OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

Description: A decision on an application, reapplication, or recertification is a determination that the applicant is either eligible or ineligible for Medicaid.

Policy: A decision as to the A/R's eligibility is made within specified time periods for each new application, reapplication and recertification. Upon reaching a decision, a written notification of acceptance, denial, withdrawal, discontinuance, reduction or change in the spenddown calculation is sent to the applicant.

The Notice of Intent sent to Temporary Assistance A/Rs who have also applied for Medicaid contains a separate statement concerning Medicaid eligibility. Where the reason for denying the TA case is also a valid reason for denying Medicaid, it is stated separately in the Notice of Intent.

New SSI beneficiaries will receive a letter from New York State informing them that they are automatically eligible for Medicaid. This letter also requests the A/R to supply information concerning third party health insurance, and information on paid or incurred medical bills for the three months prior to the month of application.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.3
358-4.1
360-2.4
360-2.5
360-2.8
360-2.9

ADMs 10 OHIP/ADM-4
89 ADM-21
82 ADM-5

Interpretation: A determination of eligibility is made within a 45-day time period. A determination of eligibility for persons eligible under the poverty based programs (pregnant women and children under age 19) is completed within 30 days. The only exception to this are cases awaiting a disability determination. A 90-day time limit is applied to situations when a disability determination is being

OTHER ELIGIBILITY REQUIREMENTS

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made. (See **CATEGORICAL FACTORS** SSI-RELATED DISABILITY) If the eligibility determination process for a disabled applicant takes more than 90 days, on or before the 90th day, the A/R is sent a written statement stating the reasons for the delay. When the applicant is eligible under a different category, Medicaid is authorized for the interim period.

Each applicant for Medicaid is notified in writing of the local district's decision regarding his/her application. In the written notification, the applicant is informed of: the action taken, the effective date of the action, the specific reason(s) for the action whether positive or negative, including supporting regulations or laws; his/her right to a conference with a representative of the district; and of his/her right to a fair hearing including the method by which s/he may obtain a hearing. The applicant is also advised that s/he may be represented at any conference or fair hearing by someone such as legal counsel, or by a relative, friend or other person and of the availability of community legal services (Legal Aid), if any. A fair hearing request may be made on the basis of: denial of assistance; failure to determine the applicant's eligibility within the time period specified; inadequacy of the amount or manner of assistance; discontinuance or reduction of coverage or assistance; objection to State policy as it affects the applicant; or any other grounds affecting the applicant's entitlement to assistance. If a recipient requests a fair hearing within the time period specified in the notice, Medicaid is continued unchanged until a decision is issued on the Fair Hearing.

A separate Medicaid eligibility determination is completed for every TA case closed or denied where the A/R also applied for or was in receipt of Medicaid, except for cases when the reason for closing or denying TA is also a valid reason for closing or denying Medicaid. In all situations, the client is advised in a separate statement of the status of his/her Medicaid eligibility.

This section describes decision and notification in detail. It is organized as follows:

Acceptance;
Denial;
Withdrawal; and
Discontinuance or reduction.