STATE OF NEW YORK
DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 10 OHIP/ADM-5

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: April 20, 2010

SUBJECT: Revised DOH-4220: Access NY Health Care Application and Release of DOH-4495A: Access NY Supplement A

SUGGESTED DISTRIBUTION:
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ATTACHMENTS:

Attachment I - DOH-4220 (Rev. 2/10), Access NY Health Care Application
Attachment II - DOH-4495A (Rev. 2/10), Access NY Supplement A
Attachment III - Summary of Revisions to DOH-4220, Access NY Health Care Application
Attachment IV - Verification of Employment
Attachment V - Self-Declaration of Income

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10 OHIP/ADM-4 10 OHIP/ADM-1 03 OMM/ADM-6 09 OHIP/INF-2 06 OMM/INF-1			18 NYCRR 360-2.2		GIS 06 MA/015

I. PURPOSE

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP/ADM) is to familiarize local departments of social services (LDSS) and other users with the revised DOH-4220, Access NY Health Care application (Attachment I) and companion forms. This ADM also introduces the Access NY Supplement A, DOH-4495A (Attachment II), which must be completed in addition to the Access NY Health Care application for certain populations.

In addition, this directive provides guidance on policy changes related to specific questions in the revised Access NY Health Care application. Guidance is also provided for LDSS regarding the use of certain district-specific forms.

II. BACKGROUND

The Access NY Health Care application was revised to support recent changes in policy which eliminate the resource test for non-SSI-Related Medicaid and Family Health Plus (FHPlus) applicants and the requirement for a personal interview for individuals applying for Medicaid and FHPlus coverage. The revised application incorporates information that may have previously been provided during the personal interview.

To simplify the eligibility rules for many applicants/recipients (A/Rs) and LDSS examiners, Sections 58 through 59(d) of Chapter 58 of the Laws of 2009 amended Sections 366 and 369-ee of the Social Services Law to eliminate the resource test for FHPlus and for all Medicaid categories except for the SSI-Related eligibility group. This change was effective January 1, 2010, and was explained in 10 OHIP/ADM-1, “Elimination of the Resource Test for Non-SSI-Related Medicaid/Family Health Plus Applicants/Recipients”.

Chapter 58 of the Laws of 2009 eliminated the requirement to conduct a personal interview as part of the process of determining eligibility for Medicaid and FHPlus as explained in 10 OHIP/ADM-4, “Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants”. This change is intended to eliminate barriers to obtaining public health insurance. Local departments of social services, Facilitated Enrollers (FEs) and deputized workers in designated outreach sites can no longer require applicants to meet with them face-to-face as a condition of eligibility. The application was revised to ensure that information necessary for making an eligibility determination is obtained from the applicant without the personal interview.

III. PROGRAM IMPLICATIONS

A. Access NY Health Care Application

The Access NY Health Care application was revised to be more user-friendly. Certain sections were reformatted and language

was simplified for increased readability. In addition, certain questions were added to aid LDSS examiners in obtaining information necessary to make eligibility determinations, particularly in response to the elimination of the requirement for a personal interview.

Examples of these revisions can be seen in Section A, formerly titled "Contact Information". This section was renamed "Applicant's Information" to make clear to the applicant that his/her information should be provided in this section. Further, "First Name" and "Last Name" were changed to "Legal First Name" and "Legal Last Name" because in many cases applicants were providing nicknames rather than legal names. A SEND PROOF icon was also added throughout the document to assist applicants in understanding when documentation is required.

Questions were added to the revised DOH-4220 to provide useful information to LDSS examiners to assist them in making eligibility determinations. In the "Home Address" field of Section A, a check box was added for applicants to indicate if they are homeless. Check boxes were also added to identify phone numbers as being a home, cell, work or other phone number. A box was also added to this section to provide applicants with the opportunity to identify an authorized representative.

To further aid LDSS examiners in their responsibilities, applicants are asked in Section B, "Household Information," if persons listed in this section have or had public health insurance coverage in the past, what type of public health coverage, and under what Client Identification Number (CIN) or Plan Identification Number, if known. The CIN is being requested in order to potentially reduce the number of duplicate CINs being assigned at application.

Also in Section B of the revised application, "Household Information," the columns were reformatted to increase readability for the applicant and to allow questions to be moved from other areas of the application to this section. The goal of this reformatting was to reduce the number of times an applicant has to write his/her name throughout the application. Wording throughout the application was also simplified. For example, terms which applicants may have had difficulty understanding, such as "head of household," were eliminated.

