TABLE OF CONTENTS

OTHER ELIGIBILITY REQUIREMENTS

OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RENEWAL

Description: The initial authorization and granting of Medicaid is based upon a written application, made on a "State-prescribed" form. The continuance of Medicaid is premised on a renewal of the recipient's eligibility for Medicaid. Department Regulations and the recipient's individual circumstances determine the frequency of recertification.

Policy: Medicaid is granted initially upon the determination of eligibility, based on a written application, made on a "State prescribed" form. An application may be made by the applicant, his/her authorized representative, or when the applicant is incompetent or incapable, by someone acting responsibly on his/her behalf, such as an adult family member, or a person or agency acting on behalf of the applicant. Continuance of Medicaid is granted upon the renewal and redetermination of the recipient's eligibility. Documentation contained in the case record is evaluated during recertification and/or reapplication.

A separate Medicaid eligibility determination is made when a Temporary Assistance (TA) case is denied or closed and the household applied for or was in receipt of Medicaid. The only exception is when the reason to deny, suspend, reduce or terminate Temporary Assistance is also a proper basis for denial, reduction or termination of Medicaid. A separate Medicaid eligibility determination is also made when a SSI recipient loses eligibility for SSI. Medicaid is continued until a separate eligibility determination can be made.

References:

SSL Sect.	366 366-a
Dept. Reg.	350.1 350.3 350.4 360-2.2 360-2.3 360-6.2
ADMs	10 OHIP/ADM-4 04 OMM/ADM-6 97 OMM/ADM-2 82 ADM-5 80 ADM-19
INF	98 OMM/INF-02

OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RENEWAL

Interpretation: An applicant for Temporary Assistance applies separately for Medicaid by indicating that s/he wants a Medicaid eligibility determination as well. An SSI recipient is granted Medicaid based upon his/her certification for SSI. When a Temporary Assistance or SSI case is closed, Medicaid is continued until a separate Medicaid determination is made. The only exception to this is when the reason to suspend or terminate Temporary Assistance is also a proper basis for the termination of Medicaid. In this case, a separate statement appears in the Notice of Intent advising the client of the action to be taken on his/her Medicaid case, the reasons for the action, the effective date of the action and the supporting regulations. The re-determination for Medicaid is completed by the end of the calendar month following the month in which Temporary Assistance is terminated. Similarly, for every SSI cash recipient whose case is closed, unless the closing is due to the death of the recipient or because the recipient moved out of state, a separate eligibility determination is made for Medicaid.

If an individual wishes to apply for Medicaid only, a separate application for Medicaid is filed and financial eligibility established using the standards of income and resources, as appropriate, governing the Medicaid Program. To continue and re-authorize assistance, a periodic re-determination of eligibility is completed. This section deals with the application and certification as follows:

New application;

Reapplication; and

Renewal.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

FACILITATED ENROLLERS

Description: Facilitated enrollers (FEs) assist applicants in the completion of the application. This assistance includes the following:

- Providing application assistance including:
  - seeing, copying and/or recording information about documents that verify eligibility requirements such as original identity and citizenship documents;
  - assisting in the completion of the application and
  - assisting in the collection of various documentation items;
- Screening the family for the appropriate program;
- Submitting the completed application, documentation and enrollment form to the local district;
- Counseling the applicant on managed care plan selection, where appropriate; and
- Following-up with the applicant to ensure that they complete the application process.

Policy: Effective April 1, 2010, an interview for Medicaid and FHPlus must not be required as a condition of eligibility. While an interview cannot be required, FEs are required to provide application assistance, as appropriate, to an applicant who seeks assistance in understanding the application process or with completing the application. The local district determines the applicant's eligibility for Family Health Plus, Medicaid and the Family Planning Benefit Program and is responsible for the enrollment of applicants into managed care plans as appropriate.

Persons requiring long-term care services such as nursing home care or personal care may not apply through facilitated enrollers.

References:

ADMs	10 OHIP/ADM-4 01 OMM/ADM-6
INFs	10 OHIP/INF-1
GISs	11 MA/007

Interpretation: When an FE meets with an applicant or authorized representative and provides application assistance, the FE will receive and submit the application to the appropriate LDSS. In this situation, the FE must submit the application to the LDSS for an eligibility determination within 15 days. If upon agreement between an FE or health plan and

the local department of social services the FE or health plan electronically fills out an application, the applicant may provide his/her signature on an electronic keypad which transmits the signature to the application to be printed and sent to the LDSS.

NOTE: If a recipient wants to add a child to his/her case between authorization periods, the recipient may seek application assistance at an FE. Facilitated enrollers will assist the individual in completing an application for the child and submit it to the appropriate LDSS.

When an applicant completes an application on his/her own, and then submits the application to the FE, or asks the FE to review the application, the FE must review the application to ensure that it is complete and all necessary documentation has been presented. Such applications become FE applications. The FE must have the applicant resign/date the application and collect current documentation. The FE must date stamp the application on the day he/she meets with the applicant, which will start the 15 day clock.

If the applicant goes to an FE to present his/her original documents, but does not submit the completed application to the FE, and the FE does not provide application assistance, the FE must make copies of the original documents, stamp the copy indicating the date the original was seen, add the lead name and the FE name on the copy, and return the original documents and copies to the applicant for submission to the LDSS.

NOTE: Local departments of social services may not require that individuals apply through an FE, nor may they require that the applicant seek application assistance from an FE. In addition, LDSSs cannot forward applications submitted directly by an applicant to an FE and require the FE to follow up in obtaining necessary documentation.

When an application is mailed directly to a Child Health Plus (CHPlus) plan that is not an FE, the application (whether it is complete or incomplete) will be mailed by the plan directly to the LDSS if the child appears Medicaid eligible. In this situation, the date of application is the date that a signed and dated application is received by the LDSS. Non-FE CHPlus plans will not refer these applicants to an FE for application assistance. In situations where the CHPlus plan is an FE, the plan must review the application to ensure it is complete and all necessary documentation has been provided before it is forwarded to

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

FACILITATED ENROLLERS

the LDSS. In such cases, the date of application is the date the FE receives the complete application. The FE has 15 business days from the date the application was received to get the application to the LDSS.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

Description: An application for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, Medicare Savings Program, the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer Treatment Programs, and/or Medicaid Buy-In Program for Working People With Disabilities (MBI-WPD) is a written, dated form prescribed by the State. The applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting on behalf of the A/R must sign it.

Policy: An applicant requesting Medicaid, Family Health Plus, the Family Planning Benefit Program, Medicare Savings Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer Treatment Programs and/or Medicaid Buy-In Program for Working People With Disabilities may make application by dropping off an application to an LDSS or by mailing the application to the local district, facilitated enroller or other designated entity.

NOTE: Access NY Health Care applications and Supplement A can be printed from the internet at:
http://www.health.state.ny.us/nysdoh/fhplus/application.htm.
However, such applications may not be completed or submitted online.

Applicants may request assistance in understanding the Medicaid program or completing an application.

As of June 11, 2010, ALL applicants applying for Medicaid only, including applicants seeking coverage of long-term care services or nursing home care will make application for benefits on the Access NY Health Care application (DOH-4220). However, if an LDSS receives the LDSS-2921 application for a Medicaid-only applicant, they must accept the application and cannot require that the DOH-4220 or the DOH-4495A also be completed. The LDSS-2921 should continue to be used when an individual is applying for Medicaid and another program, such as Temporary Assistance, Child Care Assistance and/or Food Stamps. Individuals who are applying for the Family Planning Benefit Program (FPBP) should use the DOH-4282, Family Planning Benefit Program Application Form. The DOH-4286 (Instructions for the Family Planning Benefit Program Application) provides guidance for completing the DOH-4282. These forms may be accessed on the DOH website, at the LDSS, or at FPBP providers. Individuals who are applying for the Medicare Savings Program (MSP) should use the DOH-4328.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

NOTE: For individuals applying on the DOH-4220, county specific absent parent forms must no longer be used.

The ACCESS NY Supplement A, DOH-4495A, must be completed if anyone who is applying is age 65 or older, certified blind or certified disabled (of any age), not certified disabled but chronically ill or institutionalized and applying for coverage of nursing home care, including care in a hospital that is equivalent to nursing home care. Supplement A must be signed and dated by the applicant and/or his/her representative and if appropriate, the applicant's spouse. An S/CC or ADC-Related applicant who requires temporary nursing home care is not required to complete Supplement A. However, if such S/CC or ADC-Related applicant has a community spouse and such spouse is in a medical institution and/or nursing facility and is likely to remain in the facility for at least 30 consecutive days, Supplement A must be completed.

NOTE: Effective April 1, 2010, an LDSS can no longer require that an application interview take place.

References:

SSL Sect. 366
366-a

Chapter 58 of the Laws of 2009

Dept. Reg. 360-2.2
360-2.3
360-2.4
360-6.2

ADMs 11 OHIP/ADM-1
10 OHIP/ADM-4
04 OMM/ADM-6
04 OMM/ADM-5
03 OMM/ADM-4
01 OMM/ADM-6
97 OMM/ADM-2
95 ADM-17
93 ADM-29
93 ADM-3
91 ADM-28
90 ADM-9
88 ADM-31

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

INFs	10 OHIP/INF-1
GISs	08 MA/003 07 MA/027 07 MA/026 96 MA/015
INFs	10 OHIP/INF-1
GISs	08 MA/003 07 MA/027 07 MA/026 96 MA/015

Interpretation: An application may be made by the applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting responsibly for him/her. The applicant or someone acting responsibly on the applicant's behalf must sign the application in ink. When both a husband and wife are applying, both spouses are required to sign the “State-prescribed form”. If only one spouse is applying, the non-applying spouse cannot be required to sign the application even though information concerning his/her financial circumstances is necessary to determine eligibility for the applying spouse.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

NOTE: If the applicant's representative signs the application, the LDSS must obtain a separate authorization from the applicant or a copy of legal guardianship. The applicant can identify the role of this person to: apply for and/or renew Medicaid, discuss his/her Medicaid application or case, and/or get copies of notices and agency correspondence. This authorization continues until it is revoked by the recipient; a reauthorization is not required at renewal. However, if the applicant is incompetent or incapacitated, a copy of the legal guardianship papers is not required, nor is a separate document authorizing the representative. In these situations, the LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant.

The date of application is the date that a signed "State-prescribed" application form, or a State-approved equivalent form or process is received by the LDSS. The application date for individuals who apply at outreach sites or facilitated enrollers is the date on which the application is started. For children under age 19 and pregnant women applying through the presumptive eligibility process, the application date is the date of the screening.

NOTE: An application is considered to be filed with the LDSS when an applicant submits a signed and dated application that includes his/her name and address. The LDSS may need more information to make a Medicaid eligibility determination, but the application date is protected.

A district cannot refuse an individual the right to apply. The applicant may be accompanied and assisted in the application process, if s/he wishes, by a person of his/her choice. The applicant may receive application assistance by an LDSS staff member, an FE, or designated staff at outreach sites such as family planning providers, providers who determine presumptive eligibility and hospitals with out-stationed workers. If requested, application assistance must be provided by the LDSS in person either as a walk-in or by appointment, over the telephone or in writing. Local departments of social services must work with the applicant or his/her representative to obtain any information missing from the application, including necessary documentation. (See **OTHER ELIGIBILITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL FACILITATED ENROLLERS)

Effective April 1, 2010, an in-person application interview with the applicant or his/her representative must not be required. Applicants for presumptive eligibility (PE) and family planning benefit program (FPBP) must be screened in person when they present at a facility for covered services by a PE provider.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

The applicant must be provided material describing the program and informing the applicant or representative of: (1) the eligibility requirements for Medicaid including the different Medicaid coverage options for persons who have a resource test; (2) the responsibility of the applicant to report all facts necessary for a proper determination of eligibility; (3) the joint responsibility of the district and the applicant to explore all facts concerning eligibility and the applicant's responsibility for securing, wherever possible, records or documents supporting his/her statements; (4) the types of verification needed; (5) the fact that any investigation essential to determine eligibility will be made; (6) the fact that the A/R may be reimbursed for paid Medicaid covered medical care and services received during the three months prior to the month of application and up until the actual date of application, if otherwise eligible; (7) the fact that after the date of application the A/R must use providers who accept Medicaid and who are Medicaid approved; and (8) the applicant's responsibility to immediately notify the district of all changes in his/her circumstances. This material/information is found in: LDSS-4148A, “What You Should Know About Your Rights and Responsibilities”; LDSS-4148B, “What You Should Know About Social Services Programs” (including OHIP-0054 and as appropriate Informational Notice to Institutionalized Individuals with Real Property); LDSS-4148C, “What You Should Know if You Have an Emergency”, also known as Books 1, 2 and 3. Local social services districts may either include this information with the application package that is either mailed or handed to the applicant(s), or the LDSS may send the booklets to the applicant(s) after they receive an application. However, the LDSS may not wait until eligibility is determined to send the information. If an LDSS chooses to provide the booklets in the application package, and the LDSS receives an application printed from the internet, the information must be sent to the applicant.

NOTE: As a condition of eligibility, certain referrals to other LDSS units such as referrals to the Child Support Enforcement Unit (CSEU) are necessary. Although there is no face-to-face interview requirement, such required referrals have not been waived or eliminated.

As a result of mandatory managed care, most applicants for Medicaid must choose a managed care plan. Although choosing a Medicaid managed care plan is not a condition of eligibility, failure to do so will result in the applicant being assigned to one, also known as auto-assignment.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

Because FHPlus is a managed care-only product, new applicants MUST select a managed care plan AND complete a managed care enrollment form as a condition of eligibility unless the A/R resides in a district that has only ONE Family Health Plus Plan. It is strongly recommended that A/Rs complete Section K of the DOH-4220 Access NY Health Care Application or Section 19 of the LDSS-2921 or the Medicaid Managed Care and Family Health Plus enrollment form whenever possible to enable the A/R to provide primary Care provider or health center choice information. If the person fails to do so, the enrollment must be entered in accordance with procedures outlined in 01 OMM/ADM 6 Section IV. C. 3. In districts that have more than ONE Family Health Plus Plan, an application is not complete unless a plan has been selected.

Prior to making a plan selection, all Medicaid and FHPlus applicants must be informed about the managed care program, available plans in the county and optional benefits. This is known as managed care "education". Managed care education may be conducted by mail, in person, by telephone or through FEs. Applicants may be referred to managed care workers or enrollment counselors at the time they choose to come into the LDSS to conduct business such as copying documents, requesting application assistance or to bring in required documentation. Districts must provide managed care education packets that include county specific information and a managed care contact for more detailed information.

MBI-WPD recipients with income below 150% of the federal poverty level may enroll in managed care. MBI-WPD recipients with income at or above 150% of the federal poverty level cannot be enrolled in managed care.

Persons in receipt of Medicare, regardless of their categorical status or income level cannot be enrolled in Medicaid managed care with some exceptions including Managed Long Term Care and Medicare Advantage Plans.

Applications for the Medicaid Cancer Treatment Program are received and processed by State DOH/OHIP staff. (See **CATEGORICAL FACTORS** MEDICAID CANCER TREATMENT PROGRAM (MCTP))

SSI-related Medicaid applicants have the option of applying for:

1. Community Coverage without Long-Term Care which includes all Medicaid covered services except nursing facility services and

community based long-term care services. SSI-related Medicaid applicants who are not seeking coverage of long-term care services may attest to the amount of their resources rather than provide proof. (See **RESOURCES** DOCUMENTATION REQUIREMENTS)

2. Community Coverage with Community-Based Long-Term Care which includes all Medicaid covered care and services except nursing facility services. (See **RESOURCES** DOCUMENTATION REQUIREMENTS) SSI-related Medicaid applicants electing to apply for this coverage must provide proof of their current resources.
3. Medicaid coverage of all covered care and services which includes nursing facility services. SSI-related Medicaid applicants electing to apply for this coverage must provide documentation of resources for the past 60 months in accordance with transfer of resource policies. (See **RESOURCES** TRANSFER OF ASSETS)

Local districts must inform SSI-related Medicaid applicants of the available coverage options and may require the applicant to sign a "Request for Medicaid Coverage" or an approved local equivalent, indicating the coverage choice an applicant made.

It is important that the applicant understand the eligibility determination process, including the effect that the documentation of resources options have on the services the SSI-related individual may receive. The applicant must also understand that it is his/her responsibility to keep the district informed of any change in his/her income and/or resources and the need for a service which s/he does not have coverage.

If a recipient has active community coverage (with or without long term care) and subsequently is admitted to a nursing facility, Supplement A must be completed and resource and trust documentation submitted for the appropriate time period(s).

If an SSI-related recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of the new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. Districts must send the recipient a "Long-Term Care Change in Need Resource Checklist" and inform the recipient of the additional documentation that is needed to determine eligibility for long-term care.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

The applicant is advised of his/her right to have an agency conference or to request a fair hearing, as appropriate. The applicant is also notified of other services for which s/he may be eligible.

Verification: All factors relating to the eligibility determination are verified. These include, but are not limited to: identity; citizenship or alien status; family composition; residence; age; income from all sources; all resources of SSI-related applicants including savings and life insurance; and medical, accident and/or health insurance.

However, Medicaid and Family Health Plus applicants whose eligibility is determined without regard to resources may attest to the amount of interest income generated by resources.

Interest income is estimated by establishing the average interest rate(s) and applying them to the resource information obtained from RFI or other third party sources. If upon review, the district finds an inconsistency between the information reported by the individual and the estimate calculated by the district, and the interest income information obtained by the district makes the individual ineligible for Medicaid or FHPlus, documentation of the interest income must be obtained from the individual. For individuals who qualify for Medicaid with a spenddown, the difference in the amount of interest income reported by the recipient must be greater than $1.00 per month before requiring further follow-up.

Districts must continue to review RFI reports to identify resources belonging to individuals who do not have a resource test to determine when a resource identified by RFI is significant enough to generate interest that would/could affect the individual's eligibility. In such instances, the district must request documentation of the interest income and re-calculate eligibility as appropriate.

The LDSS must contact the applicant to get additional information that is required to make an eligibility determination. Options for obtaining information include: calling the applicant to get information over the phone and notating and initialing it on the application and recording a note in the case record as to the date of the telephone conversation with the Applicant; if information is missing from the various sections of the application a photocopy of the incomplete pages may be mailed to the applicant to complete and return to the agency.

If the applicant is unable to provide the district with acceptable proof of

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

his/her eligibility, collateral sources are used to secure verification. By signing the application, the applicant agrees to an investigation confirming any information s/he provided. However, it may be necessary, due to district procedures or requirements of outside agencies, to have a separate consent form signed by the applicant before collateral sources are contacted and information verified.

NOTE: If an SSI-related Medicaid applicant attests to his/her resources, the local social services district may continue to independently verify the accuracy of the information provided by the applicant. However, the Medicaid eligibility determination cannot be delayed pending this verification.

If the applicant claims paid or unpaid medical bills for the three-month period prior to the month of application, eligibility for that period must also be established. This three-month period is retroactive from the month in which the person applied. There is no three-month retroactive period for Family Health Plus or the Family Planning Benefit Program (FPBP). When an applicant eligible for Family Health Plus or FPBP has medical bills within the three months prior to application, the bills can only be paid if there is an agency error or delay or the A/R is financially eligible for Medicaid during the three-month retroactive period and has met his/her spenddown.

NOTE: A person does not have to be living to have unpaid medical expenses covered by Medicaid. A representative may apply on behalf of the deceased person. Medical expenses may be paid for a deceased person, provided the person was eligible at the time the medical service was rendered.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

When providing application assistance to an applicant who has brought his/her application to the local department of social services, the LDSS may offer to screen the application, but may not require that the application be screened. If during the screening the LDSS finds that the case will be ineligible/denied based on income, the district must continue to process the application, request income documentation and render a decision with proper notice.

Documentation: Sufficient to establish an audit trail:

Photocopies may be used. A primary source for eligibility documentation is any previous case record.

When citing documents, the date, issuing authority, file number and such pertinent data as necessary to determine authenticity must be recorded in the applicant's file.

Applicants must show original or certified copies of documents that document identity and citizenship. These documents may be presented at the LDSS to an FE, designated staff at an outreach site including deputized workers, or to designated staff at an entity in the community with which the LDSS has established a Memorandum of Understanding (MOU) for purposes of verifying that original documents have been seen. (It is not necessary for the LDSS to enter into a separate agreement from those that currently exist with entities such as community based organizations (CBOs) or plan FEs, family planning providers, presumptive eligibility qualified entities or Article 28 prenatal care providers.) Such community organizations will not validate the authenticity of the documents, nor will they determine if the identity and/or citizenship documentation requirement has been satisfied.

Local departments of social services must allow applicants at least 10 days to provide requested documentation. If an applicant is requested to provide documentation necessary to make an eligibility determination and does not do so within the required time period and does not ask for more time or assistance in obtaining documentation, his/her application may be denied.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

NOTE: If an applicant seeking Medicaid coverage of nursing facility services does not meet a request for documentation deadline and the applicant is eligible for Medicaid coverage, QMB, SLIMB, or QI the case must be opened for the coverage for which the applicant is eligible.

If an application is submitted and all necessary information is included, an application must not be denied due to the failure to provide information that is inconsequential. For example: An application must not be denied if supporting documentation of a water expense or childcare expense is not submitted if the applicant can be determined eligible without this deduction.

The determination of eligibility is made promptly, generally within 45 days of the date of application. Determinations for persons eligible under the poverty-based programs (pregnant women and children under age 19) are completed within 30 days. Determinations of eligibility based on a disability are completed within 90 days. Under certain circumstances additional time may be required, such as when there is a delay on the part of the applicant, an examining physician or because of an administrative or other emergency that could not be controlled by the district.

NOTE: If the district is waiting for essential information, the reason for the delay is noted in the record. The applicant is notified by letter of the reason for the delay in his/her eligibility determination. Although the DOH-4220 asks the applicant to list a Client Identification Number (CIN) or an identification number from a plan card, if this information is not provided, the LDSS must not deny the application or request the information from the applicant.

Disposition: The eligibility worker reviews the application for completeness and accuracy. The LDSS must contact the applicant to obtain additional information that is needed to make an eligibility determination. If the application is being made through a facilitated enroller, the facilitated enroller does not forward the application to the district until the application is complete. (See **OTHER ELIGIBLITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL FACILITATED ENROLLERS) When the applicant fails or refuses to provide information essential to the eligibility determination, s/he is informed in writing that his/her application is denied, the reasons for the denial and his/her right to a fair hearing.

NOTE: If a community applicant who is age 65 or older, certified blind

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

or certified disabled, or not certified disabled is found eligible for Medicaid or FHPlus based on ADC-Related budgeting, eligibility cannot be denied based on the applicant's failure to complete Supplement A. If an S/CC applicant is chronically ill and he/she failed to comply with a disability review or did not complete Supplement A, the applicant cannot be denied coverage if otherwise eligible for Medicaid under an S/CC budget or FHPlus.

If the LDSS believes that the applicant is the fiscal responsibility of another district, the LDSS where the individual is applying may take a "courtesy application" and forward it to the district of fiscal responsibility. The agreed upon district of fiscal responsibility shall obtain any information missing from the application.

