2065 – FAMILY MEDICAID APPLICATION PROCESSING

POLICY STATEMENT

The Family Medicaid application process begins with the request for medical assistance and ends with notification to the Assistance Unit (AU) of its eligibility status.

BASIC CONSIDERATIONS

Order of Eligibility

Family Medicaid eligibility is determined in the following order:

- Newborn
- LIM
- other Family Medicaid COAs based on LIM eligibility criteria, i.e., TMA, 4MCS
- RSM
- PeachCare for Kids™
- Family Medicaid Medically Needy.

NOTE: Medicaid eligibility for a child in foster care is determined first under the IV-E FC program. If ineligible under IV-E FC, Medicaid eligibility is determined under CWFC Medicaid. Refer to Chapter 2800, Assistance to Children in Placement.

Application Requirements

An application for any Family Medicaid class of assistance may be made with any of the following forms:

- Form 297
- SUCCESS Application for Assistance (AFA)
- PeachCare for Kids™ application
- Internet Medicaid application
- Low Income Subsidy Application – SSA 1020B (LISA-application for Medicare Part D subsidy)
- Form 222
- Form 94
- Form 700
- Form DMA632W- Women's Health Medicaid Application
- Women's Health Medicaid Review Form
- Form 632 Presumptive eligibility for Pregnancy
- Planning for Healthy Babies (P4HB) application

A completed application consists of a signed (not typed name on signature line) application with information sufficient to contact the applicant or personal representative (PR). Any information that is missing, incomplete or otherwise unclear may be obtained from the applicant or PR after the signed application is received and logged by the agency.

BASIC CONSIDERATIONS (cont.)

Application Requirements (cont.)

A new signed application is required in the following situations:

- When completing an add a program for a BG member who is now requesting Medicaid and had not requested coverage for him/herself on the last application filed.
- An application was previously correctly denied due to failure to provide required verification. Applicant wants to reapply in a subsequent month for ongoing benefits. Although the application date of the first application is protected, the applicant should sign another application unless there is good cause for not initially providing the verification.
- An application was previously correctly denied for not meeting a basic or financial eligibility criteria. A/R now meets the criteria and wants to reapply for ongoing benefits. Have the applicant complete and sign another application.
- An applicant applied for him/herself and children, but the case trickled to a lower COA. A change then occurs that would make him/her eligible.

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 applicant is already a Medicaid member and is changing to another COA, or a continuing Medicaid determination (CMD) is being completed.
- Adding a Newborn Medicaid case
- If a BG member is being added.

NOTE: Homeless AUs are **NOT** required to provide a physical address, but must provide sufficient information to establish Georgia residency. The applicant's statement is acceptable unless conflicting information is known to the agency.

PROCEDURES

Application Screening

Screen the application to determine the following:

- current receipt of the benefits for which the AU is applying
- current receipt of other benefits.

Interview Requirements

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

PROCEDURES (cont.)

Interviewing Requirements (cont.)

The applicant/member is considered to be the primary source of information. The applicant/member may authorize a PR to apply and provide information on his/her behalf, however, because the applicant/member is considered the best source of information, every attempt should be made to obtain necessary information from the applicant/member. If information provided by a PR is questionable or unclear, attempt to contact the applicant/member for clarification, unless contact with the applicant/member is precluded by physical or mental limitations.

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

- FTF interview

  NOTE: A FTF interview may **not** be required of the applicant or PR and an application may **not** be denied solely for failure to complete a FTF interview.

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

Orally or in writing, inform the applicant/member 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 applicant/member or PR:

- services provided by DFCS and how to obtain those services
- requirements of eligibility and the applicant/member's responsibility to provide correct information to establish eligibility
- HIPAA and confidentiality
- basic and financial eligibility requirements
- Clearinghouse requirements for any AU/BG member over 16
- potential Medicaid COAs
- potential coverage for three months prior to the month of application
- periodic renewals

PROCEDURES (cont.)

Interviewing Requirements (cont.)

- timely reporting of changes and how/where changes are to be reported
- assignment of TPR
- the role of Child Support Services, assignment of medical support rights to the State, and Good Cause for non-compliance
- the applicant's right to the following:
  - a fair hearing
  - a decision within SOP
  - non-discrimination.

In addition, explain the following to an AU that includes a pregnant woman:

- the right to apply and how to apply for TANF 45 days prior to the expected date of delivery
- continuous financial eligibility for the pregnant woman
- presumptive eligibility (PE) Medicaid process and how to apply at a public health facility or other qualified provider if the Medicaid eligibility determination for the pregnant woman cannot be made the same day that the application is filed. Accept the Medicaid application even if the applicant applies for PE Medicaid.

Mandatory Forms

Refer the applicant/member to other appropriate services such as family planning, Health Check and WIC as requested by the applicant or as determined by the agency. Refer to Chapter 2900, Referrals.

Complete the mandatory forms below when processing a Family Medicaid application:

- Application for Assistance
- Eligibility Determination Document or other written interview form
- Form 297-A (**only** if Form 297 is used to apply).
- Form 297-M Medicaid Addendum (**only** if Form 297 is used to apply).
- Form 216- Declaration of Citizenship form
- Form 5460- Notice of Privacy Practices (HIPAA)

PROCEDURES (cont.)