A significant change to the application is how citizenship and immigration information is gathered on the application. This information is now required in Section B, "Household Information". The applicant is instructed to check one box that broadly indicates his/her current citizenship or immigration status, as well as the statuses of all other applying household members, except pregnant women. The applicant will be able to choose from, "U.S. Citizen," "Immigrant/non-citizen," "Non-immigrant (Visa holder)," and "None of the above". The applicant is still required to send acceptable proof of this information for him/herself and all other applying household members. Local department of social services examiners must continue to review

the documents provided by the applicant to determine citizenship and immigration status. The application refers applicants to the "Documents Needed When You Apply for Health Insurance" which includes a list of documents that provide identity, citizenship and immigration status.

The "Household Income" section (Section C) and the "Health Insurance" section (Section D) were also revised. The formatting was changed to help the applicant read and complete these sections, and questions were added to assist LDSS examiners in collecting information that previously would have been obtained during the interview. For example, a check box was added to the "Household Income" section for applicants to indicate if they are self-employed, and to indicate if they have any income in each of the income categories (earnings from work, unearned income, contributions and/or other).

Section F, "Blind, Disabled, Chronically Ill or Nursing Home Care," was created to identify applicants who are blind, disabled (categorically SSI-Related), chronically ill or in receipt of nursing home care and to direct such applicants to complete Supplement A (see Section III.B. below).

In addition, language was revised to emphasize the need for certain applicant actions. For instance, in Section I, "Health Plan Selection," the language was strengthened to indicate that FHPlus and Child Health Plus (CHPlus) applicants must choose a health plan to receive health services. It also clarifies that most people applying for Medicaid must also choose a health plan, and failure to do so may result in being automatically enrolled in a health plan, unless the applicant(s) is/are determined exempt from health plan enrollment.

The signature lines have been moved to a separate section of the revised application (Section J), rather than being placed after the "Terms, Rights and Responsibilities". This change is intended to increase the visibility of the signature lines to ensure that applicants submit a signed application.

Other general changes to the application include the elimination of references to the "Women, Infants and Children" (WIC) program and to the "Prenatal Care Assistance Program" (PCAP). The Office of Health Insurance Programs learned that the WIC program has a separate application and does not accept the Access NY Health Care application. The PCAP references have been eliminated from the application as a result of the passage of Chapter 484 of the Laws of 2009, which eliminated statutory references to PCAP. However, pregnant women with limited income may still be eligible for presumptive eligibility and free health insurance under Medicaid. Pregnant women who participate in Medicaid will continue to receive a wide range of services designed to ensure a healthy pregnancy, including prenatal visits, health education and specialty medical care.

B. ACCESS NY SUPPLEMENT A, DOH-4495A

The Access NY Supplement A, DOH-4495A (Attachment II) was created to capture information needed to determine Medicaid eligibility for individuals who are or may be categorically SSI-Related. In addition to the Access NY Health Care application, Supplement A must be completed if anyone who is applying is:

- Age 65 or older;
- Certified blind or certified disabled (of any age);
- Not certified disabled but chronically ill; or
- Institutionalized and applying for coverage of nursing home care, including care in a hospital that is equivalent to nursing home care.

IV. REQUIRED ACTION

A. Access NY Health Care Application (DOH-4220)

The revised Access NY Health Care application (DOH-4220) must be in use by June 11, 2010, approximately 60 days from its anticipated date of availability. After this date, all older versions of the Access NY Health Care application should be discarded. However, if an LDSS receives a 5/08 version of the Access NY Health Care application after this date, the district must accept the application.

The revised Access NY Health Care application (Rev. 2/10) should be used for all applicants applying for Medicaid only, including applicants seeking coverage of long-term care services and nursing home care. However, if an LDSS receives the LDSS-2921 application for a Medicaid-only applicant, they must accept the application and cannot require that the DOH-4220 or DOH-4495A also be completed. The LDSS-2921 should continue to be used when an individual is applying for Medicaid and another program, such as Temporary Assistance, Child Care Assistance and/or Food Stamps.

Individuals who are applying for the Medicare Savings Program (MSP) only should continue to complete the DOH-4328, “Application for the Medicare Savings Program”. However, if an individual submits the Access NY Health Care application, it must be accepted and eligibility for the MSP must be determined for all Medicaid and MSP applicants. The Access NY Supplement A does not have to be completed if the person is applying for the MSP only.