NOTE: The date the first district received the application is protected as the date of application. (See **OTHER ELIGIBILITY REQUIREMENTS** DISTRICT OF FISCAL RESPONSIBILITY (DFR))

Exception: When an applicant claims to have a disability or when it appears that an applicant may meet the criteria for disability, the district has 90 days from the date of application to make a determination of eligibility. This 90-day period is not used as a waiting period before granting assistance, if the applicant is eligible under a different category. Coverage is authorized as soon as eligibility is established. A note is made in the record as a reminder to re-budget the recipient, adjust any spenddown amounts and claim FP coverage for the retroactive period when the A/R is certified disabled. When it is necessary to hold a potential disability case beyond the 90-day period, this is not a basis for denying Medicaid to an otherwise eligible applicant or for terminating assistance.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

FAMILY PLANNING BENEFIT PROGRAM (FPBP) APPLICATION

Policy:

Local social services districts must determine FPBP eligibility for persons of childbearing age who are determined ineligible for Medicaid, and Family Health Plus. When a family or individual applies for Medicaid/ Family Health Plus and is determined ineligible, FPBP eligibility is determined for all applicants of child-bearing age. Children must be referred to CHPlus.

Persons can apply for the FPBP using the DOH-4282 and DOH 4286, FPBP application and instructions. When the application is for the Family Planning Benefit Program (FPBP) only, family planning providers and local county health departments can assist in the application process if the provider has a memorandum of understanding (MOU) with the district/SDOH. In addition, all Article 28 providers and others designated by the State Department of Health who have been trained must provide application assistance. Districts are encouraged to work with these entities to enter into MOUs, so that the application process can be facilitated. All applications taken by these family planning providers who have an MOU with the district will be forwarded to the local district for final eligibility determinations.

FPBP applicants must be informed, by the person who provides application assistance, of the benefits available under Medicaid, and Family Health Plus and of their right to apply for Medicaid and Family Health Plus. When the applicant's reported income is at or below the Medicaid or Family Health Plus income standards, the individual/family is encouraged to apply for these programs and the application requirements are explained. After this discussion, if the applicant chooses to apply for the FPBP only, the applicant completes the Family Planning Benefit Program application (DOH-4282) and signs the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement on the back of the application. The applicant is advised that s/he may apply for Medicaid or Family Health Plus at any time in the future.

References:

SSL	366(1) (a) (11)
ADMs	10 OHIP/ADM-4 03 OMM/ADM-2 02 OMM/ADM-7
INFs	10 OHIP/INF-1

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

FAMILY PLANNING BENEFIT PROGRAM (FPBP) APPLICATION

Interpretation: Persons under the age of 21 who want to apply for family planning services only, are living with their parents, and do not have their parents' financial information complete the "Family Planning Benefit Program" application. This application is available at the LDSS, on the Internet, on the DOH website, and at an FPBP provider who has an MOU. (See **INCOME** FAMILY PLANNING BENEFIT PROGRAM (FPBP) BUDGETING METHODOLOGY for budgeting guidelines.) Adults who choose not to apply for Medicaid and Family Health Plus also use the Family Planning Benefit Program application.

When the applicant requests confidentiality, the applicant is instructed to write "confidential" in the margin and circle the mailing address, if different from the applicant's residence address. However, if the application contains a different mailing address, and/or the "Yes" box is checked in answer to the question, "Do you need these services kept confidential?", the application is treated as confidential, regardless of whether the applicant circled the mailing address or wrote "confidential" in the margin. Regular procedures regarding good cause claims must be followed.

Minors receiving Child Health Plus who have confidentiality concerns about using their Child Health Plus coverage for family planning services are allowed to enroll in FPBP, if otherwise eligible.

Medicaid and Family Health Plus recipients are not eligible for FPBP. These health care programs include family planning services.

Individuals who apply for Medicaid or Family Health Plus and are determined ineligible, have their eligibility determined for FPBP. Individuals who are financially eligible for FPBP, but who choose not to participate in FPBP, must be sent the appropriate notice to the confidential mailing address the A/R has provided if confidentiality has been requested.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

MEDICARE PART D LOW INCOME SUBSIDY APPLICATION

Description: Low income individuals not enrolled in Medicaid or in one of the Medicare Savings Programs (QMB, SLIMB, QI) who wish to have assistance paying Medicare Part D monthly premiums, deductibles and co-payments must apply for the federal Low Income Subsidy (LIS) Program.

Policy: Applications for LIS may be made with the Social Security Administration. Applicants may call the Social Security Administration or apply online at www.socialsecurity.gov. Applicants may receive assistance from the local Office for the Aging.

References:

SSL Sect. 366-2 (b) (1)

ADMs 05 OMM/ADM-5

GISs 06 MA/003
05 MA/024

Interpretation: Individuals who apply for Medicaid or Medicare Savings and are found eligible will automatically be enrolled in Low Income Subsidy (LIS).

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

REAPPLICATION

Description: A reapplication for Medicaid is an application made by a former recipient whose eligibility was terminated or an applicant whose previous application was denied by the district.

Policy: A reapplication for Medicaid must be as complete and accurate as a new application for Medicaid.

When an applicant is denied and reapplies within 30 days, a new written application on the "State prescribed" form is not required. In this situation, the date of application is the date that a written request for reapplication is received.

References:

SSL Sect	366 366-a
Dept. Reg.	360-2.2 350.4(a)(5)
ADMs	04 OMM/ADM-6 93 ADM-29

Interpretation: When a reapplication is made, any previous application or record available in the local district is used for reference and documentation of eligibility factors not subject to change (e.g., date of birth). This includes verified information available through the Welfare Management Systems (WMS) in an active or closed case record. If documentation is available in the record, it can be used to verify or supplement data the applicant has available. In every case, the reapplication must be as complete and accurate as an original application, factors relating to eligibility verified and documented. If the reapplication is made within 30 days of a previous case closing, attestation rules apply.

In all instances where there is a previous record or application, a cross-reference is made to verify accuracy and consistency with the current reapplication. When inconsistencies are apparent, the worker pursues the factual data to resolve such inconsistencies.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

REAPPLICATION

Verification/ Documentation: Needed verification and documentation are identical to that of a new application. (See **OTHER ELIGIBILITY REQUIREMENTS** NEW APPLICATION).

NOTE: The case record is a primary source for documentation. A/Rs are not asked to provide information that is contained in the case record, unless such information is subject to change (e.g., work history).

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

Description: A recertification/renewal for Medicaid is a review of current eligibility factors to determine whether to continue, change or discontinue Medicaid based upon the eligibility of the recipient.

All active Medicaid cases, including those receiving both Medicaid and Temporary Assistance, are recertified periodically. Generally, the recipient must submit a written renewal (recertification) to continue Medicaid. The re-authorization period may not exceed one year.

Policy: Each month, the district/State produces reports of cases due for renewal, generally at least 60 days prior to the date coverage expires. Based on the district's entry of the appropriate code in the Client Notices System (CNS), a renewal package is produced and mailed to the recipient, or districts may opt to have the State automatically generate the renewal package through a one-time entry in the AFA field on WMS. This process is described in a WMS/CNS Coordinator Letter dated November 1, 2004.

The renewal package advises the recipient that coverage is expiring and explains the need for the recipient to provide current information and, in some cases, documentation to the local district. The deadline for returning the renewal form and the return address are included. It is the responsibility of the recipient to return the renewal form and the required documentation to the local district by the deadline provided.

Prior to September 1, 2011 the signatures of all adults applying for Medicaid/FHPlus were required on the renewal form. Effective September 1, 2011, only the signature of one applying adult is required on the renewal form.

NOTE: The renewal form for community cases, except for FPBP cases, contains pre-printed information from the Welfare Management System (WMS). It provides space for the recipient to amend the pre-printed information and provide new information, when appropriate.

Effective January 1, 2012, SSI-related single individuals and couple households with fixed incomes and whose resources are less than 85% of the Medicaid resource limit at application or last renewal whichever is later will have their case automatically renewed by the State. Such cases include SSI-related individuals or married couples 18 years of age or older with an Individual Categorical Code of Aged, Blind or Disabled, a Budget Type of SSI-related, Social Security as the only source of income and resources at or below 85% of the applicable Medicaid resource limit. Cases not included: Medicare

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

Savings Program only, nursing facility services and excess income. Neither the individual nor couple will be required to mail in a renewal form.

NOTE: Social services districts remain responsible for processing any changes reported by recipients whose case has automatically been renewed. Districts must take appropriate action based on the type of change reported.

NOTE: If an Upstate recipient wishes to add a child to his/her case between renewal periods, a separate application is not required. A recipient may simply call the LDSS and request the addition. If needed, documentation for the child must be provided and the LDSS must provide a notice of decision regarding the eligibility determination.

If an Upstate recipient wishes to add an adult to his/her case mid-renewal, a new application must be completed by the adult to be added to the case.

Children 18 to 21
Medicaid renewal for children ages 18 to 21 who are final-discharged from foster care (Chaffee Children) is done on the Chafee Medicaid renewal form.

As a passive renewal, if the renewal is not returned via United States Postal Service (USPS) eligibility must be authorized for another year, but never past the 21st birthday.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

If the renewal form is returned by the USPS with a forwarding address label that is within the district, the renewal form must be re-sent to this address. If the form is not returned as undeliverable, coverage must be re-authorized for another 12 month period, not to exceed the child's 21st birthday.

If the renewal form is returned by the USPS with a forwarding address label that is outside the district, the renewal form must be resent to the address provided by the USPS. If the renewal is returned by the child confirming the address, the case should be renewed for a 12-month period and then transferred in accordance with 08 OHIP/LCM-1. If the child has moved out of New York State or is deceased, the case may be closed.

SSI cash recipients

Individuals who receive Medicaid based on their eligibility for SSI are renewed (recertified) for Medicaid by virtue of their renewal (recertification) for SSI cash. SSI cash recipients need not be reauthorized yearly. Their authorization will be open-ended until December 31, 2049. Local districts use the SDX to confirm that an cash SSI recipient continues to be eligible for SSI and, therefore, Medicaid.

References:

SSL Sect. 366
366-a
366-a (2)
366-a (5) (d)
369-ee (2)

Chapter 58 of the Laws of 2010

Dept. Reg. 360.1
360-2.2(e)
360-6.2

ADMs 11 OHIP/ADM-1
11 OHIP/ADM-9
09 OHIP/ADM-1
08 OHIP/ADM-4
04 OMM/ADM-6
03 OMM/ADM-2

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

INFs	10 OHIP/INF-1
LCM	94 LCM-84
GIS	11 MA/015 11 MA/012 11 MA/002 04 MA/021

Interpretation: The period covered by a recertification may vary by category and circumstances but may not extend beyond one year. Most recipients are certified for one year; however, when a recipient is unemployed or receives variable or seasonal income, s/he may require more frequent recertification.

Verification/ Documentation: Renewing community Medicaid recipients who are not seeking coverage of institutional based nursing facility services all FHPlus recipients, recipients of the Medicare Savings Program (MSP), the Family Planning Benefit Program (FPBP), participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may, at renewal attest to the amount of their income, resources as appropriate, child/adult care expenses and to their residence, even if their address has changed since their last eligibility determination.

SSI-related recipients who are participating in the MBI-WPD program must continue to document their employment status.

All persons renewing and who do not have a resource test may attest to the amount of interest income generated by resources.

For persons other than those receiving chronic care, a reported change in circumstances may be treated as a renewal. A recipient's attestation of a change in circumstances by telephone is sufficient to re-budget the case, and a written statement documenting the change is no longer required. However, if the recipient requests to add an individual to the case, documentation requirements must be met.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

NOTE: When a recipient reports a change that does not require a new budget, such as an address change, the worker must confirm that no other changes in the household have occurred in order to consider this report as a renewal.

When the renewal is being handled by New York Health Options/the Enrollment Center and the individual reports a change within three months prior to the end of the authorization period and the LDSS is treating such report as a renewal, New York Health Options must be contacted by fax and requested to withdraw the renewal from HEART.

In counties that have combined Food Stamp (FS) and Medicaid units, renewals received for FS may also be used to renew the Medicaid case and authorize 12 months of Medicaid coverage if the A/R is found eligible for FS.

INCOME:

In lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration), the Work Number Website (TALX, used for obtaining employment and wage verification), the currently stored budget, or actual income documentation from a current Food Stamp or HEAP case. When using RFI, districts must only consider information from the most recent calendar quarter (the calendar quarter immediately preceding the current calendar quarter) as current. Information from any prior calendar quarter is to be considered a “no hit” on RFI. At any point after initial application, only Bendex and UIB may be regarded as primary sources of verification to close a case.

RESIDENCE:

Documentation of a change of address is not required at renewal unless the district has information to the contrary. If a renewal is returned to by the U.S. Postal Service with a forwarding address label, the renewal must be re-mailed to the new in-district address. No additional documentation of the address change is required. If the forwarding address label indicates the recipient lives in a different county, the renewal must be re-mailed to the new

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

address. If the renewal is returned by the recipient, it must be processed by the district before the case is transitioned to the new district (See **OTHER ELIGIBILTIY REQUIREMENTS** STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY). Districts must discontinue coverage to persons who fail to respond to the renewal.

RESOURCES:

SSI-related recipients authorized for Community Coverage without Community-Based Long-Term Care and Community Coverage with Community-based Long-Term Care must itemize their current resources and attest to the value such resources. Districts must verify the accuracy of the resource information through collateral investigations. If there is an inconsistency in the information reported by the recipient and the current information obtained by the district, eligibility must be re-determined using the newly obtained information. If the SSI-related individual is found resource ineligible, eligibility must be determined for FHPlus or Medicaid under a category with no resource test. If the SSI-related individual is not eligible for FHPlus or Medicaid as a non-SSI-related recipient and further information about a resource is required to make a determination, the recipient must be notified to provide the necessary information. If the individual fails or refuses to provide such information, the case must be discontinued for failure or refusal to provide information necessary to make a determination.

INTEREST INCOME:

All community Medicaid recipients who are not seeking coverage of institutional based nursing facility services all FHPlus recipients, recipients of the Medicare Savings Program (MSP), the Family Planning Benefit Program (FPBP), participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may, at renewal attest to the amount of interest income generated by resources.

Interest income is estimated by establishing the average interest rate(s) and applying them to the resource information obtained from RFI or other third party sources. If upon review, the district

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

finds an inconsistency between the information reported by the individual and the estimate calculated by the district, and the interest income information obtained by the district makes the individual ineligible for Medicaid or FHPlus, documentation of the interest income must be obtained from the individual. For individuals who qualify for Medicaid with a spenddown, the difference in the amount of interest income reported by the recipient must be greater than $1.00 per month before requiring further follow-up.

Districts must continue to review RFI reports to identify resources belonging to individuals who do not have a resource test to determine when a resource identified by RFI is significant enough to generate interest that would/could affect the individual's eligibility. In such instances, the district must request documentation of the interest income and re-calculate eligibility as appropriate.

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

Recipients are not required to document and verify items that remain constant, such as age and identity. However, some of the information printed on the renewal form such as a person moving into the household, health insurance premiums and new health insurance whether the premium is paid by the individual or the local social services district, and the employment of MBI-WPD participants must be documented.

If a recipient is paying a health insurance premium and fails to document the premium amount and s/he is eligible without the deduction, the case must be processed without the deduction. If the recipient needs the deduction to remain eligible OR the local department of social services is reimbursing the recipient for the premium (other than a Medicare premium), the case must be pended and the documentation requirements form (LDSS-2642) sent, allowing 10 days for the recipient to submit proof of the payment or premium. If the recipient fails to respond to the request for documentation, the case must be re-budgeted without the premium amount as a deduction and reimbursement of premiums are discontinued with appropriate notice.

Recipients who are, or expect to be participating in the excess income program will be requested to submit proof of their income (and child/adult care and third party health insurance) so that their spenddown amount can be calculated as precisely as possible. If a recipient who is eligible to participate in the Excess Income program fails to document income, eligibility must be based on the income the recipient has attested to. SSI-related Medicaid recipients who are receiving or seeking institutional based nursing facility services are required to document their income, current resources and new residence. However, if these individuals fail to submit documentation of income, new residence, resources or other required information, districts must send a documentation requirements form (LDSS-2642) requesting the missing documentation. If the recipient does not return the requested documentation within 10 days, districts must not discontinue coverage, but must authorize Community Coverage with Community-based Long-Term Care, if the individual remains otherwise eligible.

SSI-related individuals in receipt of Community Coverage without Community-Based Long Term Care OR Community Coverage with Community-Based Long Term Care who request an increase in coverage to Community Coverage with Community-Based Long Term

OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

Care or Medicaid coverage of institutional based nursing facility services respectively, must document income and resources including resource documentation for the full transfer of assets look back period for coverage of institutional-based nursing services.

Supplemental Security Income (SSI) recipients that lose eligibility for such benefits are given an extension to allow for continued Medicaid eligibility to be determined. If the former SSI recipient is in receipt of Community-based Long-term Care services he/she must document income and resources as part of the redetermination process. At subsequent renewals, the individual is allowed to attest to income and resources.

All SSI cash recipients who enter a nursing facility and appear on the SDX with a "Pay Status Code" of EO1 (eligible - no payment) are sent a letter by the district informing them of their continued eligibility for Medicaid. In addition, the income of these individuals is reviewed to determine the amount, if any, of their net available monthly income (NAMI) to be contributed toward the cost of care.

NOTE: Documentation of income, residence and resources, as appropriate, at initial application is still required for ALL applicants.

OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

Description: A decision on an application, reapplication, or recertification is a determination that the applicant is either eligible or ineligible for Medicaid.

Policy: A decision as to the A/R's eligibility is made within specified time periods for each new application, reapplication and recertification. Upon reaching a decision, a written notification of acceptance, denial, withdrawal, discontinuance, reduction or change in the spenddown calculation is sent to the applicant.

The Notice of Intent sent to Temporary Assistance A/Rs who have also applied for Medicaid contains a separate statement concerning Medicaid eligibility. Where the reason for denying the TA case is also a valid reason for denying Medicaid, it is stated separately in the Notice of Intent.

New SSI beneficiaries will receive a letter from New York State informing them that they are automatically eligible for Medicaid. This letter also requests the A/R to supply information concerning third party health insurance, and information on paid or incurred medical bills for the three months prior to the month of application.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.3
358-4.1
360-2.4
360-2.5
360-2.8
360-2.9

ADMs 10 OHIP/ADM-4
89 ADM-21
82 ADM-5

Interpretation: A determination of eligibility is made within a 45-day time period. A determination of eligibility for persons eligible under the poverty based programs (pregnant women and children under age 19) is completed within 30 days. The only exception to this are cases awaiting a disability determination. A 90-day time limit is applied to situations when a disability determination is being

OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

made. (See **CATEGORICAL FACTORS** SSI-RELATED DISABILITY) If the eligibility determination process for a disabled applicant takes more than 90 days, on or before the 90th day, the A/R is sent a written statement stating the reasons for the delay. When the applicant is eligible under a different category, Medicaid is authorized for the interim period.

Each applicant for Medicaid is notified in writing of the local district's decision regarding his/her application. In the written notification, the applicant is informed of: the action taken, the effective date of the action, the specific reason(s) for the action whether positive or negative, including supporting regulations or laws; his/her right to a conference with a representative of the district; and of his/her right to a fair hearing including the method by which s/he may obtain a hearing. The applicant is also advised that s/he may be represented at any conference or fair hearing by someone such as legal counsel, or by a relative, friend or other person and of the availability of community legal services (Legal Aid), if any. A fair hearing request may be made on the basis of: denial of assistance; failure to determine the applicant's eligibility within the time period specified; inadequacy of the amount or manner of assistance; discontinuance or reduction of coverage or assistance; objection to State policy as it affects the applicant; or any other grounds affecting the applicant's entitlement to assistance. If a recipient requests a fair hearing within the time period specified in the notice, Medicaid is continued unchanged until a decision is issued on the Fair Hearing.

A separate Medicaid eligibility determination is completed for every TA case closed or denied where the A/R also applied for or was in receipt of Medicaid, except for cases when the reason for closing or denying TA is also a valid reason for closing or denying Medicaid. In all situations, the client is advised in a separate statement of the status of his/her Medicaid eligibility.

This section describes decision and notification in detail. It is organized as follows:

Acceptance;
Denial;
Withdrawal; and
Discontinuance or reduction.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

ACCEPTANCE

Description: When an application for Medicaid is accepted, Medicaid is authorized for a stated person(s) for a specific period of time. The applicant is notified as to who was accepted or denied and the effective date of authorization.

Policy: When an application is accepted and Medicaid is authorized, notification in writing shall be sent to the applicant.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5
ADMs	04 OMM/ADM-6 97 OMM/ADM-2 96 ADM-15 89 ADM-21 87 ADM-41

Interpretation: Written notification to the applicant includes a copy of the applicant's budget and an explanation of what care or services are authorized. If limitations are placed upon care or services, the limitations are explained in the letter. A copy of the notice is also sent to the medical provider (e.g., nursing home or hospital), as appropriate.

When only certain members of the applying household (group applying) are accepted for coverage, the coverage is explained in the notice to the applicant. The notice also advises the applicant of his/her responsibility to inform the district of any changes in his/her financial situation and/or any other changes affecting eligibility.

In addition to the standardized notice, an A/R with excess income (See **INCOME** EXCESS) is given a copy of the "Explanation of Excess Income Program" letter. When appropriate, a copy of the "Provider/Recipient Letter" and the Optional Pay-In Program for Individuals with Excess Income" (See 96 ADM-15) is sent to A/Rs with excess income. The "Provider/Recipient Letter" lists incurred medical expenses for which the A/R is responsible or partially responsible. A copy of the "Provider/Recipient Letter" is

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

ACCEPTANCE

also sent to the provider for billing purposes. When the medical expenses are for services from more than one provider, a separate form is completed for each provider to protect the A/R's confidentiality. When the A/R is a patient in a nursing facility or is approved for nursing home care, a letter of notification is sent to both the nursing home and the A/R clearly stating the A/R's liability toward the cost of care. When the A/R is an institutionalized spouse, the community spouse is also sent a copy of the notice.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DENIAL

Description: A denial is a determination that an applicant is not eligible for Medicaid.

Policy: When an application for Medicaid is denied, a written notification is sent to the applicant.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.3
358-4.1
360-2.3
360-2.4
360-2.5
360-2.8
360-2.9

ADMs 10 OHIP/ADM-4
04 OMM/ADM-6
97 OMM/ADM-2
96 ADM-15
89 ADM-21
87 ADM-4

INFs 10 OHIP/INF-1

GIS 10 MA/015

Interpretation: An application for requested Medicaid coverage may be denied because the applicant is ineligible or because the applicant's eligibility cannot be determined due to his/her failure to cooperate in establishing eligibility.

When a decision is reached, a letter is sent to the applicant, including a copy of the budget, when applicable, informing him/her of the reason for the denial and of his/her right to: a conference with a representative of the local district; and a fair hearing as outlined in **OTHER ELIGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION. A copy of the notice is also sent to the Medical provider (e.g., nursing home and hospital) as appropriate.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DENIAL

When an applicant is denied due to excess income and the applicant is ADC-related, SSI-related, a pregnant woman, or under age 21, the letter explains how excess income may be utilized to "spend down" to the Medically Needy Income level. (See **INCOME** MEDICALLY NEEDY INCOME LEVEL). The letter further explains local district procedures regarding the applicant's use of the excess income, including the "Optional Pay-In Program for Individuals with Excess Income."

NOTE: If an LDSS receives an application for a child who is ineligible for Medicaid due to excess income or immigration status and a plan selection has been made, the LDSS must, on a daily basis, mail the application and documentation, including a copy of the ineligible Medicaid budget for cases denied for excess income, directly to the selected CHPlus plan. If a plan selection has not been made and there is only one CHPlus plan in the county, the application and supporting documentation is mailed directly to that plan. If a plan selection was not made and there are multiple CHPlus plans available in the county, the LDSS must send the application and supporting information to the Corning Tower, Room 1619, Empire State Plaza, Albany, New York 12237.

