STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

MEDICAID PROGRAM ACTION

Eligibility Transmittal

DATE: June 1, 2009

PROGRAM IDENTIFIER: 435.060109139
Medicaid Regional Offices

SUBJECT: Revised Application Processing Policy

This transmittal issues revised policy for the Medicaid Eligibility Policy and Procedures Manual. In September 2008, staff was informed this generic manual would be compiled over time by adding additional sections as policy is re-issued or revised. The material included in this transmittal comprises the Application Processing portion of Chapter 101, Application and Redetermination Processes. It is anticipated the remainder of Chapter 101 will be issued next month.

FILING INSTRUCTIONS

- **VOLUME III**
  - Remove pages 3000 through 3102 from Section C, Application and Redetermination Process.
  - Make a note in the Table of Contents cross-referencing the above pages with the Medicaid Eligibility Policy and Procedures Manual.
- **HEALTH BENEFITS MANUAL**
  - Remove pages 6000 through 6004 from Section F, Application Process.
  - Make a note in the Table of Contents cross-referencing the above pages with the Medicaid Eligibility Policy and Procedures Manual.
  - In addition, cross-reference the following subsections in Section F with the Medicaid Eligibility Policy and Procedures Manual:

Section F, Page 6005 - 6007	Conducting the Interview
Section F, Page 6007	Collecting and Documenting Information
Section F, Page 6008	Withdrawal of Application
Section F, Page 6009 - 6010	Evaluating Information for Eligibility Determination

- **MEDICAID ELIGIBILITY POLICY AND PROCEDURES MANUAL**
    - File the attached Table of Contents and pages 100 through 651 of Chapter 101; Application and Redetermination Processes, in sequence with previously issued material in the Medicaid Eligibility Policy and Procedures Manual.

If you have questions concerning the material in this transmittal, contact the Bureau of Enrollment.

Robert L. Robinson
Executive Director

RLR: JB: jb

Attachments

cc: All Holders of Medicaid Eligibility Manuals

MISSISSIPPI DIVISION OF MEDICAID
ELIGIBILITY POLICY AND PROCEDURES MANUAL

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101.01 INTRODUCTION

This chapter provides guidelines for processing applications and redeterminations for all Medicaid coverage groups and the Children's Health Insurance Program.

The application process consists of all activities completed during the timely processing period from the time a signed application form is received by the regional office until a notice of approval or denial is mailed to the applicant.

A redetermination is a full review of all variable eligibility factors, conducted at specific intervals for each recipient, to determine whether or not eligibility continues. A redetermination is similar to an initial eligibility determination; however, basic information, such as age, citizenship, Social Security Number, etc., does not have to be re-verified.

101.02 GENERAL INFORMATION

101.02.01 ACCESS TO THE APPLICATION PROCESS

Access to the regional office should not be a barrier for individuals wishing to apply. Each office where Medicaid Specialists are located should be accessible for handicapped persons.

There may be times when individuals coming to the office or an out-stationed site make staff aware that they are unable to enter the facility due to illness or incapacity. When this occurs, appropriate staff will go to the person to provide the services needed.

Each Regional Office:

- Provides adequate physical facilities to receive persons who come to the office in orderly surroundings.
- Receives courteously and promptly all persons who come to or contact the office.
- Provides an application form to anyone who requests one.
- Allows any individual the right to apply for any benefit, regardless of circumstances. This includes allowing a clearly ineligible individual to apply if he desires.
- Communicates in a clear and courteous manner information regarding services offered through the agency.

ACCESS TO THE APPLICATION PROCESS (Continued)

- Determines as soon as possible if the person asking for help is seeking a type of assistance which the agency offers. If the individual is not requesting a type of assistance offered by the regional office, he should be referred to another community agency or resource to meet his needs, if one is available.

101.02.02 SPECIAL ASSISTANCE

Each office is required to provide services to the limited English proficient, deaf, blind and disabled applicants, who are mentally or physically impaired and lack someone to act for them.

The instructions below provide guidance for communicating with any applicant or recipient, who is known to be deaf, hard of hearing, blind or visually impaired, or otherwise limited English proficient, illiterate, and/or requires communication assistance.

- **Blind Applicants** – Read forms to the applicant in their entirety and assist in completion of the forms. Explain the various program requirements and services offered through the agency and answer any questions the applicant may ask.

- **Deaf Applicants** – When needed, secure a person proficient in sign language or communicate in writing to relate an explanation of the programs and to answer any questions, and assist in the application process.

- **Illiterate Applicants** – Read forms to the applicant in their entirety and assist in the application process. Explain the various program requirements and services offered through the agency in terms and phrases which the applicant can understand.

- **Language Barrier Applicants** – When interpreter services are needed, use the Language Line to secure the assistance of an interpreter capable of communicating in the applicant's language to assist in the application process and relate the services offered.

101.02.03 REASONABLE EFFORTS TO ASSIST ALL APPLICANTS

It is required that specialists make reasonable efforts to assist all applicants in order to have the applicant's eligibility determined. Assistance includes, but is not limited to, the following:

- Help with forms completion;
- Help with securing a representative, if needed;
- Help in obtaining necessary information from third parties; and
- Providing information that will assist the applicant in making informed decisions about Medicaid eligibility. Medicaid program policies are public information. Each applicant has a right to know the policies that will impact his eligibility.

