OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

Description: An application for Medicaid, ***Family Health Plus, Child Health Plus A, the Family Planning Benefit Program, Medicare Savings Program, Breast and Cervical Cancer Treatment Program, 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 responsibly for him/her, must sign it.

Policy: An applicant requesting Medicaid, ***Family Health Plus, Child Health Plus A, and/or the Family Planning Benefit Program,*** must make application in person, through another person acting on his/her behalf, or by mail to the ***local*** district, ***or facilitated enroller or other designated entity***. An applicant requesting ***MBI-WPD or who needs Medicaid coverage for long-term care services, such as nursing home, personal care or home care,*** must make application in person, through another person acting on his/her behalf, or by mail to the ***local*** district***.*** When an application is made by mail, a personal interview is conducted with the applicant or with his/her representative at a site designated to receive applications.

References:

SSL Sect. 366
366-a

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

ADMs ***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
90 ADM-9
88 ADM-31

GIS 96 MA/015

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Interpretation:

An application may be made by the applicant in person, 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.

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 ***facilitated enroller or the local district***. The application date for individuals who apply at outreach sites ***or facilitated enrollers*** is the date on which the ***signed and completed*** application is received at such sites. 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. If need be, the applicant may be assisted by a district staff member in the completion of the application. ***(See page 365.1 for information about facilitated enrollers).***

A personal interview is conducted with the applicant or his/her representative. There is an exception. A personal interview is not required for any child who has been placed in the custody of the Office of Children and Family Services or the local social services Commissioner. Generally, no decision or authorization may be made prior to the face-to-face interview, unless the interview is waived.

When the application is only for a pregnant woman and/or children under the age of 19, the personal interview may be conducted by an outreach provider's staff, a **Prenatal Care Assistance Program** (PCAP), or a qualified provider **(designated entity)**.

When the application is for the Family Planning Benefit Program (FPBP) only, designated entities, such as family planning providers, who have a memorandum of understanding (MOU) with the local district can assist in the application process. Districts are encouraged to work with these entities, so that the application process can be facilitated, including the delegation of the face-to-face interview. All applications taken by these family planning providers who have an MOU with the district will be forwarded to the district for final eligibility determinations.

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At the time of the personal interview the applicant ***is 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.

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. An application is not complete unless a plan has been selected. Even in local districts where there is only one plan available, the applicant must complete the Managed Care Organization enrollment form before the application can be accepted. Prior to making a plan selection, applicants must be informed about managed care and the managed care options available to them.

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 managed care.

Applications for the Breast and Cervical Cancer Treatment Program are received and processed by State DOH/OMM staff (see pages 40.3 – 40.4).

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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. 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 page 303.4).***

2. ***Community Coverage with Community-Based Long-Term Care which includes all Medicaid covered care and services except nursing facility services (see page 303.9). 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. Medicaid applicants electing to apply for this coverage must provide documentation of resources for the past 36 months (60 months for trusts) immediately preceding the date the individual requests coverage (see page 353). Single Individuals and Childless Couples must provide resource documentation for the past 12 months (see page 361).***

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 s/he 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 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

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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 Process: 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, when appropriate, including savings and life insurance; and medical, accident and/or health insurance. 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 a 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. When an applicant eligible for Family Health Plus 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.***

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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.

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.

Disposition: The interviewer, together with the applicant and/or his/her representative, reviews the application for completeness and accuracy. If the applicant has not provided all the required documents, the application is held until the district receives the documents. ***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.*** 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.

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, such as a birth certificate from another State and it will take more than the appropriate time, 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.

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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.