PPA Records to Department Personnel. All PPA records including the accompanying bank statements, cancelled checks and invoices, must be kept in the facility at all times and must be available to Department of Social Services personnel upon request. The request may be made in person, or by mail.

6. Patient Signatures. It is recognized that not all patients in Long-Term Care Facilities are capable of signing their names. If the patient absolutely cannot sign, then two signatures are needed on the voucher, that of the custodian of the fund and the manager or their designees.

7. Patients with Balances of \$275.00. Patients whose PPA balances held by the facility reach \$275.00 require the establishment of a burial reserve.

8. Specialized Accounting Situations. If the Department auditor and the owner, administrator, or comptroller of a facility or group of facilities reach agreement as to the establishment of a "specialized" accounting system designed to meet particular needs of that facility, the new system must be followed. The Department must agree to any changes in writing. In addition, any of these regulations may be waived at the option of the Department.

9. Request to See PPA Records by Patient or His Authorized Representative, Relative, Guardian, Conservator or Ombudsman. The facility shall, within a reasonable period of time, allow the following persons to see the PPA records of an individual patient: (a) The patient, or his authorized representative, or (b) a responsible relative, or (c) guardian, or (d) conservator, or (e) ombudsman, or (f) representative of the Department of Social Services.

In lieu of this, the facility may send copies of the records in the general ledger to the person making the request.

10. Items That May Not Be Charged to Personal Fund Allowance. When the facility is Trustee for the PPA, the funds must be used only for the patient's personal needs. The funds shall not be used to purchase items included in the per diem rate set by the Rate Setting Commission for the facility or allowable under the Medical Care Plan on a vendor payment basis, or includable under the Rate Setting Regulations. Therefore, patients' gowns, geri-chairs, physical therapy, speech therapy and other like items are not chargeable.

To guide you further, a partial list of items that cannot be charged to the patient's Personal Allowance Fund appears below.

This list is not intended to preclude the facility from purchasing items which are not reimbursed through the per diem or on a fee for service basis and charging them through the PPA funds.

- (a) Group activities or entertainment which occurs within the facility.
- (b) Parties organized by the facility.
- (c) Medically necessary drugs, medicines or medical supplies.
- (d) Funeral expenses, up to \$600.00.
- (e) Room and board to the facility.
- (f) Wheelchair purchase, rental or repair. (The facility is not, however, expected to provide customized, i.e., motorized wheelchairs.)

- (g) Physical restraints.
- (h) Transportation to obtain necessary medical treatment.
- (i) Gifts to relatives in excess of \$25.00.
- (j) Medically necessary treatment ordinarily paid for under the Title XIX program.

11. **Withdrawal of Personal Needs Funds.** At no time may any funds be withdrawn from the Personal Fund account for use in the business or operating expense of the facility or for the personal use of any employee, administrator, owner or relative thereof. The Personal Funds are not available for loan to anyone.

12. **Individual Unable to Use Monthly Personal Needs Allowance and His Account Accrues.** A. At the time of admission the facility should contact the District Office Resource Unit to determine if the individual has assets.

B. If the individual has no assets when his account accrues to a balance of \$275.00 the facility will apply any excess over \$250.00 to a bank account for the patient established for burial purposes only. When a burial account accrues to \$600.00 and the patient's account in the facility has a balance of \$275.00, any excess over \$250.00 must be applied to the monthly cost of care.

C. If the individual has the maximum assets allowed (\$250.00 personal funds plus \$600.00 burial reserve) the balance in the patient's account may accrue an additional \$25.00. Any amount over \$275.00 in personal funds must be applied towards the patient's monthly cost of care.

D. To serve as notice to the Department and the recipient that personal funds in excess of \$275.00 have been applied to the cost of care, the facility will complete Form W-138 "Application of Excess Personal Funds to Cost of Care" in quadruplicate and will distribute it as follows: One copy is attached to the W-291N Billing Form and submitted to the Medical Disbursements' Section in Central Office. The second copy is sent to the appropriate District Office for filing in the case record, the third copy is given to the recipient and the fourth copy is kept on file by the facility.

There have been instances where accumulated personal funds have been transferred to families. The facility will be held responsible for such transfers except upon specific approval of the Department of Social Services. Money gifts at Christmas and relative birthdates are exceptions to the above, but must be reasonable.

13. **Personal Funds of a Patient Who is Transferred to Another Long-Term Care Facility.** If a patient is transferred or released to another Long-Term Care facility, the patient shall leave retaining his or her bank book; the balance of the patient's funds shall be sent to the new facility within ten (10) days of the transfer date. This shall include any cash held in the facility plus any amount held in aggregate trustee bank account.

14. **Discharge or Release of a Patient to Community Living.** The patient who has been discharged from the facility to the community shall leave retaining his or her bank book or with a check for the balance of his PPA account. The amount shall reflect the cash held in the facility plus the bank balance.