If an LDSS receives a Common Application (LDSS-2921) for a child under 19 years of age who is ineligible for Medicaid due to excess income or immigration status, the "Release of Information to the Child Health Plus Program" form must be signed if an eligibility determination for Child Health Plus is desired. The LDSS must mail a copy of the application (LDSS-2921), the release form, supporting documents, a copy of the denial letter and a copy of the Medicaid budget that shows ineligibility to the Community Based Organization (CBO) in their county. If there is more than one CBO the LDSS does business with, the LDSS should select the CBO that is geographically closest to the applicant's residence address.

If an LDSS receives a renewal or a request between renewal periods to add a child under 19 to a recipient's Medicaid case and the child is determined ineligible based on excess income or immigration status, the LDSS must send a manual denial notice and a blank DOH-4220 and instruct the individual to apply for CHPlus.

In all instances, if the LDSS has confirmed income information through UIB, SDX or the Child Support Collection unit, such information must be forwarded with the CHPlus application.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

WITHDRAWAL OF APPLICATION

Description: After the submission of a written application, but before the applicant is notified by the local social services district of his/her eligibility determination, the applicant may withdraw his/her request for Medicaid.

Policy: When an application is withdrawn by the applicant, the district registers it as withdrawn.

References:

SSL Sect.	366
	366-a
Dept. Reg.	358-3.1
	358-3.3
	358-4.1

Interpretation: The decision to withdraw an application can only be made by the applicant or by the person making the application on behalf of the applicant. When the withdrawal is made in person, the applicant or representative is asked to sign the application as appropriate or sign a statement declaring his/her desire to withdraw the application. When the request is by phone, a notation is made on the application. In addition, an adequate notice is issued to the applicant/representative confirming the voluntary withdrawal. No further action is taken on the application; however, the applicant may reapply at any time. Original documents, such as birth certificates, are returned to the applicant, but any photo static copies and the application remain with the district and are not returned to the applicant.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DISCONTINUANCE OR REDUCTION

Description: A discontinuance of Medicaid is a termination of all benefits under the program. The reduction of Medicaid is a change of benefit coverage from more extensive coverage to less extensive coverage or to an increase in the recipient's liability, i.e., a change from Community Coverage with Community-Based Long-Term Care to Community Coverage without Long-Term Care, or a change from full coverage to a spenddown.

Policy: A determination by the district to discontinue or reduce a recipient's Medicaid coverage is communicated to the recipient in a letter of intent to discontinue or reduce Medicaid. Generally, the notice is sent at least ten days in advance of the proposed action. Under certain circumstances, it is not necessary to send a notice of intent ten days in advance of the action. (See **OTHER ELIGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION) Where the A/R is in receipt of both Medicaid and Public Assistance, any notice to discontinue or reduce Temporary Assistance also includes a statement advising the client of the status of his/her Medicaid eligibility.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.3
358-4.1
360-2.3
360-2.6
360-2.7
360-2.8
360-2.9

ADMs 04 OMM/ADM-6
97 OMM/ADM-2
89 ADM-21
83 ADM-27
81 ADM-55
80 ADM-19

Interpretation: A Medicaid case is discontinued because of the recipient's ineligibility for continued assistance, failure to cooperate, permanent removal from the district or other factors which affect continued eligibility. Generally, a letter of notification

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DISCONTINUANCE OR REDUCTION

is sent (See **OTHER ELGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION), at least 10 days in advance of the proposed action, to the recipient advising him/her of: the action to be taken; the effective date of the action, the reason(s) why the action(s) is/are being taken; the supporting law or regulation; the client's right to request a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of the notification and the date of the proposed action, Medicaid is continued without reduction until the fair hearing decision is rendered.

A reduction in Medicaid coverage also requires that a letter of notification be sent at least 10 days in advance of the proposed reduction. The letter of notification advises the client: that his/her Medicaid is being reduced; the effective date of the action; the reason why the action is being taken; the supporting law or regulations; the recipient's right to a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of receiving the notice and the date of the proposed reduction, Medicaid is continued without reduction until the fair hearing decision is rendered.

When an A/R is in receipt of Temporary Assistance and Medicaid or SSI cash and the cash benefit is discontinued, a separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance is terminated. The Notice of Intent to Discontinue Temporary Assistance contains a separate statement advising the client of the status of his/her Medicaid: continued until a separate determination can be made; discontinued and the reasons why; or continued until the next recertification. When an SSI cash benefit is discontinued, and there is adequate information in the local district’s records, the recipient's eligibility is determined without contacting the recipient. The recipient is notified of the eligibility decision. When Medicaid eligibility cannot be determined due to inadequate information, the recipient is contacted and required to provide the necessary information. Medicaid is continued pending the receipt of the information. The recipient is given 30 days to provide this information.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION
DISCONTINUANCE OR REDUCTION

TIMELY NOTICE

Policy: When a recipient's Medicaid coverage is terminated or reduced, the recipient is adequately notified in writing 10 days in advance of the action (See **OTHER ELIGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION DISCONTINUANCE OR REDUCTION). However, if one of the following conditions has resulted in the termination or reduction of Medicaid, it is not necessary to send a notice 10 days in advance of the action. Instead, the adequate notice is sent by the date of the termination. These conditions are:

1. The recipient has provided a signed statement that s/he no longer wants Medicaid.

2. The recipient is admitted or committed to an institution that does not qualify for federal financial participation.

3. The recipient's whereabouts are unknown and his/her mail has been returned by the post office indicating no known forwarding address.

References:

Dept. Reg.	360-2.7 358-3.3(d)
ADM	89 ADM-21

OTHER ELIGIBILITY REQUIREMENTS

RETROACTIVE ELIGIBILITY PERIOD

Description: Medicaid is granted initially upon the determination of eligibility, based on a written application made on a "State prescribed" form. Generally the date of application is the date the signed "State prescribed" application form, or a State-approved equivalent form or process is received by the LDSS. (See **OTHER ELIGIBILITY REQUIREMENTS** APPLICATION, CERTIFICATION, RENEWAL NEW APPLICATION)

Paid or unpaid medical bills for the three-month period prior to the month of application may be eligible for payment/reimbursement.

Policy: If during the three-month period prior to the month an application is filed with an LDSS, the applicant indicates that he or she has paid or unpaid medical bills, eligibility for such retroactive period must be established.

References:

ADM 10 OHIP/ADM-9

Dept. Regs. 18 NYCRR 360-7.5 (a)

GISs
03 MA/025
03 MA/019
02 MA/033
98 MA/011
95 MA/032

Interpretation: The three month retroactive period begins on the first day of the third month that precedes the month the applicant applies for assistance.

For example: If the signed application is received on April 30th, the three month retroactive period is the period between January 1st through March 31st.

When the applicant indicates that there are unpaid medical bills in the retroactive period, eligibility for that period must be established regardless of whether the applicant applies for Medicaid only or applies for Medicaid as part of his/her application for Temporary Assistance or SSI or if the applicant is found eligible for Family Health Plus or another Medicaid Program. (See **INCOME** EARNED WAGES, SALARIES AND CONTRACTUAL INCOME)

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

Description: Reimbursement of paid medical expenses may be made to Medicaid recipients or their representatives for covered care and services obtained during the recipients' retroactive eligibility periods (pre and post -application periods).

Policy: Social services districts must reimburse, at the Medicaid rate, Medicaid eligible individuals or their representative for qualifying medical expenses paid during the three-month retroactive eligibility period.

Direct reimbursement is not limited to the Medicaid rate or fee in instances where agency error or delay caused the recipient or the recipient's representative to pay for medical services which should have been paid under the Medicaid program.

NOTE: Social Services districts have the option of reimbursing eligible recipients directly or requesting the Department to make payments for expenses that the district has determined to be reimbursable.

References:

ADM 10 OHIP/ADM-9

Dept. Regs. 18 NYCRR 360-7.5 (a)

GISs
03 MA/025
03 MA/019
02 MA/033
98 MA/011
95 MA/032

New York State Fiscal Reference Manual, Volume 1 Chapter 7 and Volume 2 Chapter 5

Interpretation: Reimbursement for paid medical expenses is limited to the Medicaid rate, after application of ALL third party reimbursement, unless there was an agency error or delay which caused the recipient or his/her representative to pay for medical services that should have been paid by the Medicaid Program.

Because Family Health Plus benefits do not begin until eligibility is determined AND enrollment in a plan has occurred, there is no reimbursement available under the FHPlus program during the three-month retroactive period. However, individuals who are otherwise eligible under the Medicaid spenddown program during the three-month retroactive period through the date of enrollment in a FHPlus

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

plan may be reimbursed for paid expenses in excess of their Medicaid spenddown.

Retroactive Period:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for paid bills that are:

- incurred during the **retroactive** eligibility period, which begins on the first day of the third month prior to the month in which the individual applied for Medicaid and ends on the date the individual applies for Medicaid;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not be excluded by the Medicaid Program.

Post-Retroactive Period:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for paid bills that are:

- incurred during the **post-retroactive** eligibility period, which begins on the date of application and ends on the date the individual receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and,
- provided by Medicaid enrolled providers.

NOTE: For new SSI recipients, reimbursement for paid medical expenses beginning three months prior to the month of application and ending on the day the recipient receives the “Dear SSI Beneficiary” letter must NOT be limited to expenses incurred from providers enrolled in the Medicaid program.

Agency Delay:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for bills that are paid as a result of an LDDS’s delay and are:

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

- incurred beginning 45 days after the date of application and before the receipt of a CBIC card; or
- incurred beginning 30 days after the date of application when the application includes a pregnant woman or child under the age of 19 and before the receipt of a CBIC card; or
- incurred beginning 90 days after the date of application when the application is based on disability and before receipt of a CBIC card; and
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not be excluded by the Medicaid Program.

FHPlus**:** After eligibility for FHPlus has been determined, the agency must process the plan enrollment by the 45th day following the eligibility decision if the decision was timely. If the decision was made after the proper timeframe, the agency must process the plan enrollment by the 45th day following the day the decision should have been made. When enrollment does not occur within these timeframes, the applicant is entitled to be reimbursed for reasonable out-of-pocket expenses paid from day 45 to the date enrollment is actually effective.

Agency Error:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for bills that are paid as a result of an LDSS's error and are:

- incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not been excluded by the Medicaid Program.

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

NOTE: Reimbursement may also be available when, due to social services district delay in the provision of authorized services such as personal care services, the recipient or the recipient's representative must pay privately to obtain covered services.

FHPlus: For individuals determined eligible for FHPlus, such recipient or his/her representative may be reimbursed for reasonable out-of-pocket expenses (as defined below) paid after the date of the agency's error (as found on the Notice of Decision) through the day the individual's FHPlus enrollment is effective. The services must be those that are covered under the FHPlus plan and must be provided by an entity or individual lawfully permitted to provide the care, services or supplies for which the recipient is requesting reimbursement.

Reimbursement in cases of agency error or delay must be made for reasonable out-of-pocket expenditures. Generally, out-of-pocket expenditures that do not exceed 110% of the Medicaid rate are always considered reasonable and may be fully reimbursed. In some instances out-of-pocket expenses that exceed this threshold may be considered reasonable if the recipient or his/her representative can demonstrate and document that the services cost more due to living in a remote location or purchasing services on a holiday or other special circumstance. In such situations, reimbursement of full-out-of pocket expenses may be warranted.

To obtain reimbursement for bills paid during the retroactive periods, the recipient must document income and resources, as appropriate, in order for eligibility to be determined for the appropriate retroactive period. In all circumstances, proof that the bills for which direct reimbursement is sought were paid must be provided. Claims not supported by proof of payment with documentation such as cancelled checks or notarized affidavits are not reimbursable.

NOTE: Once a CBIC card is received, NO reimbursement may be made for expenses incurred after that date and paid by a recipient.

Social services districts must provide information concerning the policy for direct reimbursement of medical expenses to all Medicaid/FHPlus applicants, including those who apply at outreach sites and to all Temporary Assistance applicants who also apply for Medicaid. The provision of the LDSS-4148B: "What You Should Know About Social Services Programs" to such applicants fulfills this requirement.

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE PERIOD

PAYMENT OF UNPAID MEDICAL BILLS

Description: Payment of unpaid medical expenses may be made to Medicaid enrolled providers for covered care and services obtained during the recipients' retroactive eligibility periods (pre and post -application periods).

Policy: Social services districts must authorize appropriate periods of eligibility for Medicaid eligible individuals who incurred qualifying medical expenses during the three-month retroactive eligibility period.

References:

ADM 10 OHIP/ADM-9

Dept. Regs. 18 NYCRR 360-7.5 (a)

GIS 03 MA/025
03 MA/019
02 MA/033
98 MA/011
95 MA/032

Interpretation:

Retroactive Period:

Payment may be made for unpaid bills that are:

- Incurred during the **retroactive** eligibility period, which begins on the first day of the third month prior to the month in which the individual applied for Medicaid and ends on the date the individual applies for Medicaid;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope, AND
- provided by Medicaid enrolled providers.

Post-Retroactive Period:

Payment may be made for unpaid bills that are:

- incurred during the **post-retroactive** eligibility period, which begins on the date of application and ends on the date the individual receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope, AND
- provided by Medicaid enrolled providers.

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE PERIOD

PAYMENT OF UNPAID MEDICAL BILLS

NOTE: Because Family Health Plus benefits do not begin until eligibility is determined AND enrollment in a plan has occurred, there is no payment of unpaid bills available under the FHPlus program during the three-month retroactive period. However, individuals who are otherwise eligible under the Medicaid spenddown program during the three-month retroactive period through the date of enrollment in a FHPlus plan may be reimbursed for paid expenses in excess of their Medicaid spenddown.

Payment is limited to Medicaid enrolled providers, at the Medicaid rate, after application of ALL third party reimbursement.

Agency Delay:

Payment may be made for unpaid bills that are:

- incurred beginning 45 days after the date of application and before the receipt of a CBIC card; or
- incurred beginning 30 days after the date of application when the application includes a pregnant woman or child under the age of 19 and before the receipt of a CBIC card; or
- incurred beginning 90 days after the date of application when the application is based on disability and before receipt of a CBIC card; and
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and
- provided by Medicaid enrolled providers.

Agency Error:

Payment may be made for unpaid bills that are:

- incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- provided by Medicaid enrolled providers.

To obtain payment for bills incurred during the retroactive periods, the recipient must document income and resources, as appropriate, in order for eligibility to be determined for the appropriate retroactive period. Once eligibility has been determined, appropriate periods of eligibility are recorded in WMS to allow payment to Medicaid enrolled providers.

OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE PERIOD

PAYMENT OF UNPAID MEDICAL BILLS

FHPlus: For FHPlus eligible individuals, there is no mechanism to provide coverage in WMS prior to plan enrollment. Therefore, payments to providers for agency error and delay cannot be processed through eMedNY. When the LDSS has determined that it is appropriate to pay expenses, a Medicaid paper claim form that lists the proper Medicaid rates, codes and billing information must be completed by the provider and submitted to the district. Such claims are paid either by the district or the Department, consistent with the choice made by the district.

NOTE: Billing statements from enrolled providers are not acceptable for payment of claims. Providers/districts must submit actual billing forms ordinarily submitted to eMedNY for processing.

OTHER ELIGIBILITY REQUIREMENTS

FINANCIAL MAINTENANCE

Description: Financial maintenance refers to the manner in which the A/R meets basic needs and non-medical expenses. The local district evaluates the completeness and consistency of the A/R's statements regarding financial circumstances.

Policy: If monthly housing expenses exceed 60/70 percent, as appropriate, of the A/R's monthly income, the A/R must provide further information on specific monthly living expenses and an explanation as to how the expenses are being met. If the LDSS determines that based on information provided by the A/R that there are discrepancies in the A/R's statements or other evidence the LDSS has that raises questions regarding the validity or reasonableness of the A/R's statements, further information may be required.

NOTE: This does not apply to A/Rs who are applying for or are in receipt of Family Planning Benefit Program or MSP only. Financial maintenance does not apply to child-only cases or to A/R's subject to post-eligibility treatment of income.

References:

SSL Sect.	366-a.4
Dept. Reg.	360-2.2 360-2.3(c)
ADM	10 OHIP/ADM-6
INFs	10 OHIP/INF-1
GISs	11 MA/016

Interpretation: Local social services districts are responsible for determining what percentage of an A/R's income is being spent on housing expenses. When an A/R reports on the ACCESS NY Health Care application (DOH-4220), the DSS-2921 or the Medicaid, Family Health Plus and/or Family Planning Benefit Program Renewal (Recertification) form that his/her share of monthly housing expenses is in excess of: 70% of the A/R's gross monthly income if living in Bronx, Kings, Manhattan, Nassau, Putnam, Queens, Richmond, Suffolk and Westchester counties; or 60% if living in any other county, the LDSS must pursue further information to evaluate how he/she is meeting basic living expenses. Monthly living expenses include: cable, phone, heat, electricity, food, transportation, credit card payments etc.

OTHER ELIGIBILITY REQUIREMENTS

FINANCIAL MAINTENANCE

NOTE: When calculating the household income to be used in the financial maintenance assessment, ALL known income of the applying members' household, including income of any non-applying legally responsible relatives must be counted, including income otherwise exempt from the Medicaid budget such as part-time wages of a 17 year old full-time student. Other means of aid or support received by the household must also be included when calculating financial maintenance. For example, Food Stamps although not counted when determining eligibility must be included in the assessment. A parent(s) total gross monthly income must be used for a child-only application in addition to the income of a non-applying child.

In situations where the A/R's share of monthly housing expenses exceeds the 60/70% level, the LDSS must send the Financial Maintenance form (DOH-4443) to the A/R for completion. Failure to complete and return the form to the LDSS will result in a denial or discontinuation of benefits.

NOTE: An application cannot be denied for failure to provide a shelter expense.

NOTE: The DOH-4443 is never sent before a determination of financial maintenance is completed and it has been determined that the A/R's share of monthly housing expenses is in excess of the allowable amount.

Disposition: The LDSS must compare the total reported expenses on the Financial Maintenance form to the A/R's income and determine if the A/R provided a sufficient explanation of how he/she is meeting monthly living expenses. Such explanations may include that bills are not being paid, bills are being paid with a credit card, or that someone else is paying the bill. Further information may be needed to explain any discrepancies. Documentation to support the A/R's explanation of how he/she is meeting monthly living expenses cannot be required. However, if the A/R cannot explain how he/she is paying for monthly expenses, the A/R's application/renewal will be denied/discontinued for failure to provide the required information.

NOTE: If the LDSS has information that an SSI-related A/R had assets (income and resources) on a previous application or renewal, and the SSI-related A/R cannot document how assets (income and resources) were spent, the possibility of a transfer of assets for the purpose of qualifying for Medicaid is considered. (See **RESOURCES** TRANSFER OF ASSETS)

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

Policy: The ownership and availability of income and resources are determined. Only those income and resources, as appropriate, available to and owned by the A/R or a legally responsible relative are considered when determining eligibility for Medicaid.

References: New York Estates, Powers and Trust Law 7-3.1

Mental Hygiene Law Article 81

SSL Sect.	104
	366.2
	366.3
Dept. Reg.	351.2
	352.16
	352.23
	360-4.3(f)
	360-4.4
	360-4.6
ADMs	96 ADM-8
	89 ADM-47
	82 ADM-6

Interpretation: Income:

Certain income, which is not actually available to the A/R, is counted when determining eligibility for Medicaid. Generally, money deducted from income to pay court-ordered support, income taxes, FICA and New York State Disability is budgeted as available when determining Medicaid eligibility. See **INCOME** UNEARNED SUPPORT PAYMENTS (VOLUNTARY AND COURT-ORDERED) for treatment of court-ordered support when deeming; and **INCOME** SSI-RELATED METHODOLOGY BLIND WORK EXPENSES for treatment of work expenses for the blind when determining eligibility for an SSI-related A/R.

Generally, when an A/R is due income, but the income is not being paid and is not within his/her control or the control of a fiduciary owing a duty to the A/R, the income is considered unavailable and not counted when determining eligibility. However, an A/R is required to apply for entitlement benefits, which would reduce or eliminate the need for assistance and care. Unemployment Insurance (UIB) and Social Security (RSDI) are

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

examples of entitlement benefits. The local district has a responsibility to assist the A/R, as needed, in obtaining such entitlement benefits.

Garnisheed income is generally considered available and is included when determining the A/R's gross income. Local districts may assist the A/R in attempting to have a garnishment removed.

When a legally responsible relative, not living in the A/R's household, is determined able to support an A/R, the contribution is not budgeted until and unless it is actually received.

When an A/R is living with a person to whom s/he is not married, the ability and willingness of the person to support the A/R is evaluated. If the A/R is actually receiving income from this person, that income is considered.

When an A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district considers the funds available for the A/R's care. If the A/R has a guardian or other fiduciary who is not meeting his/her obligations, it may be appropriate for the local district to take legal action to compel him/her to utilize funds for the A/R's medical care and services, to have him/her replaced, or to seek a money judgment against the fiduciary or an order of contempt.

Currently unavailable income from any source is reviewed to determine the likelihood of its affecting the continued eligibility of a recipient. For example, if the recipient is expected to receive income in six months, the situation is reviewed after six months.

Ownership:

In order to determine whether or not resources are available to the SSI-related A/R, it is necessary to determine who owns the resource.

When the SSI-related A/R and one or more persons jointly own a resource (financial institution accounts, real estate, stocks, bonds, etc.) the general rule is that such property is considered available to the A/R to the extent of his or her interest in the property. In the

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related A/Rs concerning the availability of financial institution accounts. Generally, for such SSI-related A/Rs it is presumed that all of the funds in a joint account belong to the SSI-related A/R. (See **RESOURCES** FINANCIAL INSTITUTION ACCOUNTS)

It is not unusual for non-legally responsible relatives to own life insurance on the life of an A/R. A parent may own a policy on the life of an adult child. When someone other than the A/R owns the policy and has the redemption rights, the life insurance is not considered an available resource of the A/R. (See **RESOURCES** LIFE INSURANCE)

Availability:

All resources owned by the SSI-related Medicaid A/R are considered available unless there is a legal impediment that precludes liquidation. If there is a legal impediment to the disposal of the resources, the resources are not counted in determining resource eligibility until the legal impediment does not exist.

A legal impediment exists when an A/R is legally prohibited from, or lacks the authority to liquidate the resource. For example, a legal impediment exists when an A/R needs the consent of a co-owner of a jointly owned resource in order to sell the resource, and the co-owner refuses to give consent.

When an SSI-related A/R is living with a legally responsible relative (LRR), the LRR's income and resources are generally considered available to the A/R.

When an A/R is residing in the community with an LRR and the LRR asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the LRR provides financial information; or (b) the LRR refuses to provide the requested financial information.

(a) When the LRR provides information, but refuses to make his/her income/resources available to the A/R, eligibility for the A/R is determinable. When completing a budget, only the income/resources, as appropriate actually available to an A/R are counted.

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

(b) When the LRR refuses to provide financial information, eligibility is generally indeterminable. However, if the A/R provides complete information concerning his/her own income and resources, as appropriate, including any jointly held resources, eligibility is determined based on the available information. If an LRR refuses to make his/her income and/or resources available for the A/R's medical care a dollar amount is budgeted for any non-medical needs that the LRR is meeting. For example, the LRR may be providing the A/R with food, shelter, and clothing. The value of these items would be considered income. The non-contributing LRR is not included in the household size.