Local departments of social services need to be aware of the following revisions (specifically detailed in Attachment III) in the Access NY Health Care application and corresponding policy implications.

1. Section A – Applicant's Information

Section A now allows an applicant to identify another person who should receive copies of Medicaid notices on his/her behalf, and the contact information for that person. The applicant can identify the role of this person to: apply for and/or renew Medicaid; discuss his/her Medicaid application or case, if needed; and/or get copies of notices and agency correspondence. If this section is completed by the applicant and the applicant is the person signing the application, there is no need for him/her to provide a separate document authorizing a representative. However, if the representative is the person signing the application, the LDSS must obtain separate authorization from the applicant or a copy of legal guardianship. This authorization continues until it is revoked by the recipient; a reauthorization is not required at renewal. If an applicant indicates that someone else should get copies of notices and correspondence, the LDSS must also send the notices and correspondence to the applicant.

NOTE: Federal Medicaid regulations provide, in the case of an incompetent or incapacitated individual, for the submission of an application by someone acting responsibly on the individual's behalf. In these situations, a copy of legal guardianship papers is not required nor is a separate document authorizing the representative. The LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant.

2. Section B – Household Information

Applicants are asked to list a Client Identification Number (CIN) or an identification number from a plan card, if someone in the case has or had Medicaid/FHPlus or CHPlus coverage in the past. If the applicant does not list a CIN/Plan Identification Number, the LDSS must not deny the application or request the information from the applicant.

In addition, in the revised application, the phrase "not needed for pregnant women" has been removed in the Social Security Number (SSN) column and replaced with "if you have one". This was revised because although a SSN is not required, if one is provided it helps identify whether the applicant is known to the Welfare Management System (WMS) and will reduce the risk of issuing a duplicate CIN. Social Security Numbers are also needed for Resource File Integration (RFI) matches. The policy on SSNs and pregnant women has not changed; the LDSS must not deny a pregnant woman for failure to provide an SSN. Furthermore, although non-applicants are not required to list their SSNs, the wording "Optional for Non-Applicants" was removed above this column. When certain data matches are available in the future, having the non-applicant's SSN may help verify the income of a parent whose child is receiving Medicaid.

3. Section C – Household Income

When an application is submitted and income is listed but no income documentation is provided, a documentation request form must be sent to the applicant requesting the missing documentation (e.g., pay stubs). The applicant must be given at least 10 calendar days to submit the missing documentation. A copy of Attachment IV, Verification of Employment, must be sent with the documentation request form in the event that the applicant does not have pay stubs or receive pay checks. The applicant can give his/her employer the form to complete and it is the applicant's responsibility to return the completed form to the LDSS. Also, if the applicant answered "Yes," to question 5 in Section D, "Health Insurance", the Employer Sponsored Health Insurance Request for Information form (DOH-4450) must be sent to the applicant. If an applicant requests assistance in obtaining income documentation from the employer, the LDSS shall send the Employment Verification form (LDSS-3707) using current procedures. When an applicant indicates he/she is paid in cash because he/she is paid "off the books" and his/her employer refuses to provide a statement of wages, the Self-Declaration of Income form (Attachment V) shall be filled out by the applicant.

In addition to the slight modification of the format of Section C, several questions were added to obtain more information regarding household income. The new questions and policy implications are as follows:

- Question 1, which asks, "Do you or any applying adult in Section B have no income?", is intended to confirm that a legally responsible relative (LRR) listed in Section B does not have income. If the applicant answers "No" but a LRR is listed as having no income, the district should follow-up with the applicant regarding the discrepancy. If the applicant checks "yes" indicating that an LRR does not have income, the LDSS examiner shall not follow-up with the applicant for an explanation. An explanation is only needed if there is no income for the entire household. The applicant has the opportunity to explain this in Question 2, which asks, "If there is no income listed above, please explain how you are living". This information will be used in conjunction with Section E relating to housing expenses and financial maintenance.

- Question 3 of Section C asks, "Have you or anyone who is applying changed jobs or stopped working in the last three months?". If the applicant indicates that he/she lost or changed jobs in the last three months and provides his/her former employer's name, even if this information still appears on the RFI system, the LDSS must accept the information on the application and not require additional documentation (e.g., Employment Verification form, LDSS-3707) from the former employer to prove loss of employment.