Mandatory Forms (cont.)

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 the forms were sent.

- Form DMA-285, Third Party Liability Health Insurance Questionnaire, when the person has other health insurance coverage. See Section 2230 for when a DMA285 can be waived, and for other TPL requirements,

Exception: A DMA-285 is not required for children in placement.

- Form 138, Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services (if a DCSS referral is required)

NOTE: The Form 138 may be mailed to the applicant. The applicant is **NOT** required to sign and return the form provided the case record is documented that the form was sent.

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

Other Required Actions

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.

Standard of Promptness

Refer to Chart 2065.1 in this section.

The eligibility determination for Family Medicaid COAs should be completed as soon as all verification is received. This should take no longer than the following time frames:

- 10 days from the date of application for pregnant women, regardless of COA
- 45 days for EMA-PgW
- 10 days from the date of report for newborns, regardless of COA
- 45 days from the date of application for all other Family Medicaid COAs

Calculate the SOP beginning with the date of application.

If the SOP date falls on a weekend or holiday, complete the application by the last workday **prior to** the weekend or holiday.

PROCEDURES (cont.)

Application Processing Standards

Observe the following standards in processing Family Medicaid applications.

- Accept the signed application on the day the application is received by the agency.
- Register the application date as the date the application was received by the agency. The application must be registered within **24 hours** of receipt by the agency.
- If the applicant or PR is not interviewed on the same day an application is filed and additional information is required, contact the applicant or PR within a reasonable timeframe to obtain the information necessary to complete the application.
- If verification or additional information is required, complete a verification checklist and mail or give to the applicant or PR. Establish a reasonable deadline for returning requested verification. Refer to 2065-6 for situations requiring verification.
- If the applicant or PR fails to meet the deadline for providing additional information, attempt to contact the applicant or PR to assess the need for an extension of the deadline or the possibility of assisting in obtaining required verification.

  NOTE: Do **not** deny an application for failure to provide verification if the verification can be obtained by the EW.
- Deny an application at the first point ineligibility is established. Do **not** leave a case pending in anticipation of the applicant becoming eligible at a future date beyond the ongoing benefit month.
- Do **not** deny an application solely because the SOP has been reached and eligibility cannot yet be determined.
- Deny an application before the SOP if the applicant 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.

PROCEDURES

Disposition of Application

Determine if the AU meets all points of eligibility.

Process applications in chronological order, with the exception of Medicaid coverage for pregnant women, based on the following:

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

If eligible, approve the application, within 45 days, for all eligible months including retroactive and ongoing months. Process applications for pregnant women within 10 days to ensure early prenatal care.

Notification

Provide the applicant adequate written notification of the eligibility determination. Adequate notification includes the reason(s) for any action taken.

A duplicate notice may be provided to the PR upon request by the applicant. The applicant, however, must receive all notices regarding his/her case(s).

Notification must explain the following:

- the basis for the approval/denial/termination
- the period of eligibility
- the reason for the action
- the AU's right to request a fair hearing
- the telephone number of the county DFCS office
- the telephone number of legal services.

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

Periods of Eligibility

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

NOTE: Certain COAs are time limited. Refer to Chapter 2100, Classes of Assistance.

CHART 2065.1 FAMILY MEDICAID FORMS

FAMILY MEDICAID CLASSES OF ASSISTANCE	MANDATORY					CONDITIONAL			
	Application	Form DMA-285 (if a/r has TPL)	Form 5460-Notice of Privacy Practices (HIPAA)	*Form 216- Declaration of Citizenship/Immigration Status See Appendix F, Forms	Form DMA-59	FORM 138 – Child Support Services (if child has NCP)	Form 122 – Child Support Services	Form 297-A – Rights and Responsibilities (if application was made via Form 297)	Form 297-M Medicaid Addendum (if application was made via Form 297)
Low Income Medicaid (LIM)	Y	Y	Y	Y		Y		Y	Y
Transitional Medical Assistance (TMA)		Y	Y	Y					
Four Months Extended Medicaid (4MCS)		Y	Y	Y					
Low Income Medicaid in a Nursing Home (LIM-NH)	Y	Y	Y	Y	Y	Y		Y	Y
Newborn Medicaid (NB)									
Right from the Start Medicaid – Pregnant Woman (RSM-PgW)	Y	Y	Y	Y				Y	Y
Right from the Start Medicaid – Child (RSM-Child)	Y	Y	Y	Y				Y	Y
PeachCare for Kids (PCK)	Y			Y					
Family Medicaid Medically Needy (FM-MN)	Y	Y	Y	Y		Y		Y	Y
Breast and Cervical Cancer Prevention and Treatment (BCCP)	Y	Y	Y	Y					
IV-E Foster Care (IV-E FC)	Y	Y	Y	Y			Y		
IV-E Adoption Assistance (IV-E AA)	Y	Y	Y	Y					
IV-B Foster Care (Child Welfare Foster Care – CWFC)	Y	Y	Y	Y			Y		
IV-B Adoption Assistance (State Adoption Assistance – SAA)	Y	Y	Y	Y					

* **NOTE**: Declaration of citizenship is not required if eligibility is determined under EMA procedures. Refer to Section 2215, Citizenship/Immigration/Identity