As appropriate the resources of a legally responsible relative, residing with the A/R, are considered in the eligibility process. However, if the legally responsible relative refuses to make his/her resources available to the A/R, Medicaid is provided to the SSI-related A/R, if s/he is otherwise eligible. The provision of assistance to such persons creates an implied contract with the legally responsible relative and the local social services district may initiate legal action to recover the cost of medical care provided. (See **OTHER ELIGIBILITY REQUIREMENTS** OWNERSHIP AND AVAILABILITY)

For married couples, at the time of initial eligibility, when one is an institutionalized spouse (See **INCOME** CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES), all countable resources are combined and considered available to the institutionalized spouse, regardless of which spouse owns the resource. The community spouse is allowed to retain resources up to the maximum community spouse resource allowance. The resources, which comprise the community spouse resource allowance are then transferred to the community spouse. These resources are no longer considered available to the institutionalized spouse. After the month eligibility is established for the institutionalized spouse, none of the community spouse's resources are considered available to the institutionalized spouse.

When the value of an A/R's countable resources exceed the appropriate resource level, the A/R is ineligible for Medicaid. (See **RESOURCES** EXCESS RESOURCES)

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

Generally, no grant or loan to an undergraduate student for educational purposes is considered an available resource. There are some variations on this policy according to the category of the A/R. (See **INCOME** LIF DISREGARDS, ADC-RELATED DISREGARDS, SSI-RELATED DISREGARDS and S/CC DISREGARDS)

When an SSI-related A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district reviews the terms of the trust or other agreements/documents to assure that the SSI-related A/R's resources are actually available for his/her care. If a trust was created from the A/R's funds, and, if the trustee has any discretion to expend any of the trust income for the benefit of the A/R, then all of the trust principal which could be expended in any way to benefit the A/R is considered available. In instances where the client has a formal fiduciary and the fiduciary is uncooperative, the local district commences a recovery proceeding under SSL 104.

If an A/R is alleged to be incapable of managing his/her own finances and there is no one with the legal authority to make decisions concerning the A/R's income/resources, the A/R's income and resources, as appropriate, are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian. The income and resources, as appropriate, are considered unavailable to the A/R prospectively and for a retroactive period of three months.

Where there is a question of availability, the local social services district documents why the resource is not considered available and any actions taken to secure the resource for the SSI-related A/R.

If an SSI-related A/R jointly owns a home, but s/he is out of the home due to an informal separation and the spouse in the home refuses to sell, the A/R's share is an unavailable resource.

Verify Status:

(a) When the A/R indicates that s/he has a joint financial institution account;

(b) When the A/R indicates joint ownership of assets;

(c) When the A/R indicates that an LRR has available assets;

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

(d) When a child in the household has assets in his/her own name;

(e) When someone other than the A/R pays the mortgage.

Documentation: Sufficient to establish an audit trail:

Copies of financial institution account statements from the bank, mortgagor or insurer, or statements of availability from the LRR.

All efforts to obtain unavailable income and/or resources, as appropriate, are documented in the case record.

OTHER ELIGIBILITY REQUIREMENTS

AUTHORIZATION

Description: Medicaid is granted to an eligible person on the basis of a signed authorization. The authorization is initiated by the district. In addition to initial eligibility determination, authorizations are required for recertifications, reauthorizations, changes and closings.

Policy: An authorization is initiated for all persons determined eligible for Medicaid. A reauthorization is initiated to continue Medicaid previously authorized. No authorization or reauthorization, except those done for SSI recipients, may exceed a period of one year beyond the date of application or recertification. When retroactive coverage is appropriate, a case may be authorized for up to 15 months, 3 months retroactive and 12 months prospective.

References:

SSL Sect.	366.1(a)
Dept. Reg.	360-6.2 354.1
ADM	10 OHIP/ADM-8
GISs	02 MA/012 98 MA/041

Interpretation: An authorization is completed for all persons determined eligible for Medicaid. Common Benefit Identification Cards or rosters are issued for all eligible individuals. Authorizations are initiated to grant Medicaid and affect changes, such as suspension or termination of Medicaid and changes in information affecting eligibility.

Most children under age 19 are guaranteed Medicaid coverage for 12 months. Each time eligibility is determined (i.e., initial determination, and at every renewal or re-determination), children under age 19, who are found fully eligible for Medicaid, are authorized for 12 months continuous coverage regardless of any changes in income or circumstances. This period of continuous coverage applies to all children who are eligible under Low Income Family (LIF) or expanded eligibility budgeting. It also applies to children in families who are on Temporary Assistance cases receiving LIF Medical Assistance, Non IV-E Foster Care children and IV-E Foster Care children, including children in the custody of the Office of Children and Family Services in IV-E eligible settings.

However, if the child or his/her representative fails to provide a social security number (SSN), provides a fraudulent SSN or the child fails to

OTHER ELIGIBILITY REQUIREMENTS

AUTHORIZATION

"pass" the SSA citizenship verification and/or subsequently fails to provide proof of citizenship and identity coverage is discontinued prior to the end of the 12-month continuous coverage period.

When an authorization is used to change eligibility information, such as family composition, marriage, change of name, death of a member of a family, living arrangements, address or limitations on care or services, it is not necessary to use more than one authorization to make changes which take place at the same time. For example, at renewal, a case can be reauthorized for another year and an address change made on the same form.

In all situations, the authorization is signed and a copy kept in the record.

OTHER ELIGIBILITY REQUIREMENTS

CARD ISSUANCE

Description: There are three types of Common Benefit Identification Cards (CBIC): permanent plastic photo; permanent plastic non-photo; and temporary paper replacement. A temporary Medicaid Authorization (DSS-2831A) form may also be issued in cases of immediate medical need. Any of these cards may be presented to a medical care provider for the purpose of verifying eligibility and coverage.

Policy: Photo and non-photo cards are plastic and issued on a permanent basis. A recipient generally uses the same card for his/her entire period of eligibility. Adults applying for or in receipt of Medicaid must comply with CBIC photo requirements unless specifically exempted.

The following Medicaid A/Rs are exempt from the photo CBIC requirements:

1. All cash SSI recipients;
2. All children under age 21 living with a responsible relative (including foster parents, guardians and KinGAP relatives);
3. All persons who apply at a location other than an LDSS authorized by the Department until the district's next contact with the person;
4. Homebound persons including those receiving personal care, home health care, or long-term home health care;
5. All persons in nursing facilities or a foster care child placed in an authorized child care agency;
6. Person residing in living arrangements operated by the Office of Mental Health (OMH), or residing in living arrangements certified or operated by the Office for People with Developmental Disabilities (OPWDD);
7. Person enrolled in the OPWDD Home Community Based Services Waiver (HCBS Waiver);
8. Persons who have their Medicaid eligibility determined by OMH or OPWDD in conjunction with the NYS Department of Health (i.e., districts 97 and 98);
9. Persons applying for the Family Planning Benefit Program (FPBP). Any individual who is currently ineligible for cash assistance or Medicaid due to noncompliance with photo requirements may be eligible for FPBP; and
10. Persons eligible for Family Health Plus.

OTHER ELIGIBILITY REQUIREMENTS

CARD ISSUANCE

When two or more adults reside in the same household, each receives his/her own card.

When an applicant is determined eligible and has an immediate medical need the district may issue a temporary Medicaid authorization (DSS-2831A) pending his/her receipt of a permanent CBIC. The DSS-2831A is intended for use between the time of determination and actual delivery of the permanent card, and is valid only for a specific number of days.

References:

ADMs
10 OHIP/ADM-4
02 OMM/ADM-7
01 OMM/ADM-6

GISs
10 MA/004
09 MA/009

Interpretation:

A CBIC is issued to each: (1) individual in receipt of SSI; (2) needy child in foster care; (3) individual determined eligible for Medicaid or Family Health Plus; or (4) individuals determined eligible as a Qualified Medicare Beneficiary (QMB). Cards are not issued for periods of retroactive coverage. Certain recipients, such as those in nursing homes or voluntary childcare institutions which receive Medicaid per diem payments do not receive a CBIC. Rather, their names are placed on a roster of eligible individuals. Rosters are generated from principal provider codes and sent to each facility.

Effective with new or replacement cards requested on or after December 12, 2009 the sequence number that appears on the card will be randomly assigned. A Date and Time stamp is included on all new and replacement cards to help recipients, providers and local district workers identify the most recently issued CBIC card.

Disposition:

Persons, who are required to have a photo CBIC, but fail or refuse, may not be denied or discontinued from Medicaid for failure to obtain such photograph. Individuals must not be called into the LDSS solely to obtain a CBIC photograph, but should be photographed at the next time there is an in-person contact. If the individual must come to the LDSS to meet a referral requirement, such as a IV-D interview, a CBIC photo may be obtained at that time.

All photo identification cards must be signed. A card may be signed by the recipient, the recipient's authorized representative, the recipient's caretaker relative, or an authorized representative of the

OTHER ELIGIBILITY REQUIREMENTS

CARD ISSUANCE

local social services agency. Children, age 13 and older, may sign their own cards.

OTHER ELIGIBILITY REQUIREMENTS

RECIPIENT RESTRICTION PROGRAM (RRP)

Policy: When an individual's utilization of Medicaid services is considered excessive, following a NYS claims review, the A/R is restricted to only primary providers. The individual is given the opportunity to select which physician, clinic, or pharmacy, etc., s/he wishes to use.

References: SSL Sect. 366

Dept. Reg. 360-6

Interpretation: Through the RRP, certain Medicaid recipients are restricted to one physician, dentist, inpatient hospital, pharmacy and/or clinic for receipt of medical care or services. A provider inquiring on the Electronic Medicaid Eligibility Verification System (EMEVS), concerning a recipient's Medicaid coverage, will be informed of any limitations including the recipient's restriction status. Information in the EMEVS provider manual expands on this information. The restriction message on EMEVS will change each time a recipient either enters the RRP or is removed from the program. Further information on the RRP may be obtained from the individual in your district who administers the program or from the State Department of Health.

OTHER ELIGIBILITY REQUIREMENTS

CO-PAY

Description: Medicaid and Family Health Plus recipients age 21 or older may be asked to pay part of the cost of some medical care/items. This is called a Co-payment or Co-pay.

Policy: Health care providers may ask for a co-payment for certain services from Medicaid and Family Health Plus recipients age 21 or older. There is a maximum of $200.00 per Medicaid recipient per year for all co-payments. The co-payment year begins on April 1 each year and ends on March 31 of the following year. Once the maximum has been reached, no co-payments will be required until the new benefit year begins. There is no maximum for Family Health Plus recipients. There is no copayment for family planning treatment, services and supplies for individuals enrolled in Medicaid or Family Health Plus. There is no copayment for any treatment, services or supplies for individuals enrolled in an FPBP case. The provider cannot refuse to give medical services or goods because the recipient indicates that s/he is unable to pay the co-payment.

References:

SSL Sect. 366
369ee

Dept. Reg. 360-7.12

Chapter 58 Laws of 2005

GISs 05 MA/026
05 MA/006

Interpretation: A Medicaid or Family Health Plus recipient age 21 or older may be asked to pay part of the cost of some medical care/items as identified below. Recipients in Managed Care plans are only required to pay prescription drug co-payments. The amounts for each are identified in **REFERENCE** CO-PAYMENT.

OTHER ELIGIBILITY REQUIREMENTS

CO-PAY

SERVICE	FFS	MC	FHP	FPBP
Inpatient Hospital	YES	NO	YES	NO
Outpatient Hospital & Clinic	YES	NO	YES	NO
Non-emergency/Non-urgent ER	YES	NO	YES	NO
Prescription drugs * (brand name) (generic)	YES	YES	YES	NO
Over-the-Counter Drugs**	YES	YES	YES	NO
Enteral/Parenteral Formulae/Supplies	YES	NO	YES	N/A
Covered Medical/Surgical Supplies ***	YES	NO	YES	NO
Laboratory	YES	NO	YES	NO
X-ray ****	YES	NO	YES	NO
Dental services	NO	NO	YES	N/A
Physician services	NO	NO	NO	NO
Family Planning services and supplies	NO	NO	NO	NO

* One co-payment charge for each new prescription and each refill
** Covered OTC e.g. smoking cessation products, insulin
*** Covered medical supplies e.g. diabetic supplies such as syringes, lancets, test strips, enteral formula
**** Radiology services e.g. diagnostic x-rays, ultrasound, nuclear medicine & oncology services

Recipients **exempt** from co-payment include the following:

Recipients under the age of twenty-one (21)

Pregnant women (This exemption continues for 2 months after the month in which the pregnancy ends.)

Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

Recipients enrolled in Medicaid Managed Care Plans (with the exception of pharmacy co-payments and OTC).

Recipients enrolled in FPBP only cases or who receive FPBP only coverage (Coverage Code 18) in an MA case.

OTHER ELIGIBILITY REQUIREMENTS

CO-PAY

Residents of Adult Care Facilities licensed by DOH or OMH and OPWDD certified community residences and recipients enrolled in a Comprehensive Medicaid Care Managed Program (CMCM), in an OPWDD Home and Community Based Services (HCBS) waiver program, or in a DOH HCBS waiver program for Persons with Traumatic Brain Injury (TBI).

Services Exempt from Co-Payment include the following:

Emergency Services

Family planning services, supplies, and treatment

Tuberculosis Directly Observed Therapy

Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, and alcohol and substance abuse clinic services

Drugs to treat tuberculosis, and birth control.

Psychotropic drugs

Prescription drugs for a resident of an Adult Care Facility licensed by the DOH.

NOTE: Co-payments are not charged by private physicians and dentists enrolled in Medicaid or, for home health and personal care services. Private physicians and dentists in Family Health Plus may charge a co-payment.

OTHER ELIGIBILITY REQUIREMENTS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD) PREMIUM PAYMENT

Policy: MBI-WPD participants with net (earned and unearned) income at least 150% and at or below 250% of the federal poverty level are required to pay a monthly premium for Medicaid. Individuals with net income below 150% of the federal poverty level pay no premium.

NOTE: A moratorium on premium payments has been instituted until such time as systems support for automated premium collection and tracking is available.

References: SSL Sect. 366(1)(a)(12)&(13)

ADMs 04 OMM/ADM-5
03 OMM/ADM-4

OTHER ELIGIBILITY REQUIREMENTS

STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

Description: The state of residence of an A/R is where s/he is domiciled. A person's domicile, or legal residence, is the principal and permanent home to which the person, wherever temporarily located, always intends to return.

Policy: Medicaid is provided to otherwise eligible persons domiciled in New York State, regardless of the length of their residence. Local districts rely on a person's intent in determining the state of legal residence, unless the person's actions are inconsistent with that intent.

References:

SSL Sect.	62
Dept. Reg.	349.4(b) 360-3.2(g)
ADMs	OMM/ADM 97-1 93 ADM-34 87 ADM-22

Interpretation: An A/R's State of residence is determined by a preponderance of factors, including, but not limited to: the address where the A/R is currently residing; the address from which s/he is registered to vote; his/her mailing address; the abandonment of any prior residence; and his/her health when s/he entered the district. The state that is responsible for providing Medicaid is the state where the A/R is domiciled.

Generally, when an SSI cash recipient enters New York State with the intent to remain, the district where s/he resides is responsible for providing him/her with Medicaid beginning with the date s/he entered New York State (provided the recipient was not placed in New York by another state). When an SSI recipient moves into New York State and continues to be eligible for SSI, the Social Security Administration (SSA) will change the state responsible for making state supplement payments to the recipient. The date of this change is the first of the month following the month in which the recipient moved. The date of the change will appear on the SDX in field 74 "Date Residency Began".

If an SSI recipient incurs a bill after entering New York State, but prior to the date in field 74 "Date Residency began" Medicaid is provided by the local district where the recipient resides. Medicaid coverage begins on the first of the month prior to the month of the

OTHER ELIGIBILITY REQUIREMENTS

STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

"Date of Residency". The SDX is adequate documentation for determining when the recipient became a resident of the State. When an SSI recipient indicates that s/he moved to New York State prior to the first of the month preceding the "Date of Residency" further investigation is required. If the SSI recipient can document that s/he became a resident of New York State at an earlier date, Medicaid is authorized from that date.

Children who are adopted or receive foster care under Title IV-E of the Social Security Act receive Medicaid from the state in which the adoptive or foster parents reside. When a family including a IV-E eligible child moves to a different state, the new state become responsible for providing Medicaid. Families of IV-E adopted children must bring documentation of IV-E eligibility to the new state of residence for Medicaid to be authorized.

Transfer of Medicaid for IV-E foster care children is accomplished with the assistance of the State's IV-E Foster Care Compact Coordinator. When a IV-E foster care child is placed in another state, once the new placement is approved by the new state, that state opens up a Medicaid case. Until the new state of residence approves the foster care placement, New York State is responsible for arranging Medical care. While a New York State Medicaid case may remain open, Children and Family Services is responsible for working with foster parents in arranging for medical care out of state.

Specific residence topics are considered in detail in the following sections:

Persons Temporarily In the State;

District of Fiscal Responsibility; and

Persons Temporarily Out of State.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Policy: Generally, each local social services district is responsible for furnishing Medicaid to otherwise eligible A/Rs who are residents of New York State (NYS) and who reside within the district.

References:

SSL Sect.	62.5
	365.5
Dept. Reg.	311.3
	311.4
	360-3.5
	360-3.6
ADMs	08 OHIP/ADM-5
	08 OHIP/ADM-3
	OMM/ADM 97-1
	94 ADM-20
	90 ADM-9
	86 ADM-40
	80 ADM-4
LCM	08 OHIP/LCM-1
INFs	06 INF-34
	06 INF-22
	90 INF-45
GISs	02 MA/010
	02 MA/006
	02 MA/001
	00 MA/018
	97 MA/028

Interpretation: Where Found Rule

When a person enters New York State with the intent to remain permanently or indefinitely and has a need for medical care, before a living arrangement is established, the local district where the person is found is responsible for providing Medicaid, if the A/R is otherwise eligible.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

When a person has not abandoned his/her residence in another state, but is unable to return to the home state due to illness, eligibility for benefits from the home state is explored. If the home state does not agree that the individual is a resident of that state for Medicaid purposes, the local district where s/he is found at the time that the person can no longer return to his/her home state is the district responsible for providing Medicaid, regardless of where the applicant is found at the time of application. If the A/R subsequently is moved to a medical facility in another district, the first district remains responsible.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

For example: While visiting his sister in Essex County from another state, Mr. Smith becomes ill and cannot return to his home state. He is hospitalized in Clinton County. While in Clinton County, Mr. Smith's sister applies on his behalf for Medicaid in Essex County. If the home state does not agree that the individual is a resident of that state for Medicaid purposes, Mr. Smith is authorized for Medicaid by Essex County. Subsequently Mr. Smith is moved to a nursing facility in Franklin County. Essex County remains fiscally responsible for Mr. Smith's Medicaid.

When a person applies for Medicaid while in a district other than his/her local district of residence, the local district in which the person is found contacts the local district of residence before assuming that district will accept and process an application. The district where the A/R is found assists in processing the application as a courtesy. This acknowledgment of fiscal responsibility is confirmed and noted in the record, prior to forwarding the courtesy application. Without such an agreement, the district in which the applicant is found accepts and processes the application. If otherwise eligible, Medicaid is authorized by the district where the applicant is found. The district may then request a fair hearing to determine the district of responsibility.

All individuals who have been determined eligible for SSI cash payments by the Social Security Administration, or who are in receipt of such payments (federal benefits and/or State Supplements) are the district of fiscal responsibility of the “where found” district. The only exceptions that apply to SSI cash recipients and eligibles include:

- Children in receipt of, or eligible for, SSI cash assistance who are in the care and custody of the Commissioner of the Local Department of Social Services remain the fiscal responsibility of the Commissioner who has custody of the child.
- Medicaid SSI eligible’s and recipients who are the responsibility of the Office of Mental Health (District 97/OMH) or the Office for People with Developmental Disabilities (District 98/OPWDD), who move to another district may remain the responsibility of OMH or OPWDD depending on the living arrangement of the individual. OMH and OPWDD will retain responsibility for

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

determining whether the Medicaid SSI recipient gains residence in another district following a move or remains the responsibility of the State. OMH or OPWDD will transfer a Medicaid SSI case to the new district when appropriate.

- Medicaid-only recipients who move to an adult care facility in another district are the fiscal responsibility of the former district. However, if the individual becomes eligible for SSI, the SSI recipient gains residence in the new district and a Medicaid case must be opened in the new district following the closing of the Medicaid case in the former district.
- SSI recipients who enter a medical facility in another district and remain eligible for SSI but for whom no SSI payment is being made (SDX Payment Status Code E01 "Eligible but no Payment") gain residence in the new district.
- SSI cash recipients who move to a medical facility in another district prior to October 20, 2008 are the fiscal responsibility of the former district. . Should the individual subsequently move and remain in receipt of SSI the district of fiscal responsibility becomes the where found district.

EXCEPTIONS TO THE "WHERE FOUND" RULE (other than SSI cash recipients/eligible's)

NOTE: Unless one of the following exceptions applies, the "where found" district is fiscally responsible for the A/R. The burden of proof is on the "where found" district to establish that an exception applies.

Temporary Absence from Legal Residence

The local social services district where a person has his or her legal residence continues to be responsible for providing Medicaid when the person is temporarily absent from the district. A person's legal residence, or domicile, is the principal and permanent home to which the person, wherever temporarily located, always intends to return. Districts rely on a person's expression of intent in determining the district of legal residence, unless the person's actions are inconsistent with the expressed intent. When a person capable of indicating intent leaves his/her district of legal residence, the person will be considered to be temporarily absent from such district if:

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

(a) the person enters another district for a specific purpose (such as rehabilitation for alcohol or substance abuse, training, schooling, or vacation); and

(b) the person intends to return to the "from" district when the specific purpose is accomplished; and

(c) the person's actions are not inconsistent with this purpose. In this situation, the "from" district continues to be responsible for providing Medicaid as long as the recipient continues to engage in the activity which prompted the temporary absence.

This responsibility continues only until the temporary purpose ends. At that point, the recipient:

- returns to his/her district of legal residence; or
- is considered to have established a new legal residence and is transitioned from the "from" district to the "where found" district; or
- becomes a transient (a homeless person without a legal residence) and immediately becomes the responsibility of the "where found" district.

When an A/R chooses to receive care or treatment in a medical facility outside his/her district of residence, the district of residence retains responsibility for the cost of the A/R's care.

Transition Rule

When a non-institutionalized recipient moves from one district to another, the district from which the recipient moved must follow the rules in **OTHER ELIGIBILITY REQUIREMENTS**, STATE RESIDENCY, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Medical Facility Rule

The local district of legal residence continues to be responsible for providing Medicaid to a person who has entered a medical facility in another district if the person is in need of Medicaid upon admission to the facility, or becomes in need during the inpatient stay, or upon discharge from the facility. This responsibility continues indefinitely until there is a break in the recipient's need for Medicaid.

When applying these provisions to a Title XIX facility operated or certified by OMH or OPWDD, regardless of where the facility is located, the district of legal residence ("from district") remains responsible until there is a "break in need".

A "break in need" is defined as one calendar month without financial eligibility. As long as an individual remains financially eligible for Medicaid, there is no break in need. If the individual has excess income and submits paid or incurred expenses totaling the amount of excess or pays the excess directly to the district, there is no break in need. If in any month, the SSI-related individual becomes resource ineligible and is unable to spend down the excess resources or does not meet an excess income liability, there is a break in need. When a break in need occurs, the district of fiscal responsibility may close the case with adequate and timely notice.