- Question 6 asks, "If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only?". This question is asked so that only individuals interested in receiving family planning benefit services are given this coverage.

  Local department of social services examiners are advised that county-specific Family Planning Exclusion Statements should not be used for applicants who apply using the revised Access NY Health Care application (2/10). Section C of the revised DOH-4220 addresses the Family Planning Benefit Program.

4. Section D – Health Insurance

The 5/08 version of the application included a question that asked if anyone who was applying and over the age of 19 was receiving coverage through a federal, State, county, municipal or school-district health benefits plan. This question has been removed in anticipation of implementing the provision to allow State, county, municipal and school district employees to apply for and enroll in FHPlus or the FHPlus Premium Assistance Program. Until this provision is implemented, LDSS examiners should look at pay stubs or other income documentation provided with the application to determine if anyone applying is a public employee.

5. Section E – Housing Expenses

This section was modified to assist the LDSS examiner in determining financial maintenance. Applicants are asked to provide their monthly housing payment, such as rent or mortgage and property taxes (if applicable). Applicants are allowed to attest to housing expenses and should not be asked to document these expenses.

A second new question in this section asks if the applicant pays for water separately, and if so, instructs the applicant to provide a copy of the water bill. The LDSS examiner can only give the additional allowance for a water expense when documentation is received, either with the application or in response to a worker request. This allowance is added to the Medicaid Income Standard to determine Medicaid eligibility for Low Income Families (LIF) and Single Individuals and Childless Couples (S/CC). A worker request for documentation of a water bill shall be made when the additional allowance amount affects eligibility under the LIF and S/CC categories of assistance. If documentation of a water bill is not provided, the applicant must not be denied, but rather he/she must be budgeted without the additional allowance.

A question was also added to Section E asking the applicant to indicate if he/she receives free housing as part of his/her pay. If the applicant answers "Yes," to this question, the

LDSS examiner must count the amount of in-kind income in the Medicaid Budget Logic (MBL) budget. The value counted must be the allowance for shelter with heat in the district-specific Public Assistance Standard of Need. If the applicant documents that the actual fair market value of the housing is less than the district-specific shelter allowance with heat, the LDSS must use the lower amount.

6. Section F – Blind, Disabled, Chronically Ill or Nursing Home Care

Section F was changed from "Housing Expenses" to "Blind, Disabled, Chronically Ill or Nursing Home Care". Applicants are instructed at the beginning of Section F, "if no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home," they may skip Section F and move ahead to Section G.

Question 1 of Section F asks, "Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution?". If the applicant answers "Yes," he/she is instructed to finish completing the Access NY Health Care application and to complete Supplement A. Supplement A is discussed in Section IV.B. of this directive. Question 2 asks, "Are you or anyone who lives with you blind, disabled or chronically ill?". If the applicant answers "Yes," he/she is also instructed to finish completing the Access NY Health Care application and to complete Supplement A.

Applicants are also advised that if they are only applying for the Medicare Savings Program, they do not need to complete Supplement A.

NOTE: Applicants who are not certified disabled but chronically ill are instructed to complete Supplement A. Examples of chronically ill are the inability to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months. Supplement A will gather resource information should the chronically ill applicant be determined certified disabled by the State or Local Disability Review Team.

7. Section G – Additional Health Questions

If an applicant indicates that he/she has past medical bills in Question 1, "Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month?", but does not submit copies of the bills, the LDSS must still determine eligibility for the retroactive period only if the district received documentation of income for that period. If eligible for Medicaid coverage, the case is opened retroactively according to current local district procedures.

Question 2 of this section asks if anyone applying has any unpaid medical or prescription bills older than the previous three months. This question has been added in case the applicant is determined to be eligible with excess income and may enroll in the spenddown program. Districts must not require copies of such bills unless the applicant may use them to meet a spenddown.

Question 3 can be used to identify individuals who may have coverage in another county, which the district can facilitate having transferred, pursuant to 08 OHIP/LCM-1, "Continued Medicaid Eligibility for Recipients who Change Residency (Luberto vs. Daines)".

8. Section H – Parent or Spouse Not Living in the Household or Deceased

For individuals applying using the revised Access NY Health Care application (2/10), county-specific absent parent forms must no longer be used. Information that was previously captured on such forms is now included in Section H of the application. In this section the applicant is asked to provide information about the spouse or parent of anyone applying who is deceased or living outside the household. Information obtained in Section H of the Access NY Health Care application shall be used by the LDSS to complete necessary referrals to the Child Support Unit. However, current referral procedures between the Medicaid Unit and the Child Support Unit remain unchanged.

