OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

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))

SSI-related 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 the past 60 months in accordance with transfer of resource policies. (See **RESOURCES** TRANSFER OF ASSETS)

Local districts must inform SSI-related 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 a recipient has active community coverage (with or without long term care) and subsequently is admitted to a nursing facility, Supplement A must be completed and resource and trust documentation submitted for the appropriate time period(s).

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.