District Placement Rule

When the A/R's district of residence arranges or participates actively in arranging for care in another local district, that district is assuming responsibility for the continuing care of that A/R, regardless of the type of facility the person enters. The A/R's district of legal residence continues to be, or becomes responsible for providing Medicaid when: a district (either the local district of legal residence or any other district) was involved in placing the eligible person into a formal residential care setting in another district. District involvement in a placement includes both direct and indirect involvement by any county agency or official governmental entity of the county including courts, mental health departments, probation departments, etc.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Homeless Rule

When a district places a homeless individual/family in temporary housing in another district, the placing district continues to be responsible for providing Medicaid during the individual/family's stay in the temporary housing. If the homeless recipient subsequently moves into permanent housing, the placing district follows the procedures found in **OTHER ELIGIBILITY REQUIREMENTS**, STATE RESIDENCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.

NOTE: When a homeless A/R relocates from one district to another and does not wish to return to the first district, s/he is treated as any other A/R moving from one district to another (See **OTHER ELIGIBILITY REQUIREMENTS**, STATE RESIDENCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.

Domestic Violence

When an eligible person enters an approved Shelter for Victims of Domestic Violence located in another district following an incident of domestic violence, the district in which the person legally resided at the time of the incident is fiscally responsible for that person while s/he resides in the approved shelter. This rule applies to persons who had been receiving Medicaid prior to the incident as well as to persons who become eligible due to lack of available income and resources while residing in the approved shelter.

This responsibility continues until the person leaves the approved shelter. If the recipient chooses not to return to the former district of legal residence, such district must follow the procedures in **OTHER ELIGIBILITY REQUIREMENTS**, STATE RESIDENCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.

Adult Care Facility

When an individual enters an adult care facility (Congregate Care Level II-adult home, enriched housing program or residence for adults) in another district and is or becomes in need of care, the district of fiscal responsibility from which the individual was admitted to the adult care facility is responsible for providing assistance and care. This responsibility continues until there is a “break in need”.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

This DFR rule does not apply to OMH, OPWDD or OASAS certified community residences, residential substance abuse treatment programs or residential care centers for adults.

A/R under age 21

The DFR for a child under age 21, is the district "where found", unless one of the current DFR exceptions applies. Districts should rely on a person's expression of intent in determining the district of legal residence, unless the person's actions are inconsistent with the expressed intent.

The district of fiscal responsibility for a child under the age of 21, who has been adjudicated incompetent, remains the district of legal residence of the parent(s) or legal guardian.

NOTE: The DFR of a newborn surrendered for adoption and not yet placed in an adoptive home is the DFR of the birth mother.

Medical Parole

The DFR for an inmate released on medical parole is the district from which the inmate was sentenced. This responsibility continues indefinitely until there is a break in need.

Non-medical Parole

The DFR for non-medical parolees who are mandated as a condition of parole to live in a particular district in a non-medical residential setting, such as a half-way house, is the district where the non-medical parole legally resided immediately prior to incarceration. This responsibility continues until there is a break in need. Once the mandate is ended or parole is completed, and the individual regains his/her freedom to exercise intent, the rules in **OTHER ELIGIBILITY REQUIREMENTS** STATE RESIDENCY, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY would apply.

See **OTHER ELIGIBILITY REQUIREMENTS** MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS for an explanation of residency rules at reinstatement.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Infants Residing with Incarcerated Mothers

The DFR for an infant residing with an incarcerated mother is the mother's district of legal residence prior to incarceration.

Children Eligible for Continuous Medicaid Coverage

A child who has lost eligibility, but is in a period of continuous coverage, who moves to another district will not have his/her coverage transitioned to the new district of residence. Continuous coverage will be provided by the former district of residence.

If a child turns age 19 during a period of continuous eligibility, the guarantee of continuous eligibility will end as of the last day of the month of the child's nineteenth birthday. However, if the child is receiving medically necessary inpatient services at that time, Medicaid coverage continues through the end of the hospitalization.

Disposition:

When the district of fiscal responsibility for the A/R has been established, that district authorizes Medicaid, if the A/R is otherwise eligible.

If a dispute based on residency occurs between local districts for an otherwise eligible A/R, either district may request a fair hearing to determine the district of fiscal responsibility. The district where the A/R is found provides Medicaid until the fair hearing decision is rendered. The district found to be responsible, if necessary, reimburses the district that assumed responsibility for the A/R prior to the fair hearing decision.

Generally, a person cannot gain residence in a district while receiving care in a Title XIX facility or a public institution.

When a pregnant woman is determined presumptively eligible for Medicaid, the district she states is her residence is fiscally responsible for care provided during the period of presumptive eligibility. Her documented district of residence may be different when a full eligibility determination is completed.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Description: Medicaid recipients who notify their district of residence of a change in residency to another district in New York State will have their Medicaid case transitioned to the new district.

Policy: Medicaid recipients who report their move from one district to another within the State will be provided coverage by their originating district for the month in which the move is reported and the following month. Coverage will be established in the new district of residence effective the first day of the second month following the month the move was reported. Eligibility will continue for the duration of the originating county's authorization period, or four months, whichever is greater. If a recipient advises the district of a move, in advance of his or her actual relocation, the originating district is responsible for providing coverage through the month of the actual move and the following month.

References:

SSL Sect. 62.5 (a)

ADMs
10 OHIP/ADM-8
09 OHIP/ADM-1
99 OMM/ADM -3
OMM/ADM 97-1
95 ADM-5
89 ADM-2

Dept. Reg. 360-1.4 (j)

LCM 08 OHIP/LCM-1

GISs
09 MA/004
02 MA/006
02 MA/001

Interpretation: Recipients in Case Types 20 (Medicaid), 24 (Family Health Plus), and recipients who receive Medicaid through a Temporary Assistance (TA) Case (Case Types 11, 12, 16 or 17) who notify their district of a move to another county, and provide their new address in writing will have their Medicaid case transitioned to the new district of residence without the need for a new application.

NOTE: This policy does not apply to Medicaid recipients who are institutionalized in a medical facility as defined in Department

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Regulations at 18 NYCRR, Section 360-1.4 (j). This means that eligibility will not be transitioned for individuals who relocate to another district from a hospital, nursing home, Intermediate Care facility, inpatient psychiatric center or inpatient alcohol treatment facility.

When a Supplemental Security Income (SSI) recipient reports a move to another district, it is important that the move be reported to the Social Security Administration following the instructions in 95 ADM-5. Districts must coordinate any closing for an SSI recipient with the opening of a case in the new district.

For recipients who report their move and provide the address in the new district in advance of his or her actual relocation, the district is responsible for providing coverage through the month of the actual move and the following month and coverage is established in the new district the first day of the succeeding month.

If a district discovers a recipient has moved out of county (the recipient has reported the move), coverage must be provided for the month of and the month following the move at which time the case must be closed.

Recipients who do not report their move in advance of his or her actual relocation will have their coverage provided by the originating district for the month in which the move is reported and the following month. Coverage is established in the new district effective the first day of the second month following the month the move was reported.

NOTE: The District of Fiscal Responsibility (DFR) rules, with the exception of the Transition Rule, remain unchanged.

CONSIDERATIONS:

Changes in Circumstances- In situations where the recipient reports their move AND other changes relative to eligibility and the information is sufficient to complete a re-determination before the case is transitioned, such re-determination should be made. Changes that result in ineligibility should be handled in accordance with existing procedures, including the discontinuance or change of coverage as appropriate. However, in no instance should a district

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

delay the transition of coverage pending receipt of further information regarding items that may change as a result of the individual's reported relocation (i.e. a change of job, which may result in a change in earned income).

Cases for which the district has not completed the eligibility determination, (i.e. a pregnant woman authorized for Presumptive Eligibility) must have such determination of eligibility completed prior to the transition of the case to the new district of residence.

Similarly, if the case is in the process of being renewed, the district must complete the renewal before transitioning the case to the new district of residence.

NOTE: For procedures for renewing children age 18 and up to 21 who are receiving Medicaid as final discharges from foster care (Chaffee provisions) that have moved, see: **OTHER ELIGIBILITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL.

Not All Case Members Moving- The eligibility of the moving household members must be determined. If determined ineligible, they must be closed, and the case is not transitioned. If eligibility continues, a new case must be opened for them and transitioned to the new district of residence. Eligibility for the remaining household members must be re-determined and appropriate action taken.

Returned Agency Correspondence Out of District Moves- Returned correspondence, including the Medicaid/FHP renewal that is returned to the district by the U.S. Postal Service with a change of address must be re-mailed to the new address with a copy of Attachment VII of 08 OHIP/LCM-1 which will provide the individual the opportunity to confirm the new address. Individuals who respond in the prescribed time frame (minimally 10 days) to the follow-up correspondence shall be considered to have reported their re-location and new address and will have their case transitioned after continued eligibility is determined. Individuals who do not respond to the follow-up correspondence will have their case discontinued having failed to renew or comply with a request for additional information.

Returned Agency Correspondence In District Moves- Correspondence returned by the U.S. Postal Service (USPS) for a recipient, including the Medicaid /FHP renewal, with a change of address, the district must

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

make an effort to confirm the new address. In order to get confirmation from the recipient of the new address, Attachment I of GIS 09 MA/004 must be included when the returned mail is forwarded to the individual. However, if the individual fails to return Attachment I of GIS 09 MA/004 verifying the new address after an established period of time (a minimum of ten days should be given) and the mail is not returned by the USPS, the LDSS will conclude that the recipient is living at the new address and must update WMS to reflect the new address.

If the district receives correspondence returned by the USPS without a forwarding address, but staff learns of an updated address within the county, e.g., associated with the recipient's food stamp case, the returned mail and Attachment I of GIS 09 MA/004 must be forwarded to the individual at the updated address. However, if the individual fails to return Attachment I of GIS 09 MA/004 verifying the new address after the established period of time and the mail is not returned by the USPS, the LDSS will conclude that the recipient lives at the address and must update WMS to reflect the new address. In accordance with the managed care contract, if a Managed Care Contractor informs the local district of a new address, this is sufficient information to update the address in WMS.

Children in Continuous Coverage Status- A child who has lost eligibility, but is in a period of continuous coverage, who moves to another district will not have his/her coverage transitioned to the new district of residence. Continuous coverage will be provided by the former district of residence.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Individuals who Notify County B of their Re-location- In situations where the recipient notifies the new district of residence of their move, the new district of residence must direct the individual to put the new address in writing. The new district must forward the new address to the district currently providing coverage so that such district may take necessary action to transition the case.

If the individual wishes to make an application in the new district of residence, all aspects of the application process must be adhered to, including documentation requirements. If the applicant(s) is found eligible, coordination in opening and closing the cases must occur between the two districts to avoid duplicate coverage.

NOTE: The Medicaid coverage of a TA case will be transitioned to the new district of residence in the event of a reported move. However, the individual must re-apply for TA in the new district of residence. If the individual also applies for Medicaid with the TA application and the determination is made prior to the transition of the Medicaid coverage, the TA/Medicaid case should be authorized.

Homeless Individuals- Homeless individuals who report a move to another district must have their case transitioned, even though they do not have a permanent address.

Admissions to District 97 (Office of Mental Health, (OMH)) and 98 (Office for People with Developmental Disabilities, (OPWDD)) Living Arrangements- Individuals who are admitted to certain District 97 and 98 living arrangements will not have their cases transitioned. When a district is contacted by a Patient Resource Office (OMH), or a Revenue Support Office (OPWDD) and advised that an individual has been admitted to a specified OMH or OPWDD living arrangement, the district must use manual notice OHIP-0014 to inform the individual that his or her Medicaid case is being transferred to District 97 or 98, effective with the date of admission to the facility.

When an individual is discharged from a specified OMH or OPWDD living arrangement, the district will be sent the Relocation Referral Form and accompanying documentation from the appropriate Patient Resource Office or Revenue Support Office. The District of Fiscal Responsibility

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

must establish uninterrupted coverage for the case, and send notice OHIP-0015.

COVERAGE CONSIDERATIONS:

Managed Care- If available, individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence.

If the same managed care plan is not available, the Managed Care disenrollment should be coordinated with the last date of coverage in the former district. Consideration may be made to disenroll the individual earlier if the individual has moved out of the plan's service area and cannot access services. Such disenrollment would enable the individual to receive fee-for-service coverage in order to access services. Future managed care enrollment should proceed according to local district requirements.

Family Health Plus (FHPlus) - If available, individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence.

Individuals who have moved to a district where only one FHPlus plan is available must be enrolled in that plan. If the FHPlus plan is not the same plan as the individual was enrolled previously, the county must take necessary steps to insure the enrollment is effective by the first day of the month following the closing in the former district of residence. This may include notifying the plan in writing if the enrollment is not processed by pull down dates.

If the same FHPlus plan is not available and more than one FHPlus plan exists in the new county of residence, the former county of residence must disenroll the individual effective the first day of the month following the second month in which the closing transaction is made. The new district of residence must provide the individual with plan selection information as soon as possible. In some instances, the former district of residence may need to delete a disenrollment to allow the new district of residence to process an enrollment.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

NOTE: Managed Care and FHPlus recipients who are receiving Guaranteed Coverage (Coverage Codes 31 and 36 respectively) have been determined to be ineligible for Medicaid. If such an individual reports a move to another district, the individual is entitled ONLY to the balance of the six month guarantee from the original county of residence.

Third Party and Medicare- When a case opens in the new district of residence, any commercial insurance, Medicare coverage and Medicare Savings Program information must be reflected on eMedNY.

If the former district of residence has been paying a commercial health insurance premium, all necessary information regarding the payment of the premium must be forwarded to the new district of residence and annotated on the Relocation Referral Form.

The new district of residence should verify that the commercial policy remains in effect. Any changes to coverage or providers should be entered in the eMedNY Third Party subsystem and the district should assume the responsibility of making the premium payments. This should be done timely to ensure the commercial health insurance coverage is not jeopardized.

CITIZENSHIP DOCUMENTATION-
For cases where the Social Security citizenship verification match confirmed citizenship, the worker must note this on the "Relocation Referral Form" which is forwarded to the new district. If the worker verified citizenship through documentation provided by the A/R or a referral to Vital Records, a copy of the verification received shall be forwarded to the new district. If an individual has not yet provided citizenship documentation or authorization for the district to confirm birth information with Vital Records, the case must be transferred to the new district, and the new district must pursue such documentation/authorization. The originating district shall note any outstanding issues concerning a recipient's citizenship/identity documentation on the referral form sent to the new district.

Disposition: Local Social Services Districts must ensure that individuals who report their move to a new district and are otherwise eligible have their Medicaid/Family Health Plus case transitioned to such new district. Appropriate and timely transactions in the Welfare Management System (WMS) must be made, and coordinated between the new and former districts to ensure appropriate access to Medicaid and Family Health Plus coverage.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

ASSISTANCE TO PERSONS TEMPORARILY ABSENT

Policy: Medicaid may be authorized for a resident of the New York State who is temporarily absent from NYS if the A/R remains in the United States (including Puerto Rico, the Virgin Islands, Northern Mariana Islands, or Guam) or in Canada, and s/he meets one of the following conditions:

(1) the residents of the A/R's district customarily use medical facilities in another state or Canada; or
(2) there are limited medical services available in the A/R's local district and the local social services district gives prior approval; or
(3) an emergency situation arises.

References:

SSL Sect.	62 365
Dept. Reg.	360-3.2(g) 360-3.5
ADM	OMM/ADM 97-1

Interpretation: An A/R is temporarily absent from the State, if before the absence s/he: was a resident of the district; has an intent to return to the State; and has not shown an intent to establish a permanent residence elsewhere.

Residents of New York State may be eligible for Medicaid coverage of medical services provided in another state if residents of the A/R's district customarily use the medical facilities in another state, or if the type of medical service required is not available in New York State and the local social services district has given prior approval. Medicaid coverage may also be authorized, if while temporarily in another state, the A/R requires emergency medical attention. The assistance of that state is sought in the application process.

NOTE: New York Medicaid will only make payment to out-of-state providers who are enrolled in New York's Medicaid program. For situations involving medical expenses incurred/paid during the three month period prior to the month of application see **OTHER ELIGIBILITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL NEW APPLICATION.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY ASSISTANCE

ASSISTANCE TO PERSONS TEMPORARILY ABSENT

If an individual is placed in a medical institution in another state, the district which placed him/her continues to be responsible for all covered necessary medical expenses incurred outside the state, since the local district arranged for the placement in a medical institution. If, however, an individual voluntarily placed him/herself in a chronic care facility in another state, abandoning his/her former residence, s/he may be considered a resident of the state to which s/he moved.

NOTE: Generally, in cases involving a question of state residence, the intent of the client to establish a permanent dwelling is the primary consideration, as long as the A/R's action is consistent with his/her intent.

Disposition: When an A/R is found to have established a legal residence (domicile) outside of New York State, a timely and adequate notice is sent to the A/R that s/he is no longer eligible for Medicaid in New York State and that s/he should apply for assistance in the State to which s/he moved.

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE

Policy: The state of residence is fiscally responsible for providing Medicaid to otherwise eligible A/Rs.

When an application is made by a person temporarily in New York State (NYS), the local district in which s/he is found assists the appropriate agency in the applicant's state of residence with the investigation to determine eligibility and make arrangements for care.

However, if the Medicaid available to the client in his/her state of residence is limited in scope and duration, NYS may authorize care after the A/R utilizes any Medicaid available from his/her home state, providing the A/R did not enter the NYS for the purposes of obtaining such care and s/he is otherwise eligible.

Persons who are placed in medical institutions in NYS by another state remain the responsibility of that State which made the placement.

References:

SSL Sect	365.1(b) 366.1(b)
Dept. Reg.	360-3.2(g) 360-3.6
ADM	OMM/ADM 97-1
LCM	93 LCM-12

Interpretation: When an A/R is temporarily absent from his/her state of residence, that state continues to be responsible for the A/R's Medicaid (See **OTHER ELIGIBILITY REQUIREMENTS** STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE for a discussion of state of residence). If the state of residence does not agree that the individual is the responsibility of that state for Medicaid purposes, then NYS Medicaid is authorized for an otherwise eligible A/R provided that the A/R did not enter NYS for the purpose of obtaining medical care.

When a person is found in NYS and is medically unable to return to his/her home state, the district where the person is found at the time s/he becomes unable to return to his/her home state is

OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE

responsible for providing his/her Medicaid, if the person is otherwise eligible and assistance is denied by the home state because of residency.

When to Verify: When an applicant indicates a recent entry or an address outside NYS, the local district establishes the client's actual State of residence. If s/he has recently entered New York State, the local district establishes that the entry was not for the purpose of receiving medical care.

Verification: When there is a question as to the A/R's state of residence, a determination of residence is based on a preponderance of the following factors: (1) the address from which s/he is registered to vote; (2) his/her mailing address; (3) the abandonment of any prior residence; and (4) his/her health.

NOTE: When there is a question as to the A/R's state of residence, generally the intent of the A/R to establish a permanent residence is the primary consideration, as long as the A/R's actions are consistent with his/her intent.

Disposition: When an A/R entered New York State for the purpose of obtaining medical care, his/her application is denied. If the A/R is a resident of another state, the local district in which s/he is found assists the state of residence in the investigation of his/her eligibility and/or the arrangement for his/her care. (See **OTHER ELIGIBILITY REQUIREMENTS** STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE)

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

Description: This section describes where Medicaid may be provided. A recipient may reside in his/her own home or a medical institution/facility. Medicaid may also be given to residents of certain public institutions/facilities. Federal reimbursement is not always available, however.

Policy: Care and services under Medicaid may be provided to an otherwise eligible A/R residing in: his/her own home; a general or chronic disease hospital; or an institution used primarily for the care of the mentally ill, when the A/R is under age 21, under age 22 if the A/R turned age 21 while residing in the institution, or is age 65 or over. Generally a person residing in a public institution may not receive Medicaid unless the public institution is: a medical facility; a community residence, not on the grounds of a major institution, serving 16 or fewer residents; a child care institution for 25 or fewer children; an emergency shelter for the homeless; a home for adults operated by a local social services district; or an OMH residential care center for adults (RCCA).

References:

SSL Sect. 365
366

Family Court Act 454

Dept. Reg. 360-3.4
360-6.6

ADMs OMM/ADM 97-1
90 ADM-18
89 ADM-2
88 ADM-50
86 ADM-23

Interpretation: The term his/her own home is broad in scope. Such living arrangement may include the person's own house or apartment, a private home for adults, an approved home for the aged or blind, a residential facility not located on the grounds of a major institution, a child care institution; and congregate care living arrangements. Persons in family care or foster care are living in their own home for Medicaid purposes. See **OTHER ELIGIBILITY REQUIREMENTS** LIVING IN OWN HOME for a discussion of the A/R living in his/her home.

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

An approved medical institution or facility includes the following, when operated according to Public Health Law or other applicable law:

- a private proprietary or non-profit nursing home ;
- the infirmary section of a home for the aged;
- a public home infirmary or similar public facility for the chronically ill;
- a hospital or nursing home section of a public institution operated for the care of persons with developmental disabilities;
- a State hospital for the mentally disabled operated by the Department of Mental Hygiene (OMH);
- a residential treatment facility for mentally disabled children certified by the Department of Mental Hygiene (OMH);
- an intermediate care facility for the developmentally disabled; and
- a hospital, other than one caring primarily for the mentally disabled.

NOTE: These definitions are NOT to be used for the purpose of determining the district of fiscal responsibility (See OMM/ADM 97-1).

Medicaid is available to otherwise eligible persons receiving inpatient psychiatric services while residing in an institution primarily for the care of the mentally ill when: the A/R is under age 21; the A/R turns age 21 during the course of his/her institutionalization, (in which case the A/R may receive assistance until s/he reaches the age of 22); the A/R is age 65 or over; or, the A/R is an FNP refugee or Cuban-Haitian entrant (in which case Medicaid may be authorized for eight months following the date of entry).

Medicaid may be provided to otherwise eligible prisoners or individuals in the detention process or to residents of another

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

public institution during the month they enter and/or leave the institution but for only that part of the month in which they are in the community. A public institution is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. Jails, prisons, secure detention facilities and half-way houses operated by the government are types of public institutions.

Children placed in secure detention facilities may receive Medicaid (if otherwise eligible) during the month they enter or leave the facility, but only for the part of the month that they reside in the community. Children placed in Office of Family and Children Services Group Homes, Foster Homes and Contract Homes, who are otherwise Medicaid eligible, may receive full Medicaid coverage and a Common Benefit Identification Card.

This section outlines living arrangements where Medicaid may be given as follows:

Living in Own Home;

Medical Facilities; and

Public Institutions.

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS

LIVING IN OWN HOME

Description: An A/R is living in his/her own home when s/he is living alone, living with friends or relatives, living in a congregate care situation or living in foster care.

Policy: Medicaid may be given to an otherwise eligible person living in his/her own home.

References:

SSL Sect.	365 366 371 374
Dept. Reg.	360-6.6(a)
ADMs	92 ADM-15 90 ADM-18
LCMs	93 LCM-89

Interpretation: For Medicaid purposes, "home" indicates a type of residence where Medicaid may be received. The term commonly used is "community based".

An A/R may live with friends and/or legally responsible relatives and be eligible for Medicaid "in his/her own home". When an applicant is living in a communal situation, the arrangement should be investigated. When the communal arrangement represents itself as an organization, whether religious or fraternal, the status of the organization is determined. If the applicant made a commitment to the organization in return for the organization agreeing to meet his/her needs, a determination is made as to whether or not this includes medical needs. In such an agreement, resources may be held in common.

An individual is living in his/her own home when s/he is living in a congregate care situation. Some examples of congregate situations are foster care for children and adult care facilities such as family type homes for adults, shelters for adults and residences for adults. These adult care facilities provide shelter for adults who, though not requiring continual medical or nursing care, are, by reason of physical or mental disability associated with age or other factors, unable to live independently.

