CHAPTER M01

APPLICATION *FOR* MEDICA*L ASSISTANCE*

M01 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	Table of Contents

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CHAPTER M01

APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 10

GENERAL INFORMATION

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
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TN #93	1/1/10	Pages 1, 6

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M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Virginia's two medical assistance programs are Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS). Collectively, these programs are referred to as medical assistance (MA). The MA programs pay medical service providers for medical services rendered to eligible individuals. When an individual submits an application for MA, his eligibility is determined for Medicaid first. If he is not eligible for Medicaid due to excess income, his eligibility is determined for FAMIS.

The policies and procedures for determining Medicaid eligibility are contained in Chapters 1 through 18 of this manual; the policies and procedures for determining FAMIS eligibility for children and pregnant women (FAMIS MOMS) are contained in Chapters 21 and 22, respectively.

The MA eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia MA must be made on an approved electronic or paper application form or telephonically through the Cover Virginia Call Center.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the MA programs and be conducted in a manner which respects the personal dignity and privacy of the individual.

B. Legal Base

The Medicaid Program is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia. The FAMIS program is established under Title XXI of the Social Security Act.

Virginia law provides that the MA programs be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Virginia Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Behavioral Health and Developmental Services (DBHDS) facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1. DMAS

The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,

- the determination of medical care covered under the State Plan,
- *oversight of the Cover Virginia Call Center and Central Processing Unit (CPU), which handles telephonic applications for MA, adding people to existing MA cases, processing referrals from the Health Insurance Marketplace (HIM) and eligibility determinations/ongoing case maintenance for the Governor's Access Plan (GAP).*
- the handling of appeals related to the MA programs,
- the approval of providers authorized to provide medical care and receive payments under the MA programs,
- the processing of claims and making payments to medical providers, and
- the recovery of MA expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and FAMIS,
- the enrollment of eligible persons in the Medicaid or FAMIS programs,
- the maintenance of case records pertaining to the eligibility of MA enrollees,
- the referral of individuals with inappropriate MA payments to the DMAS Recipient Audit Unit, and
- the referral of certain individuals to the Health Insurance Marketplace.

M0110.110 Confidentiality

***A.* Confidentiality**

MA applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their information.

***B.* Release of Client Information**

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the MA programs, which include but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

C. Use of System Searches

Searches of online information systems, including but not limited to the State Online Query-Internet (SOLQ-I),the State Verification Exchange System (SVES) *and the Federal Data Hub* are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

The Federal Data Hub is to be accessed only for information necessary to determine eligibility for MA cases processed in the Virginia Case Management System (VaCMS). It may not be used for other public assistance programs.

D. Release of Information to Medical Providers

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Virginia *MA* providers by DMAS without the applicant's/enrollee's consent. Enrollee consent is not needed for the DSS agency to provide confirmation of an individual's eligibility, the dates of eligibility, and any patient pay responsibility if the medical provider is unable to obtain that information from the member verification system or from DMAS staff. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources because the provider does not need that information for medical treatment or payment.

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Providers and their contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record. Information should not be provided from case records unless the release of such information is for purposes directly related to the administration of the *MA programs*.

Local agencies may release *MA* enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is being released to an identifiable provider.

E. Release to Authorized Representatives *and Other Application Assistants*

1. Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative.

It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

2. Application Assistants

Application assistants are authorized under the Affordable Care Act (ACA) to provide assistance with completing the MA application and renewal, and with explaining and helping the individual to meet documentation requirements. They must be authorized by the individual, but they ***cannot*** *sign forms, receive notices or other communications or otherwise act on behalf of the individual.*

Although they do not have the same CommonHelp system privileges as authorized representatives, Certified Application Counselors (CAC) and Navigators are permitted access to certain information regarding an applicant's MA eligibility without a separate authorization from the applicant when they have assisted with the application.

a. Certified Application Counselors

CAC are individuals authorized to assist individuals with obtaining health insurance coverage, including Medical Assistance. CAC are generally under the supervision of a non-profit organization and do not receive a fee for providing application counseling.

b. Navigators

Navigators receive federal funding to assist individuals with obtaining health insurance coverage, including Medical Assistance.

F. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

G. Ownership of Records

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

H. Release of Client Information with Consent

As part of the application process for *MA*, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in M0110.110 B above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent is to be documented in the case record.

I. Release of Client Information without Consent

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, the U.S. Citizenship and Immigration Services (USCIS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with USCIS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in the following situations:

1. Social Services Employees

to employees of state and local departments of social services for the purpose of program administration;

2. Program Staff in Other States — to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;

3. DMAS & LDSS Staff — between state/local department of social services staff and DMAS for the purpose of supervision and reporting;

4. Auditors — to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and

5. For Recovery Purposes — for the purpose of recovery of monies for which third parties are liable for payment of claims.

J. Client's Right of Access to Information

Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality

1. Freedom of Information Act (FOIA)

Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.

2. Client May Be Accompanied

The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:

- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,

The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

3. Client May Contest Information

Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified.

When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

M0110.120 Address Confidentiality Program (ACP)

A. Purpose

The Virginia Attorney General's Office's ACP was created to help a victim of domestic violence who has recently moved to a new location that is unknown to the abuser. The victim wants to keep the new address confidential. Effective July 1, 2011, this program was made available statewide.

B. All Mail Goes to Richmond P.O. Box Address

The ACP offers a substitute mailing address for the individual in a high risk situation. An individual participating in the ACP will have an ACP authorization card that can be used to verify participation in the program; a participant will use a post office box address in Richmond as his address. This address is to be accepted as a mailing address. No locality, FIPS code, or other geographic identification is included on the ACP authorization card.

The actual physical address of the participant **MUST NOT** be entered in into any of the VDSS automated systems. Only the mailing address (which is P.O. Box 1133, Richmond, Virginia, 23218) is entered into the computer systems as the participant's residence address; no separate mailing address is entered.

C. Accept Participant's Verbal Statement of Residency

Virginia state residency and locality residency is established by the participant's verbal statement that he is residing in the locality where he is applying for assistance.

D. Third Party Liability (TPL)

When an individual in the ACP is covered on the abuser's private health insurance plan (TPL), do not add the TPL coverage in the enrollment system. For an individual with TPL who is already receiving MA at the time of entry into the ACP, delete the TPL. Notify the DMAS TPL Unit by e-mail at tplunit@dmas.virginia.gov to ensure that the insurance is not billed or added back to the individual's case record upon a subsequent data match with the insurance company.

E. Refer to Local Domestic Violence Program

Please refer any victims of domestic violence to the local Domestic Violence Program for consideration of the ACP, for safety planning, and other services. Local domestic violence advocates are currently receiving training about the ACP. In most localities, the applications for the ACP program will be completed with the DV advocates as a part of in depth safety planning.

M0110.200 Definitions

A. Adult Relative

means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.

B. Applicant

means an individual who has directly or through his authorized representative made written application for MA at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.

C. Application for Medical Assistance means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application for the Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.