101.03 DEFINITIONS

101.03.01 APPLICANT

An individual whose application has been received by the Division of Medicaid.

101.03.02 RECIPIENT/BENEFICIARY

An applicant approved for and receiving benefits.

101.03.03 INCAPACITATED INDIVIDUAL

An individual who is unable to act on his own behalf due to a physical or mental condition.

101.03.04 INCOMPETENT INDIVIDUAL

An individual adjudged to be mentally incompetent by a court.

101.03.05 INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY (LEP)

An individual who is unable to communicate effectively in any language other than his native language.

101.03.06 SENSORY IMPAIRED INDIVIDUAL

An individual who has a partial, profound or complete loss of hearing or sight.

101.03.07 LEGAL GUARDIAN OR CONSERVATOR

A person who has court documents which prove a legal guardianship or conservatorship has been established for the applicant. The application is filed in the name of the applicant; however, the guardian or conservator must provide eligibility information and sign the application form.

101.03.08 AUTHORIZED REPRESENTATIVE

A person who is acting responsibly for the applicant with his knowledge and consent. The authorized representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The authorized representative must be authorized in writing by the applicant to act on his behalf. The application is filed in the name of the applicant. The authorized representative can provide eligibility information and sign the application form.

DEFINITIONS (Continued)

101.03.09 **DESIGNATED REPRESENTATIVE**

A person acting responsibly for an applicant because the physical or mental condition of the applicant is such that he cannot authorize anyone to act for him nor can he act for himself. The designated representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The application must be filed in the name of the applicant with the designated representative providing the eligibility information and signing the application form.

101.03.09A **Documenting Authorized and Designated Representative Status**
- ❖ **Aged, Blind and Disabled Programs**

The Client's Designation section of the DOM-302, Designated Representative Statement, is used to verify authorized representative status. The applicant and representative will both sign the form.

The section of the DOM-302 entitled, "Statement of Self Designation by Representative", is used to document designated representative status. The representative will sign the form.

101.03.09B **Documenting Authorized and Designated Representative Status**
- ❖ **Families, Children and CHIP Programs**

When the FCC head of household is unable to act on his own behalf, a representative may be designated. The head of household must sign the DOM-FCC-302, Designated Representative Statement, permitting an authorized representative to participate in the interview and eligibility process on behalf of the HOH.

A non-applicant caretaker, who is not the legal parent of the applicant children, is a designated representative. The section of the DOM-FCC-302, entitled Statement of Self Designation by Representative, must be completed when this situation exists.

Self-designation is not required when the non-applicant caretaker is a legal parent of one or more of the applicant children.

DEFINITIONS (Continued)

101.03.10 APPLICATION

An application is the action by which an individual indicates his intent to apply for medical assistance.

101.03.11 APPLICATION FORM

All applications must be filed on the Application for Mississippi Health Benefits form, the Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs form or an exact facsimile of these forms. The application form is a legal document, completed by the applicant or a person acting on behalf of the applicant, that signifies intent to apply and:

- Is the official agency document used to collect information necessary to determine eligibility;
- Is the applicant's formal declaration of financial and other circumstances at the time of application;
- Is the applicant's certification that all information provided is true and correct;
- Provides notice to the applicant of his rights and responsibilities; and
- May be introduced as evidence in a court of law;

101.03.12 REQUEST FOR INFORMAL MEDICAID ELIGIBILITY OPINION

An individual seeking assistance from other social service agencies may be required to obtain a statement from the Division of Medicaid that he is not eligible for Medicaid in order to obtain that agency's services. If the individual indicates through questioning that none of the categorical requirements would be met, i.e., the person is not aged, blind, disabled, pregnant, under age 19 or part of a family with dependent children, the regional office may provide the individual with a statement that he is not eligible based on the self-declared information. The statement must also explain to the individual that the decision is not an official denial and cannot be appealed. If an official denial notice is required, an application must be filed and a decision rendered after all eligibility factors have been examined according to policy. In addition, the statement issued by the office cannot be used to indicate a person's ineligibility due to financial or other non-categorical eligibility criteria. If the person appears categorically eligible, an application must be filed to obtain an eligibility decision.

101.03.13 ABD RESOURCE ASSESSMENT

When either member of a couple, the Institutional Spouse (IS) or Community Spouse (CS), or a representative acting on behalf of either the IS, CS, or the couple, requests an assessment of the couple's resources, the regional office will use the following guidelines:

- An assessment is separate from an application for Medicaid. If the IS wishes to apply for Medicaid, an assessment is not required. Resources will be evaluated under Spousal Impoverishment rules and appropriate notice of eligibility will be issued.

- When the couple only wants to know how Medicaid will evaluate their total resources if an application were filed, an assessment is required.

- If one spouse has not yet entered an institution on the date the assessment is requested, an assessment cannot be provided.

- An assessment is a "snapshot" of the couple's total countable resources in the month of the institutionalization, i.e., what was true in the month the IS entered an institution for 30 consecutive days or longer on or after 9/30/1989.

- An assessment provides a written evaluation of resources to the couple giving the following information:
    - Total value of countable resources;
    - The basis for the determination;
    - The CS' share based on the maximum standard allowed as of the month of the assessment;
    - Whether the IS would be currently resource-eligible if an application were to be filed.

