OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

PREGNANT WOMEN

The local social services district will authorize Medicaid for the presumptively eligible woman. If the woman does not submit the required documentation by the date specified on the documentation checklist, without good cause, her presumptive case may be closed after appropriate notification.

Eligibility for pregnant women is determined as follows:

(a) If the net household income is equal to or less than 100% of the federal poverty level, the Medicaid level or Medicaid Standard (whichever is most beneficial), the woman and any infant under age one are fully eligible for all Medicaid services.

(b) If the net household income is above 100% of the federal poverty level and does not exceed 200% of the federal poverty level, the woman is eligible for ambulatory Medicaid prenatal care services and any infant under age one is fully eligible for all Medicaid services. If the net household income exceeds 200% of the federal poverty level, the pregnant woman is referred to the local social services district to determine eligibility for Medicaid under the "spenddown" provisions.

Disposition: A pregnant woman may be determined presumptively eligible for Medicaid. The provider completes a preliminary assessment of the woman's income and establishes her eligibility based on Department guidelines. If the woman's income is less than 100% of the federal poverty level, she is eligible for all ambulatory Medicaid services. When the income is above 100% but less than or equal to 200% of the poverty level, the pregnant woman is eligible for ambulatory prenatal care Medicaid services only. For the pregnant woman to continue her coverage past the period of presumptive eligibility, she submits the required documentation to the local social services district. Only one period of presumptive eligibility is allowed per pregnancy.

Presumptive Medicaid eligibility begins on the date the provider determines presumptive eligibility. This is usually the date of the pregnant woman's first visit or the date services were first rendered to her. This is also the date of application for on-going Medicaid. Presumptive eligibility continues until a finding of eligibility is made or if the woman does not file a Medicaid application, until the last day of the month following the month after the woman was first found to be presumptively eligible.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

Policy: Presumptive eligibility is a means of immediately providing Medicaid covered care and services to children under the age of 19. A Qualified Entity (QE) performs a preliminary assessment of the child's eligibility based upon guidelines established by the Department. If the child is found to be presumptively eligible for Medicaid s/he is provided full Medicaid care and services for a limited period of time during which a full determination of eligibility is performed.

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References: SSL Sect. 364-i4. (a)-(e)

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Interpretation: A child under the age of 19 is presumed eligible for full Medicaid coverage when a Qualified Entity determines that the child's household income does not exceed the appropriate federal poverty level (133% for children ages 1-5; 100% for children ages 6-18; and 200% for children under the age of 1).

The information used in the presumptive eligibility determination may be attested to and does not have to be verified in order to authorize presumptive coverage.

The household size is determined by counting the child and the mother of the applying child, and, if she is pregnant, count as 2 (mother plus the unborn child). Count the legal spouse and/or father of the child, if they live in the household. Count as 1 the Caretaker Relative (if no parents live in the household) and if the Caretaker Relative will also be applying for Medicaid. Count all of the children under age 21 in the household whether or not they are applying. Do not count persons who receive Temporary Cash Assistance or SSI cash assistance.

The following deductions from monthly gross income of the household (including the income of the caretaker relative, if they are part of the household count and are applying for Medicaid) are allowed: $90 from earned income (See **INCOME** ADC, LIF, AND S/CC-RELATED BUDGETING METHODOLOGY $90 WORK EXPENSE DISREGARD); child care from employment income (See **INCOME** ADC, LIF, AND S/CC-RELATED BUDGETING METHODOLOGY CHILD/INCAPACITATED ADULT CARE COST);

OTHER ELIGIBILITY REQUIREMENTS
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CHILDREN UNDER THE AGE OF 19

$100 from child support received (See **INCOME** ADC, LIF, AND S/CC-RELATED DISREGARDS); and health insurance premiums (See **INCOME** ADC, LIF, S/CC AND SSI-RELATED BUDGETING METHODOLOGY HEALTH INSURANCE PREMIUM), if not already deducted from the wages. Do not count grants, loans, or student wages or grants of Temporary Assistance (TA) and Supplemental Social Security Income (SSI). All resources are disregarded.