15. **Death of a Patient While in a Long-Term Care Facility.** If a Title XIX recipient in a facility expires, funds on deposit in his account become part of his estate. Immediately upon the death of the recipient, the facility will notify the District Office Resource Supervisor. Within seven (7) days of the patient's death the Department of Social Services District Office Resource Supervisor will inform the facility as to the disposition of the patient's funds.

16. **Patient is transferred to a Hospital and Does Not Return to Facility.** If a patient is transferred to a hospital and does not return to the facility, the balance of the PPA must be sent to the patient within ten (10) days after he/she leaves the

hospital. If the patient cannot be located, the Department of Social Services should be contacted.

(Effective June 30, 1978)

Sec. 17-2-144. Annual accounting to the department of PPA balance

Annually, by each June 1st, an accounting must be made to the Department of Social Services reflecting the balance of the PPA for each patient for whom the facility handles the funds. If money is held in an aggregate trustee bank account, the balance for each patient must be accompanied by a bank statement. A bank statement is not necessary for individual patient bank accounts. The accounting must consist of the following:

- (a) Recipient's name
- (b) Welfare number
- (c) Welfare Service Office
- (d) Petty cash held in facility for patient
- (e) Balance held in bank book for patient
- (f) Balance held in Trustee account for patient
- (g) Any other money being held for patient for whom facility is trustee

If the facility is not trustee for any patient's money it *must so state* by each June 1st to the Department.

The accounting to the Department must be submitted by June 1st of each year on the Statement of Patient's Personal Fund Account (Form W-411) and must be dated, signed by the administrator of facility, and mailed to:

Connecticut State Department of Social Services
Internal Audit Division
110 Bartholomew Avenue
Hartford, Connecticut 06115

(Effective June 30, 1978)

Sec. 17-2-145. Accounting of personal funds upon sale of a facility

If the facility is sold, an accounting must be made to the Department of the Personal Funds balances which are to be transferred to the new owner. This accounting must consist of the use of the "Statement of Patient's Personal Fund Account" form (the same format as the annual accounting) and must be signed and dated by both the seller and the buyer. In the case of corporations it must be signed by a person authorized on behalf of the corporation. In a partnership, one or both partners may sign; if a sole owner, he/she must sign. The accounting must be accompanied by the most current bank statement and must be reconciled accurately with the statement. The W-411 form must be mailed to the same address as in Item 17.

The Department will not enter into a contract with a new owner unless this information is submitted.

If the facility does not handle any Patient's Personal Allowance it must so state upon sale of the facility.

Should changes occur in personnel responsible for personal needs funds accountability, appropriate changes in authorized signature for checking accounts or designated Trustee for Savings Passbooks shall be made at financial institutions and documented. The supporting data is to be made available for review purposes.

(Effective June 30, 1978)

**A Reporting Law for Protection of the Elderly which
provides for the Establishment of a Protective
Services Program for Elderly Persons**

Secs. 17-2-146—17-2-151.

Repealed, March 27, 1990.

Sec. 17-2-152. Reserved

Secs. 17-2-153—17-2-154.

Repealed, May 10, 2000.

**Use of Provider Numbers by Physicians Salaried by
General Hospitals and Public and Private
Institutions and Clinics**

Secs. 17-2-155—17-2-156.

Repealed, May 11, 1998.

Secs. 17-2-157—17-2-162.

Repealed, October 14, 1982.

Sec. 17-2-163. Requirements for skilled nursing, intermediate care and chronic disease facilities in taking deposits or prepayments on behalf of patients who are applicants for Title XIX (Medicaid), who are subsequently determined eligible for Title XIX (Medicaid) and the requirements for these facilities to refund such deposit or prepayment

(a) Any prepayment or deposit made by or on behalf of an applicant for Title XIX (Medicaid), which is accepted by a facility, must be refunded to the payor when Title XIX (Medicaid) eligibility is established.

(b) Any such prepayment or deposit cannot exceed \$1,500.00 and such prepayment or deposit shall be placed in escrow as designated by the Department of Income Maintenance.

(c) Upon a determination of eligibility, the payment held in escrow shall be refunded to the payor and the Title XIX payment shall be made to the facility. Upon a determination of ineligibility, the payment held in escrow may be transferred to the facility operating account unless the applicant requests a Fair Hearing, in which case the payment shall continue to be held in escrow until final disposition of the administrative appeal.

(d) One escrow bank account is sufficient to handle the deposits. Documentation in the form of receipts and disbursements by the individual must be available to the Department of Income Maintenance showing dates, purpose and disposition. Subsidiary accounts for each person shall be maintained to provide adequate record of transactions and current balances.

(e) Where a prepayment or deposit is to be refunded, the full amount paid for services rendered during the period of Title XIX eligibility must be refunded. Example: If the Department of Income Maintenance payment was \$30.00 for a service toward which the recipient had made a \$40.00 deposit or prepayment, the facility must refund the full \$40.00 and accept the \$30.00 payment as payment in full for that service.

(f) The Department of Income Maintenance shall not pay a facility for services for which a prepayment or deposit is being held in escrow until such time as the

escrow account is refunded to the person who made such payment. Any payment for services made by the Department of Income Maintenance is subject to the criteria of existing program policy.

