

2060 – ABD MEDICAID APPLICATION PROCESSING

POLICY STATEMENT	The ABD Medicaid application process begins with the receipt of a signed application for medical assistance and ends with written notification to the applicant/recipient (A/R) of the eligibility determination.
BASIC CONSIDERATIONS	<p>Eligibility for ABD Medicaid Classes of Assistance (COA) is determined in the following order:</p> <ul style="list-style-type: none"> • FBR COAs • LA-D/ Medicaid Cap COAs • Q-Track • ABD Medically Needy. <p>NOTE: QMB and SLMB may be approved while an eligibility determination for FS, TANF or another Medicaid COA is pending. A Medicaid member cannot be dually eligible for QI-1 and another Medicaid COA.</p> <p>Applications are normally processed by the DFCS office located in the county in which the applicant resides.</p> <p>Exceptions:</p> <ul style="list-style-type: none"> • If an A/R is confined to a nursing home or swing bed, the application is processed in the county where the nursing home/ swing bed is located. However, if at the time the application is received the A/R is no longer in that facility, the county where the A/R currently resides processes the application. • If the A/R is applying under the Hospital COA, the application is processed in the county in which the A/R resided prior to entering the hospital, where the A/R currently resides or where the PR resides. The case should be processed in the county in which it is most advantageous for the A/R or PR. The DFCS office in the county where a hospital is located may opt to process an application that has been received from the hospital.
PROCEDURES Application Requirements	<p>The application date is the date a signed application is received by any county DFCS office. EXCEPTION: When Long Term Care Unit applications are received via Internet or facsimile, the application date is the date the form was transmitted.</p> <p>An application for any ABD Medicaid COA may be processed from any of the following application documents:</p> <ul style="list-style-type: none"> • Form 297 • SUCCESS Application for Assistance (AFA) • Form 700

PROCEDURES**Application
Requirements
(cont.)**

- Low Income Subsidy Application – SSA 1020B (LISA-application for Medicare Part D)
- Long Term Care Online Application
- Form 508
- PeachCare for Kids® Application
- Medicaid Streamlined Application
- Form 632 Presumptive eligibility for Pregnancy
- Form 632W- Women’s Health Medicaid Application
- Women’s Health Medicaid Review Form
- COMPASS Online Application
- COMPASS Medicaid Renewal
- Federally Facilitated Marketplace (FFM) application
- Form 632H Qualified Hospital Presumptive Eligibility Application

A completed application consists of a signed (not typed name on signature line) application with information sufficient to contact the A/R or PR. The signature does not necessarily have to be that of the A/R. Any other information that is missing, incomplete or otherwise unclear may be obtained from the A/R or PR after the signed application is received and registered in the system by the agency.

A new signed application is required in the following situations:

- Adding a program for an A/R who has been an ineligible spouse in an active Medicaid AU and who is now requesting Medicaid for him/herself under a different COA from a recipient spouse
- An application was previously correctly denied due to failure to provide required verification. A/R wants to reapply in a subsequent month. Although the application date of the first application is protected, have the A/R sign another application for the subsequent month(s) unless there is good cause for not initially providing the verification.
- An application was previously correctly denied due to not meeting a basic or financial eligibility criteria. A/R now meets this criteria. Have the A/R complete and sign another application for subsequent month(s).

A new application is NOT required in the following situations:

- If the system denies the application because the worker has not acted timely on the case
- If the A/R is already a Medicaid recipient and is changing to another COA, a continuing Medicaid determination (CMD) is being completed or if an SSI recipient is entering a NH
- If a current Medicaid recipient is being added as a recipient to an existing Medicaid AU, such as SSI added to Q Track or Q Track added to AMN

PROCEDURES
(cont.)

**Application
Requirements
(cont.)**

Application Screening

- A non-Medicaid applicant (NM, NA, etc.) is added to an existing Medicaid AU, even if the AU trickles to a lower COA or the spenddown amount is increased.

Screen the application to determine the following:

- Current receipt of the benefits for which the A/R is applying
- Current receipt of other benefits available through the agency.

**Interview
Requirements**

A face-to-face (FTF) interview is **not** a requirement for any Medicaid COA. At the eligibility worker's (EW) discretion or the request of the A/R or PR, a FTF interview may be scheduled; however, an application may **not** be denied for failure to appear for an interview.

