OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

Description: An application for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, Medicare Savings Program, the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer Treatment Programs, and/or Medicaid Buy-In Program for Working People With Disabilities (MBI-WPD) is a written, dated form prescribed by the State. The applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting on behalf of the A/R must sign it.

Policy: An applicant requesting Medicaid, Family Health Plus, the Family Planning Benefit Program, Medicare Savings Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer Treatment Programs and/or Medicaid Buy-In Program for Working People With Disabilities may make application by dropping off an application to an LDSS or by mailing the application to the local district, facilitated enroller or other designated entity. Applicants may request assistance in understanding the Medicaid program or completing an application.

As of June 11, 2010, ALL applicants applying for Medicaid only, including applicants seeking coverage of long-term care services or nursing home care will make application for benefits on the Access NY Health Care application (DOH 4220). 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 the 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) should use the DOH-4328.

NOTE: For individuals applying on the DOH-4220, county specific absent parent forms must no longer be used.

The ACCESS NY Supplement A, DOH 4495A, 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. Supplement A must be signed and dated by the applicant and/or his/her representative and if appropriate, the applicant's spouse. An S/CC or ADC-Related applicant who requires temporary nursing home care is not required to complete Supplement A. However, if such S/CC or ADC-Related applicant has a community spouse and such

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spouse is in a medical institution and/or nursing facility and is likely to remain in the facility for at least 30 consecutive days, Supplement A must be completed.

NOTE: Effective April 1, 2010, an LDSS can no longer require that an application interview take place.

References:

SSL Sect. 366
366-a

Chapter 58 of the Laws of 2009

Dept. Reg. 360-2.2
360-2.3
360-2.4
360-6.2

ADMs 10 OHIP/ADM-4
04 OMM/ADM-6
04 OMM/ADM-5
03 OMM/ADM-4
01 OMM/ADM-6
97 OMM/ADM-2
95 ADM-17
93 ADM-29
93 ADM-3
91 ADM-28
90 ADM-9
88 ADM-31

GISs 08 MA/003
07 MA/027
07 MA/026
96 MA/015

Interpretation:

An application may be made by the applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting responsibly for him/her. The applicant or someone acting responsibly on the applicant's behalf must sign the application in ink. When both a husband and wife are applying, both spouses are required to sign the “State-prescribed form”. If only one spouse is applying, the non-applying spouse cannot be required to sign the application even though information concerning his/her financial circumstances is necessary to determine eligibility for the applying spouse.

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NOTE: If the applicant's representative signs the application, the LDSS must obtain a separate authorization from the applicant or a copy of legal guardianship. The applicant can identify the role of this person to: apply for and/or renew Medicaid, discuss his/her Medicaid application or case, and/or get copies of notices and agency correspondence. This authorization continues until it is revoked by the recipient; a reauthorization is not required at renewal. However, if the applicant is incompetent or incapacitated, a copy of the legal guardianship papers is not required, nor is a separate document authorizing the representative. In these situations, the LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant.

The date of application is the date that a signed "State-prescribed" application form, or a State-approved equivalent form or process is received by the LDSS. The application date for individuals who apply at outreach sites or facilitated enrollers is the date on which the application is started. For children under age 19 and pregnant women applying through the presumptive eligibility process, the application date is the date of the screening.

NOTE: An application is considered to be filed with the LDSS when an applicant submits a signed and dated application that includes his/her name and address. The LDSS may need more information to make a Medicaid eligibility determination, but the application date is protected.

A district cannot refuse an individual the right to apply. The applicant may be accompanied and assisted in the application process, if s/he wishes, by a person of his/her choice. The applicant may receive application assistance by an LDSS staff member, an FE, or designated staff at outreach sites such as family planning providers, providers who determine presumptive eligibility and hospitals with out-stationed workers. If requested, application assistance must be provided by the LDSS in person either as a walk-in or by appointment, over the telephone or in writing. Local departments of social services must work with the applicant or his/her representative to obtain any information missing from the application, including necessary documentation. (See **OTHER ELIGIBILITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL FACILITATED ENROLLERS)

Effective April 1, 2010, an in-person application interview with the applicant or his/her representative must not be required. Applicants for presumptive eligibility (PE) and family planning benefit program (FPBP) must be screened in person when they present at a facility for covered services by a PE provider.

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The applicant must be provided material describing the program and informing the applicant or representative of: (1) the eligibility requirements for Medicaid including the different Medicaid coverage options for persons who have a resource test; (2) the responsibility of the applicant to report all facts necessary for a proper determination of eligibility; (3) the joint responsibility of the district and the applicant to explore all facts concerning eligibility and the applicant's responsibility for securing, wherever possible, records or documents supporting his/her statements; (4) the types of verification needed; (5) the fact that any investigation essential to determine eligibility will be made; (6) the fact that the A/R may be reimbursed for paid Medicaid covered medical care and services received during the three months prior to the month of application and up until the actual date of application, if otherwise eligible; (7) the fact that after the date of application the A/R must use providers who accept Medicaid and who are Medicaid approved; and (8) the applicant's responsibility to immediately notify the district of all changes in his/her circumstances. This material/information is found in: LDSS-4148A, “What You Should Know About Your Rights and Responsibilities”; LDSS-4148B, “What You Should Know About Social Services Programs”; LDSS-4148C, “What You Should Know if You Have an Emergency”, also known as Books 1, 2 and 3. Local social services districts may either include this information with the application package that is either mailed or handed to the applicant(s), or the LDSS may send the booklets to the applicant(s) after they receive an application. However, the LDSS may not wait until eligibility is determined to send the information. If an ldss chooses to provide the booklets in the application package, and the LDSS receives an application printed from the internet, the information must be sent to the applicant.