When the child under age 19's family income is equal to or less than the appropriate federal poverty level, s/he is presumptively eligible for all Medicaid covered care and services.

The qualified entity who has a signed MOU with SDOH:

- completes a personal screening interview with the A/R using the DOH-4441, "Medicaid Presumptive Eligibility for Children Screening Form";

- contacts the designated toll-free number to determine whether the screened eligible child is entitled to PE (**NOTE**: a child is entitled to only ONE period of PE in a 12 month period);

- provides the applying household a determination letter on the approved form, "Presumptive Eligibility for Children Screening Determination Letter", OHIP-0012 indicating their findings, and advises the applying household of the next steps in the process, which includes mandatory completion of a full application for Medicaid (DOH 4220, ACCESS NY Application) if eligible for PE, and/or referrals to the LDSS, or to a Facilitated Enroller if ineligible for PE.

- informs the applicant/representative of his/her rights and responsibilities as well as issuing required informational materials and brochures;

- assists the PE eligible applicant/representative with the "Access NY Health Care Application", DOH-4220 which must be completed, signed and properly documented in order for the LDSS to determine ongoing Medicaid eligibility. Responsibilities including requesting and compiling necessary documentation are delegated to the QE;

NOTE: QE's may enter into formal agreements with Facilitated Enrollers (FEs) to assist them in the Medicaid application,

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

documentation requirement and collection process. However, the QE continues to be responsible for the PE screening process and issuance of the PE screening determination form.

- forwards the completed application package (the PE for Children Screening form; PE for Children Determination letter; DOH 4220 application form; and, all documentation needed to determine eligibility) within 21 days from the date of initial screening (or within a reasonable extended timeframe if the applicant is making a good-faith effort to secure necessary documentation).

- QEs are not to forward completed PE screening forms to the LDSS for children who do not screen as PE eligible. The QE should provide the ineligible household with the DOH-4220 application form to complete and submit to a Facilitated Enroller or to the LDSS. Children are to be referred to FEs and/or Child Health Plus health plans.

The local social services district:

- designates one or more staff as a liaison to the designated QEs;

- accepts completed PE/MA application packets from the QE and processes them in a timely manner, but in no event later than 30 days from the date of the QE screening/assessment for pregnant women and children, and within 45 days for all other applications not requiring a disability determination;

- allows for a reasonable extension of time and extends PE coverage so that the applying household and/or the QE/FE can obtain required documentation;

- determines eligibility for the 3-month retroactive period as appropriate **NOTE**: Retroactive eligibility cannot be provided to children who are eligible for presumptive coverage only ;

- provides notice of the results of the final Medicaid eligibility determination simultaneously to the applicant and the QE including the CIN for billing purposes;

- documents in the case record delays in the receipt of completed applications from the QE that result in untimely determinations of eligibility;

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

- open and maintain Medicaid case (s) including all undercare and renewals for individuals found eligible for ongoing coverage for a period of no less than 12 months from the date of screening/application. If the PE-only eligible child turns age 19 during the PE authorization period, authorizes the PE-only case to the last day of the month in which the child turns age19;

Disposition:

Parents/guardians of children up to age 19 may attest to basic information including citizenship, identity, residency, household size and composition and income during a brief interview with a Qualified Entity. The QE may provide services under Medicaid presumptive eligibility when the screened child's estimated family income (after applying simple disregards), does not exceed the applicable income standards. The PE eligible child may receive all care, services and supplies covered by the Medicaid program, from any Medicaid enrolled provider, prior to a full Medicaid determination by the LDSS. A CBIC card will not be issued for the PE period. Cards will be issued only for fully eligible MA children.

Children screened eligible for PE may receive ONE presumptive coverage authorization period in a 12-month period. Children found fully eligible will be authorized for no less than 12 months of Medicaid coverage OR through the last day of the month in which their 19th birthday occurs, whichever is earlier.

A completed MA application, DOH 4220, must be submitted by the QE along with the PE screening form and supporting documentation.