A telephone interview **is** required for ABD institutional COAs and Adult Medically Needy (AMN) COAs.

The A/R is the primary source of information for him/herself. The A/R may authorize a PR to apply, interview and provide information on his/her behalf. However, because the A/R is considered the best source of information, s/he must be contacted to confirm that the information obtained is correct. This may be accomplished either by telephone, by mail, fax or in person, unless contact with the A/R is precluded by physical or mental limitations.

Information necessary to complete an eligibility determination may be obtained by any of the following methods:

- telephone call
- mail
- FTF interview
- home visit
- e-mail
- facsimile

Orally or in writing, inform the A/R about the Medicaid program(s) for which s/he may be entitled. Provide relevant information pamphlets or other printed material.

Explain the following information to the A/R and/or PR:

- Services provided by DFCS and the right to apply for them
- Requirements of eligibility and the A/R's responsibility to provide information to establish eligibility and benefit level, including the following:
 - basic eligibility requirements
 - financial requirements
 - periodic renewals

PROCEDURES**Interview
Requirements
(cont.)**

- timely reporting of changes
- assignment of TPL
- medically needy requirements, if applicable
- vendor payment/cost share, if applicable

- The applicant's right to the following:
 - a fair hearing
 - prompt action within the standard of promptness (SOP)
 - confidentiality
 - non-discrimination in the processing of the application
 - services available to the family from other agencies

**Mandatory
Forms**

Complete the mandatory forms below when processing an ABD Medicaid application. Refer to Chart 2060.1 in this section.

- Application for assistance
- Eligibility Determination Document (EDD) or other written interview form

NOTE: It is not necessary to print the EDD.

- Form 297A, Rights and Responsibilities, and 297M, Medicaid Addendum (**only** if Form 297 is used to apply for assistance)

- Form 5460- Notice of Privacy Practices(HIPAA)

NOTE: Notice of Privacy Practices and Form 297-A may be mailed to the applicant. The applicant is **NOT** required to sign and return either form, provided the case record is documented that these forms were sent.

- Form 216- Declaration of Citizenship

NOTE: This form is not required if 94 (rev. 5/10 or later), 222 (Rev. 7/10 or later), 508 (Rev. 5/12 or later), 700 (Rev. 11/09 or later), **COMPASS Medicaid application, or FFM application** are used as they contain the required language to meet the needs of the declaration.

- Form DMA 285, Third Party Liability Health Insurance Questionnaire, when the person has other health insurance coverage. See Section 2230 for TPL requirements.

EXCEPTION: A DMA 285 is **not** required when application is made for QMB, SLMB, or QI-1 via Form 700. Send a copy of Form 700 to DCH/TPL in lieu of Form DMA 285 if the client has medical insurance. Attach a copy of the insurance card, front and back, if available.

PROCEDURES**Other Required
Actions**

Complete any other forms as necessary depending on the COA and the A/R's circumstances.

Standard of Promptness (SOP)

Determine if the A/R meets all points of eligibility.

Complete mandatory clearinghouse requirements.

Follow appropriate documentation standards for ABD Medicaid.

Explore Medicaid eligibility for the three prior months.

Obtain required verification.

For LA-D A/Rs whose income exceeds the Medicaid Cap, provide the following as a handout to the A/R or PR:

- Qualified Income Trust (QIT) – A Guide for Trustees
- Qualified Income Trust (QIT) Worksheet
- Certification of DCH Approved Qualified Income Trust
- Copies of the approved QIT templates

Eligibility should be processed as soon as all verification is received, this should take no longer than the following time frames;

- 45 calendar days beginning with the application date for aged or blind applicants.
- 60 calendar days beginning with the application date for disabled applicants.
- 10 working days beginning with the application date for all Q-Track applicants.

NOTE: If the 45/60 day SOP date falls on a weekend or holiday, complete the application by the last workday prior to the weekend or holiday.

Application Processing Standards

Observe the following standards in processing ABD applications:

- Register the application within **24 hours** of the agency's receipt of the application.
- If the A/R or PR is not interviewed on the same day an institutional COA application is filed, contact the A/R or PR within a reasonable timeframe to conduct the required telephone interview.
- If the A/R or PR is not interviewed on the same day a non-institutional COA application is filed, and additional information is required, contact the A/R or PR within a reasonable timeframe.
- If verification or additional information is required, complete a verification checklist and mail or give to the A/R or PR. Establish a reasonable deadline for returning requested verification.
- If the A/R or PR fails to meet the deadline for providing additional information, attempt to contact the A/R or PR to assess the need for an extension of the deadline or the possibility of assisting in obtaining required verification.

PROCEDURES
Application Processing
Standards
(cont.)

NOTE: Do **not** deny an application for failure to provide verification if the verification can be obtained by the EW. Contact the nursing home or appropriate case manager by the 30th calendar day from the application date if the LOC instrument has not been received. Document and follow-up as necessary.

- Deny an application at the first point ineligibility is established. Do **not** leave a case pending in anticipation of the A/R becoming eligible at a date beyond the ongoing benefit month.
- Deny the application within two days of SOP if the nursing home or case manager has failed to submit the LOC instrument to the authorized approval source.

NOTE: If the LOC approval source has received the LOC instrument but has not yet completed it, do **not** deny the application.

- Do **not** deny an application solely because the 45th/60th/10th day has been reached and eligibility cannot yet be determined.
- Deny an application before the SOP if the A/R or PR fails to cooperate in the application process or fails to supply necessary information that s/he is capable of obtaining and DFCS has no direct means of obtaining.

Disposition of the
Application

Determine if the A/R meets all points of eligibility.

Process applications in chronological order, when possible, with the exception of Q-Track applications, based on the following:

- date of application
- whether all information is available to determine eligibility.

NOTE: See Page 4 this section for SOP guidelines.

If eligible, approve the application ongoing and for any retroactive months, if appropriate.

Notification

Provide adequate notification to the A/R of the eligibility determination. A copy may also be sent to a PR at the request of the A/R. Adequate notification includes the reason(s) for any action taken.

The notice must include the following:

- the basis for the approval/denial/termination
- the period of eligibility
- the reason for the action
- the A/R's right to request a fair hearing
- the telephone number of the county DFCS office
- the telephone number of legal services
- the amount of medical expenses required to meet the

PROCEDURES**Notification
(cont.)**

- ABD Medically Needy spenddown, if the A/R meets all eligibility requirements other than income.
- For LA-D cases in which a penalty is imposed: the duration of the penalty, the Undue Hardship Waiver Form and information that the A/R has 12 days in which to submit the form with supporting info to the MES. See [Section 2342](#), Appendix I and Appendix F for form.

Generic denial reasons may be used as a secondary or tertiary denial/termination reason, but never as the sole reason for denial/termination.

**Period of
Eligibility**

Approve Medicaid and continue eligibility as long as the A/R continues to meet the requirements of the COA under which they are approved. A CMD must be completed prior to denial or termination of any Medicaid COA. Refer to [Section 2052](#), Continuing Medicaid Determination.

EXCEPTION: A COA that has been approved using EMA criteria does not require a CMD when terminated.

**Property Search
Requirements**

Conduct a property search on required ABD Medicaid applicants for the following reasons:

- to verify the value and status of all real property in which the A/R or deemor declare ownership interest.
- to detect any undisclosed property in which the A/R or deemor may have ownership interest.
- to detect and verify any transfer of real property affected by the A/R.

A property search must be completed if a questionable situation regarding ownership of property is discovered during the eligibility determination process.

If necessary, conduct a property search by checking the current tax digest and transfers for the past 60 months in the grantee/grantor book for the county in which the A/R resides or did reside prior to entering LA-D.

CHART 2060.1 – ABD MEDICAID PROPERTY SEARCH REQUIREMENTS

If:	Then a search of the TAX DIGEST is:	Then a search of the GRANTEE/GRANTOR record is:
the COA is AMN	Not required, unless questionable	Not required, unless questionable
the COA is LA-D (See Chart page 9)	Required	Required

the COA is a Public Law or SSI	Required	Not required, unless questionable
the COA is Q-Track only	Not required, unless questionable	Not required, unless questionable
the A/R has not lived in Georgia during the 24 months prior to the month of application,	Not required	Not required, unless questionable

PROCEDURES**(cont.) Out of County
Property Search**

Request assistance in completing a property search from the DFCS office in another county where the client may have resided for a substantial period of time before moving to the current county of residence using Form 991, MAO Property Record Search. Review the exceptions to property search requirements to determine the necessity for a property search.