9. Section I – Health Plan Selection

Revisions have been made to this section to emphasize who must enroll in a health plan and how applicants can get information on what plans are available in their county. Applicants are instructed to call the New York Medicaid CHOICE (the managed care enrollment broker for New York State, Maximus) hotline for more information. In districts that do not utilize the enrollment broker, Maximus will refer applicants to the managed care unit in their LDSS. Local departments of social services are reminded that enrollment information must be accepted from Section I. Recipients cannot be required by districts or plans to complete a separate enrollment form. If recipients indicate their preferred primary care doctor in Section I, this information must be sent to the plan by the LDSS.

B. <u>Supplement A (DOH-4495A)</u>

In addition to completing the Access NY Health Care application, applicants who are age 65 or older, certified blind or certified disabled, not certified disabled but chronically ill, or institutionalized and applying for coverage of nursing home care, must complete Supplement A. SSI-Related applicants applying for Medicaid, but not for coverage of community-based long-term care services, may attest to their resources. SSI-Related applicants

applying for Medicaid coverage of community-based long-term care services must submit documentation of the current amount of their resources. These two coverage groups must fill out Sections A through F of Supplement A and sign page 6 of the Supplement. Aged, certified blind or certified disabled applicants who are institutionalized and applying for coverage of nursing home care must complete the entire Supplement and sign the last page of the Supplement. If the LDSS-2921 is submitted, the applicant is not required to complete Supplement A. SSI-Related Medicaid applicants should be encouraged to complete the Access NY Health Care application and Supplement A when they are: age 65 or older; certified blind or certified disabled; not certified disabled but chronically ill; or institutionalized and applying for coverage of nursing home care.

NOTE: In accordance with 10 OHIP/ADM-1, an institutionalized S/CC or ADC-Related applicant who requires temporary nursing home care is budgeted under community rules, and, therefore, is not required to complete Supplement A. If the S/CC or ADC-related applicant has a community spouse, spousal rules apply if the institutionalized spouse is in a medical institution and/or nursing facility and is likely to remain in the facility for at least 30 consecutive days. Under spousal rules there is a resource test and Supplement A must be completed. If an unmarried S/CC or ADC-Related applicant is in permanent absence status in a medical facility, a disability determination must be completed before eligibility can be established for Medicaid coverage of nursing facility services. The applicant is required to complete Supplement A, unless the LDSS-2921 was submitted.

1. Section A – Applicant's Information

Section A asks for the legal name, Social Security Number and marital status of the individual(s) for whom Supplement A is being completed. All other demographics are captured on the Access NY Health Care application.

2. Section B – Blind, Disabled or Chronically Ill

Applicants completing Supplement A are asked three questions regarding their health to assist the LDSS in identifying individuals who are certified blind or chronically ill. This information will help districts identify individuals who should have an Aid to the Disabled (AD) review pursued through the State or Local Disability Review Team. This section also provides information on the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) to help districts identify individuals who may benefit from the MBI-WPD.

3. Section C – Adult Home or Assisted Living Facility

Section C asks if the applicant is living in an adult home or assisted living facility. This information will help districts assure the applicant receives the appropriate income level for budgeting purposes.

4. Section D – Resources/Assets

Section D identifies the type of coverage the applicant can apply for and the required resource documentation, if any, that must be provided for each coverage type. Applicants must check one of the three boxes.

- The first type of coverage is Medicaid coverage without coverage of community-based long-term care services. An applicant may attest to the amount of his/her resources. The applicant is not required to submit resource documentation. This coverage does not include nursing home care, home care or any community-based long-term care services.

- The second type of coverage is Medicaid coverage including coverage of community-based long-term care services. The applicant must submit documentation of the current amount of his/her resources. Services covered under this type of coverage are listed in Section D of Supplement A.

- The third type of Medicaid coverage includes coverage of nursing home care for the institutionalized individual, including care in a hospital that is equivalent to nursing home care. Resource documentation must be submitted back to February 8, 2006, or the past 60 months, whichever is less. If the individual has a trust, documentation of trust assets must be submitted for the past 60 months.