- A "Resource Assessment Notice" will be used to document the information specified above to the couple or their representative.

101.04 FILING THE APPLICATION

Individuals inquiring about program eligibility requirements should be informed of their opportunity to apply. If an application is requested, the regional office must provide an application to the individual or mail it, as applicable. If another person or agency refers the name of an individual in need of medical assistance to the regional office, an application will be mailed if an address is available.

101.04.01 RIGHT TO APPLY

Individuals wishing to file an application must be afforded the opportunity to do so without delay. When an individual inquires about making an application at any regional office, an application form must be provided and the person offered the opportunity to file that day. A clearly ineligible person may file an application that must be accepted by the regional office and then denied.

101.04.02 ASSISTANCE WITH APPLICATION

The agency must allow an individual or individuals of the applicant's choice to accompany, assist and represent the applicant in the application or redetermination process.

101.04.03 APPLICATION FILE DATE

The application file date is the date a valid application form is received by the agency. To be valid, the application must be a Division of Medicaid application form or an exact facsimile and it must be signed by the applicant or his representative. Applications may be received by a regional office in one of the following ways:

- In person in any regional office, official out-stationed location or other location outside the regional office where eligibility staff are on official duty, such as a nursing home, hospital or other public facility;
- By mail in any regional office;
    - Applications received by mail which arrive after the end of the month, but were postmarked by the last day of the month will be considered to have been received by the regional office on the last day of the month in which they are postmarked.
- By fax or electronically in any regional office;

APPLICATION FILE DATE (Continued)

- Faxed applications will be accepted as filed on the date received. However, the application with original signature must be provided and filed in the case record.
- Scanned applications submitted electronically are handled in the same manner as faxed applications.

101.04.04 PROTECTED APPLICATION DATES FOR MEDICAID APPLICANTS

An applicant who applies for Medicaid on any basis is entitled to have eligibility determined under all available coverage groups. Therefore, an individual who files an FCC application does not also have to file an ABD application to be evaluated for potential eligibility in an ABD program and vice versa. Any application received by the regional office must be evaluated across ABD and FCC program lines to determine if eligibility exists under any category of Medicaid coverage.

This also includes applications filed through another certifying agency, such as the Social Security Administration (for SSI applicants). If an individual is denied SSI, but would qualify in any available Medicaid-only coverage group, the regional office is required to use the SSI application date as the protected filing date for Medicaid benefits. If the individual is eligible for Medicaid-only, the regional office must determine eligibility using the SSI application date as the Medicaid application date. Additional information may be needed to determine eligibility; however, the application date is the SSI application date and the case must be documented to reflect this.

101.04.05 WHO CAN FILE THE APPLICATION

An application can be filed by one of the following individuals, as applicable to the case:

- Adult applicants;
- Certain minor applicants, including;
    - A pregnant minor of any age requesting coverage solely due to pregnancy or
    - A married minor living with a spouse; or
    - A minor living independently; or
    - A minor living his/her parents and applying only for the minor's own children.
- The parent who has primary physical custody of a minor child;
- Either parent of a minor child when physical custody is equally divided between legal parents;
- The legal guardian or conservator;
- An authorized representative;
- A designated representative

101.04.06 APPLICATIONS RECEIVED FROM MS RESIDENTS OUT-OF-STATE

Applications made for Mississippi residents who are temporarily out of the state may be accepted. Generally the applicant must return to the state before the application processing period ends. However, the application of someone who is hospitalized in another state and planning to return to Mississippi when discharged may be processed in the usual manner. If the application is approved, the specialist must review eligibility every three (3) months to determine the individual's continued intent to reside in MS.

101.04.07 OUT OF STATE APPLICANTS

Applications received from persons residing in another state will be denied and notice mailed to explain that the applicants will need to reapply upon arrival in MS with intent to reside. Persons who are in MS for a temporary purpose, such as a visit, who intend to return to their home out of state are not eligible for Mississippi Medicaid or CHIP. However, applicants must always be given the right to make an application if they wish to do so and receive a decision on their case.

101.04.08 APPLICATIONS COMPLETED BY TELEPHONE INTERVIEW

For some types of applications, a telephone interview is permissible. When a telephone interview is conducted, the application completed by the specialist will be mailed to the applicant for review and signature. The application file date is the date the application is received back in the regional office with the applicant's original signature, not the date the telephone interview was conducted.

101.04.09 RESIDENCE CHANGE DURING THE APPLICATION PROCESS

If the applicant reports moving to another location within the state during the application process, the application must be completed by the first regional office, and if approved, transferred to the new location. If the application is denied, do not transfer the record until the person reapplies in the second location.

If the applicant reports moving out of the state during the application process, determine when the move occurred. If otherwise eligible, the applicant may be approved for Medicaid for any requested retroactive months through the month of the move. If the applicant would be CHIP-eligible, the application will be denied since CHIP eligibility is for a future month.

NOTE: If only some members of the applicant family are moving from the state, identify the adults and/or children who remain MS residents and handle their ongoing eligibility accordingly.