D. Attorney-In-Fact (Named in a Power of Attorney Document) means a person authorized by a power of attorney document (also referred to as a "POA") to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney-in-fact to apply for *MA* on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine if it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

E. Authorized Representative An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative's responsibilities). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative. An individual's spouse is permitted to be an authorized representative for *MA* purposes as long as the spouse and applicant are living together, or lived together immediately before the applicant's institutionalization; no written designation is required.

EXCEPTION: Staff in DBHDS facilities may also act as authorized representatives in their facilities without a written statement.

F. Child means an individual under age 21 years.

G. Competent Individual means an individual who has **not** been judged by a court to be legally incapacitated.

H. Conservator means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

I. Family Substitute Representative means a spouse age 18 or older or designated relative age 18 or older who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.

J. Guardian means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

K. Incapacitated Individual means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.

L. Legal Emancipation of a Minor means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

M. Medical Assistance means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, FAMIS and FAMIS MOMS.

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

1. Explanation of the *Medical Assistance Programs* The local agency must furnish the following information in written form, and orally as appropriate, to all applicants and enrollees, and to other individuals upon request:

- the eligibility requirements,
- services covered *under the MA programs,*

- the rights and responsibilities of applicants and enrollees, and
- the appeals process.

When the *MA* rights and responsibilities are explained verbally, the eligibility worker must document in the case record (electronic or hard copy) that they were explained and the applicant/enrollee's acknowledgement. The applicant/enrollee's failure to acknowledge receipt of the rights and responsibilities is not a condition for *MA* eligibility and cannot be used to deny, delay or terminate *MA* coverage.

The following materials must be given to the individuals specified below:

- The brochure "Virginia Department of Social Services Division of Benefit Programs," form # B032-01-0002, contains information about the Medicaid Program and must be given to all applicants;

- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; and

- *A copy of the handbook corresponding to the program in which the individual was enrolled* must be given to all recipients and must be given to others upon request.

Applicants may also be given *MA* Fact Sheets as appropriate.

2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

3. Voter Registration

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each *Temporary Assistance to Needy Families* (TANF), *Supplemental Nutrition Assistance Program (*SNAP), and *MA* applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and enrollee the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

a. Exceptions to Offering Voter Registration

The only exception to offering voter registration application services is when:

- the individual has previously indicated that he is currently registered to vote where he lives,
- there is a completed agency certification form in the individual's case record indicating the same, and
- the individual has not moved from the address where he stated that he was registered to vote.

b. Prohibitions

Local social services agencies and agency staff are prohibited from the following activities when providing voter registration application services:

- seeking to influence an individual's political preference;
- displaying any political preference or party affiliation;
- making any statement to the or taking any action the purpose or effect of which is to discourage the individual from applying to register to vote; or
- making any statement to an individual or taking any action the purpose of which is to lead the individual to believe that a decision to register or not register has any impact on the individual's eligibility for assistance or the benefit level that they may be entitled to receive.

c. Voter Registration Services

Each local social services agency must provide the following voter registration services:

- distribution of voter registration application forms;
- assistance to individuals in completing the registration application form, unless such assistance is refused, and ensuring that all spaces on the form are completed;
- ensuring that the certification statement on the application for benefits or statement of facts is completed; and
- acceptance of voter registration application forms for transmittal to the local general registrar.

1) Each completed registration application must be submitted to the local general registrar every Friday (if Friday is a holiday, the forms must be forwarded to the local registrar on the last working day before Friday.) Completed forms are to be forwarded to the local registrar in an envelope, notated with an "A" in the upper left-hand corner and listing the number of completed registration applications included in the envelope.

1) For split/combined agencies, all voter registration applications are to be transmitted to the general registrar in the locality where the local social services agency is located.

2) If the individual chooses, he may take a voter registration application to be mailed to the State Board of Elections at his own cost.

d. Voter Registration Application

In Virginia, one voter registration application form will be used to serve a twofold purpose:

- the voter registration application will be completed by the individual with necessary assistance from local agency staff during the

  application/review process and left at the local agency for transmittal to the local general registrar; or

- for individuals who do not wish to complete the voter registration during the application process, they may take a voter registration form for mail-in registration.

e. **Individuals Required to be Offered Voter Registration Services**

In order to be offered voter registration services, an individual must:

- be a member of the *MA household or* family unit.

- be at least 18 years old by the next general election. General elections are held in all localities on the Tuesday after the first Monday in November or on the first Tuesday in May to fill offices regularly scheduled by law to be filled at those times.

  If any question arises as to whether the individual will turn 18 before the next general election, complete the registration application and the local registrar will determine if the individual may be registered.

- be present in the office at the time of the application or renewal interview if an interview takes place, or when a change of address is reported in person. If a change of address is not reported in person, a registration application will be sent to the individual upon request. Any change in the *household* composition that does not occur concurrent with an application, renewal or change of address will be handled at the next scheduled renewal.

Any individual accompanying the applicant/enrollee to the local agency who is not a member of the assistance unit (including payees and authorized representatives) will not be offered voter registration services by the local agency. However, a registration application is to be provided to the non-unit member upon request.

Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.

f. **Voter Registration Application Sites**

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, SNAP, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking *MA* applications at hospitals or local health departments and by Medicaid staff at the state's *Department of Behavioral Health and Developmental Services'* facilities.

B. Information Made Available to the Public in General

1. Availability of Manual

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services. *The full Medicaid Eligibility Manual is available on the Virginia DSS web site at www.dss.virgninia.gov*.

2. MA Handbooks and Fact Sheets

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The handbooks *available for each MA program* include basic information about the programs and provide a listing of rights and responsibilities. To supplement the *MA* handbooks, fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. *A copy of the handbook corresponding to the program in which the individual was enrolled* must be given to all recipients *after enrollment* and must be given to others upon request. The handbook is also available on the internet at www.dmas.state.va.us.

C. Inquiries

1. General Inquiries

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, MA handbooks, or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at www.dss.state.va.us and the Virginia Department of Medical Assistance Services website at www.dmas.state.va.us for additional information.

- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" should not be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.

- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional *MA* consultants, and central office *MA* employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for MA.

All *MA* staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state *MA* staff.

2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional *MA* consultant. Do not refer questions from attorneys (or legal questions in general) to the *Office of the* Attorney General. These attorneys are responsible for providing legal advice to the regional *MA* consultant and are not authorized to give legal advice to the public.

M0110.400 Retention of Case Information

A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. Records of active cases must be maintained for as long as the client receives benefits, while closed records must be maintained for a minimum of three years from the date of closure.

B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,
- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under the medical assistance programs. Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications.

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the *MA* programs *are* being administered.

M0110.500 VIRGINIA DSS STRENGTHENING FAMILIES INITIATIVE PRACTICE MODEL

A. Introduction

The Virginia DSS Strengthening Families Initiative (SFI) Practice Model sets forth standards of professional practice and serves as a values framework to define relationships, guide thinking and decision-making, and structure beliefs about individuals, families, and communities. The Practice Model suggests a desired approach to working with and delivering services to Virginia's citizens.

B. Practice Model Principles

The principles of the Practice Model are:

1. All children, adults and communities deserve to be safe and stable.
2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.
3. Self-sufficiency and personal accountability are essential for individual and family well-being.
4. All individuals know themselves best and should be treated with dignity and respect.
5. When partnering with others to support individual and family success, we use an integrated service approach.
6. How we do our work has a direct impact on the well-being of the individuals, families, and communities we serve.

M0110, Appendix 1 contains the full SFI Practice Model.

C. Policy

Medicaid and other benefit programs are designed to provide supportive benefits to assist families who are unable to provide the necessities of life and maintain minimum standards of health and well-being through their own efforts. Gathering relevant information about a family's situation and evaluating that information against the eligibility criteria for the benefit programs are the basis for making the eligibility determinations.

The process of gathering relevant information also includes an assessment of need for service programs and other resources to assist the family. This process includes following the Practice Model described above. If other needs exist, the eligibility worker must refer the family for appropriate services or resources within the agency or community. Eligibility workers may consult with their supervisors and other agency staff as necessary to gather information to facilitate making such referrals.

VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Virginia Department of Social Services
Strengthening Families Initiative Practice Model

The Virginia Department of Social Services Practice Model sets forth our standards of professional practice and serves as a values framework that defines relationships, guides thinking and decision-making and structures our beliefs about individuals, families and communities. We approach our work every day based on various personal and professional experiences. While our experiences impact the choices we make, our Practice Model suggest s a desired approach to working with others and provides a clear model of practice, inclusive of all agency programs and services, that outlines how our system successfully practices. Central to our practice is the family. Guided by this model, we strive to continuously improve the ways in which we deliver programs and services to Virginia's citizens.

1. All children, adults and communities deserve to be safe and stable.

- Every child has the right to live in a safe home, attend a safe school and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and community partners and across all programs and services.

- Every adult has the right to live and work in a safe environment. We value all programs that address domestic and family violence and the abuse, neglect and exploitation of older or incapacitated adults.

- We value individual and family strengths, perspectives, goals and plans as central to creating and maintaining a safe environment. The meaningful engagement and participation of children, adults, extended fa mily and community stakeholders is a necessary component of assuring safety.

- When legal action is necessary to ensure the safety of a child and/or an adult, we use our authority with respect and sensitivity.

- Individuals are best served when services are person-centered, family-focused and community-based and aim to preserve the family unit and prevent family disruption.

2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.

- We believe mothers, fathers, and children thrive in safe, stable, healthy families. We value family structures that support the best interests of children; however, we believe that children do best when raised in intact, two-parent families.

- Both parents should be actively involved in the lives of their children, even if they are not the primary caregiver.

- Healthy, lifelong family connections are crucial to the development of children, the stability of the family and the support of infirm, dependent or aging adults. Through the services we provide, we seek out, promote and preserve these healthy ties to family members and to others in the community to whom the family is connected or who may provide support.

3. Self-sufficiency and personal accountability are essential for individual and family well-being.

- Family members support each other in ways the social services system cannot. We value the intra-family resources and supports that are available within the context of any family as a pathway to self-sufficiency and personal accountability.

- We believe employment, training and education are keys to self-sufficiency. We believe in employment and training programs that remove barriers and create opportunities for individuals and families.

- Individuals and families face unique challenges that impact their ability to maintain self-sufficiency. We value all programs and services that assist individuals and families to regain and maintain self-sufficiency and achieve personal accountability.

- Both custodial and noncustodial parents should provide necessary financial resources to support their children.

- We believe that parents and caregivers serve as role models in teaching the importance of self-sufficiency and personal accountability.

- We support asset development strategies to help individuals and families weather short-term emergencies and improve long-term stability.

4. All individuals know themselves best and should be treated with dignity and respect.

- All programs and services should be culturally and linguistically sensitive to all individuals.

- Individuals and families are empowered when they have access to information and resources.

- We support programs for vulnerable populations including children, the elderly and individuals with disabilities.

- The measure of success differs with every individual. We strive to understand children, adults, and families wit hin the context of their own values, traditions, history and culture.

- The voices of children, individuals and families are heard, valued and included in decision-making processes related to programs and services.

5. When partnering with others to support individual and family success, we use an integrated service approach.

- Cooperation, coordination and collaboration within and outside of the social services system are essential to providing the most comprehensive services to families. We are committed to working across programs, divisions, agencies, stakeholder groups and communities to improve outcomes for the childre n, individuals, families and communities we serve.

- Through the development of policies, procedures, standards and agreements across systems, we will share information, solve problems and overcome barriers.

- We value prevention networks that link effective public and private programs and community-based organizations that identify individuals and families before they need services.

- We believe in partnering across programs and systems in order to provide a full array of services along the continuum of care. We are committed to working within and outside of the social services system to identify and address service gaps.

6. How we do our work has a direct impact on the well-being of the individuals, families and communities we serve.

- Children, individuals and families deserve trained, skillful professionals to engage and assist them. We hire, develop and maintain a workforce that aligns with our practice model.

- Clear expectations, effective supervision, leadership and proper resource supports are critical for the workforce to do their job effectively.

- We believe in creating and maintaining a supportive working and learning environment with accountability at all levels.

- We value the provision of high-quality, timely, efficient and effective services. We believe relationships and communication should be conducted with honesty, transparency, integrity, empathy and respect within and outside of our social services system.

- The collection and sharing of accurate, outcome-driven data and evidence-based information is a critical part of how we continually learn and improve. We use data to inform, manage, improve practice, measure effectiveness and guide decisions.

CHAPTER M01
APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 20

MEDICAL* ASSISTANCE *APPLICATION

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

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M0120.000 MEDICAL ASSISTANCE APPLICATION

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M0120.000 Medical Assistance Application

M0120.100 Applying for Medical Assistance

A. Right to Apply

An individual cannot be refused the right to complete an application for medical assistance (MA) for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

B. Signed Application Required

An application for MA must be signed to be valid. Paper forms must bear the signature of the applicant or an individual authorized to apply on his behalf. Applications submitted electronically or through the approved telephonic process meet the signature requirement.

1. Unsigned Application

A paper application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

2. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. *For paper applications*, return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

If an electronic application does not bear a valid signature, the agency must obtain a valid signature from the applicant or his authorized representative for the case record. The signature page of a paper application form can be used.

M0120.150 When An Application Is Required

A. New Application Required

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

B. Application NOT Required

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. *An application is not needed for a child turning age one when the child was deemed to be eligible based on the mother's enrollment at the time of birth. A renewal following the procedures in M1520 must be completed when the child turns one.*

Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

M0120.200 Who Can Sign the Application

A. Individuals in State Facilities

Staff with certain Virginia state agencies may assist individuals who are in state residential facilities in applying medical assistance.

1. Patients in DBHDS Facilities

Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications *signed and submitted* by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.

2. Incarcerated Individuals

Inmates of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted by DOC or DJJ staff.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the “committee” for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. A spouse, aged 18 or older, may sign the application for his spouse when they are living together.

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant cannot sign his or her name on a paper application but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature:_____

1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative’s responsibilities). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.

EXCEPTION: Patients in the DBHDS facilities may have applications submitted by DBHDS staff.

2. Family Substitute Representative

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is age 18 years or older and is willing to take responsibility for the applicant's MA business will be the applicant's "family substitute" representative. The family substitute representative will be, in this preferred order, the applicant's:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

3. No Individual authorized to sign

If the applicant is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, the applicant's inability to sign the application must be verified. Verification is by a written statement from the applicant's doctor that says that the applicant is not able to sign the *MA* application because of the applicant's diagnosis or condition. Follow these procedures:

a. Determine if anyone has begun the process to have a guardian or conservator appointed for the applicant.

b. If action has been initiated to obtain a guardian for the applicant, meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

   If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send written notice to the applicant to extend the pending application.

   Once the guardian/conservator has been appointed, request verification of the appointment and that the application be signed by the guardian or conservator. Retain a copy of the application and mail the original application to the guardian/conservator. Allow 10 days for the signed application and guardian/conservator papers to be returned. If the application form and guardian/conservator papers are not returned to the agency by the specified date, deny the application because it is invalid.

c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

   If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

   Continue to pend the application until the APS investigation is completed. If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the applicant, or the applicant must sign a statement designating an authorized representative. Give the applicant 10 working days to return the signed application to the agency.

d. If the application form is not signed by the applicant or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

4. Procedure for Who Can Sign the Application

When preparing to determine the *MA* eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for *MA* for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for *MA* on his behalf?

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for *MA* on his behalf. Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY *MA* because of an invalid application.

NO: Does the applicant have at least one of the following who is age 18 or older:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny *MA*.

C. Applicants Under Age 18

1. Child Applicant

A child under age 18 years is not legally able to sign his own *MA* application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals who is age 18 or older must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for MA for his own child because he is the parent of the child.

3. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application form, posted on SPARK at *http://spark.dss.virginia.gov/divisions/dfs/iv_e/* is used for the IV-E Foster Care eligibility determination. A separate MA application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an MA application for the child.

b. Non-IV-E

The Cover Virginia Application for Health Coverage & Help Paying Costs is used for the MA eligibility determination of a **non-IV-E** Foster Care *child. Applications for non-IV-E Foster Care children may also be filed online.* The MA application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, an MA application form must be filed and the parent or legal guardian must sign the application.

4. Adoption Assistance & Special Medical Needs Children

a. IV-E

A separate *MA* application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the *MA* application form.

b. Non-IV-E

Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.

1) Placed by a Virginia agency

A*n MA* application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency. The child's adoptive parent signs and files the application for the child.

2) Placed by another state

Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the *MA* application form and a separate application is not required when:

- the other state is an ICAMA member state, and
- the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non-Title IV-E Adoption Assistance children.

All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in M0120, Appendix 3.

A*n MA* application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate. The child's adoptive parent signs and files the *MA* application for the child.

D. Deceased Applicant

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

- the deceased received a Medicaid-covered service on or before the date of death, and
- the date of service was within a month covered by the *MA* application.

If the above conditions were met, an application may be made by any of the following:

- his guardian or conservator,
- attorney-in-fact,
- executor or administrator of his estate
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain *MA* payment file a*n MA* application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

Retroactive FAMIS coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month.

E. Enrollee Turns 18

When a child who is enrolled in *MA* Medicaid turns 18, it is not necessary to obtain a new application signed by the enrollee.

As long as the enrollee is under age 21, he does not need to authorize a parent with whom he lives for the parent to continue to conduct the enrollee's *MA* business.

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

A signed application for MA is required for all initial requests for medical assistance, except for:

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born to a Medicaid *or FAMIS*-eligible mother.

***1.* Title IV-E Foster Care & Medicaid Application**

The Title IV-E Foster Care & Medicaid Application, form #032-03-636 (available at: http://spark.dss.virginia.gov/divisions/dfs/iv_e/ is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown), the appropriate pages from *Appendix E* can be used to collect the information. The pages must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application, form #032-03-636, is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.

***2.* Auxiliary Grant (AG)**

An application for AG is also an application for Medicaid. A separate MA application is not required.

***3.* Exception for Certain Newborns**

A child born to a mother who was Medicaid or FAMIS eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for medical assistance to age 1 year.

If the child was born to a mother who was covered by Medicaid outside Virginia or by another state's Children's Health Insurance Program at the time of the child's birth, verification of the mother's MA Medicaid coverage must be provided by the parent or authorized representative or an application must be filed for the child's eligibility to be determined in another MA group.

4. Forms that Protect the Application Date

a. Low Income Subsidy (LIS) Medicaid Application

The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by the Social Security Administration (SSA) to states to be treated as an application for Medicaid, if the LIS applicant agrees. *LIS application data is sent to LDSS via the SSA Referral Inbox in VaCMS. The LDSS must generate an LIS Medicaid application and cover sheet and mail them to the individual. The individual must return the application or apply for Medicaid online or by telephone in order for his Medicaid eligibility to be determined. If the individual submits the application, the date of LIS application with the SSA is treated as the date of the Medicaid application.*

b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send a valid Virginia MA application to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at: http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf.

B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). Applications may be made electronically through CommonHelp or the Health Insurance Marketplace. When an individual applies for assistance through the Marketplace and is assessed as being Medicaid-eligible, his application data is electronically transmitted to the local DSS for a final determination of eligibility.

Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.

The following paper forms have been prescribed as application forms for Medicaid and FAMIS:

1. Streamlined Applications

The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:

- the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices, including Appendix D for applications submitted for aged, blind or disabled and/or long-term care applicants, *and Appendix E for when a Families and Children (F&C) Medically Needy determination is requested.*
- the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices and
- the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.

The Cover Virginia application form contains additional questions regarding health insurance ending and state employee benefit plans necessary to determine FAMIS eligibility. If a federal form is used to apply for a child who is not eligible for Medicaid, the worker will need to obtain the additional information from the applicant.

***2.* BCCPTA Medicaid Application**

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by *individuals* screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

3.* *Replaced Application Forms

The following forms were replaced by the streamlined application forms effective October 1, 2013. While agencies should accept and process any of these forms should they be submitted, additional information will need to be obtained using the new forms.

- *Application for Benefits (#032-03-824)*
- *The Application/Redetermination for Medicaid for SSI Recipients (#032-03-091)*
- *The Medicaid Application/Redetermination for Medically Indigent Pregnant Women (#032-03-040)*
- *The Health Insurance for Children and Pregnant Women (#FAMIS-1)*
- *The Application for Adult Medical Assistance form (#032-03-0222)*
- *The Plan First Application (#DMAS-65E)*

4.* *If Additional Information is Required

Applicants may apply for MA on any valid application form. Regardless of which new application form is used, if additional information is required to determine an applicant's eligibility in another covered group, send the applicant a written request asking for the information and give the applicant at least 10 business days to return the pages and the required verifications to the agency.

M0120.400 Place of Application

A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of locality residence is not required. *MA* applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

1. Locality of Residence

Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence or where the individual last lived outside of an institution .

2. Joint Custody Situations

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for application/ enrollment purposes.

B. Foster Care, Adoption Assistance, Department of Juvenile Justice

1. Foster Care

Responsibility for taking applications and maintaining the case belongs as follows:

a. Title IV-E Foster Care

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody. Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for *MA* and are not eligible for *MA* in Virginia (see M0230).

2. Adoption Assistance

Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.

3. Virginia Department of Juvenile Justice/Court (Corrections Children)

When a child is in the custody of the Virginia Department of Juvenile Justice (DJJ) or is the responsibility of a court (corrections children), responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided prior to going into the DJJ system.

C. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except DBHDS facilities and the Virginia Veteran's Care Center, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

Exception: If the applicant is applying for or receives SNAP, responsibility for processing the *MA* application and determining *MA* eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

D. Individuals in DBHDS Facilities

1. Patient in a DBHDS Facility

If an individual is a patient in a state DBHDS institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining eligibility rests with the state department of social services' eligibility technicians located in DBHDS facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in DBHDS facilities is located in Subchapter M1550.

If an individual is a patient in a State DBHDS Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

2. Patient Pending Discharge (Pre-release Planning)

a. General Policy

For DBHDS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DBHDS facility but *MA* eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate local department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the DBHDS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the DBHDS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

d. Eligibility Determination and Enrollment

The local agency determines the patient's MA eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for MA in the locality, he is not enrolled in MA until the day he is discharged from the DBHDS institution.

When the individual is discharged, the DBHDS discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.

e. Coverage Begin Date

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the DBHDS institution.

E. Individuals In Virginia Veteran's Care Center

MA applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

F. Incarcerated Individuals and DJJ Supervisees

Inmates of state correctional facilities and *individuals under the age of 21 under the supervision of DJJ (placed in a facility or receiving services from any court services unit or DJJ contractor)* may apply for Medicaid, limited to inpatient hospitalization and as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the individual was living prior to incarceration or DJJ/court custody. Applications are not to be refused because an applicant is an inmate of a public institution at the time of application

If the individual did not reside in Virginia prior to becoming incarcerated or *committed to* DJJ, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit an application for medical assistance only or may apply for MA in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. Application Date

The application date is the earliest date the signed application for medical assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf.

The application may be received by mail, fax, hand delivery, electronically or telephonically. The date of receipt by the agency must be recorded. If an application is received after the agency's business hours, the date of the application is the next business day. *Exception: For CommonHelp applications, if the application is received after business hours and the next business day is in the following month, the date of the application is the actual date it was submitted.*

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to request a medically needy evaluation. If the evaluation is requested within 10 calendar days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

D. Hospital Presumptive Eligibility

The Affordable Care Act requires states to allow approved hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible coordinating the HPE Agreement with hospitals, providing training and technical assistance, and Monitoring the appropriate use of the HPE enrollments. HPE is not available to individuals who are already enrolled in Medicaid or FAMIS.

a. HPE Enrollment

To enroll an individual in HPE coverage, the hospital obtains basic Demographic information about the individual, as well as attestations from the individual of Virginia residency including locality, U.S. citizenship or lawful presence, Social Security number, household size and income, and Requirements related to covered group. No verifications are required

Hospital staff determines eligibility and enrolls eligible individuals in HPE via The provider portal in the Medicaid Management Information System (MMIS). The enrollment is not entered in the Virginia Case Management System (VaCMS). The individual is enrolled in the appropriate Aid Category (AC) for His covered group. Once the hospital receives confirmation of the HPE Enrollment, the hospital is responsible for notifying the individual of his HPE Coverage and that he must file a full MA application by the end of the following month in order for his continued eligibility to be determined and his coverage to remain uninterrupted.

The HPE covered groups and the ACs are:

- Pregnant Women (AC 035)
- Child Under Age 19 (AC 064)
- Low Income Families with Children (LIFC) (065)
- Former Foster Care Children Under Age 26 (077)
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) (067)
- Plan First (084) (effective May 1, 2014).

Individuals enrolled on the basis of HPE receive a closed period of coverage Beginning with the date of the HPE determination through the last day of the Following month or the date MA eligibility is determined by an LDSS, Whichever comes first. Enrollment in HPE is not based on the date of the Hospital admission or on the first day of the month.

While enrolled as HPE, individuals in the Child Under Age 19 years, LIFC, Former Foster Care Children Under Age 26 and BCCPTA covered groups

receive full Medicaid benefits. HPE pregnant women coverage (AC035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy.

b. LDSS Procedures

The MMIS User's Guide for DSS, available at http://dmasva.dmas.virginia.gov/Content_pgs/dss-elgb_enrl.aspx, contains procedures for completing the MA enrollment of an individual who was enrolled in HPE at the time of application.

1) Application Processing

For MA coverage to continue beyond the following month, the Individual must submit a full MA application to the LDSS. While the LDSS does not determine eligibility for HPE, when the application is received and pended in VaCMS, the individual's coverage in the HPE AC must be extended by the eligibility worker, as necessary, while the application is processed. The worker must enter data directly into MMIS to extend the coverage; MMIS will calculate the 45 day period.

Example: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) by the hospital for the period of 3-5-14 through 4-30-14. On 4-20-14, she submits an MA application to her LDSS> the 45th processing day will fall after the HPE End date; therefore the worker reinstates HPE coverage in MMIS in AC 065, using the MA application date. The effective date of the reinstatement is 5-1-14, the day after the HPE coverage ends. MMIS will automatically populate the end date with 6-3-14, the MA application date plus 44 days.

Note: the 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.

2) Applicant is Eligible

Full MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other that the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date.

If an individual who is eligible for ongoing coverage was enrolled in a full-benefit HPE covered group, his ongoing coverage is reinstated in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.

> **Example:** Billy Jones is a child enrolled in HPE coverage (AC 064) by the hospital for the period of 2-14-14 through 3-31-14. His parent submits an MA application on 2-18-14. The parent did not indicate receipt of any medical services in the retroactive period. Billy is determined eligible for Medicaid coverage in
> AC 092.
>
> The child's Medicaid entitlement begins with the month of the MA application. The worker enrolls him using AC 092 in a closed period of coverage from 2-1-14 through 2-13-14, the day before the begin date of HPE coverage. The worker also reinstates the child's ongoing coverage beginning 4-1-14.

If an individual who was enrolled in HPE in a partial-benefit covered group, (i.e. pregnant women or Plan First) is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.

> **Example:** Jane Scott was enrolled in HPE AC 035 (pregnant women) for the period of 3-13-14 through 4-30-14. She filed an MA application on 3-28-14. Based on the expected delivery date on the application, she was also pregnant during the month prior to her HPE determination. The worker determines that she was eligible for Medicaid as a pregnant woman in AC 091 and completes a retro cancel reinstate, using Cancel Reason 024, beginning 2-1-14.

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE.

3) Applicant is Not Eligible

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination), using Cancel Reason 008.

Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. Because the individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment, advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

The individual's HPE coverage is valid regardless of whether or not the individual is eligible for ongoing coverage; do not refer the case to the DMAS Recipient Audit Unit.

1) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, his HPE coverage will be automatically terminated. No involvement or notice from the LDSS is required.

E. Governor's Access Plan (GAP)

GAP covers uninsured, low-income adults ages 21-64 years with serious mental illness (SMI) who are not eligible for any existing full-benefit MA entitlement program. Eligibility determinations and ongoing case maintenance for eligible individuals are handled by dedicated staff in the Cover Virginia GAP unit. GAP is not a medical assistance program for which LDSS staff have responsibility. However, LDSS staff is involved in the transfer process when individuals transition between GAP and Medicaid or FAMIS MOMS.

Eligibility for GAP is a two-step process. The individual must: 1) receive a GAP SMI screening and 2) meet non-financial and income eligibility requirements. SMI evaluations will be completed by community services boards, Federally Qualified Healthcare Centers, inpatient psychiatric hospitals, or general hospitals with inpatient psychiatric units. GAP uses Medicaid non-financial requirements and Modified Adjusted Gross Income for household composition and income eligibility.

The GAP income limit is 95% of the Federal Poverty Level (FPL) plus the 5% FPL disregard as appropriate. GAP eligibility can begin no earlier than January 12, 2015. For applications received on or after February 2015, eligibility will begin the first day of the month of application, provided all eligibility requirements are met that month. There is no retroactive coverage in GAP. The Aid Category for GAP coverage is 087.

Additional information about GAP is available at: http://www.coverva.org/gap.cfm.

Commonwealth of Virginia
Department of Social Services

NOTICE REGARDING MEDICAID APPLICATION REQUIREMENTS

A Medicaid application has been filed on the behalf of _____ (name of applicant). However, the application is not valid and cannot be processed because the application must be signed by one of the following persons:

- the parent of a person under age 18,
- the adult who is the legal guardian or has legal custody of a person under age 18,
- any adult related by blood or marriage with whom a person under age 18 lives,
- the person for whom Medicaid is requested if the person is over age 18 or an emancipated minor,
- the authorized representative for the person who is requesting assistance, who may be
  - any person to whom he/she has legally given power of attorney, or
  - any person who he/she has designated by a signed written statement to apply on his/her behalf for Medicaid or public benefits, or
- the guardian, conservator, or committee of a person over age 18 who has been judged legally incapacitated by a court of law.

Please return the signed application and the authorized representative statement (if needed) by _____ so that the application may be processed. Thank you.
(date)

_____ _____
Signature Date

_____
Title

_____
Agency Name

_____
Phone Number

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP: STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY: STATE: ZIP: HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER:

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER : _____ DATE: _____

032-03-384/1

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services or be notified of the reason for any delay.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____
Signature or Mark **Date**

_____ _____
Witness/Authorized Representative **Date**

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Alabama	Yes	Yes	Reciprocity with ICAMA member states only
Alaska	Yes	Yes	Reciprocity with all states
Arizona	Yes	Yes	Reciprocity with all states
Arkansas	Yes	Yes	Reciprocity with all states
California	Yes	Yes	Reciprocity with all states
Colorado	Yes	Yes	Reciprocity with all states
Connecticut	Yes	Yes	Reciprocity with ICAMA member states only
Delaware	Yes	Yes	Reciprocity with all states
District of Columbia	Yes	**No**	
Florida	Yes	Yes	Reciprocity with ICAMA member states only
Georgia	Yes	Yes	Reciprocity with all states
Hawaii	Yes	**No**	
Idaho	Yes	Yes	Reciprocity with all states
Illinois	Yes	**No**	
Indiana	Yes	Yes	Reciprocity with all states
Iowa	Yes	**No**	
Kansas	Yes	Yes	Reciprocity with all states
Kentucky	Yes	Yes	Reciprocity with ICAMA member states only
Louisiana	Yes	Yes	Reciprocity with all states
Maine	Yes	Yes	Reciprocity with all states
Maryland	Yes	Yes	Reciprocity with all states
Massachusetts	Yes	Yes	Reciprocity with all states
Michigan	Yes	Yes	Reciprocity with all states
Minnesota	Yes	Yes	Reciprocity with all states
Mississippi	Yes	Yes	Reciprocity with all states
Missouri	Yes	Yes	Reciprocity with all states
Montana	Yes	Yes	Reciprocity with ICAMA member states only
Nebraska	Yes	**No**	
Nevada	Yes	**No**	
New Hampshire	Yes	**No**	
New Jersey	Yes	Yes	Reciprocity with ICAMA member states only
New Mexico	No	**No**	
New York ***	Yes	**No**	
North Carolina	Yes	Yes	Reciprocity with ICAMA member states only
North Dakota	Yes	Yes	Reciprocity with ICAMA member states only
Ohio	Yes	Yes	Reciprocity with all states
Oklahoma	Yes	Yes	Reciprocity with all states
Oregon	Yes	Yes	Reciprocity with all states

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Pennsylvania	Yes	Yes	Reciprocity with all states
Rhode Island	Yes	Yes	Reciprocity with ICAMA member states only
South Carolina	Yes	Yes	Reciprocity with all states
South Dakota	Yes	Yes	Reciprocity with all states
Tennessee	Yes	Yes	Reciprocity with all states
Texas	Yes	Yes	Reciprocity with all states
Utah	Yes	Yes	Reciprocity with ICAMA member states only
Vermont			
Virginia	Yes	Yes	Reciprocity with ICAMA member states only
Washington	Yes	Yes	Reciprocity with all states
West Virginia	Yes	Yes	Reciprocity with all states
Wisconsin	Yes	Yes	Reciprocity with all states
Wyoming			

* *per COBRA 1985 law, the ICAMA member state's Medicaid program covers its own Non-IV-E (state-local) Adoption Assistance [AA] children).*

** *the ICAMA member state's Medicaid program covers Non-IV-E AA children who have adoption assistance agreements with another state and move to the state.*

*** *ICAMA Associate Member State*
ICAMA Non-Member State (Vermont, Wyoming)

CHAPTER M01
APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 30

APPLICATION PROCESSING

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

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M0130.001 Medical Assistance Application Processing Principles

A. Introduction

Under the Affordable Care Act (ACA), the Medicaid and FAMIS medical assistance (MA) programs are part of a continuum of health insurance options available to Virginia residents. MA application processing is based on several principles that are prescribed by the ACA.

B. Principles

1. Single Application

Applications for affordable health insurance, including qualified health plans with Advance Premium Tax Credit (APTC) assistance and MA, are made on a single, streamlined application. The application gathers information needed to determine eligibility for both APTC and MA.