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS

MEDICAL FACILITIES

Description: Medical facilities are hospitals, skilled nursing facilities and intermediate care facilities which have an operating certificate issued to them by the New York State Department of Health or the Department of Mental Hygiene and have a Medicaid Provider agreement issued by the State Medicaid agency.

Policy: Medicaid may be given to an otherwise eligible person in an approved medical facility.

NOTE: This definition is NOT to be used for the purpose of determining the district of fiscal responsibility. (See OMM/ADM 97-1 and **OTHER ELIGIBILITY REQUIREMENTS** DISTRICT OF FISCAL RESPONSIBILTY)

References:

SSL Sect.	365 366
	Public Health Law, Article 28 Mental Hygiene Law, Article 31 Mental Hygiene Law, Article 16
Dept. Reg.	360-6.6(b) - (f)
ADM	OMM/ADM 97-1
INF	88 INF-15
LCM	93 LCM-89

Interpretation: An approved medical institution or facility includes the following when operated in accordance with the provisions of the Public Health Law, Mental Hygiene Law or other applicable law:

- a private proprietary, public or non-profit nursing home;
- the approved infirmary section of a home for the aged;
- a public home infirmary or other similar public facility for the chronically ill;
- an approved hospital or nursing home section of a public institution operated for the care of persons with developmental disabilities;

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS

MEDICAL FACILITIES

- a general or chronic disease hospital; an institution operated primarily for the care of the mentally disabled, for individuals under age 22 if the A/R turned age 21 while residing in the institution or is age 65 or over or under age 21; or the A/R is an FNP refugee or Cuban-Haitian entrant in which case s/he receives Medicaid (if otherwise eligible) for eight months following the date of entry; and,

- an ICF for the developmentally disabled.

Medicaid may be provided to inpatients in public, voluntary or proprietary hospitals in New York State which: are in possession of a valid operating certificate issued in accordance with the provisions of Article 28 of the Public Health Law; are enrolled in the New York State Medicaid program including possession of a provider agreement, and have in effect a hospital utilization review plan.

NOTE: Medicaid may be provided in a hospital located outside New York State if the hospital: is in compliance with such legislation and requirements established by the official agency in the state in which that care is received; has a Medicaid provider agreement; and is enrolled in the New York State Medicaid program.

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS

PUBLIC INSTITUTIONS

Description: A public institution is a non-medical facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Public institutions do not include a community residence serving 16 or less residents; or a child care institution serving 25 or less residents.

Policy: Medicaid cannot be provided to residents of non-medical public institutions, except when the public institution is:

- a shelter for homeless adults operated by a social services district, regardless of size;

- a correctional facility nursery. An infant/child residing in a correctional facility nursery while the mother is serving a prison term may receive Medicaid (See **OTHER ELIGIBILITY REQUIREMENTS** PUBLIC INSTITUTIONS INFANTS RESIDING WITH INCARCERATED MOTHERS);

- a public emergency shelter for homeless adults. Persons residing in a public emergency shelter for homeless adults may be eligible for Medicaid when the A/R is: in receipt of or eligible for S/CC; over the age of 18 and otherwise eligible; or SSI-related. However, an SSI-related A/R may be claimed FP for only six (6) months during a nine (9) month stay within 12 consecutive months. When the six months of federal participation expires, the SSI-related A/R may be claimed FNP. Persons residing in a family shelter are not subject to such categorical restrictions; or,

- a public home operated by a county. Residents of a county-operated public home may be eligible for Medicaid, without federal reimbursement.

References:

SSL Sect.	365 366
Dept. Reg.	360-3.4(a)(1) 491.1-4 500.2 500.1

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS

PUBLIC INSTITUTIONS

ADMs
95 ADM-04
94 ADM-20
88 ADM-50
86 ADM-23
81 ADM-10
79 ADM-87

Interpretation: Except as listed above, Medicaid is not available to residents of non-medical public institutions.

In any month an otherwise eligible Medicaid recipient enters or leaves a public institution (in which Medicaid is not available), Medicaid may be authorized for only that portion of the month the individual is residing in the community (except as listed above).

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS
PUBLIC INSTITUTIONS

INFANTS RESIDING WITH INCARCERATED MOTHERS

Description: Certain correctional facilities operate nurseries for infants born to inmates. Children, born to women serving prison sentences, may live in the nursery for up to eighteen (18) months. This includes a standard twelve (12) month stay plus a possible 6 month extension if there is a reasonable probability that the mother will be released within the 18 months. In the event that the mother is not released within the allotted time, the child is placed in foster care or with relatives.

Policy: Infants and children residing in correctional facilities (where their mothers are incarcerated) are not considered "inmates" of a public institution and therefore may be eligible for Medicaid.

The child is an individual under age 21 and fulfills the requirements of one of the categories. (See **CATEGORICAL FACTORS** UNDER AGE 21) The child is budgeted as a household of one, residing in the community. After allowing appropriate disregards, the child's income is compared to the Medically Needy Income Level or Medicaid Standard (and MBL Living Arrangement Chart as appropriate), whichever is most beneficial.

The district in which the mother resided at the time of her sentencing is the district of fiscal responsibility for the child. The district of fiscal responsibility designates a person to review the application. The designated person may be a district employee or the district's Commissioner may enter into a Memorandum of Understanding (MOU) with the Superintendent of the facility, designating a correctional facility employee.

The mother of the child or the mother's representative must complete an application (See **OTHER ELIGIBILITY REQUIREMENTS** APPLICATION, CERTIFICATION AND RENEWAL) and submit it to the designated person at the correctional facility. The designated person reviews the application and forwards the application packet to the district of fiscal responsibility. The district of fiscal responsibility processes the application and determines the child's Medicaid eligibility.

The date of application is the date that a signed State-prescribed application form, a State-approved equivalent form or process is

OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS
PUBLIC INSTITUTIONS

INFANTS RESIDING WITH INCARCERATED MOTHERS

received by the designated person. Eligibility may be established for up to three (3) months prior to the month of application. (See **OTHER ELIGIBILITY REQUIREMENTS** AUTHORIZATION) However, Medicaid cannot be authorized for the period prior to the child's birth.

References: SSL Sect. 65
366

Dept. Regs. 369.1 & .2
360-2.2

ADMs OMM/ADM 97-1
95 ADM-04

Interpretation: Completed applications are forwarded to the district of fiscal responsibility by the designated person at the correctional facility.

The child's eligibility is determined as if s/he resided in the community, as a household of one.

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS

Description: Medicaid coverage must be suspended for recipients incarcerated in a New York State Department of Correctional Services or local correctional facility and reinstated at the time of release from such facility.

Policy: An inmate of a State Department of Correctional Services or local correctional facility that was in receipt of Medicaid immediately prior to incarceration shall have eligibility maintained during incarceration. In addition, Medicaid coverage must be reinstated upon release from the correctional facility.

References:

SSL Sect.	366 (1-a)
Dept. Regs.	360-3.4 (a) (1) 360-3.4 (c)
ADMs	08 OHIP/ADM03
LCMs	08 OHIP/LCM-1
GISs	11 MA/20 11 MA/010 09 MA/010

Interpretation: Suspension of Medicaid**:**

Medicaid must be suspended for Case Type 20 (MA) recipients and single individuals in a Case Type 22 who are expected to be incarcerated for at least 30 days and who at the time of incarceration have one of the following Coverage Codes: 01 (Full), 02 (Outpatient), 06 (Provisional), 10 (Anciliary Coverage Due to Prohibitive Transfer), 11 (Legal Alien), 15 (Perinatal), 18 (Family Planning Services Only), 19 (Community Coverage With Community-Based Long-Term Care), 20 (Community Coverage Without Long-Term Care), 22 (Outpatient Coverage Without Long-Term Care), 21 (Outpatient Coverage With Community-Based Long-Term Care), 23 (Outpatient Coverage With No Nursing Facility Services), 24 (Community Coverage Without Long-Term Care, Legal Alien During Five-year Ban, NYC only), and 30 (Pre-paid Capitation Plan). Also, Family Health Plus (FHPlus) coverage will be suspended for Case Type 24 (FHPlus) recipients who at the time of incarceration have Coverage Code

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS

06 (Provisional, not yet enrolled, Upstate only), Coverage Code 20 (Community Coverage Without Long-Term Care) or 34 (FHPlus).

NOTE: Districts are advised to call their local district liaison for further instructions when an individual with Coverage Code 10 or 23 becomes incarcerated.

In situations where the incarcerated individual was part of a multi-person household, a determination of the remaining household's ongoing eligibility must be performed utilizing the following guidelines:

- Permanent Absence- When a recipient is incarcerated in a New York State Department of Correctional Services (DOCS) facility, the individual shall be considered permanently absent from the household.
- Temporary Absence- When a recipient is incarcerated in a local correctional facility (jail), the individual shall be considered temporarily absent unless the district has information that the absence will be permanent.

NOTE: Medicaid will be suspended for Case Type 22 recipients (MA-SSI) by the State utilizing information from the New York State Department of Corrections and Community Supervision and the New York State Division of Criminal Justice Services.

Incarcerated individuals whose Medicaid or FHPlus has been suspended and who are subsequently released to a New York State local correctional facility, an Office of Mental Health (OMH) facility or Office of Children and Family Services (OCFS), formerly known as the Division for Youth (DFY), facility or other agency must have their eligibility for Medicaid continued in suspend status.

Discontinuation of Medicaid:

1. At incarceration MA Coverage must be discontinued for recipients with Coverage Code 07 (Emergency Services Only).
2. In addition, individuals with Coverage Code 31 or 36 (Active for Guarantee Coverage Only) must have their managed care guarantee coverage discontinued with appropriate notice.
3. At incarceration, Medicaid coverage and the premium payment must be discontinued for Case Type 20 and single Case Type 22 recipients

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS

who are expected to be incarcerated at least 90 days who at incarceration have Coverage Code 09 (Medicare Savings Program) or Coverage Code 17 (COBRA, AHIP and third-party health insurance), because Medicaid payment of these premiums is not cost effective. However, Case Type 20 (MA) recipients with Coverage Code 09 who are participating in the spenddown program must have their case suspended and their premium payment discontinued.

NOTE: It may not be appropriate to discontinue health insurance premium payments if the policy covers other household members.

Medicaid and FHPlus must be discontinued with appropriate notice for recipients who are incarcerated out-of-state or in a federal penitentiary within New York State.

Incarcerated individuals who are released to the federal government, other state law enforcement, immigration or who are deceased must have their Medicaid discontinued with appropriate notice.

Re-Instatement of Medicaid

Upon notification from DOCS or a Local Correctional Facility that an individual whose Medicaid or FHPlus authorization had been placed in suspend status, and is being released to Parole or has completed his/her sentence without community supervision, Medicaid coverage must be re-instated in the district where the releasee had coverage immediately prior to incarceration. Coverage will begin on the first day of the release month and continue for the following four months.

Released to the Community Without Supervision

If a formerly incarcerated recipient who has been released to the community without supervision contacts the LDSS with a change of address, the LDSS must update the recipient's address on WMS to ensure that the renewal packet will be mailed to the correct address. If the new address is in another district, the case must **not** be transferred to the new district until the five-month reinstatement period has expired, the renewal process has been

completed and a determination of ongoing eligibility is made pursuant to 08 OHIP/LCM-1,"Continued Medicaid Eligibility for Recipients Who Change Residency (Luberto v. Daines)".

The LDSS where the former inmate had coverage immediately prior to the incarceration must issue the mail-in renewal packet to the former inmate at the address on WMS. For recipients who have been released from a New York State Department of Correctional Services (NYS DOCS) facility to the community without supervision, the address listed on WMS will be a NYS DOCS facility. If the recipient has not contacted the LDSS with an updated address, the mail-in renewal packet must be mailed to the former inmate at NYS DOCS facility address found on WMS.

Released to the Community With Parole Supervision

The address of parolees released from a NYS DOCS facility will automatically be posted to WMS as that of his/her parole officer. If a parolee informs the LDSS of a change of address, the LDSS may record the address change in the case record but must **not** update the recipient's address on WMS or transfer the case (if there is an out of county move) until the five-month reinstatement period has expired, the renewal process has been completed and the recipient is determined to be eligible.

The LDSS where the former inmate had coverage immediately prior to the incarceration must issue the mail-in renewal packet to the former inmate at the address of his/her Parole Officer listed on WMS. Such Parole Officer will provide the mail-in renewal packet to the parolee as soon as possible.

Mail-In Renewal Returned to District With Out-of County Address

In cases where the mail-in renewal is returned to the district with an out-of-county address, the district must determine ongoing eligibility for the former inmate, and if eligible, the district will authorize coverage for the usual 12 month period. Once coverage has been authorized, the district may transfer the case to the new district of residence pursuant to procedures outlined in 08 OHIP/LCM-1.

If the district determines the individual is ineligible for Medicaid or FHPlus as a result of the renewal the coverage shall be discontinued with appropriate notice.

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS

Releasee Residing with Family Members

In situations where the releasee is residing with family members, his/her ongoing eligibility shall be redetermined at renewal, after the five month reinstatement period, as a member of the household. If the releasee is a member of a currently eligible Medicaid/FHP household, eligibility for the other household member(s) shall also be reviewed.

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER

Description: Generally, Medicaid coverage must be suspended for recipients age 21-64 admitted to a psychiatric center and reinstated at the time of release from such facility.

Policy: When a district is notified that a Medicaid recipient age 21-64 is a resident of a psychiatric center, the district must suspend Medicaid coverage, barring certain exceptions. Upon notification of discharge from the psychiatric center, Medicaid coverage must be reinstated in the district of fiscal responsibility immediately prior to admission.

NOTE: Districts will be notified of admissions and discharges from State Operated Psychiatric Centers by the State Department of Health in conjunction with the Office of Mental Health (OMH). However, should a district become aware that an individual age 21-64 has entered a private (non-state operated) psychiatric hospital, Medicaid coverage must also be suspended and re-instated.

References:

SSL Sect.	365.2 (a) & (b) 366 (1) (c) & (d)
Dept. Regs.	360-3.4 (a) (2)
ADMs	11 OHIP/ADM-3
INFs	89 INF-43

Interpretation:

Suspension of Medicaid**:**

On a monthly basis DOH will run a file provided by OMH to identify individuals age 21-64 who have been in a State psychiatric center for at least 30 days and have an active Medicaid/FHPlus case**.**

Medicaid must be suspended for Case Type 20 (MA) recipients with one of the following Coverage Codes: 01 (Full), 02 (Outpatient), 06 (Provisional), 10 (All Services Except Nursing Facility Services), 11 (Legal Alien), 15 (Perinatal), 18 (Family Planning Services Only), 19 (Community Coverage With Community-Based Long-Term Care), 20 (Community Coverage Without Long-Term Care), 22 (Outpatient Coverage Without Long-Term Care), 21 (Outpatient Coverage With Community-Based Long-Term Care), 23 (Outpatient Coverage With No Nursing Facility Services), 24 (Community Coverage Without Long-Term Care, Legal Alien During Five-year Ban, NYC only), and 30 (Pre-paid Capitation Plan). Also, Family Health Plus (FHPlus) coverage will

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER

be suspended for Case Type 24 (FHPlus) recipients who at the time of admission have Coverage Code 06 (Provisional, not yet enrolled, Upstate only), Coverage Code 20 (Community Coverage Without Long-Term Care) or 34 (FHPlus).

In situations where the individual was part of a multi-person household, a determination of the remaining household's ongoing eligibility must be performed. The psychiatric center resident shall remain in the household count unless the district receives notification from OMH that the resident's stay is other than temporary.

Medicare Part A and /or B premium payments and payments for third-party health insurance coverage must be discontinued and the Buy-In closed. If the individual is enrolled in a managed care plan, he/she must be dis-enrolled. NOTE: It may not be appropriate to discontinue payment of third-party health insurance premiums which cover other Medicaid/FHPlus household recipients.

Medicaid coverage will not be suspended for Temporary Assistance (TA)/Medicaid recipients if the individual continues to receive TA benefits based on the individual's temporary admission to a psychiatric center. For these individuals, Medicaid coverage will continue. Also, Supplemental Security Income (SSI) beneficiaries will continue to receive Medicaid coverage based on the receipt of SSI.

Exceptions to Suspension:

1. Medicaid Coverage must be discontinued for recipients with Coverage Code 07 (Emergency Services Only).
2. Individuals with Coverage Code 31 or 36 (Active for Guarantee Coverage Only) must have their managed care guarantee coverage discontinued with appropriate notice.
3. Individuals authorized for Medicare Savings Program (coverage code 09) must have their coverage discontinued.
4. Individuals with coverage code 17, Health Insurance Continuation Only- COBRA, AHIP must have their coverage discontinued. **NOTE**: If the COBRA/AHIP policy covers other eligible household members, it may not be appropriate to discontinue payment of health insurance premiums.

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER

5. Case Type 20 (MA) recipients with Coverage Code 09 who are participating in the spenddown program must have their case suspended and their premium payment discontinued. Recipients who have been authorized for MSP-only must have their MSP Buy-in span end-dated in eMedNY.

Re-Instatement of Medicaid

Upon notification from DOH/OMH that an individual whose Medicaid or FHPlus authorization had been placed in suspend status is being discharged from the psychiatric center such individual must have their Medicaid coverage reinstated with the coverage they had immediately prior to their admission to the psychiatric center. Medicaid coverage must be reinstated for five months (the month of discharge, plus four months) with appropriate notice at the individual's current address.

In situations where the releasee is residing with family members who are not in receipt of Medicaid or FHPlus, his/her ongoing eligibility shall be redetermined at renewal as a member of the household, after the five month reinstatement period. If the releasee is a member of a currently eligible Medicaid/FHP household, eligibility for the other household member(s) must be reviewed at renewal.

Exceptions to Re-Instatement

1. Medicaid eligibility must be redetermined for individuals who are being discharged to an SNF. While a new application is not required, Supplement A to the DOH-4220 is required if resource information must be captured.

2. Coverage for individuals who are being discharged to the custody of the United States Immigration and Customs Enforcement (ICE) must be discontinued.

3. Individuals who are being discharged to a NYS or local correctional facility will continue to have their coverage suspended.

4. Coverage must be discontinued for individuals who are being discharged to another state's law enforcement.

5. Coverage for individuals who are being discharged to the Federal Bureau of Prisons must have their coverage discontinued.

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER

6. Coverage for individuals who are being discharged to an OMH operated living arrangement (i.e. a State operated family care home, community residence or residential care center for adults) must be discontinued. Once the county case is closed, OMH will open a case in District 97.

7. Coverage must be discontinued for individuals who have died in the psychiatric center.

8. The DFR prior to admission to the psychiatric center must discontinue coverage for individuals who turn 65 and remain in the psychiatric center. Once the district closes its case, OMH will determine eligibility for the individual.

9. Coverage for an individual discharged to an Office for People with Developmental Disabilities (OPWDD) must be discontinued. Once the district has closed its case, OPWDD will open a case in District 98.

10. Medicaid and FHPlus must be discontinued for individuals who have moved to another state.

11. Medicaid and FHPlus must be discontinued for individuals who are discharged to an out-of-state psychiatric center.

OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRRs)

Description: A legally responsible relative is a person who is legally responsible for the support and care of one or more relatives.

Policy: For Medicaid purposes, a legally responsible relative is:

- a spouse of a Medicaid A/R; or
- a parent of a child under the age of 21. However, the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:
- 18 years of age or older;
- under the age of 18, but expected to be living separately from the parental household for 30 days or more; or
- participating in one of the home and community-based waivered programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-1.4(h) 360-4.3(f)
ADMs	OMM/ADM 97-2 89 ADM-47
GISs	00 MA/021 91 MA/007

OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRRs)

Interpretation: When an A/R is living with a legally responsible relative (LRR), the LRR's income and resources are generally considered available to the A/R.

When an A/R is residing in the community with an LRR and the LRR asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the LRR

OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRRs)

provides financial information; or (b) the LRR refuses to provide the requested financial information.

(a) When the LRR provides information, but refuses to make his/her income/resources available to the A/R, eligibility for the A/R is determinable. When completing a budget, only the income/resources, as appropriate, actually available to an A/R are counted.

(b) When the LRR refuses to provide financial information, eligibility is generally indeterminable. However, if the A/R provides complete information concerning his/her own income and resources, as appropriate, including any jointly held resources, eligibility is determined based on the available information.

A dollar amount is budgeted for any non-medical needs that the LRR is meeting. For example, the LRR may be providing the A/R with food, shelter, and clothing. The value of these items would be considered income. The non-contributing LRR is not included in the household size.

If Medicaid is provided because of the failure or refusal of an LRR to make income and resources available, an implied contract is created with the non-contributing LRR. Recovery for the cost of any care provided may be pursued through legal channels.

NOTE: The income/resources of parents are not considered in the eligibility determination for their pregnant daughters (of any age), regardless of where the pregnant daughter resides.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)

SPOUSE

Description: A spouse is an A/R's legal husband or wife. (See definitions in the **GLOSSARY**) A spouse is a legally responsible relative (LRR). A spouse may be of either sex.

Policy: The spouse of an individual in need of Medicaid, if of sufficient financial ability, is responsible for that person's medical needs. (See **RESOURCES** THIRD PARTY RESOURCES for utilization of third party health insurance benefits.)

References:

SSL Sect.	101
	366(3)(a)
Dept. Reg.	360-1.4(h)
	360-4.3(f)
	360-4.10
	360-7.11(b)(ii)
ADMs	OMM/ADM 97-2
	91 ADM-37
	91 ADM-31
	90 ADM-29
	89 ADM-47
	82 ADM-20
	82 ADM-6
GISs	08 MA/024
	08 MA/023

Interpretation:

Spouses Living Together

When an A/R is **living with** his/her spouse, the spouse's income and resources are generally considered available to the A/R (See **OTHER ELIGIBILITY REQUIREMENTS** HOUSEHOLD COMPOSITION and OWNERSHIP AND AVAILABILITY for budgeting methodologies and availability).

When the spouse asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the spouse provides financial information; or (b) the spouse refuses to provide the requested financial information. In both instances, at a minimum, a notation is entered into the case record. (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES for general treatment of legally responsible relatives.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)

SPOUSE

Spouses Living Apart in the Community

When an A/R is residing in the community apart from his/her spouse who is also residing in the community, the spouse may be requested to contribute toward the cost of medical care provided to the A/R. The amount of the requested contribution depends on the spouse's financial ability to support and the category of the A/R.

To determine the amount of the requested contribution from a spouse residing in the community, but not in the A/R's household:

- when there is a child in the household under the age of 21, the case is referred to the Child Support Enforcement Unit (IV-D);

- when the A/R is S/CC, local district Public Assistance procedures determine the contribution; or

- when the A/R is SSI-related, the spouse is requested to contribute twenty-five percent (25%) of his/her otherwise available income which exceeds the minimum monthly maintenance needs allowance (MMMNA), plus any family member allowance(s). (See **RESOURCES** PERSONS IN MEDICAL FACILITIES COMMUNITY SPOUSE and **RESOURCES** FAMILY MEMBER ALLOWANCE)

The local district requests the LRR other than a community spouse to contribute any excess resources, as appropriate, to the support of the Medicaid A/R. Only the income/resources, as appropriate, actually received from a spouse not residing in the A/R's household are counted when determining eligibility.

When the spouse asserts that his/her income/resources are not available to the A/R, at a minimum, a notation is entered into the case record.

Institutionalized Spouse with a Community Spouse

When an A/R is an institutionalized spouse and his/her spouse is a community spouse, spousal budgeting rules determine the

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)

SPOUSE

treatment of the couple's income and resources. See **INCOME** PERSONS IN MEDICAL FACILITES ASSESSMENT/ DETERMINATION OF INCOME AVAILABLE FOR THE COST OF CARE for the full explanation of the assessment and budgeting of income/resources.

If Medicaid is provided, in the instance of failure or refusal, an implied contract is created with the non-contributing spouse. Recovery of the cost of any care provided may be pursued through legal channels.

Both Spouses Institutionalized

When both spouses are institutionalized they are treated as two separate households, whether or not they share a room.

Institutionalized Waiver Participant with a Community Spouse

When one spouse is a waiver participant and his/her spouse is a community spouse, spousal budgeting rules as specified in **INCOME** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS) are applied.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)

PARENTS AND CHILDREN

Description: A child is a person under the age of 21. Generally, parents are legally responsible for their children under the age of 21.

Policy: A parent of a child under the age of 21 is legally and financially responsible for his/her child. However, the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

- 18 years of age or older;
- under the age of 18 but expected to be living separately from the parental household for 30 days or more; or
- participating in one of the home and community-based waivered programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-1.4(h) 360-4.3(f)
ADMs	OMM/ADM 97-2 82 ADM-6
LCM	95 LCM-106
GIS	91MA007

Interpretation: Generally, parents, including adoptive and step-parents (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN STEP-PARENTS), are financially and legally responsible for their children under the age of 21. However, the income/resources of the parent or step-parent are not considered in the eligibility determination if the child is pregnant. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who meets one of the criteria specified above.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)

PARENTS AND CHILDREN

The income/resources of parents are counted in the determination of eligibility for certified blind/disabled child(ren) under the age of 18, unless the child is living or expected to be living separate and apart from the parent(s) for 30 days or more. Even though the child returns to the household in less than 30 days, if s/he was expected to be absent for 30 days, the income/resources of his/her parents are not considered in the eligibility determination for the child during the entire 30 days s/he was expected to be absent.

The income/resources of parents are considered in the eligibility determination for their certified blind/disabled child(ren). If the child is participating in one of the home and community-based waivered programs provided pursuant to Section 1915(c) of the Social Security Act the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

The income/resources of parents are not considered in the eligibility determination for their pregnant daughters (of any age), regardless of where the child resides.

When the child's parent is absent from the household, a referral is made to the Child Support Enforcement Unit (IV-D). IV-D will pursue the absent parent for medical support and paternity establishment as appropriate.

Only the income/resources, as appropriate, actually received (from his/her absent parent) by an A/R are counted when determining eligibility.

See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES (LRRs) for the general treatment of legally responsible relatives.

See **OTHER ELIGIBILITY REQUIREMENTS** OWNERSHIP AND AVAILABILITY for treatment of a non-cooperative parent residing with the A/R.

See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN STEP-PARENTS when the child has a step-parent.

Verify Status: When there is a certified blind/disabled or pregnant child in the household.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)

PARENTS AND CHILDREN

Documentation:

(a) Certificate of blindness/disability.

(b) Proof of absence or expected absence of a certified blind/disabled child, such as a doctor's statement.

(c) Statement from a medical provider that the minor is pregnant.

(d) Participation in a home and community-based waiver program where parental income/resources are not considered in the determination of eligibility.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

ABSENT PARENTS

Description: Absent parents are legally responsible for their children under the age of 21.

Policy: Generally, the income of parents is considered in the eligibility determination of children under the age of 21. The income/resources of the parents of a pregnant minor are not considered in the determination of eligibility regardless of where the pregnant minor resides.

References:

SSL Sect. 101
366

Dept. Reg. 360-1.4(h)
360-4.3(f)
360-7.11(b)(iii)

ADMs OMM/ADM 97-2
89 ADM-47

INFs 07 OHIP/INF-1

Interpretation: The income actually contributed by an absent parent is considered in the determination of eligibility. A referral is made to the Child Support Enforcement Unit (IV-D) to determine the amount of any contribution, medical support, paternity and any appropriate recovery.

In situations of evenly shared (physical and legal) custody of a child(ren) the child's eligibility is determined using the parental income of the applying household and the child's own income, if any. Child support payments count as income to the applying household that is in receipt of the payment and the payment is subject to the $100 child support disregard. If the child(ren) would be eligible in both parent's separate households, the child's Medicaid is authorized in the case of the household that applies first.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

EMANCIPATED MINOR

Description: For Medicaid purposes, an emancipated minor is a person who: is age 16 or over; has completed his/her compulsory education; is living separate and apart from his/her family; and not in receipt of or in need of foster care.

Policy: Medicaid may be authorized for an emancipated minor who is otherwise eligible.

References: Dept. Reg. 349.5

Interpretation: When a child leaves his/her family household to live on his/her own, the child, if otherwise eligible, may receive Medicaid on his/her own behalf. This child must fulfill the requirements of an emancipated minor by being age 16 or over, having completed compulsory education, and living away from home and not in need of foster care.

The parents of an emancipated minor are legally responsible relatives for him/her. The parental liability for support should be established (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN IV-D REQUIREMENTS) by an appropriate referral to the Child Support Enforcement Unit (IV-D) for medical support and paternity establishment as appropriate.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

Description: Title IV Section D (IV-D) of the Social Security Act was established to: secure and enforce child support and medical support from absent parents; establish paternity when necessary; and to provide a parent locator service. For more detailed information regarding IV-D refer to the Public Assistance Source Book, Section VIII-T.

Policy: Generally, a Medicaid household including a child under the age of 21, whose parent is absent from the home, must as a condition of eligibility meet the requirements to secure medical support and establish paternity, unless good cause not to cooperate exists OR they are otherwise exempt. Not all IV-D requirements apply to the Medicaid program; pursuit of cash support is not a requirement for Medicaid A/Rs.

NOTE: In situations of equally (50-50) shared custody of a child(ren) a referral to the Child Support Enforcement Unit (CSEU) should be made except when good cause is established, they are otherwise exempt, or instances where medical support/health insurance is already being provided. The referral would be made for the parent that does not reside in the household in which the child receives Medicaid unless they are otherwise exempt.

Cases to refer to IV-D:

- MA cases that include a child under the age of 21 with an absent parent, and/or for whom paternity has not yet been established, provided the case does not meet the exemption criteria, shall be referred to the CSEU. At no time during a women's pregnancy shall a referral be made for the pregnant woman or her children. Referrals are made after the end of the month of the 60 day post-partum period.

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Cases exempt from referral to IV-D:

- Child-only MA cases for all children under the age of 21, including children living on their own and children in receipt of SSI;
- Parents or step-parents who already provide health insurance and/or cash medical support for the child for whom paternity has already been established regardless of living arrangements;

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

- Intact households in which both parents (married or unmarried) reside together with their common children; however, a referral may be made for the establishment of paternity;
- Transitional medical assistance (TMA) recipients; deceased absence parent;
- A child released for or pending adoption;
- When good cause is claimed by the A/R at any time during the application, determination or authorization period, until the final good cause determination is completed. If good cause is found to exist, the non-referral status continues until the reason for good cause no longer exists; and
- Any case where the parents' income and resources are not used in determining eligibility for the child, such as:
    - A child participating in one of the community-based waiver programs;
    - A pregnant minor
    - A certified blind or certified disabled child 18 years of age or older, or if under age 18, expected to be living separately from the parents' household for at least 30 days;
    - A child who chooses to apply for, and/or is in receipt of family planning benefits only (coverage code 18); or
    - IV-E adoption children.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

Under the Family Court Act (FCA), support orders must require legally responsible relatives to make use of any health insurance coverage available to cover the child on whose behalf a child support petition is brought. The cost of providing such health insurance for the child is prorated between the parents.

If neither parent has health insurance available, the FCA requires the court to direct the custodial parent to apply for Medicaid or Child Health Plus for the child. If the child is eligible for one of those programs, the parents' obligation is to pay the cost of any required premium or family contribution, such as co-payments, that are the responsibility of the recipient under the Medicaid or Child Health Plus programs, which cost shall be prorated between the parents. The court also has the ability to order cash medical support when no health insurance is available by applying a formula.

A direction by the court to seek Medicaid or Child Health Plus for the child does not eliminate the parents' obligation to utilize for the child's benefit any health insurance coverage that may subsequently become available.

References:

SSL Sect.	111
	366.3
	366.4(h)
	367-a.2(b)
Dept. Reg.	369.2(b)
	360-4.3(f)
	360-7.11
	441.2

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

ADMs	99 ADM-5 92 ADM-40 89 ADM-47 89 ADM-23
INFs	07 OHIP/INF-1 90 INF-45
GIS	08 MA/031

Interpretation: The eligible parent or other caretaker/relative of a child under the age of 21 whose parent is absent from the home must meet the following IV-D requirements, for medical support only unless it is a child-only MA case:

Cooperate in good faith with the State and the local social services district to establish the paternity of a child born out of wedlock, to locate any absent parent or putative father and to establish, modify, and enforce support orders.

The term "cooperation" includes providing information for the A/R to complete the DSS-2860, Child Support Referral form and, if required, appearing at the local Child Support Enforcement Unit (CSEU) to be interviewed. A Medicaid applicant who is not pregnant or in the 60 day postpartum period or otherwise exempt must assist in completing the DSS-2860 appear at the CSEU, as necessary, and cooperate with the CSEU unless good cause not to cooperate is found to exist.

A Medicaid recipient's continued cooperation with the CSEU is prerequisite to his or her ongoing eligibility to receive Medicaid. An A/R's Medicaid eligibility is not delayed or denied, however, if the A/R is complying but, through no fault of the client, the IV-D process has not been completed.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

The local district:

(1) mails or provides all client books at application and recertification, including Client Information Book I (DSS-4148A), which addresses clients' rights and responsibilities regarding child support;

(2) advises all Medicaid-Only A/Rs in writing via the DOH-4220 (ACCESS NY application), unless they are otherwise exempt, that, as a condition of initial and ongoing eligibility, they will be required to cooperate in:

(a) obtaining third party health insurance (TPHI) and medical payments for themselves and any other individuals for whom the Medicaid-Only A/R can legally assign rights;

(b) establishing paternity of a child born out of wedlock for whom the Medicaid-Only A/R can legally assign rights; and

(c) obtaining medical support for their children (unless it is a child-only MA case).

NOTE: Pregnant women should not be referred to the CSEU until after the 60-day post partum period. To the extent possible, prior to such referral, local districts continue to pursue the availability of TPHI. If a pregnant minor does not want her parents contacted, however, TPHI is not pursued. All other Medicaid-Only A/R's must cooperate in establishing paternity and securing medical support.

An A/Rs failure, without good cause or other exemption, to cooperate renders such person ineligible for Medicaid. Their children under age 21, however, are authorized to receive Medicaid if they are otherwise eligible;

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

(3) Medicaid worker or an appropriate designee determines whether an A/R who claims to have good cause for refusing to cooperate does have good cause that can be verified.

(4) refers to the CSEU cases which include a non-pregnant child under age 21 whose paternity has not been established or whose parent(s) are absent from the home unless they are in a child-only MA case. Mails or provides the DSS-2860 form and informs A/Rs who are required to appear in the CSEU that they must bring the completed DSS-2860 to their CSEU interview. Applicants are referred to the CSEU prior to their eligibility determination or, if practicable, prior to their eligibility interview;

(5) obtains necessary documentation from A/Rs;

(6) takes appropriate action (notices and procedures) when notified by CSEU via the DSS-2859, Child Support Information Transmittal that an A/R who is not pregnant has failed to cooperate.. The A/R's children are not denied or discontinued from Medicaid for this reason;

(7) takes appropriate action in Medicaid cases reported in the IV-D/Medicaid Interface Report and in DSS-2859 referrals from the CSEU. The weekly IV-D/IV-A Interface Report provides information to Medicaid workers about status changes in child support cases, including location of absent parents, paternity establishment, support order actions and third party health insurance coverage;

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

(8) responds to CSEU requests for Medicaid eligibility and payment information via the OHIP-0030, Medicaid Medical Support Transmittal;

(9) at recertification and other client contacts, asks recipients for new and changed information about absent parents, forwards information to the CSEU via the OHIP-0030 form; and

(10) budgets child support as unearned income in a Medicaid-Only case with the $100 child support disregard.

The local district informs the A/R that s/he has a right to claim good cause as an exception to the cooperation requirement. The A/R may refuse to meet any or all of the IV-D requirements when s/he has good cause to do so. The following circumstances are considered good cause:

(1) when cooperation may be against the best interests of the child. Cooperation in establishing paternity or seeking support is deemed to be against the best interest of the child only if the A/R's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- physical harm to the child for whom support is sought;
- emotional harm to the child for whom support is sought;
- physical harm to the parent or caretaker relative with whom the child is living;
- emotional harm to the parent or caretaker relative with whom the child is living;

(2) the child for whom support is sought was conceived as a result of incest or forcible rape;

(3) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

IV-D REQUIREMENTS

the A/R is currently being assisted by an authorized agency (LDSS or a voluntary agency) to resolve the issue of whether to parent the child or place him/her for adoption,

(4) and discussions have not gone on for more than three months.

If an A/R refuses to meet the IV-D requirements and s/he cannot show good cause, s/he is denied Medicaid.

Documentation: An A/R who claims good cause must provide corroborative evidence within 20 days from the day the claim was made. A district may extend this 20 day period when the A/R has difficulty obtaining evidence.

Statement from a medical provider that the A/R is pregnant including the EDC (due date).

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

STEP-PARENTS

Description: A step-parent is the spouse of an A/R's parent, including an adoptive parent. For Medicaid purposes step-parents are legally responsible for their step-children under the age of 21.

Policy: A step-parent of a child under the age of 21 is legally and financially responsible for his/her child. However, the income of a step-parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

- 18 years of age or older;
- under the age of 18 but expected to be living separately from the parental household for 30 days or more; or
- participating in one of the home and community-based waivered programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-4.3(f) 360-7.11
ADMs	91 ADM-8 82 ADM-6 75 ADM-21

Interpretation: Generally, step-parents are responsible for their step-children under the age of 21. However, the income/resources of step-parents are not considered in the determination of eligibility when the child is pregnant; age 18 or over and certified blind/disabled or participating in a home and community-based waiver program.

The income/resources of step-parents are not considered in the determination of eligibility for their certified blind/disabled step-child age 18 or older, regardless of where the child resides. The

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

STEP-PARENTS

income/resources of step-parents are considered in the determination of eligibility for their certified blind/disabled step-child under the age of 18, unless the child is living or expected to be living separate and apart from the step-parent for 30 days or more. Even though the child returns to the household in less than 30, days, if s/he was expected to be absent for 30 days his/her step-parent's income/resources are not considered in the eligibility determination for the child during the entire 30 days s/he was expected to be absent.

The income/resources of a step-parent are not considered in the eligibility determination of a child participating in a home and community-based waiver program pursuant to Section 1115 of the Social Security Act.

Although step-parents are financially responsible for their step-children under Social Services Law, a local district may not presume that the step-parent's income/resources, as appropriate, are available to the child. The step-parent must actually be contributing to the support of the child for the step-parent's income/resources, as appropriate, to be considered when determining eligibility for the child. If a step-parent refuses to support the child for whom s/he is responsible, care is provided to the child, if s/he is otherwise eligible. The district may take action to recover the cost of care from the legally responsible step-parent.

When a step-parent is divorced from the child's parent, there is no longer an obligation on his/her part to support the step-child. In case of abandonment or desertion on the part of the step-parent, the obligation to support the child still exists under Social Services Law.

Verify Status: When the A/R indicates there is a step-parent in the household.

When there is a certified blind/disabled child in the household.

Documentation: (a) Marriage certificate, birth certificate.

(b) Certificate of blindness/disability.

(c) Proof of absence or expected absence of a certified blind/disabled child, such as a doctor's statement.

OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN

STEP-PARENTS

(d) Statement from a medical provider that the minor is pregnant.

(e) Participating in a home and community-based waiver program under Section 1115 of the Social Security Act wherein the income/resources of the parent or step-parent are not considered in the determination of eligibility of the child.

OTHER ELIGIBILITY REQUIREMENTS

HOUSEHOLD COMPOSITION

Description: Household composition is defined as the individuals included in the Medicaid household. Certain individuals are required to be included in the Medicaid household whether or not they are applying for Medicaid (i.e., LRRs living in the household). The household composition varies depending on the category of the individuals for whom eligibility is being determined.

Policy: Medicaid may be given to an otherwise eligible individual, household, or a portion of the applying household. A Medicaid household's size determines which income and resource, as appropriate, levels are used in the determination of eligibility.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 82 ADM-6
INFs	07 OHIP/INF-1

Interpretation: This section discusses the following household compositions:

- Low Income Families (LIF), ADC-related, Pregnant Women and Children, family/household size
- SSI-related household size
- Singles/Childless Couples (S/CC) household size

OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION

LOW INCOME FAMILIES (LIF), ADC-RELATED, PREGNANT WOMEN AND CHILDREN

Description: For applicants in the Low Income Families (LIF) and ADC-related categories and pregnant women and children, the household/family size:

Must include:

- The applicant and applying family members
- Legally responsible relatives
  - o Parents- The household of a parent with joint (equally shared) physical custody of their child who applies with his or her child(ren) includes both the parent and the child(ren). If the other parent in the second household with equally shared physical custody also applies for Medicaid, that household includes that parent and his or her children as well.
  - o Stepparents when the stepparent has acknowledged that s/he is supporting the child. (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN STEP-PARENTS for more information on stepparents.)
  - o Spouses

May include:

- Non applying siblings
- Non applying related children
- Applying related children (e.g. nieces)
- Applying care taker relatives (e.g. aunts, uncles, grandparents) if there is no parent in the household AND the designated caretaker relative has taken a parental role for the child. The caretaker relative must be applying and if there is more than one person eligible to be designated as a caretaker relative in the household, only one can be designated as the caretaker for Medicaid purposes (See **CATEGORICAL FACTORS** ADC-RELATED RELATIONSHIP OF CHILD TO CARETAKER RELATIVE).
- Unwed father of an unborn if paternity has been established AND he is making his income available to the pregnant woman
- Children under the age of 21 of applying adults
- Children eligible under Chaffee provisions
- Children in receipt of an adoption subsidy

OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION

LOW INCOME FAMILIES (LIF), ADC-RELATED, PREGNANT WOMEN AND CHILDREN

Must not include:

- Children and siblings over the age of 21
- SSI cash recipients
- Family Assistance/Safety Net Assistance cash recipients
- Unrelated foster care children
- Parents of pregnant minors
- Non-legally responsible relatives over age 21
- Unrelated household members (e.g. roommates)

Determining eligibility is a two-step process:

1. Count as many persons in the household as possible. If the child or the person seeking eligibility is not found eligible;
2. Remove the "May Counts" from the household of the applicant(s) and determine eligibility.

Policy: Medicaid may be authorized for an entire household or the portion of a household that is determined eligible. All persons in a household may apply on the same application, regardless of whether or not their eligibility is determined in the same budget/household. A child(ren) in receipt of an adoption subsidy may be removed from the household for budgeting purposes if the child(ren) makes the rest of the family ineligible. Federal law mandates states provide Medicaid coverage for adopted IV-E children.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 91 ADM-8 90 ADM-9 82 ADM-6
INFs	07 OHIP/INF-1 90 INF-45
LCMs	95 LCM-106
GISs	00 MA/021 00 MA/007

OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION

LOW INCOME FAMILIES (LIF), ADC-RELATED, PREGNANT WOMEN AND CHILDREN

Interpretation: When determining eligibility, initially include all the Must counts and May counts in the household. In the event that the applicant(s) are not found eligible, the May Counts should be removed from the household. This option must be explained to the applicant. It is the A/R's choice of who is applying and who of the May Counts are counted in the household size.

A child who is eligible for and receiving Adoption Assistance payments is automatically eligible for Medicaid.

A single individual under age 21 living separate and apart from his/her parents is a one-person household.

Disposition: Families with children under age 21 residing in the household, persons under age 21 living alone, and pregnant women may all be eligible under LIF. This group includes families without a deprivation factor as well as families with a deprivation.

The household size of a pregnant woman is increased by one to account for the additional needs associated with pregnancy regardless of the number of expected births.

Children not found eligible for Medicaid, must be referred to Child Health Plus for an eligibility determination.

OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION

SSI-RELATED

Description: For adults (age 18 or over) who are aged, certified blind or certified disabled, a Medicaid household is the aged, blind or disabled person and his/her spouse who lives with him/her if the spouse is: (1) also aged, certified blind or certified disabled; or (2) has remaining income after allocations which is equal to or greater than the difference between the medically needy income level for one, and the medically needy income level for two.

For other aged, certified blind or certified disabled adults who live with their spouses, a Medicaid household consists of one person for income purposes, but consists of two persons for resource purposes.

For all other aged, certified disabled or certified blind A/Rs, a Medicaid household consists of one person.

Policy: Medicaid may be given to an otherwise eligible individual, household or a portion of the applying household.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 91 ADM-27 82 ADM-6

Interpretation: A person who is SSI-related (at least age 65, certified disabled or certified blind) is only a household of two when residing with a spouse who:

- is also SSI-related; or
- has remaining income after allocations (See **INCOME** SSI-RELATED BUDGETING METHODOLOGY ALLOCATION) which is equal to or greater than the difference between the medically needy income level for one, and the medically needy income level for two.

OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION

SINGLES/CHILDLESS COUPLES (S/CC)

Description: An S/CC household is comprised of an individual or married couple who are (1) at least age 21 but not yet 65; (2) not certified blind or disabled; (3) not pregnant; and (4) not caretaker relatives of children under age 21.

Policy: Medicaid may be given to an otherwise eligible individual; household; or a portion of the applying household.

References:

SSL Sect. 365
366

Dept. Reg. 360-4.2

ADMs OMM/ADM 97-2

Interpretation: The S/CC household includes the individual and his/her spouse residing with him/her.

If a spouse living in the household refuses to make his/her income available, eligibility for Medicaid must be determined by counting only the applicant's income (household of one).

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

Policy: All A/Rs, as a condition of eligibility for Medicaid, must be identified.

References:

SSL Sect.	366
Dept Reg.	351.11(b)(2)(ii)(a) 351.2(a) 360-2.3
INF	08 OHIP/INF-1
ADM	93 ADM-29
GIS	08 MA/028 08 MA/009

Interpretation: It is the responsibility of the applicant to establish his/her identity. When the A/R's name changes due to marriage, divorce or legal proceedings, the local district documents the change as appropriate.

Effective July 1, 2006, the Deficit Reduction Act of 2005 (DRA) amended federal Medicaid statute to require that all United States (U.S.) citizens applying for or renewing Medicaid coverage provide "satisfactory documentary evidence" of their U.S. citizenship and identity.

NOTE: The provisions of the DRA do not apply to immigrants. Individuals with satisfactory immigration status can continue to receive Medicaid in New York State as described in OMM 04 ADM-07.

For individuals who present other than primary documents, including birth certificates, LDSS must obtain additional proof of identity, such as a driver's license. If no other identity document is available for a child under age 16, a parent or guardian may certify to the child's identity, as long as an affidavit has not been used to document citizenship.

Verification: Identity documents presented by applicants/recipients (A/Rs) must be originals or copies certified by the issuing agency. Districts may copy or scan the documents for the LDSS files. The worker should make photocopies of any original documents and annotate on the copy that she or he saw the original or a document certified by the issuing agency.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

The DRA requires all states to obtain documentary evidence from citizen A/Rs and maintain this documentation in their case files, or risk losing federal matching funds. The federal government has stated that a U.S. passport book/card, or a Certificate of Naturalization (N-550 or N-570), or a Certificate of U.S. Citizenship (N-560 or N-561) issued by the United States Department of Homeland Security is considered a "primary" document. A New York State Enhanced Driver's License (EDL) or Native American Tribal Document is also considered a primary document. If an individual states they do not have one of these documents, LDSS may and should continue to accept birth certificates as proof of U.S. citizenship, however, an additional identity document is required from the identity section in the attached desk aid.