101.04.10 WHERE TO FILE THE APPLICATION

Applications should be filed with the regional office that serves the applicant's county of residence. However, applications for individuals living in another RO's service area must be accepted by any regional office. The regional office must review each application upon receipt and confirm the accuracy of the address if there is a question about the responsible office. The following guidelines should be followed based on the appropriate situation:

101.04.10A APPLICATION FILED WITH CORRECT REGIONAL OFFICE

When the application is received by the regional office responsible for the applicant's county of residence, staff will:

- Date stamp the application form to establish the timely processing period;
- Register the application within 48 hours of receipt;
- If the applicant or representative applies in the office and an in-person interview is required or requested, the regional office will provide the opportunity to be interviewed that day.
    - If the individual cannot be interviewed that day, an interview must be scheduled for the next possible date within ten (10) calendar days from the date the application was received.
- If the application is received in the mail or other than in person and an in-person interview is required or requested, the interview must be scheduled within 10 days of the date the application was received and an appointment notice mailed to the applicant.

101.04.10B APPLICATION FILED IN PERSON WITH INCORRECT REGIONAL OFFICE

When the application is filed in person by an applicant who does not live in the regional office's service area, the following procedures will be followed:

- The receiving office will accept the application and date-stamp it to clearly indicate the date of receipt.
    - Applications for individuals who do not live in the RO service area must not registered in the MEDS or MEDSX systems.
- Processing time begins whenever any regional office receives the application, whether or not it is the appropriate office based on the applicant's residence address.

APPLICATION FILED IN PERSON WITH INCORRECT REGIONAL OFFICE (Continued)

- The receiving office must offer an in-person interview on the day the application is received if it is filed in person.
    - If the applicant or representative is interviewed, the intake worker will complete the application, answer all questions, explain rights and responsibilities, etc.
    - Copies will be made of the documents and verifications obtained from the applicant. If information is needed, a request will be issued to the applicant.
    - The applicant will be informed of the regional office location that will complete the application and handle future contacts and reviews.
- The receiving office will mail the application (and other information gathered during the interview, if one was conducted) to the correct regional office within 24 hours of receipt of the application.
- The correct office will then register the application within 48 hours of receipt using the actual application date.
    - The actual application date is the date the application was received and date-stamped in the original office not the date the second office receives it.

101.04.10C APPLICATION FILED BY MAIL WITH INCORRECT REGIONAL OFFICE

When the application is filed by mail (or other than in person) by an applicant who does not live in the regional office's service area, the following procedures will be followed:

- The receiving office will accept and date-stamp the application to clearly indicate the date of receipt.
    - Applications for individuals who do not live in the RO service area must not registered in the MEDS or MEDSX systems.
- Processing time begins whenever any regional office receives the application, whether or not it is the appropriate office based on the applicant's residence address.
- The receiving office must mail the application (with any attachments provided) to the appropriate regional office within 24 hours.

APPLICATION FILED BY MAIL WITH INCORRECT REGIONAL OFFICE (Continued)

- The correct office will begin processing the application, which must be registered within 48 hours using the actual application date.
    - The actual application date is the date the application was received and date-stamped by the original office, not the date the second office receives it.

When the following circumstances occur, the receiving regional office will be responsible for processing an application outside of the RO's service area:

101.04.11 APPLICATIONS REGISTERED TO THE INCORRECT REGIONAL OFFICE

- If the application is already registered when the receiving office discovers the applicant does not live in the RO service area, the receiving office must complete the eligibility determination.
- Supervisory staff must ensure:
    - The case is completed before it is transferred to the appropriate office; and
    - The applicant is notified of the office which will handle future contacts and case reviews.

101.04.12 APPLICATIONS NOT FORWARDED TO CORRECT OFFICE IN A TIMELY MANNER

- Applications which have not been mailed to the correct regional office by the end of the 2nd day following receipt of the application will be registered and processed by the receiving office.
- Supervisory staff must ensure:
    - The case is completed before it is transferred to the appropriate office; and
    - The applicant is notified of the office which will handle future contacts and case reviews.

101.05 INTERVIEW

Refer to individual program chapters for specific interview requirements. Whenever an applicant requests an in-person interview, one will be conducted even if the program does not require an interview.

At the interview the specialist reviews household composition and relationships to explain the individuals who are required to be included in the application and/or budgetary process, those who cannot be included and persons whose inclusion is optional. The specific programs and services available to the applicant and/or his family through Division of Medicaid are discussed and any questions the applicant has are addressed. In addition, referrals for services offered by other agencies are made, as appropriate.

101.05.01 INTERVIEW DISCUSSION

Whenever an interview is conducted, the following are specific areas must be addressed, if applicable:

- The agency must allow an individual or individuals of the applicant's choice to accompany, assist and represent the applicant in the application or redetermination process.
- Eligibility requirements for the coverage group(s) the applicant appears potentially eligible in;
- Coverage is limited to only one source of eligibility, i.e., SSI, ABD or FCC. If the individual is eligible under another source, that source must terminate before ABD or FCC eligibility begins.
- Use and purpose of the application, including that the applicant is agreeing to all of the rights and responsibilities specified on the application by signing the form;
- Standards of Promptness;
- Assignment of Third Party Rights;
- Quality Control review process;
- Use of Social Security Numbers in computer matching programs;
- Appeal Rights;

INTERVIEW DISCUSSION (Continued)

- Child Support Requirements;
- Available services such as the Cool Kids program and the annual physical for adults ;
- Verification requirements and methods to be used to establish eligibility, including collateral contacts, documentary verification and other records;
- Change reporting requirements
- The income of a stepparent cannot make a stepchild ineligible.

