OTHER ELIGIBILITY REQUIREMENTS

NEW APPLICATION

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 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, 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.

OTHER ELIGIBILITY REQUIREMENTS

NEW APPLICATION

Applications for the Breast and Cervical Cancer Treatment Program are received and processed by State DOH/OMM staff (See **CATEGORICAL FACTORS** MEDICAID CANCER TREATMENT PROGRAM (MCTP) BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER).