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/member of the eligibility determination.

BASIC CONSIDERATIONS

Eligibility for ABD Medicaid Classes of Assistance (COA) is determined in the following order:

- FBR COAs
- LA-D/ Medicaid Cap COAs
- Q-Track
- ABD Medically Needy.

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.

Applications are normally processed by the DFCS office located in the county in which the applicant resides.

Exceptions:

- If an applicant/member 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 applicant/member is no longer in that facility, the county where the applicant/member currently resides processes the application.

- If the applicant/member is applying under the Hospital COA, the application is processed in the county in which the applicant/member resided prior to entering the hospital, where the applicant/member currently resides or where the PR resides. The case should be processed in the county in which it is most advantageous for the applicant/member 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.

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Application Requirements

The application date is the date a signed application is received by any county DFCS office. **EXCEPTION:** When Long Term Care pilot applications are received via Internet or facsimile, the application date is the date the form was transmitted.

An application for any ABD Medicaid COA may be processed from any of the following application documents:

- Form 297
- SUCCESS Application for Assistance (AFA)
- Form 700

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Application Requirements (cont.)

- Low Income Subsidy Application – SSA 1020B (LISA-application for Medicare Part D
- Internet Medicaid Application
- Form 222
- PeachCare for Kids™ Application
- Form 94
- Form 632 Presumptive eligibility for Pregnancy
- Form 632W- Women's Health Medicaid Application
- Women's Health Medicaid Review Form
- 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/member or PR. The signature does not necessarily have to be that of the applicant/member. Any other information that is missing, incomplete or otherwise unclear may be obtained from the applicant/member 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 applicant/member 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 member spouse
- An application was previously correctly denied due to failure to provide required verification. Applicant/member wants to reapply in a subsequent month. Although the application date of the first application is protected, have the applicant/member 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. applicant/member now meets this criteria. Have the applicant/member 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 applicant/member is already a Medicaid member 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 member is being added as a member to

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an existing Medicaid AU, such as SSI added to Q Track or Q Track added to AMN

- 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.

Application Screening

Screen the application to determine the following:

- Current receipt of the benefits for which the applicant/member 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 applicant/member 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.

The applicant/member is the primary source of information for him/herself. The applicant/member may authorize a PR to apply, interview and provide information on his/her behalf. However, because the applicant/member 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 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:

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

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 and/or PR:

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

- financial requirements
- periodic renewals
- timely reporting of changes
- assignment of TPR
- medically needy requirements, if applicable
- vendor payment/cost share, if applicable

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Interview Requirements (cont.)

- 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
- 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.

Other Required Actions

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

Determine if the applicant/member meets all points of eligibility.

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Other Required Actions (cont.)

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 applicant/members whose income exceeds the Medicaid Cap,
provide the following as a handout to the applicant/member and/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

Standard of Promptness (SOP)

Eligibility should be processed as soon as all verification is received, this should take no longer then 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 applicant/member or PR is not interviewed on the same day an institutional COA application is filed, contact the applicant/member or PR within a reasonable timeframe to conduct the required telephone interview.
- If the applicant/member or PR is not interviewed on the same day a non-institutional COA application is filed, and additional information is required, contact the applicant/member or PR within a reasonable timeframe.
- If verification or additional information is required, complete a verification checklist and mail or give to the applicant/member or PR. Establish a reasonable deadline for returning requested verification.
- If the applicant/member or PR fails to meet the deadline for providing additional information, attempt to contact the applicant/member or PR to assess the need for an extension

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Application Processing Standards (cont.)

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.

- 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 applicant/member 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 applicant/member 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 applicant/member 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 applicant/member of the eligibility determination. A copy may also be sent to a PR at the request of the applicant/member. 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

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Notification (cont.)

- the reason for the action
- the applicant/member'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 ABD Medically Needy spenddown, if the applicant/member 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 applicant/member 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 applicant/member 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 applicant/member and/or deemor declare ownership interest.
- to detect any undisclosed property in which the applicant/member and/or deemor may have ownership interest.
- to detect and/or verify any transfer of real property affected by the applicant/member.

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 applicant/member 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:**	and 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 applicant/member 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 applicant/member or deemor who owns or has owned out of state property within the 60 month look back period
- The applicant/member alleges having a current ownership interest in real property located in a state other than Georgia.
- The applicant/member alleges having sold real property located in a state other than Georgia, and the applicant/member 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.

SPECIAL CONSIDERATIONS FOR SSI APPLICANTS (cont'd)

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**	**Application**	**Form 5460-Notice of Privacy Practices(HIPAA)**	**CCSP Communicator**	**CCSP Level of Care**	**DMA - 59**	**DMA 6 or 6A, other LOC Instrument**	**MRWP/CHSS Communicator Form 1008**	**Katie Beckett Cost-Effectiveness Form, (704)**	**Katie Beckett LOC Determination Routing Form (705)**	**Katie Beckett Care Plan (706)**	**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
MRWP/CHSS	Y	Y	Y				Y	Y							Y	Y	Y	Y	Y	Y
Katie Beckett	Y	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	