The following explanations are specific to ABD and must be addressed as applicable:

- Estate Recovery provision;
- Medicaid Income;
- Income Trust provision.
- The income and resources of a spouse must be considered for the applicant's eligibility in the at-home ABD programs whether the spouse is applying or not;
- For institutional applicants, the spouse's resources must be considered toward the applicant's eligibility. The spouse's income is considered when a spousal allocation is requested.

The following explanations are specific to FCC and must be addressed as applicable:

- All possibilities for Medicaid eligibility must be tested before considering CHIP eligibility. Children who qualify for Medicaid cannot be approved for CHIP;
- Requested verifications must be provided for each person included in the application. Failure to provide information may result in individual or multiple denials, depending on the program or type of verification which is lacking.
- The income of an applicant's spouse must be considered toward the applicant's eligibility unless the spouse receives SSI.
- The income of a legal parent living in the home with applicant children must be considered toward the children's eligibility unless the parent receives SSI.
- Verification of personal information, income and expenses is not needed for household members who are not included in the application process.

101.05.02 CONCLUDING THE INTERVIEW

At the conclusion of the interview, the applicant or his representative must have an understanding of the following:

- Additional information the applicant must provide or actions he must take for eligibility to be determined;
- Actions the agency must take to determine eligibility,
- Notification, including written notice of approval and issuance of Medicaid or CHIP cards or denial and/or the right to appeal any decision;
- Redeterminations, i.e., annual eligibility reviews for children and annual or more frequent reviews, if necessary, for adults.

101.06 STANDARDS OF PROMPTNESS

Eligibility must be determined within the appropriate timeframes for the program type as discussed below. If there is a delay in processing, the reason must be clearly documented in the record.

101.06.01 REGIONAL OFFICE RESPONSIBILITIES

Each regional office must have controls in place which ensure timely application processing at all staff levels, including sufficient time for supervisory review and corrections. Applications should generally be processed in the order in which received, taking into consideration promptness and delay in receipt of verifications, and in some cases, urgent need. Under no circumstances should an application be approved without the proper verifications and documented eligibility for each applicant.

101.06.02 EXCEPTIONS TO TIMELY PROCESSING

The agency must determine eligibility within established standards, except in unusual circumstances when a decision cannot be reached because of:

- Failure or delay on the part of the applicant;
- Administrative or other emergency delay that could not be controlled by the agency such as:
    - Staff vacancies or illness of eligibility staff lasting two months or more;
    - Wholesale desk reviews on active cases mandated by court order, Federal regulations of wholesale increase in benefits, such as Social Security, VA, etc., which require extensive staff time;
    - Computer problems arising from control of systems by an outside agency.

Time standards may not be used by the agency as a waiting period before determining eligibility or as a reason to deny eligibility because the agency has not determined eligibility within the time standards.

101.06.03 STANDARDS OF PROMPTNESS

❖ **Aged, Blind and Disabled Programs**

Federal rules require that applications be approved or denied, and the applicant notified, within 45 days from the date the application was filed. The processing timeframe is 90 days when a disability determination is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the 45-day standard applies.

The applicable standard of promptness, i.e., 45 or 90 days, is applied to an ABD application from the date an application is filed to the date the notice of decision is mailed to the applicant. When there is a delay, the reason must be documented in the record.

101.06.03A STANDARD OF PROMPTNESS

❖ **Families, Children and CHIP Programs**

The FCC programs have a 30-day standard of promptness. No more than 30 days may lapse from the date an application is filed to the date the notice of decision is mailed to the applicant. Any delays in processing FCC applications must be client-caused or requested. When there is a delay, the reason must be documented in the record.

CHIP actions must be authorized no later than the last CHIP deadline that falls prior to or on the 30th day after the application date, with CHIP benefits to begin the following month.

101.07 DISPOSITION OF APPLICATIONS

Specialists must determine eligibility based on information contained on the application form as well as information secured during the application process. Appropriate DOM forms, along with other legal or official documents which support the eligibility decision must be filed in the case record.

As part of the eligibility process, information provided by the applicant and/or obtained from other sources must be verified, documented and evaluated by the specialist prior to making the eligibility decision.

101.07.01 MAKING AN ELIGIBILITY DECISION

- Verified - Verification is the substantiation, confirmation or authentication of an assertion, a claim or previously submitted information.

  The specialist will accept reasonable documentary verification provided by the individual and will be primarily concerned with how adequately the verification proves the statements on the application form.

  Verification provided by an applicant or beneficiary must never be discarded, destroyed, ignored or altered.

- Documented –All cases must be thoroughly documented. Documentation is the written record of all information pertaining to the eligibility decision.

  Case documentation includes the completed application form, the specialist's verbal and written contacts with the applicant, information requested and received from applicant or third party sources, such as governmental or nongovernmental agencies, businesses and individuals, and notification of the eligibility decision.

  When an applicant claims no income or resources, the specialist must fully document the facts provided to substantiate these claims. "Applicant states none" is not sufficient documentation. The record must also show why the statement of the applicant or beneficiary is reasonable and acceptable.