NOTE: As a condition of eligibility, certain referrals to other LDSS units such as referrals to the Child Support Enforcement Unit (CSEU) are necessary. Although there is no face-to-face interview requirement, such required referrals have not been waived or eliminated.

As a result of mandatory managed care, most applicants for Medicaid must choose a managed care plan. Although choosing a Medicaid managed care plan is not a condition of eligibility, failure to do so will result in the applicant being assigned to one, also known as auto-assignment.

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Because FHPlus is a managed care only product, new applicants MUST select a managed care plan AND complete a managed care enrollment form as a condition of eligibility unless the A/R resides in a district that has only ONE Family Health Plus Plan. It is strongly recommended that A/Rs complete Section K of the DOH-4220 Access NY Health Care Application or Section 19 of the LDSS-2921 or the Medicaid Managed Care and Family Health Plus enrollment form whenever possible to enable the A/R to provide primary Care provider or health center choice information. If the person fails to do so, the enrollment must be entered in accordance with procedures outlined in 01 OMM/ADM 6 Section IV. C. 3. In districts that have more than ONE Family Health Plus Plan, an application is not complete unless a plan has been selected.

Prior to making a plan selection, all Medicaid and FHPlus applicants must be informed about the managed care program, available plans in the county and optional benefits. This is known as managed care "education". Managed care education may be conducted by mail, in person, by telephone or through FEs. Applicants may be referred to managed care workers or enrollment counselors at the time they choose to come into the LDSS to conduct business such as copying documents, requesting application assistance or to bring in required documentation. Districts must provide managed care education packets that include county specific information and a managed care contact for more detailed information.

MBI-WPD recipients with income below 150% of the federal poverty level may enroll in managed care. MBI-WPD recipients with income at or above 150% of the federal poverty level cannot be enrolled in managed care.

Persons in receipt of Medicare, regardless of their categorical status or income level cannot be enrolled in Medicaid managed care with some exceptions including Managed Long Term Care and Medicare Advantage Plans.

Applications for the Medicaid Cancer Treatment Program are received and processed by State DOH/OHIP staff. (See **CATEGORICAL FACTORS** MEDICAID CANCER TREATMENT PROGRAM (MCTP))

Medicaid applicants have the option of applying for:

1. Community Coverage without Long-Term Care which includes all Medicaid covered services except nursing facility services and

community based long-term care services. SSI-related Medicaid applicants who are not seeking coverage of long-term care services may attest to the amount of their resources rather than provide proof. (See **RESOURCES** DOCUMENTATION REQUIREMENTS)

2. Community Coverage with Community-Based Long-Term Care which includes all Medicaid covered care and services except nursing facility services. (See **RESOURCES** DOCUMENTATION REQUIREMENTS) SSI-related Medicaid applicants electing to apply for this coverage must provide proof of their current resources.
3. Medicaid coverage of all covered care and services which includes nursing facility services. SSI-related Medicaid applicants electing to apply for this coverage must provide documentation of resources for prior periods in accordance with transfer of resource policies. (See **RESOURCES** TRANSFER OF ASSETS)

Local districts must inform Medicaid applicants of the available coverage options and may require the applicant to sign a "Request for Medicaid Coverage" or an approved local equivalent, indicating the coverage choice an applicant made.

It is important that the applicant understand the eligibility determination process, including the effect that the documentation of resources options have on the services the SSI-related individual may receive. The applicant must also understand that it is his/her responsibility to keep the district informed of any change in his/her income and/or resources and the need for a service which s/he does not have coverage.

If an SSI-related recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of the new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. Districts must send the recipient a "Long-Term Care Change in Need Resource Checklist" and inform the recipient of the additional documentation that is needed to determine eligibility for long-term care.

The applicant is advised of his/her right to have an agency conference or to request a fair hearing, as appropriate. The applicant is also notified of other services for which s/he may be eligible.

Verification: All factors relating to the eligibility determination are verified. These include, but are not limited to: identity; citizenship or alien

status; family composition; residence; age; income from all sources; all resources of SSI-related applicants including savings and life insurance; and medical, accident and/or health insurance.

The LDSS must contact the applicant to get additional information that is required to make an eligibility determination. Options for obtaining information include: calling the applicant to get information over the phone and notating it on the application; if information is missing from the various sections of the application a photocopy of the incomplete pages may be mailed to the applicant to complete and return to the agency.

