OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

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Description: A recertification/renewal for Medicaid is a review of current eligibility factors to determine whether to continue, change or discontinue Medicaid based upon the eligibility of the recipient.

All active Medicaid cases, including those receiving both Medicaid and Temporary Assistance, are recertified periodically. Generally, the recipient must submit a written renewal (recertification) to continue Medicaid. The re-authorization period may not exceed one year.

Policy: Each month, the district/State produces reports of cases due for renewal, generally at least 60 days prior to the date coverage expires. Based on the district's entry of the appropriate code in the Client Notices System (CNS), a renewal package is produced and mailed to the recipient, or districts may opt to have the State automatically generate the renewal package through a one-time entry in the AFA field on WMS. This process is described in a WMS/CNS Coordinator Letter dated November 1, 2004.

The renewal package advises the recipient that coverage is expiring and explains the need for the recipient to provide current information and, in some cases, documentation to the local district. The deadline for returning the renewal form and the return address are included. It is the responsibility of the recipient to return the renewal form and the required documentation to the local district by the deadline provided.

Prior to September 1, 2011 the signatures of all adults applying for Medicaid/FHPlus were required on the renewal form. Effective September 1, 2011, only the signature of one applying adult is required on the renewal form.

NOTE: The renewal form for community cases, except for FPBP cases, contains pre-printed information from the Welfare Management System (WMS). It provides space for the recipient to amend the pre-printed information and provide new information, when appropriate.

Effective January 1, 2012, SSI-related single individuals and couple households with fixed incomes and whose resources are less than 85% of the Medicaid resource limit at application or last renewal whichever is later will have their case automatically renewed by the State. Such cases include SSI-related individuals or married couples 18 years of age or older with an Individual Categorical Code of Aged, Blind or Disabled, a Budget Type of SSI-related, Social Security as the only source of income and resources at or below 85% of the applicable Medicaid resource limit. Cases not included: Medicare

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Savings Program only, nursing facility services and excess income. Neither the individual nor couple will be required to mail in a renewal form.

NOTE: Social services districts remain responsible for processing any changes reported by recipients whose case has automatically been renewed. Districts must take appropriate action based on the type of change reported.

NOTE: If an Upstate recipient wishes to add a child to his/her case between renewal periods, a separate application is not required. A recipient may simply call the LDSS and request the addition. If needed, documentation for the child must be provided and the LDSS must provide a notice of decision regarding the eligibility determination.

If an Upstate recipient wishes to add an adult to his/her case mid-renewal, a new application must be completed by the adult to be added to the case.

Children 18 to 21
Medicaid renewal for children ages 18 to 21 who are final-discharged from foster care (Chaffee Children) is done on the Chafee Medicaid renewal form.

As a passive renewal, if the renewal is not returned via United States Postal Service (USPS) eligibility must be authorized for another year, but never past the 21st birthday.

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If the renewal form is returned by the USPS with a forwarding address label that is within the district, the renewal form must be re-sent to this address. If the form is not returned as undeliverable, coverage must be re-authorized for another 12 month period, not to exceed the child's 21st birthday.

If the renewal form is returned by the USPS with a forwarding address label that is outside the district, the renewal form must be resent to the address provided by the USPS. If the renewal is returned by the child confirming the address, the case should be renewed for a 12-month period and then transferred in accordance with 08 OHIP/LCM-1. If the child has moved out of New York State or is deceased, the case may be closed.

SSI cash recipients

Individuals who receive Medicaid based on their eligibility for SSI are renewed (recertified) for Medicaid by virtue of their renewal (recertification) for SSI cash. SSI cash recipients need not be reauthorized yearly. Their authorization will be open-ended until December 31, 2049. Local districts use the SDX to confirm that an cash SSI recipient continues to be eligible for SSI and, therefore, Medicaid.

References:

SSL Sect. 366
366-a
366-a (2)
366-a (5) (d)
369-ee (2)

Chapter 58 of the Laws of 2010

Dept. Reg. 360.1
360-2.2(e)
360-6.2

ADMs 11 OHIP/ADM-1
11 OHIP/ADM-9
09 OHIP/ADM-1
08 OHIP/ADM-4
04 OMM/ADM-6
03 OMM/ADM-2

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INFs	10 OHIP/INF-1
LCM	94 LCM-84
GIS	11 MA/015 11 MA/012 11 MA/002 04 MA/021

Interpretation: The period covered by a recertification may vary by category and circumstances but may not extend beyond one year. Most recipients are certified for one year; however, when a recipient is unemployed or receives variable or seasonal income, s/he may require more frequent recertification.