2. No Wrong Door

Individuals may apply for MA through their local department of social services (LDSS), through the Health Insurance Marketplace (HIM), *through CommonHelp,* or through the Cover Virginia Call Center. *HIM applications and telephonic applications received by the Cover Virginia Central Processing Unit (CPU) are sent to the LDSS for either case management or LDSS processing.*

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. LDSS are to rely on EDSV as the first course of action and are to request information from the applicant only when it is not available through an approved data source or the information is inconsistent with agency records.

The Federally-managed Data Services Hub (the Hub) provides verification of a number of elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS).

Searches of online information systems, including but not limited to the Hub, State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

4. Processing Time

Agencies are required by the State Plan to adhere to prescribed standards for the processing of MA applications, including applications processed using the self-directed functionality in VaCMS. The amount of time allowed to process an application is based on the availability of required information and verifications, as well as the covered group under which the application must be evaluated.

When all necessary information is available through EDSV, it is expected that the application be processed without delay.

When it is necessary to request information from the applicant and/or a disability determination is required, the processing standards in M0130.100 are applicable.

M0130.050 Incarcerated Individuals

A. Introduction

Virginia has two MA initiatives for incarcerated individuals: 1) pre-release planning (application processing) for individuals transitioning from or leaving a correctional facility and 2) coverage limited to medical services received during an inpatient hospitalization. For the purpose of these initiatives, incarcerated individuals include those individuals being held in Virginia Department of Corrections (DOC) facilities, regional and local jails, and youth being held in Virginia Department of Juvenile Justice (DJJ) facilities. Incarcerated individuals must meet all MA eligibility requirements and can only be eligible for MA payment for medical services when they are not physically residing in the correctional facility.

Staff employed by DOC or DJJ are responsible for coordinating the application process and communicating information for individuals held in their facilities and the LDSS. DOC/DJJ staff assigned to assist in the application process will be identified on the application or in a separate document on agency letterhead. Communication between the staff assisting the individual and the LDSS handling the application is permitted. Direct communication between the incarcerated individuals and the LDSS may be prohibited, depending on the facility placement.

Once an individual is released from a DOC facility, the individual will be responsible for all matters pertaining to his MA eligibility and involvement of the correctional facility staff will end. DJJ staff may continue to assist juveniles returning to the community as long as the juvenile continues to receive DJJ services.

Individuals in regional or local jails may file their own applications or may name an authorized representative, including facility staff, to assist with the application process and ongoing eligibility. The authorized representative statement must indicate if the authority to act on the applicant's behalf will continue after the applicant is no longer incarcerated.

Applications are to be processed in the same manner and within the same processing time standard as any other MA applications.

Individuals who are actively enrolled in MA programs at the time of incarceration are not required to file a new application, but are subject to partial reviews based on the change in their living situation (see M1520.100) and annual renewals (see M1520.200). Ongoing case maintenance for individuals enrolled for inpatient services will be provided by the LDSS where the individual lived prior to incarceration.

B. Pre-release Planning

Pre-release planning permits individuals who are completing their term of confinement to apply for MA and have their eligibility determined prior to release. Eligibility is to be determined based on the living arrangement anticipated upon release. Applications are not to be refused or denied because an applicant is an inmate of a public institution. Individuals who are determined to meet all Medicaid eligibility requirements are to be

enrolled in the appropriate MA coverage after release and beginning with the date of release. The DOC/DJJ staff or the individual can contact the LDSS to report the actual date of release. Enroll the individual in the appropriate MA coverage and provide the individual's enrollee identification number so services can be accessed without delay. Send notice of the eligibility determination to the individual at the address where he will be living. A copy of the notice must also be sent to DOC/DJJ staff if the individual was in one of their facilities.

Pre-release planning for individuals being held by the DOC is coordinated by assigned staff and the Offender Release Services-Community Release Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Pre-release planning for juveniles being held by the DJJ is coordinated by assigned staff and the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond, Virginia 23219.

Pre-release planning for individuals in regional and local jails is handled by the individual and/or his authorized representative.

1. Release to a Community Living Arrangement

Individuals returning to a community living arrangement (outside of an institution) will have their eligibility determined based on their anticipated living situation upon release. If it is anticipated that the individual will enter a community living arrangement in a different locality from the one he lived in prior to incarceration, the application will be processed by the locality of prior residence and if eligible, transferred to the new locality of residence. Application processing is not to be delayed based on the individual's change in locality. Denied applications are not transferred.

2. Release to an Institutional Placement or Long-term Care (LTC) Services

Applications for incarcerated individuals in need of placement in an institution or community-based care (CBC) services are processed by the locality where the individual lived prior to incarceration. If the individual lived outside of Virginia prior to incarceration and he plans to remain in Virginia, the application is processed in the locality where the correctional facility is located.

Correctional facility staff will notify the agency where the individual is housed if a pre-admission screening is needed for nursing facility or CBC services. The pre-admission screening is to be done by the LDSS in the locality where the correctional facility is located even if the application is being processed by another locality. Correctional facility staff will coordinate with the screening team, service provider and eligibility worker to ensure the eligible individual can receive necessary medical support/services when released.

C. Inpatient Hospitalization (Medicaid Only)

*Incarcerated individuals (adults and juveniles) who meet **all** Medicaid eligibility requirements, including a categorically needy (CN) covered group (see M0310.108), are eligible for Medicaid coverage limited to inpatient hospitalization services. These individuals are not considered to be inmates of ineligible institutions while they are hospitalized.*

Information about the individual's incarceration and initial dates of inpatient hospitalization must be provided, along with the verifications needed for the Medicaid application. Medicaid coverage for inpatient hospitalization for incarcerated individuals is based on the month of application and can include up to three months prior to the month of application, provided all eligibility requirements were met. Enroll eligible individuals in aid category (AC) 109 regardless of the covered group. AC 109 identifies the individual as eligible for coverage limited to inpatient hospitalization and ensures claims will be paid correctly.

Eligibility in AC 109 may continue as long as the individual continues to meet all Medicaid eligibility requirements and remains incarcerated. Set the first annual renewal date for 11 months from the date of application for incarcerated individuals other than pregnant women. If the individual is a pregnant woman, set the renewal date based on the expected delivery date and the post-partum period to determine if she will meet a full benefit CN covered group after the pregnancy ends. Incarcerated individuals are not referred to the Health Insurance Marketplace.

Non-citizen incarcerated individuals who meet all Medicaid eligibility requirements other than alien status may be eligible for Medicaid payment limited to emergency services received during an inpatient hospitalization. Determine eligibility for emergency services using the policy in M0220.500 B and enroll eligible individuals using the procedures in M0220.600.

All communication regarding individuals incarcerated in DOC facilities who have inpatient hospitalizations must be sent to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Applications for juveniles in DJJ facilities will be coordinated through the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

Applications for individuals in regional or local jails may be submitted by the individual or his authorized representative.

M0130.100 Processing Time Standards

A. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Pregnant Women

Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within

10 working days, the agency must determine just the MA eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant written notice on the 10th day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the written notice must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the Low-income Families with Children (LIFC), Medicaid pregnant women, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in the LIFC, pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a written notice on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-calendar-day processing time limit is reached.