(Effective May 8, 1980)

Sec. 17-2-164. Payments made on behalf of an applicant of Title XIX (Medicaid) who is a patient at a skilled nursing, intermediate care and chronic disease facility which is considered as income and not a deposit or prepayment

Payments made to a Title XIX (Medicaid) applicant for his own use are considered as income available to him and must be counted in determining his financial eligibility for Medicaid. These payments shall not be regarded as available income until the applicant attains a personal asset account of \$250.00 and a burial reserve of \$600.00, when program policy so allows.

(Effective May 8, 1980)

Secs. 17-2-165—17-2-178. Reserved

**Property Transfers Made by Applicants for or Recipients of
Town Assistance Benefits Which Result in Ineligibility
for Such Benefits**

Sec. 17-2-179.

Repealed, September 23, 1988.

Secs. 17-2-180—17-2-183.

Repealed, December 21, 1990.

Secs. 17-2-184—17-2-186. Reserved

Transfer of Assets

Secs. 17-2-187—17-2-188.

Repealed, December 21, 1990.

Secs. 17-2-189—17-2-204. Reserved

The AFDC Food Standard

Sec. 17-2-205.

Repealed, December 21, 1990.

Sec. 17-2-206. Reserved

Pilot Voluntary Work Program

Sec. 17-2-207. Pilot voluntary work program

(a) General

The Department of Income Maintenance administers a Pilot Voluntary Work Program to serve heads of AFDC households, with an emphasis on persons who have received such aid for ten years or longer. Participation in the program is voluntary and the program operates in the Norwalk, Connecticut area. Persons who wish to participate must register with the Work Incentive (WIN) Demonstration

Program, “The Job Connection.” The Pilot Program prepares long-term recipients of AFDC to enter work directly, or to take part in additional training or education with the goal of becoming economically self-sufficient.

(b) **The Pilot Voluntary Work Program**

The Program is to serve at least 50 persons and includes:

- (1) an orientation and assessment of each participant’s vocational, academic and motivational strengths and weaknesses;
- (2) the design of an individualized employability plan for each participant;
- (3) pre-employment remedial education designed to place emphasis on the essential skills for daily living and for seeking, obtaining and sustaining employment;
- (4) individual counseling sessions with a career development counselor and group sessions to strengthen self-confidence and reinforce pre-employment skills;
- (5) integration of life skills with basic educational skills. Participants will receive life skills certificates upon achieving specific knowledge levels and for attainment of skills unrelated to academic achievements; and
- (6) referral to work, education or training upon completion of the program.

(c) **Support Services**

Support services such as child care and transportation are provided through the Work Incentive (WIN) Program, as is reimbursement for reasonable expenses needed to meet the requirements of the program.

(d) **Program Operator**

The program is operated by an outside agency under contract with the Department of Income Maintenance.

(e) **Duration**

The Pilot Voluntary Work Program shall continue for as long as funding is available as authorized by the legislature.

(Effective June 27, 1986)

Secs. 17-2-208—17-2-213. Reserved

Public Assistance Checks Cashed by Banking Institutions

Sec. 17-2-214. Definition

As used in section 17-2-215, “banking institution” means a state bank and trust company, national banking association, state or federally chartered savings bank, state or federally chartered savings and loan association, state or federally chartered credit union or other state or federally chartered banking institution having an office within this state.

(Effective October 28, 1988)

Sec. 17-2-215. Public assistance checks cashed by banking institutions

No banking institution shall be liable to reimburse the State of Connecticut for a loss incurred as a result of wrongful payment of any Public Assistance check provided that acceptable forms of identification as described in subsection (a) of this section are used and providing the procedures listed in subsection (b) of this section are followed.

(a) Documents issued by public or private organizations as a means of identifying an individual are considered acceptable forms of identification. The identification document must include the signature of the payee or a unique number by which the organization can identify the payee. Acceptable forms of identification may be issued by the following organizations:

- (1) the Department of Income Maintenance
- (2) the Department of Motor Vehicles
- (3) other State agencies
- (4) federal agencies
- (5) municipalities
- (6) employers
- (7) credit card companies
- (8) banking institutions
- (9) unions

(b) The following procedures will be adhered to when cashing checks:

(1) The check must be signed by the payee at the time of cashing, or signed again if previously signed.

(2) Two acceptable identification documents must be required.

(3) In combination the two acceptable identification documents must present the following:

(A) signature

(B) photograph

(C) a unique number by which the payee can be identified by the organization issuing the identification document

(4) The signature on any identification document must appear to match the signature on the check.

(5) The types of identification documents used must be clearly recorded on the check, or, if recorded on computer or other medium, must include the date of the transaction and be presented to the Department upon notification to the bank of a stop payment action.

(6) An identification number from the identification documents must be clearly recorded on the check, or, if recorded on computer or other medium, must include the date of the transaction and be presented to the Department upon notification to the bank of a stop payment action.

(7) A clear bank photograph may be substituted for a photo ID.

(Effective October 28, 1988)