Section D requires the applicant to list all resources owned by the applicant, his/her spouse, and parent(s), including custodial accounts. The questions regarding resources have been moved from the Access NY Health Care application to Supplement A. Applicants who have completed Supplement A must not be required to complete the Long-Term Care Documentation Requirement Checklist (OHIP-0021), the Burial Reserve Acknowledgement (DSS-3827), or the Long-Term Care Change in Need Resource Checklist (DOH-4319).

If the applicant completes the LDSS-2921, the district cannot require the applicant to complete Supplement A. Supplement A can be used instead of the Long-Term Care Change in Need Resource Checklist (DOH-4319) when applicable (see 10 OHIP/ADM-1).

The directions in Section D advise applicants for nursing home care that they must provide an explanation of each bank transaction of $2,000 or more. This amount was determined pursuant to discussions with LDSS and State Department of Health (DOH) Legal staff. Having a set dollar amount statewide will standardize the resource information that must be provided with the application. After reviewing this initial information regarding transactions, the LDSS may request documentation of transfers made during the look-back period. If the district identifies that transfers for less

than fair market value may have been made, districts can still review all transactions made during the transfer look-back period.

5. Section E – Real Property

This section determines if the applicant owns or has a legal interest in any real property that is not his/her primary residence. Ownership of real property is reviewed in order to determine if it is a countable resource.

6. Section F - Homestead

This section is used to determine if a homestead is an exempt resource for Medicaid. A homestead is an exempt resource as long as it is the primary residence of the applicant or certain family members. If the applicant or family member no longer resides in the home, the property is evaluated to determine if it is a countable resource.

If the applicant does not need coverage of nursing home care, he/she is instructed to stop at the end of Section F and to sign the last page of Supplement A. If the applicant needs coverage of nursing home care, he/she must complete Sections G through I and sign the last page of Supplement A.

7. Section G – Applicant Living in a Long-Term Care Facility/ Nursing Home

This section will capture information regarding an applicant’s admission to a long-term care facility/nursing home and includes information on the applicant’s previous address.

8. Section H – Asset Transfers

Section H asks the applicant and the applicant’s spouse if a transfer of assets was made. The applicant should continue to receive the Explanation of the Effect of Transfer of Asset(s) on Medical Assistance Eligibility (LDSS-4294). This informational notice explains how a transfer of assets may affect his/her eligibility. The policies and procedures contained in 06 OMM/ADM-5, “Deficit Reduction Act of 2005 – Long Term Care Medicaid Eligibility Changes,” continue to apply to SSI-Related Medicaid applicants who are eligible for Medicaid coverage of nursing facility services.

9. Section I – Tax Returns

The applicant’s last four years of income tax returns must be submitted, if the applicant and/or his/her spouse filed income tax returns. These tax returns must include 1099s, if applicable, and all schedules and forms.

10. Last Page

The last page (page six) of Supplement A explains the State's policy on liens and recoveries, as well as federal and State laws regarding transfer of assets for less than fair market value, and annuities. The form, Disclosure of Annuities (Attachment VII of 06 OMM/ADM-5) can be eliminated for all individuals who complete and sign Supplement A.

The applicant or his/her representative must sign and date Supplement A. The applicant's spouse must also sign and date Supplement A.

NOTE: If a community applicant who is age 65 or older, certified blind or certified disabled, or not certified disabled is found eligible for Medicaid or FHPlus based on ADC-Related budgeting, eligibility cannot be denied based on the applicant's failure to complete Supplement A. If an S/CC applicant is chronically ill and he/she failed to comply with a disability review or did not complete Supplement A, the applicant cannot be denied coverage if otherwise eligible for Medicaid under an S/CC budget or FHPlus.

C. Application Reprint/Supplement A

An initial supply of the application and Supplement A is being delivered to each LDSS. Following the delivery of this initial supply, the application/Supplement A will be available in the DOH warehouse upon request.

Local departments of social services are reminded that only districts and community-based facilitated enrollment lead agencies may order directly from the DOH warehouse. Health plans performing facilitated enrollment activities are responsible for printing their own supplies of the DOH-4220. It is the responsibility of the LDSS to provide supplies of the DOH-4220 to all other outreach organizations (e.g., hospitals).

V. SYSTEM IMPLICATIONS

None.

VI. EFFECTIVE DATE

The provisions of this ADM are effective May 1, 2010.

Donna Frescatore

Donna Frescatore, Deputy Commissioner
Office of Health Insurance Programs