  When action is taken to deny the application because the applicant has not provided the information necessary to determine eligibility within the specified timeframe, documentation in the record must show an appropriate request(s) was issued to the applicant.

MAKING AN ELIGIBILITY DECISION (Continued)

- Evaluated –Information provided by the applicant or obtained through third party sources must be assessed prior to making an eligibility decision. When information is not logical, consistent or reasonable, it must be resolved prior to determining eligibility.

  When there is conflicting information, the reliability of each source of information must be evaluated and the case record should specify which source was accepted and why. The final determination of eligibility is made based on the most reliable source available.

101.07.02 SUPERVISORY REVIEW

Each ABD and FCC eligibility determination must be reviewed by a supervisor, who is responsible for the accuracy, completeness and consistency of information contained in the case record. The supervisor is attesting to the validity of the action taken on the case when it is authorized in MEDS or MEDSX.

101.07.03 CONCEPT OF THE PRUDENT MAN

Evaluation of case information must be based on the concept of the prudent or reasonable man. This concept is taken from the practice of law and refers to the element of judgment that is exercised by persons in making choices, determining goals and in evaluating statements of others.

As indicated, the specialist should seek further information or a logical and reasonable explanation of the circumstances when an applicant declares no income or resources, but states his payments for shelter, utilities, food, etc., are all current. The specialist will ask the applicant to explain how he has managed to pay his expenses when he has no income or how he has managed to pay his expenses when he has no income or resources.

There may be a logical explanation and the applicant may be able to offer evidence that (1) he has had income in the past which has recently terminated; (2) he had resources or cash savings which he has now exhausted; or (3) he has paid his past living expenses by incurring debts, establishing credit, obtaining loans, etc. When the applicant or recipient can offer no logical explanation of how he had paid his past living expenses when he has no income or resources or offers vague explanations, such as "I just get by", etc., and cannot verify how expenses are being met, then eligibility cannot be determined and the application must be denied or assistance terminated.

101.07.04 USE OF COLLATERAL CONTACTS

When documents are available from the applicant, the applicant is generally the source used to supply needed verification. However, at times information may also be obtained directly from third parties. The general rule for verification is to verify only the information which is material to the individuals' eligibility.

The specialist has permission to obtain needed verifications based on the signed and dated application form. When it is necessary to request information from banks, insurance companies, or other sources that do not disclose information without a signed release, the DOM-301, Authorization to Release Information, should be used. Public records or records available from other agencies may be consulted without the consent of the individual.

Applicants should not be asked to verify information from sources which the agency has access to. This includes SSI, Social Security and other federal or state benefit information that is available to the agency.

101.07.05 APPLICATION ACTIONS

All applications will be subject to one of the following actions:

- **Approval** – When all of the eligibility factors are met, the application is approved.

- **Denial** – When one or more eligibility factors are not met, the application is denied.

  NOTE: Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

- **Withdrawal** – When the applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation.

  If the applicant is present, the specialist will obtain the request for withdrawal in writing. When the request to withdraw is not made in person, the specialist will document the case to reflect the specifics of the request. The application will be denied and appropriate notice issued.

101.07.06 REQUESTING INFORMATION FROM THE APPLICANT

The applicant has the primary responsibility for providing documentary evidence to verify statements made on the application or to resolve any questionable information. When additional information is needed, the applicant must be given written notice of the actions he must take to complete the eligibility process.

This includes a written interview appointment when an application is received by mail or the applicant is unable to complete the interview on the day the application is filed and an interview is required or requested.

When an appointment must be scheduled or additional information is needed to complete the application process, the specialist will take action based on program type to ensure applicants are provided a reasonable opportunity to meet the requirements for eligibility, as follows:

101.07.07 INFORMATION REQUESTS

- **Aged, Blind and Disabled Programs**

The ABD applicant will be issued a 307, Request for Information to provide the information or take other requested action. At the end of this request period, if the ABD applicant has not supplied all necessary information or taken the all necessary action to determine eligibility, a follow-up request via DOM 309, Second Request for Information, will be issued.

101.07.07A REQUEST FOR ADDITIONAL TIME

If the ABD applicant subject to 45-day processing subsequently contacts the agency to request additional time, the specialist will explain the information that is still needed and inform the applicant they have the remainder of the 45-day processing period to provide the information. The specialist will verbally provide the final due date for the information, which will be the 45th day from the application date.

If the ABD applicant needs assistance in obtaining information, the specialist will assist in any way possible. However, if the applicant has not fully complied by the end of the 45-day period, the application must be denied because required verifications were not provided.

101.07.07B FAILURE TO PROVIDE REQUESTED INFORMATION

❖ **Aged, Blind and Disabled Programs**

If the ABD applicant subject to 45-day processing has not fully responded to the DOM-309, Second Request for Information, by the due date and has not contacted the agency to request additional time as discussed above, the pending application will be rejected because of the refusal or failure of the applicant, after due notice, to take all necessary steps to enable the agency to establish his eligibility or ineligibility.

The MEDS denial notice must be documented in the comment section to advise the applicant of the specific information that is the basis for the denial. In addition, the case must be appropriately documented to support all of the actions taken.