If the applicant is unable to provide the district with acceptable proof of his/her eligibility, collateral sources are used to secure verification. By signing the application, the applicant agrees to an investigation confirming any information s/he provided. However, it may be necessary, due to district procedures or requirements of outside agencies, to have a separate consent form signed by the applicant before collateral sources are contacted and information verified.

NOTE: If an SSI-related Medicaid applicant attests to his/her resources, the local social services district may continue to independently verify the accuracy of the information provided by the applicant. However, the Medicaid eligibility determination cannot be delayed pending this verification.

If the applicant claims paid or unpaid medical bills for the three-month period prior to the month of application, eligibility for that period must also be established. This three-month period is retroactive from the month in which the person applied. There is no three-month retroactive period for Family Health Plus or the Family Planning Benefit Program (FPBP). When an applicant eligible for Family Health Plus or FPBP has medical bills within the three months prior to application, the bills can only be paid if the A/R is financially eligible for Medicaid during the three-month retroactive period or has met his/her spenddown.

NOTE: A person does not have to be living to have unpaid medical expenses covered by Medicaid. A representative may apply on behalf of the deceased person. Medical expenses may be paid for a deceased person, provided the person was eligible at the time the medical service was rendered.

When providing application assistance to an applicant who has brought his/her application to the local department of social services,

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the LDSS may offer to screen the application, but may not require that the application be screened. If during the screening the LDSS finds that the case will be ineligible/denied based on income, the district must continue to process the application, request income documentation and render a decision with proper notice.

Documentation: Sufficient to establish an audit trail:

Photocopies may be used. A primary source for eligibility documentation is any previous case record.

When citing documents, the date, issuing authority, file number and such pertinent data as necessary to determine authenticity must be recorded in the applicant's file.

Applicants must show original or certified copies of documents that document identity and citizenship. These documents may be presented at the LDSS to an FE, designated staff at an outreach site including deputized workers, or to designated staff at an entity in the community with which the LDSS has established a Memorandum of Understanding (MOU) for purposes of verifying that original documents have been seen. (It is not necessary for the LDSS to enter into a separate agreement from those that currently exist with entities such as community based organizations (CBOs) or plan FEs, family planning providers, presumptive eligibility qualified entities or Article 28 prenatal care providers.) Such community organizations will not validate the authenticity of the documents, nor will they determine if the identity and/or citizenship documentation requirement has been satisfied.

Local departments of social services must allow applicants at least 10 days to provide requested documentation. If an applicant is requested to provide documentation necessary to make an eligibility determination and does not do so within the required time period and does not ask for more time or assistance in obtaining documentation, his/her application may be denied.

If an application is submitted and all necessary information is included, an application must not be denied due to the failure to provide information that is inconsequential. For example: An application must not be denied if supporting documentation of a water expense or childcare expense is not submitted if the applicant can be determined eligible without this deduction.

The determination of eligibility is made promptly, generally within 45

days of the date of application. Determinations for persons eligible under the poverty-based programs (pregnant women and children under age 19) are completed within 30 days. Determinations of eligibility based on a disability are completed within 90 days. Under certain circumstances additional time may be required, such as when there is a delay on the part of the applicant, an examining physician or because of an administrative or other emergency that could not be controlled by the district.

NOTE: If the district is waiting for essential information, the reason for the delay is noted in the record. The applicant is notified by letter of the reason for the delay in his/her eligibility determination. Although the DOH-4220 asks the applicant to list a Client Identification Number (CIN) or an identification number from a plan card, if this information is not provided, the ldss must not deny the application or request the information from the applicant.

Disposition:

The eligibility worker reviews the application for completeness and accuracy. The ldss must contact the applicant to obtain additional information that is needed to make an eligibility determination. If the application is being made through a facilitated enroller, the facilitated enroller does not forward the application to the district until the application is complete. (SEE **OTHER ELIGIBLITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL FACILITATED ENROLLERS) When the applicant fails or refuses to provide information essential to the eligibility determination, s/he is informed in writing that his/her application is denied, the reasons for the denial and his/her right to a fair hearing.

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.

If the LDSS believes that the applicant is the fiscal responsibility of another district, the ldss where the individual is applying may take a "courtesy application" and forward it to the district of fiscal responsibility. The agreed upon district of fiscal responsibility shall obtain any information missing from the application. (See **OTHER ELIGIBILITY REQUIREMENTS** DISTRICT OF FISCAL

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RESPONSIBILITY (DFR))

Exception: When an applicant claims to have a disability or when it appears that an applicant may meet the criteria for disability, the district has 90 days from the date of application to make a determination of eligibility. This 90-day period is not used as a waiting period before granting assistance, if the applicant is eligible under a different category. Coverage is authorized as soon as eligibility is established. A note is made in the record as a reminder to re-budget the recipient, adjust any spenddown amounts and claim FP coverage for the retroactive period when the A/R is certified disabled. When it is necessary to hold a potential disability case beyond the 90-day period, this is not a basis for denying Medicaid to an otherwise eligible applicant or for terminating assistance.