**Out of State
Property Search**

Conduct an out of state property search using Form 991 only if one of the following situations occurs:

- any LA-D A/R or deemor who owns or has owned out of state property within the 60 month look back period
- The A/R alleges having a current ownership interest in real property located in a state other than Georgia.
- The A/R alleges having sold real property located in a state other than Georgia, and the A/R cannot give a reasonable account of the disposition of the proceeds from the sale.

**SPECIAL
CONSIDERATIONS
FOR SSI APPLICANTS**

The Social Security Administration (SSA) accepts and processes applications for Supplemental Security Income (SSI) at local SSA offices. Any individual applying for ABD Medicaid at DFCS who appears to be financially eligible for SSI must be referred to the local SSA office to file an application. The ABD Medicaid application would be denied pending the outcome of the SSI application. An exception to this may be QMB in some situations.

SSI applicants have the right to have any month for which they have been determined ineligible for a SSI payment for a reason other than failure to meet the disability criteria examined for eligibility under ABD Medicaid. Refer to [Section 2053](#), Retroactive Medicaid.

DFCS is responsible for determining Medicaid eligibility on SSI applicants for the following months:

- the three months prior to the month of SSI application for SSI approvals and denials
- intervening months associated with a SSI application for which the applicant is ineligible for a SSI payment for a reason other than failure to meet disability.

A SSI applicant who wants a determination of ABD Medicaid eligibility for intervening or prior months should contact DFCS to apply for that period of time. These months are protected indefinitely until such time as an eligibility determination has been made.

Refer to [Section 2053](#), Retroactive Medicaid, for processing procedures for retroactive months associated with a SSI application.

	MANDATORY														CONDITIONAL				
ABD MEDICAID CLASS OF ASSISTANCE	Form 216- Declaration of Citizenship/Immigration Status *See Note below chart	Application	Form 5460-Notice of Privacy Practices(HIPAA)	CCSP Communicator	CCSP Level of Care	DMA - 59	DMA 6 or 6A, other LOC Instrument	NOW/COMP Communicator Form 1008	Katie Beckett Cost- Effectiveness Form (704)	Katie Beckett LOC Determi- nation Routing Form (705)	Katie Beckett Worksheet	Hospice Care Communicator	Independent Care Waiver Communicator	TPL	Rights/Responsibilities Form 297A, and 297M Addendum (if application is made via F-297)	Estate Recovery, form 315	Social Data Report Form 188 and/or DAS Form 71	SMEU Cover Letter Form 245 (if SMEU is required)	Property Search
SSI Medicaid – Retroactive Months	Y		Y											Y			Y	Y	Y
Pickle (PL 94-566)	Y	Y	Y											Y	Y				Y
Disabled Adult Child (PL 99-643)	Y	Y	Y											Y	Y				Y
Former SSI-Disabled Child	Y	Y	Y											Y	Y				Y
Disabled Widow(er)	Y	Y	Y											Y	Y				Y
Widow(er) Age 60-64 (PL 100-203)	Y	Y	Y											Y	Y				Y
1984 Widow(er) (PL 99-272)	Y	Y	Y											Y	Y				Y
1972 COLA (PL 92-603)	Y	Y	Y											Y	Y				Y
Community Care Services Program	Y	Y	Y	Y	Y									Y	Y	Y	Y	Y	Y
NOW/COMP	Y	Y	Y				Y	Y						Y	Y	Y	Y	Y	Y
Katie Beckett	Y	Y	Y				Y		Y	Y	Y			Y	Y			Y	
Hospice (at home or institutionalized)	Y	Y	Y									Y		Y	Y	Y	Y	Y	Y
30 Day Hospital	Y	Y	Y											Y	Y		Y	Y	
Independent Care Waiver Program	Y	Y	Y				Y						Y	Y	Y	Y	Y	Y	Y
Nursing Home	Y	Y	Y			Y								Y	Y	Y	Y	Y	Y
QMB	Y	Y	Y											Y	Y				
SLMB	Y	Y	Y												Y				
QI-1	Y	Y	Y												Y				
QDWI	Y	Y	Y											Y	Y				
ABD Medically Needy (AMN)	Y	Y	Y											Y	Y		Y	Y	

*Not required if 94,222, 508, 700, or COMPASS application is used as they contain the required language for the declaration.