2. 45/90 Day Requirement

Applications for which information in addition to that provided on the application is required, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45th calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 *G.3*).

The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of MA is mailed to the applicant. The applicant must be informed of the agency's time standards.

The eligibility worker must allow at least 10 calendar days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

3. Early Denial Before Deadline Date

When the 45-day processing deadline date falls on a weekend or a holiday, the LDSS may deny an individual's application on the last business day before the deadline date if all necessary verifications have not been received. If the early denial action is taken, however, the LDSS must re-open the application if the individual provides the necessary information on or before the 45th day deadline.

If the individual's application is re-opened and he is determined eligible, the LDSS must enroll the individual and send a notice to the individual notifying him of the approval and the begin date of coverage.

4. Processing Priority

Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other covered services. These applications must be processed as quickly as possible.

5. Time Standard Exceptions

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,
- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

B. Application for Retroactive Coverage

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance *indicates on the application* that he, or anyone for whom he requests assistance, received a covered medical service within the retroactive period. *The covered service may be listed by the applicant as an actual medical service on the application, or information on the application may indicate that a service was received, such as the birth of a child or Medicare coverage during the retroactive period.*

An individual may request retroactive coverage at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved. **There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined.**

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which retroactive eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or proof that the individual applied for the SSN, and date of birth.

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA. At the time of the initial MA application, verify the SSA record of the individual's name.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in VaCMS (see M0130.200 B.1 below). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either SVES or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.

For purposes of the case record only, the agency may choose to set up the case in the individual's alleged name before it is changed on the Social Security card.

2. SSN

The SSN of an individual for whom medical assistance is requested must be provided by the applicant and verified by the worker through SSA. The Hub or SOLQ-I may be used to verify the individual's SSN.

B. Required Verifications

1. The Federally-managed Data Services Hub

The Hub is a data center that links the following federal systems:

- Social Security Administration
- Internal Revenue Service (IRS)
- Systematic Alien Verification for Entitlements (SAVE).

Income verification by the Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9).

Information from other sources, such as the Work Number, may become available via the Hub in the future.

2. Other Verification Sources

An individual must provide verifications of certain MA eligibility requirements when they cannot be verified through EDSV. Before taking action on the application, the applicant must be notified in writing of the required information.

The eligibility worker must allow at least 10 calendar days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record. If the applicant reports to the EW that he needs help to obtain certain verifications, the EW must attempt to assist the applicant. If the verification cannot be obtained, the application must be denied.

3. Copy Verification Documents

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

4. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility. *Individuals whose applications are denied due to the inability to determine eligibility are not referred to the HIM. See M0130.300 D.2.*

When the deadline date falls on a weekend or holiday, LDSS may choose to deny the application (or cancel coverage) before the deadline date. However, if the early denial or cancel action is taken, LDSS must re-open the application if the individual provides the necessary information on or before the original deadline date. If the individual's application is re-opened and he/she is determined eligible, the LDSS must send a notice to the individual notifying him of the changed action.

C. Verification of Nonfinancial Eligibility Requirements

1. Verification Not Required

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

- Virginia state residency;
- pregnancy.

2. Verification Required

The following information must be verified:

- application for other benefits;
- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older; and
- disability and blindness.

See M0130.200 E below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age and disability.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. SSN Verification

The Federal Hub, SVES or SOLQ-I may be used to verify the individual's SSN. However, to verify the SSA record of the individual's name at the initial Medicaid application, *SSA data from the Hub* or SVES must be used because it verifies the spelling, etc., of the individual's name in the SSA records.

2. Exceptions to SSN Requirements

Children under age one born to Medicaid-eligible mothers *or born to mothers covered by FAMIS* are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met. A child eligible in this covered group does not need *to provide* a Social Security number.

Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

3. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration (SSA) office. Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for medical assistance.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in the *eligibility/enrollment system*, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "999101306" as the individual's SSN.

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are exempt from this requirement.

Non-citizens applying for Medicaid payment limited to emergency services are not subject to the legal presence requirement. An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

2. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

3. Failure to Provide Proof of Legal Presence

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at:
http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

4. Relationship to Other Medicaid Requirements

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200 D. does **NOT** meet the SSN requirement.

F. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

1. Use of Federal Income Tax Data

Federal Income Tax data is used for the income eligibility determination for the MAGI population. The Hub provides verification of income reported to the IRS. When an applicant is a member of a tax household for which federal income taxes were filed in the previous calendar year, the income information reported to the IRS may be used for the eligibility determination. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100.

2. SSA Data

Social Security and/or Supplemental Security Income must be verified through SSA. *The Federal Hub links to SSA data. SOLQ-I may also be used.* The State Data Exchange (SDX) system should only be used as an alternate method when the *Hub* or SOLQ-I is not available.

3. $0 (Zero) Income Procedures – Applicable Only to F&C MAGI Cases Processed in VaCMS

When an individual whose income must be counted for the eligibility determination reports $0 income at application, search the Virginia Employment Commission (VEC) online quarterly wage data and unemployment records and other agency records to verify the absence of income. If the individual receives benefits through other benefit programs and/ or childcare, income information in those records must also be reviewed.

If the VEC inquiry and review of other agency records confirms that the individual has not received wages, unemployment compensation, or other unearned income within the most recent reporting period, document the absence of verifiable income and determine or redetermine income eligibility.

If the inquiry indicates recent or current income that is countable for the MAGI determination, contact the individual and ask about the income (name of employer, amount of wages and period earned, date of unemployment payment, etc.). If it appears there is a mistake and the income belongs to someone other the individual, discontinue further inquiry and document the finding in the record.

If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow ten calendar days for the return of the verifications.

If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

When an MA application is received by the LDSS agency, the agency must determine through a "file clearance" search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications.

Applications submitted by individuals currently enrolled as PE or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

The evaluation of eligibility requirements must be documented in writing for cases not processed in the eligibility determination computer system. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the Medicaid non-financial requirements.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering limited coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

If an applicant (other than a Medicare beneficiary or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals with Medicare and deceased individuals and are not referred to the HIM.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

If an applicant indicates that he has been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. His enrollment may begin with the month of application or the earliest month in the application's retroactive period that he met the residency requirement per M0230.

b. Enrollment

MA enrollees must be enrolled in the Medicaid Management Information System (MMIS), either through the system interface with the eligibility determination system or directly by the eligibility worker.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a QHP can be determined.

c. Delays

The notice must state that there is a delay in processing the application, including the reason.

d. Other Actions

Other actions for which a notice must be sent include when a request for re-evaluation of an application in spenddown status has been completed.

E. Notification for Retroactive Entitlement Only

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one notice is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a notice must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request can be verbal or written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement or by a verbal statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the applicant withdraws an application, the eligibility worker must send a notice of action on MA to the applicant.

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

Applications received requesting MA for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A notice will be sent to the applicant when a duplicate application is denied.