Verification/ Documentation: Renewing community Medicaid recipients who are not seeking coverage of institutional based nursing facility services all FHPlus recipients, recipients of the Medicare Savings Program (MSP), the Family Planning Benefit Program (FPBP), participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may, at renewal attest to the amount of their income, resources as appropriate, child/adult care expenses and to their residence, even if their address has changed since their last eligibility determination.

SSI-related recipients who are participating in the MBI-WPD program must continue to document their employment status.

All persons renewing and who do not have a resource test may attest to the amount of interest income generated by resources.

For persons other than those receiving chronic care, a reported change in circumstances may be treated as a renewal. A recipient's attestation of a change in circumstances by telephone is sufficient to re-budget the case, and a written statement documenting the change is no longer required. However, if the recipient requests to add an individual to the case, documentation requirements must be met.

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NOTE: When a recipient reports a change that does not require a new budget, such as an address change, the worker must confirm that no other changes in the household have occurred in order to consider this report as a renewal.

When the renewal is being handled by New York Health Options/the Enrollment Center and the individual reports a change within three months prior to the end of the authorization period and the LDSS is treating such report as a renewal, New York Health Options must be contacted by fax and requested to withdraw the renewal from HEART.

In counties that have combined Food Stamp (FS) and Medicaid units, renewals received for FS may also be used to renew the Medicaid case and authorize 12 months of Medicaid coverage if the A/R is found eligible for FS.

INCOME:

In lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration), the Work Number Website (TALX, used for obtaining employment and wage verification), the currently stored budget, or actual income documentation from a current Food Stamp or HEAP case. When using RFI, districts must only consider information from the most recent calendar quarter (the calendar quarter immediately preceding the current calendar quarter) as current. Information from any prior calendar quarter is to be considered a “no hit” on RFI. At any point after initial application, only Bendex and UIB may be regarded as primary sources of verification to close a case.

RESIDENCE:

Documentation of a change of address is not required at renewal unless the district has information to the contrary. If a renewal is returned to by the U.S. Postal Service with a forwarding address label, the renewal must be re-mailed to the new in-district address. No additional documentation of the address change is required. If the forwarding address label indicates the recipient lives in a different county, the renewal must be re-mailed to the new

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address. If the renewal is returned by the recipient, it must be processed by the district before the case is transitioned to the new district (See **OTHER ELIGIBILTIY REQUIREMENTS** STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY). Districts must discontinue coverage to persons who fail to respond to the renewal.

RESOURCES:

SSI-related recipients authorized for Community Coverage without Community-Based Long-Term Care and Community Coverage with Community-based Long-Term Care must itemize their current resources and attest to the value such resources. Districts must verify the accuracy of the resource information through collateral investigations. If there is an inconsistency in the information reported by the recipient and the current information obtained by the district, eligibility must be re-determined using the newly obtained information. If the SSI-related individual is found resource ineligible, eligibility must be determined for FHPlus or Medicaid under a category with no resource test. If the SSI-related individual is not eligible for FHPlus or Medicaid as a non-SSI-related recipient and further information about a resource is required to make a determination, the recipient must be notified to provide the necessary information. If the individual fails or refuses to provide such information, the case must be discontinued for failure or refusal to provide information necessary to make a determination.

INTEREST INCOME:

All community Medicaid recipients who are not seeking coverage of institutional based nursing facility services all FHPlus recipients, recipients of the Medicare Savings Program (MSP), the Family Planning Benefit Program (FPBP), participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may, at renewal attest to the amount of interest income generated by resources.

Interest income is estimated by establishing the average interest rate(s) and applying them to the resource information obtained from RFI or other third party sources. If upon review, the district

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finds an inconsistency between the information reported by the individual and the estimate calculated by the district, and the interest income information obtained by the district makes the individual ineligible for Medicaid or FHPlus, documentation of the interest income must be obtained from the individual. For individuals who qualify for Medicaid with a spenddown, the difference in the amount of interest income reported by the recipient must be greater than $1.00 per month before requiring further follow-up.

Districts must continue to review RFI reports to identify resources belonging to individuals who do not have a resource test to determine when a resource identified by RFI is significant enough to generate interest that would/could affect the individual's eligibility. In such instances, the district must request documentation of the interest income and re-calculate eligibility as appropriate.