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Recipients are not required to document and verify items that remain constant, such as age and identity. However, some of the information printed on the renewal form such as a person moving into the household, health insurance premiums and new health insurance whether the premium is paid by the individual or the local social services district, and the employment of MBI-WPD participants must be documented.

If a recipient is paying a health insurance premium and fails to document the premium amount and s/he is eligible without the deduction, the case must be processed without the deduction. If the recipient needs the deduction to remain eligible OR the local department of social services is reimbursing the recipient for the premium (other than a Medicare premium), the case must be pended and the documentation requirements form (LDSS-2642) sent, allowing 10 days for the recipient to submit proof of the payment or premium. If the recipient fails to respond to the request for documentation, the case must be re-budgeted without the premium amount as a deduction and reimbursement of premiums are discontinued with appropriate notice.

Recipients who are, or expect to be participating in the excess income program will be requested to submit proof of their income (and child/adult care and third party health insurance) so that their spenddown amount can be calculated as precisely as possible. If a recipient who is eligible to participate in the Excess Income program fails to document income, eligibility must be based on the income the recipient has attested to. SSI-related Medicaid recipients who are receiving or seeking institutional based nursing facility services are required to document their income, current resources and new residence. However, if these individuals fail to submit documentation of income, new residence, resources or other required information, districts must send a documentation requirements form (LDSS-2642) requesting the missing documentation. If the recipient does not return the requested documentation within 10 days, districts must not discontinue coverage, but must authorize Community Coverage with Community-based Long-Term Care, if the individual remains otherwise eligible.

SSI-related individuals in receipt of Community Coverage without Community-Based Long Term Care OR Community Coverage with Community-Based Long Term Care who request an increase in coverage to Community Coverage with Community-Based Long Term

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care or Medicaid coverage of institutional based nursing facility services respectively, must document income and resources including resource documentation for the full transfer of assets look back period for coverage of institutional-based nursing services.

Supplemental Security Income (SSI) recipients that lose eligibility for such benefits are given an extension to allow for continued Medicaid eligibility to be determined. If the former SSI recipient is in receipt of Community-based Long-term Care services he/she must document income and resources as part of the redetermination process. At subsequent renewals, the individual is allowed to attest to income and resources.

All SSI cash recipients who enter a nursing facility and appear on the SDX with a "Pay Status Code" of EO1 (eligible - no payment) are sent a letter by the district informing them of their continued eligibility for Medicaid. In addition, the income of these individuals is reviewed to determine the amount, if any, of their net available monthly income (NAMI) to be contributed toward the cost of care.

NOTE: Documentation of income, residence and resources, as appropriate, at initial application is still required for ALL applicants.