101.07.07C COMPLIANCE AFTER DENIAL

If the ABD applicant subsequently provides all needed information to complete the application after the denial, but prior to or on the 45th day, the specialist will re-register the application in MEDS using the original application date and process the case based on the most recent application form. There is no requirement to re-interview the applicant or obtain an updated signature on the application form. However, if the information needed to complete the application has not been provided in full by the 45th day, a reapplication is required.

NOTE: If the ABD application is denied because the client did not appear for a required interview, the above procedures are not applicable and a reapplication must be filed.

101.07.07D APPLICANTS SUBJECT TO 90-DAY PROCESSING

Applicants, subject to the 90-day standard of promptness, will be denied at the end of the standard of promptness if they have failed to provide all required information.

101.07.08 INFORMATION REQUESTS

❖ **Families, Children and CHIP Programs**

When an interview appointment is needed for the FCC applicant, it will be scheduled within 10 days of the application date using the DOM 307, Request for Information. In addition, general information needed to complete the application process will be requested on the appointment notice.

If additional information is identified at the interview or the applicant needs additional time to provide some or all of the information previously requested, a second 307 will be issued for the information to be provided.

101.07.08A REQUEST FOR ADDITIONAL TIME

If an FCC applicant subsequently contacts the agency to request additional time to provide verifications, the specialist will explain the information that is still needed and inform the applicant they have the remainder of the 30-day processing period to provide the information. The specialist will verbally provide the final due date for the information, which is the 30th day following the application date.

If the FCC applicant needs assistance in obtaining information, the specialist will assist in any way possible. However, if the applicant has not fully complied by the end of the 30-day period, the application must be denied because required verifications were not provided.

101.07.08B FAILURE TO PROVIDE REQUESTED INFORMATION

❖ **Families, Children and CHIP Programs**

When the FCC applicant is issued a DOM 307, but fails to fully comply, the application will be held until the 15th day following the application date or until the request period on the most recent DOM 307 has expired, whichever is later. The application will then be denied, provided the applicant has not contacted the agency to request additional time.

To summarize, the specialist will take the later of the following actions:

- Hold the FCC application until the 15th day following the application date; and then deny if the applicant has not contacted the agency to request additional time; or

FAILURE TO PROVIDE REQUESTED INFORMATION (Continued)
Families, Children and CHIP Programs

- Hold the FCC application until the request period on the most recent 307 has expired and then deny if the applicant has not contacted the agency to request additional time.

The MEDSX denial notice must be documented using the "Message to be Included in Notice" section to advise the applicant of the specific information that is the basis for the denial. In addition, the case must be appropriately documented to support all of the actions taken.

101.07.08C COMPLIANCE AFTER DENIAL

If any FCC applicant subsequently provides all documentary evidence needed to complete the application after denial of the application, but prior to or on the 30th day following the application date, the specialist will re-register the application in MEDSX using the original application date and process the case based on the most recent application form. There is no requirement to re-interview the applicant or obtain an updated signature on the application form. However, if the information needed to complete the application has not been provided by the 30th day as discussed above, a reapplication is required.

NOTE: If the application is denied because the client did not appear for the interview, the above procedures are not applicable and a reapplication is required.

101.08 ELIGIBILITY DATES

101.08.01 BEGINNING DATES OF MEDICAID ELIGIBILITY

Medicaid applicants, including an applicant who dies prior to filing an application or dies prior to completion of the application process, may qualify for Medicaid on one of the following dates:

- The first day of the month of the application, provided all eligibility factors are met for the first day of the month;
- The first day of the month after the month of application in which all eligibility factors are met;
- The first day of the first, second or third month prior to the month of application when conditions are met for retroactive Medicaid.

101.08.02 BEGINNING DATES OF CHIP ELIGIBILITY

The benefit start date for CHIP is a future month. Coverage authorized by the 21st day of a month (or the first business day prior to the 21st if it falls on a weekend or holiday) is effective on the first of the following month.

There is one exception for limited retroactive coverage in CHIP. The start date for a CHIP-eligible newborn may be retroactive to the date of birth if:

- The application for the newborn is filed within 31 days of birth; and
- The approval is authorized by the supervisor within 60 days of the application.

The 31-day count for the application to be filed begins the day following the date of birth.

101.08.03 TERMINATION DATES

Eligibility for a Medicaid or CHIP recipient will end on one of the following days of the month, unless otherwise noted:

- The last day of the month in which the client was eligible; or
- The death date of the recipient. or
- The date the recipient entered a public institution.
    - CHIP EXCEPTION: CHIP eligibility is terminated on the last day of the month in which the child entered the public institution.

101.08.04 RETROACTIVE MEDICAID ELIGIBILITY

Retroactive Medicaid eligibility may be available to any Medicaid applicant who received medical care prior to applying for Medicaid. Applicants may qualify for coverage for a 3-month period prior to the month of the application. Retroactive eligibility can cover all 3 months of the prior period or any month(s) in the 3-month period. In addition:

- Each applicant must be informed of the availability of retroactive Medicaid coverage.
- The applicant's statement is accepted regarding medical expenses incurred in the retroactive period.
- Retroactive Medicaid may also be available to an individual who is added to a case (e.g., child returns home).
- The applicant does not have to be eligible in the month of application (or current month) to be eligible for one or more months of retroactive Medicaid.

  NOTE: Children have continuous eligibility. Refer to the FCC program section for instructions on how to handle children who do not have current month eligibility, but are eligible in a retroactive month.
- The applicant or recipient may ask for retroactive Medicaid coverage at any time.
- The date of application, rather than the date of the eligibility determination, establishes the beginning of the three-month retroactive period.
- There is no provision for retroactive coverage in the Qualified Medicare Beneficiary (QMB) program. QMB eligibility begins the month following supervisory authorization. However, QMB applicants may be eligible for retroactive coverage and coverage in the application month in the Specified Low-Income Medicare Beneficiary (SLMB) program.

101.08.04A DECEASED APPLICANTS

An application for retroactive Medicaid coverage may be made on behalf of a deceased person. Retroactive eligibility can cover all 3 months prior to the month of application or any month(s) in the 3-month period if the deceased person is found to be eligible.

101.08.04B SSI ELIGIBLES

Persons eligible for SSI may be eligible for additional months of eligibility beyond the SSI retroactive period. This period of coverage includes the month of application for SSI and any other missing months of eligibility that exist until the month the SSI payment begins. The SSI eligible person must apply for and be determined eligible for ABD coverage for the interim period of missing SSI eligibility.

An application for the interim period of missing SSI eligibility can be filed at any time and may or may not be filed in conjunction with an application for SSI retroactive Medicaid.

101.08.04C DETERMINING RETROACTIVE MEDICAID ELIGIBILITY

❖ **Aged, Blind and Disabled Programs**

Eligibility in a retroactive month cannot be assumed based on current month eligibility. Determine eligibility for each month separately using the eligibility rules in effect for that month, actual income received in each month and actual resources available in each month.

NOTE: Annual Cost-of-Living Adjustment (COLA) increases in Federal benefits cannot be used to determine ABD eligibility in any given year until the Federal Poverty Level (FPL) limits have been implemented for that year. Therefore, when determining retroactive or ongoing eligibility for the months of January, February and possibly March, the prior benefit amount must be budgeted, rather than the actual amount.

101.08.04D DETERMINING RETROACTIVE MEDICAIELIGIBILITY

❖ **Families, Children and CHIP Programs**

Actual income received in the retroactive month(s) must be verified only if the normal income in those months is significantly more or less than the verified income that is used to determine ongoing eligibility. Accept the applicant's statement regarding income sources and amounts in the retroactive period unless there is some reason to question the accuracy of the statement.

For purposes of determining Extended Medicaid eligibility, retroactive Medicaid can be used to determine whether an applicant would have been eligible for Medical Assistance (85) in three of the last six months.

101.09 PROCESSING APPLICATIONS OF EMPLOYEES AND FAMILY MEMBERS

Applications for DOM employees, members of their households and immediate family members require special processing and maintenance as follows.

- DOM employees must not process their own application, redetermination, or change. They must not directly view, add, remove, replace or edit system information or documents and verifications in the case record.

- Further, DOM employees must not process or maintain case(s) that include a member of their household or immediate family. They must not process the application, redetermination or change on these individuals' cases. They must not directly view, add, remove, replace or edit system information or documents and verifications in the case record.

- Immediate family includes the employee's spouse, children, children's spouses and the following relations to the employee *or* employee's spouse: mother, father, step-parent, brother, sister, niece, nephew, grandparent, grandchildren.

- Individuals living in the home with the employee are included as immediate family members even if they are not one of the relationships listed above.

- DOM employees, household members and their immediate family members must be marked as DOM employees in MEDS and MEDSX to limit system access to all members of the case. The case records must be maintained in a locked file by the person responsible for the case.

- Cases involving family and friends can potentially represent an impropriety or conflict of interest to an employee; therefore, it is the employee's responsibility to inform the supervisor if the application or case of a family member or friend has been assigned to them.

- DOM employees must never directly or indirectly influence or request that another DOM employee process an application for themselves, family members, household members or friends outside of normal assignment and authorization processes.

- Individuals who fail to follow the guidelines for processing applications for employees and their family members are subject to disciplinary action.

Procedures for Processing Applications of DOM employees, Members of Their Household or Immediate Family Members

Any application or active case involving a DOM employee, household member or immediate family member, as defined above, in any regional office must be processed using the following guidelines:

The Applicant is	The Person to Interview & Process the Application is	The Person to Review & Authorize the Action is
DOM Employee	Division Director (DD)	Bureau Director, Deputy (BDD)
Employee's Spouse or Minor or Adult Child	Division Director	Bureau Director, Deputy
Other Immediate Family or Household Member	Assistant Supervisor Assigned by DD	Division Director
DD, DD's Spouse or Minor or Adult Child	Bureau Director, Deputy	Bureau Director, Deputy
Other Immediate Family Member or Household Member of DD	Assistant Supervisor	Bureau Director, Deputy
BDD, BDD's Spouse or Minor or Adult Child	Division Director	State Office Manager
Other Immediate Family Member or Household Member of BDD	Division Director	State Office Manager

Prior to authorizing eligibility, the regional Division Director, Bureau Director, Deputy or State Office Manager, as appropriate, will thoroughly review the case and determine the accuracy of the eligibility decision. This may include additional contact with the applicant or others when deemed necessary to make a determination of eligibility.