Documentation: An A/R who uses a primary document, such as a U.S. passport book/card, to establish citizenship is not required to submit a second document to prove identity. All other A/R's must establish their identity by providing a document from the following list or as otherwise specified below:

- Driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used.
- School identification card with a photograph of the individual.
- U.S. military card or draft record.
- Identification card issued by the Federal, State or local government with the same information included on a driver's license.
- Military dependent's identification card.
- Certificate of Degree of Indian Blood or other United States Native American/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual, such as age, weight, height, race, sex and eye color.
- U.S. Coast Guard Merchant Mariner card.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

- A cross-match with a Federal or State government, public assistance, law enforcement, or corrections agency's data system. Some examples are (but not limited to): State Data Exchange (SDX), Beneficiary Data Exchange (BENDEX) and State Online Query (SOLQ).

- If none of the above identity documents is available, a combination of three or more corroborating documents that, when taken as a whole, reasonably verify the A/R's identity. Acceptable documents include marriage certificates, divorce decrees, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas) and/or property deeds or titles. Voter registration cards are not acceptable. All corroborating documents must contain consistent identifying information. None of the documents may have been used to establish the A/R's citizenship. This method of proving identity may be used only when the A/R submitted second or third level evidence of citizenship.

SPECIAL RULES FOR CHILDREN YOUNGER THAN AGE 16

Children who are younger than age 16 may have their identity documented through other means:

- Clinic, doctor or hospital record.

- School records, including report card or nursery or daycare record. The LDSS must verify the records with the issuing school.

- If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under age 18 when a school ID card or driver's license is not available to the child until she or he is 18 years of age.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

SPECIAL RULES FOR DISABLED INSTITUTIONALIZED INDIVIDUALS

The LDSS may accept an identity affidavit signed under penalty of perjury by the director or administrator of a nursing facility or other residential care facility in which a disabled A/R resides. The LDSS should first pursue all other means to verify identity before accepting such an affidavit. The affidavit need not be notarized.

HOMELESS INDIVIDUALS

Homeless individuals often need assistance from the eligibility worker in obtaining acceptable proof of identity, citizenship or immigration status. When the applicant is a homeless individual, it may be difficult for him/her to establish his or her identity, citizenship or immigration status. However, just because an individual is homeless, she/he still must be identified. Proving one's identity is a requirement of the Medicaid program.

The eligibility worker may accept any of the aforementioned documents listed in the Identity section of the attached desk aide, as proof of identity for the homeless individual. If none of the identity documents listed above or in the desk aid is available, a combination of three or more corroborating documents may be used.

NOTE: If an individual is unable to verify his or her identity, citizenship or immigration status, workers should not assume she/he is therefore eligible for coverage of an emergency medical condition. The provisions of the DRA do not apply to immigrants applying for the treatment of an emergency medical condition. However, verification of identity is a requirement for this coverage and all other covered services.

"JOHN/JANE DOE"

A Medicaid application submitted by a "John/Jane Doe" individual (i.e., an individual who is unable to verify his or her identity) should be evaluated in the same manner as any other Medicaid applicant, that is, these individuals are required to meet the same documentation requirements as any other Medicaid applicant. A true "John/Jane Doe" individual is not eligible for Medicaid coverage for the treatment of an emergency medical condition. Verification of identity is a requirement for this coverage and all other covered services.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

Desk Guide: The desk aid/chart entitled "Documents Establishing U.S. Citizenship and Identity" reflects the final federal regulations on acceptable documentation for citizenship and identity and is attached on the next page.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY Ver: 11/19/07

PRIMARY CITIZENSHIP DOCUMENTS

Primary Documents	Explanation: Highest reliability; proves U.S. citizenship and identity. No other document required.
United States passport	The Department of State issues this document. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.
Certificate of Naturalization (DHS Forms N-550 or N-570)	Department of Homeland Security (DHS) issues for naturalization.
Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)	Department of Homeland Security (DHS) issues certificates of citizenship to individuals who derive citizenship through a parent.

SECONDARY CITIZENSHIP DOCUMENTS

Secondary Documents	Explanation: Districts should attempt to obtain the most reliable document available. Satisfactory reliability when a primary document not available; also requires an identity document.
A U.S. public birth certificate showing birth in: • One of the 50 U.S. States; • District of Columbia; • American Samoa; • Swain's Island; • *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the U.S. (on or after January 17, 1917); • *Northern Mariana Islands (after November 4, 1986 (NMI local time); or • Guam (on or after April 10, 1899)	The birth record document may be issued by the State, Commonwealth, territory or local jurisdiction. It must have been issued before the person was five years of age. Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the United States, the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. * See additional requirements for Collective Naturalization, on page 5.
Certification of Report of Birth issued by the Department of State (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY continued Ver: 11/19/07

SECONDARY DOCUMENTS (continued)

Secondary Documents continued	Explanation: Satisfactory reliability when a primary document not available; also requires an identity document.
A Report of Birth Abroad of a U.S. Citizen (FS-240)	The Department of State consular office prepares and issues this document. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
Certification of birth issued by Department of State (Forms FS-545 or DS-1350)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form-545. Treat an FS-545 the same as the DS-1350.
United States Citizen Identification Card (I-197 or prior version I-179)	The former Immigration and Nationality Services (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
Northern Mariana Identification Card (I-873)	The former INS issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
American Indian Card (I-872)	DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976.
Official Military record of service showing U.S. place of birth	The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).
Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000	Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000 (P.L. 106-395). Applies to adopted or biological children born outside the U.S.

THIRD LEVEL DOCUMENTS

Third Level Documents	Explanation: Satisfactory reliability when a primary or secondary document is not available; also requires an identity document
Extract of hospital record on hospital letterhead established at the time of the person's birth that was created at least 5 years before the initial application date and that indicates a U.S. place of birth	DO NOT ACCEPT a souvenir "birth certificate" issued by the hospital. Note: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY continued

Ver: 11/19/07

THIRD LEVEL DOCUMENTS (continued)

Third Level documents continued	Explanation: Satisfactory reliability when a primary or secondary document is not available; also requires an identity document
Life, health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date	Life, health or other insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. Note: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.
Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth	Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. Entries in a family bible are not considered religious records.
Early school record showing U.S. place of birth	Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents. School records must be verified with the school's administration.

FOURTH LEVEL DOCUMENTS

Fourth Level Documents	Explanation: Satisfactory reliability when a primary, secondary or third level document is not available; should be used only in the rarest of circumstances; also requires an identity document.
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950)	The census record must also show the applicant's age. Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or social services district should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form also requires a fee.
Other documents as listed in the explanation column that were created at least 5 years before the application for Medicaid (For children younger than 16, near the time of birth or 5 years before the application)	This document must be one of the following and show a U.S. place of birth: • Seneca Indian tribal census record; • Bureau of Indian affairs tribal census records of the Navajo Indians; • U.S. State Vital Statistics official notification of birth registration; • Delayed U.S. public birth record that was recorded more than 5 years after the person's birth; • Statement signed by the physician/midwife who was in attendance at the time of birth; or • Bureau of Indian Affairs Roll of Alaska Natives.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY continued Ver: 11/19/07

FOURTH LEVEL DOCUMENTS (continued)

Fourth Level Documents continued	Explanation: Satisfactory reliability when a primary, secondary or third level document is not available; should be used only in the rarest of circumstances; also requires an identity document.
Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5-years before the application date) showing a U.S. place of birth	Admission records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Written Affidavit	Affidavits should ONLY be used in rare circumstances. The affidavit must contain the following information under the following circumstances: • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • The two affidavits can be combined in a joint affidavit. • At least one of the individuals making the affidavit cannot be related to the applicant or recipient. • The person(s) making the affidavit must be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted. • The affidavit must also be signed under penalty of perjury by the person making the affidavit, but need not be notarized. • A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained must also be obtained.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY (continued) Ver: 11/19/07

When primary evidence of citizenship is not available, a document from the list of Secondary, Third, or Fourth Level Documents may be presented and must be accompanied by an identity document the list below.

IDENTITY DOCUMENTS

Documents to Establish Identity	Explanation: This section includes a list of acceptable documents that establish identity when a primary document is not available:
	• A driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Do not accept a Canadian driver's license; • School identification card with a photograph of the individual; • U.S. military card or draft record; • Identification card issued by Federal, State, or local government with the same information included on the driver's license; • Military dependent's identification card; • Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska Native Tribal document with photo or other identifying information; • U.S. Coast Guard Merchant Mariner card; • A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency's data system; • If none of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable; • Disabled individuals in residential care facilities may have their identity attested to by the facility director or administrator, on behalf of the individual in the facility when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury, but need not be notarized. • Children under age 16 may have their identity documented using other means: o Clinic, doctor or hospital record; o School records including report card, day care or nursery school record. Records must be verified with the issuing school; o If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver's license is not available to the child until she or he is 18 years of age.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY (continued) Ver: 11/19/07

COLLECTIVE NATURALIZATION

Territories	Explanation: Evidence that establishes U.S. citizenship for collectively naturalized individuals.
Puerto Rico	• Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's or recipient's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or • Evidence that the applicant/recipient was a Puerto Rican citizen and the applicant's/recipient's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.
U.S. Virgin Islands	• Evidence of birth in the U.S. Virgin Islands, and the applicant/recipient's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or • The applicant/recipient's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or • Evidence of birth in the U.S. Virgin Islands and the applicant/recipient's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932).
Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Island [TTPI])	• Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); • Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or • Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). **NOTE**: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

OTHER ELIGIBILITY REQUIREMENTS

CITIZENSHIP AND IMMIGRATION STATUS

Policy:

Medicaid is provided to otherwise eligible residents of the United States who are citizens, nationals, or individuals in satisfactory immigration status (i.e. qualified or persons Permanently Residing in the United States Under Color of Law (PRUCOL). Medicaid coverage is limited to coverage for the treatment of emergency medical conditions for otherwise eligible individuals who are not qualified (i.e. temporary non-immigrants, short term visa holders, foreign students, etc.) or who are not in satisfactory immigration status (i.e., undocumented).

Citizens, nationals, qualified immigrants and PRUCOL immigrant applicants for Medicaid must provide appropriate documentation of their citizenship or satisfactory immigration status. Such individuals must also sign a declaration, under penalty of perjury, that they are citizens, nationals or immigrants with satisfactory immigration status and must provide or apply for a Social Security Number.

Individuals who are initially eligible for Medicaid as a "deemed" newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

NOTE: Special provision is made for individuals who are not qualified, but who, on August 4, 1997, were residing in certain residential facilities or were diagnosed with AIDS (as defined by the Centers For Disease Control) and receiving Medicaid based on a determination that they were "permanently residing in the United States under color of law" (PRUCOL). Such individuals will continue to receive full Medicaid benefits if they are otherwise eligible.

NOTE: Citizenship and immigration status are not considered when determining Medicaid eligibility for a pregnant woman. A pregnant woman does not need to document her citizenship/immigration status until the month following the month in which the 60-day postpartum period ends.

References:

SSL Sect	122
	131-k
Dept Reg.	349.3
	351.1
	351.2
	360-3.2(j)

OTHER ELIGIBILITY REQUIREMENTS

CITIZENSHIP AND IMMIGRATION STATUS

ADMs	04 ADM 07
	97 ADM-23
	88 ADM-22
	88 ADM-4
	82 ADM-24
INFs	07 OHIP/INF-2
	06 OMM/INF-5
GISs	10 MA/006
	08 MA/009
	04 MA/014
	02/MA/016
	02 MA/002
	01 MA/033
	01 MA/030
	01 MA/026

OTHER ELIGIBILITY REQUIREMENTS

CITIZENSHIP AND IMMIGRATION STATUS

This section deals with the following groups:

Citizens:
Nationals;
Native Americans;

Satisfactory Immigration Status:
Qualified;

Battered;

Veterans and Active Duty Exceptions;

Victims of Trafficking;

PRUCOL (permanently residing in the United States under color of law);

Temporary Protected Status (TPS);

Visa Statuses:
Temporary non-immigrants (immigrants admitted on a temporary basis); and

Special non-immigrants (immigrants admitted on a K, S, V, U visa); and

Undocumented/illegal:
Treatment of an Emergency Medical Condition

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

Description: A citizen is a person who was born in the United States or who has been naturalized.

Policy: Medicaid may be given to citizens of the United States who are residents of New York State and who are otherwise eligible. The Deficit Reduction Act of 2005 (DRA) amended federal Medicaid Statute to require that all United States citizens applying for or renewing Medicaid coverage provide "satisfactory documentary evidence" of their citizenship. For applications submitted after October 1, 2010 individuals declaring to be U.S. citizens and presenting a valid SSN will have their citizenship confirmed via the Social Security Administration (SSA) citizenship verification process.

NOTE: Naturalized citizens will not have their citizenship verified through the SSA process.

Applicants/recipients (A/Rs) declaring to be U.S. citizens, who are eligible for or enrolled in Medicare or receiving Supplemental Security Income (SSI) are exempt from documenting both citizenship and identity. These individuals have already established their citizenship and identity to the Social Security Administration (SSA).

The Tax Relief and Health Care Act of 2006 (PL 109-432) amended the DRA further to exempt A/Rs in receipt of Social Security Disability Insurance (SSDI) and children under Title IV-B on the basis of being a child in foster care and IV-E on the basis of adoption or receiving foster care assistance.

The provisions of Section 211 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 also eliminates citizenship documentation requirements for deemed newborns.

References:

SSL Sect.	122 131-k
Public Law	109-432
Dept. Reg.	349.3 360-3.2(f)
ADM	10 OHIP/ADM-8
INF	08 OHIP/INF-1

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

GIS 10 MA/006

Interpretation: Natural born citizens and individuals who acquire citizenship through naturalization and who are residents of the State of New York may receive Medicaid, if otherwise eligible. For the Medicaid program, identity, citizenship and/or satisfactory immigration status must be documented. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for the purpose of Medicaid eligibility.

All persons who were born in the United States are, with rare exception, United States citizens. United States citizenship can also be acquired by naturalization or acquired by persons who are born in another country and whose parent(s) are citizens of the United States. Lengthy residence in this country or marriage to a U.S. citizen does not by itself bestow citizenship.

Individuals who are initially eligible for Medicaid as a "deemed" newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

Newborns processed through the existing newborn process are excluded from being sent for citizenship verification.

Applicants declaring to be U.S. citizens do not have to provide proof of citizenship as a condition of initial eligibility. The response from SSA will be displayed in the Welfare Management System as a Birth Verification Indicator (BVI). A BVI value of "1" is generated when a recipient's allegation of citizenship is consistent with SSA data. No further action is required and no additional documentation of citizenship, identity or date of birth is required. If the SSA verification process fails to confirm citizenship and identity and the LDSS is unable to resolve any inconsistency, the A/R must be given 90 days to either authorize the LDSS to obtain verification of birth from Vital Records and provide the LDSS with identity documentation or provide the district with original documentary evidence to support their declaration of citizenship and identity.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

A/Rs may also bring their original documents or certified copies to a Facilitated Enroller (FE) or other qualified entity designated by the LDSS for this purpose. If the FE processed the original application, the FE will forward the verified copies to the LDSS. Otherwise, the facilitator will photocopy the original documents and notate on the copies that the originals or certified copies were seen, and return the documents to the recipient. The recipient must send the copies to the LDSS.

During the 90 day period, the individual remains enrolled in Medicaid. After 90 days, if documentary evidence has not been provided to verify citizenship and identity, the district must discontinue Medicaid for the individual with timely notice. However, the recipient continues to be eligible for any remaining months in a six-month managed care guarantee enrollment period. **NOTE**: If a parent or caretaker relative does not comply with providing citizenship and identity documentation to the district for an applying child under the age of twenty-one when the SSA match fails, ONLY the child's Medicaid eligibility can be discontinued.

Naturalized citizens are required to show documentary proof of their acquired citizenship by presenting their original or certified copy of the Certificate of Naturalization or their US Passport to the LDSS, FE or qualified entity designated by the LDSS. These individuals are allowed 90 days from the date of notification to supply their original or certified copy of naturalization document or US Passport. **NOTE**: Medicaid coverage must not be delayed pending receipt of such documentation if the individual is otherwise eligible.

Once a person's citizenship is documented, it need not be re-documented unless that person's citizenship becomes questionable.

However, individuals who re-apply after their declaration of citizenship did not validate and who did not comply with the request to provide proof of citizenship and identity, will not be forwarded to SSA for citizenship verification. These individuals will be required to provide documentation of identity and U.S. citizenship or immigration status at reapplication.

Documentation: If the SSA verification process fails to confirm citizenship and identity and the LDSS is unable to resolve any inconsistency, original documentary evidence to support their declaration of citizenship and identity must be obtained.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

The following are examples of items which constitute primary documentation of U.S. citizenship:

Documents which Establish both Citizenship and Identity

- U.S. passport book/card;
- Certificate of Naturalization (N-550 or N-570);
- Certificate of U.S. Citizenship (N-560 or N-561);
- NYS Enhanced Driver's License (EDL); Or
- Native American Tribal Document

Secondary Documents which Establish Citizenship but also require one identity document from the Identity Documentation list below:

- U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 4/11/1899), Virgin Islands of the U.S. (on or after 2/25/1927), Northern Mariana Islands (after 11/3/1986 [NMI local time]), or Guam (on or after 4/10/1899);
- Certification of Report of Birth issued by the Department of State (DS-1350) ;
- Report of Birth Abroad of a U.S. Citizen (FS-240);
- Certification of birth issued by Department of State (Forms FS-545 or DS-1350);
- U.S. Citizen Identification Card (I-197 or I-179);
- Northern Mariana Identification Card (I-873);
- American Indian Card with classification code of "KIC" (I-872);
- Final adoption decree showing U.S. place of birth;

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

- Evidence of U.S. civil service employment before 6/1/1976;
- Military record of service showing U.S. place of birth (i.e., DD-214); or
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Third Level Documents which Establish Citizenship but are less reliable than Secondary Documents (Also requires an identity document)

- Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth;
- Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth);
- Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or
- Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.

Fourth Level Documents which Establish Citizenship but are the least reliable and should only be used in rarest of circumstances (Also requires an identity document)

- Federal or State census record showing U.S. citizenship or a U.S place of birth; or
- The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth):
    - Medical (clinic, doctor, or hospital) record;
    - Seneca Indian tribal census;
    - Bureau of Indian Affairs tribal census records of the Navajo Indians;
    - U.S. State Vital Statistics official notification of birth registration;
    - Delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

- Statement signed by the physician/midwife who was in attendance at the time of birth; or
- Bureau of Indian Affairs Roll of Alaska Natives;

- Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S place of birth; or
- Written affidavit (to be used only in rare instances). The affidavit must contain the following information under the following circumstances:
  - There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.
  - The two affidavits can be combined in a joint affidavit.
  - At least one of the individuals making the affidavit cannot be related to the applicant or recipient.
  - The person(s) making the affidavit must be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted.
  - The affidavit must also be signed under penalty of perjury by the person making the affidavit, but need not be notarized.

  A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained must also be obtained.

Evidence that Establishes U.S. Citizenship for Collectively Naturalized Individuals

Puerto Rico

- Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or
- Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

U.S. Virgin Islands

- Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or
- The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932.

Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI])

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time); or
- Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time), or
- Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time). If a person entered the NMI as a non-immigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

HOMELESS INDIVIDUALS

Homeless individuals often need assistance from the eligibility worker in obtaining acceptable proof of identity, citizenship or immigration status. When the applicant is a homeless individual, it may be difficult for him/her to establish his or her identity, citizenship or immigration status. However, just because an individual is homeless, she/he still must be identified. Proving one's citizenship is a requirement of the Medicaid program.

The eligibility worker may accept any of the aforementioned documents listed in the citizenship section above or in the attached desk aide, as proof of citizenship for the homeless individual.

NOTE: If an individual is unable to verify his or her identity, citizenship or immigration status, workers should not assume she/he is therefore eligible for coverage of an emergency medical condition.

"JOHN/JANE DOE"

A Medicaid application submitted by a "John/Jane Doe" individual (i.e., an individual who is unable to verify his or her identity) should be evaluated in the same manner as any other Medicaid applicant, that is, these individuals are required to meet the same documentation requirements as any other Medicaid applicant. A true "John/Jane Doe" individual is not eligible for Medicaid coverage for the treatment of an emergency medical condition. Verification of identity is a requirement for this coverage and all other covered services.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

Documentation Guide
Citizenship and Immigrant Eligibility for Health Coverage in New York State

Category 1: U.S. Citizens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
United States Citizen: (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.) Note: Listed are the most common documents used to prove U.S. citizenship. The list is not exhaustive and there are other documents that can establish U.S. citizenship. **CITIZENSHIP REMINDERS:** A birth certificate can no longer be accepted as proof of both citizenship and identity. If the birth certificate is presented as proof of citizenship, the worker must obtain another form of identity document from the Identity documentation list, such as a driver's license. All documents must be originals or copies certified by the issuing agency. Workers are required to photocopy the original/certified copy and annotate the copy with their initials and the date of the review.	**Primary Documents** (No other document required) ►U.S. Passport; ►Certificate of Naturalization (N-550 or N-570); or ►Certificate of U.S. Citizenship (N-560 or N-561). **Secondary Documents** (When a primary document is unavailable, a secondary document may be used, but also requires ONE identity document from the identity documentation list below.) ►U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (after 11/4/1986 [NMI local time]), or Guam (on or after 4/10/1899); ►Certification of Report of Birth issued by the Department of State (DS-1350); ►Report of Birth Abroad of a U.S. Citizen (FS-240); ►Certification of birth issued by Department of State (Forms FS-545 or DS-1350); ►U.S. Citizen Identification Card (I-197 or I-179); ►Northern Mariana Identification Card (I-873); ►American Indian Card with classification code of "KIC" (I-872); ►Final adoption decree showing U.S. place of birth; ►Evidence of U.S. civil service employment before 6/1/1976; ►Military record of service showing U.S. place of birth (i.e., DD-214); or ►Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.	C	YES	A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP. Note: Pregnant women are excluded from this requirement.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)	**Third Level Documents** (When a primary or secondary document is not available; also requires an identity document.) ►Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth; ►Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth); (When a primary or a secondary document is not available: also requires ONE identity document.) ►Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or ►Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.	C	YES	A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP. Note: Pregnant women are excluded from this requirement.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)	**Fourth Level Documents** (Are the least reliable and should only be used in rarest of circumstances; also requires an identity document.) ►Federal or State census record showing U.S. citizenship or a U.S place of birth; or ►The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth): ▪ Medical (clinic, doctor, or hospital) record; ▪ Seneca Indian tribal census; ▪ Bureau of Indian Affairs tribal census records of the Navajo Indians; ▪ U.S. State Vital Statistics official notification of birth registration; ▪ Delayed U.S. public birth record that is recorded more than 5 years after the person's birth; ▪ Statement signed by the physician/midwife who was in attendance at the time of birth; or ▪ Bureau of Indian Affairs Roll of Alaska Natives; ►Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S. place of birth; or ►Written affidavit (to be used only in rare instances). The affidavit must contain the following information under the following circumstances: • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • The two affidavits can be combined in a joint affidavit. • At least one of the individuals making the affidavit cannot be related to the applicant or recipient. • The person(s) making the affidavit must be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted. • The affidavit must also be signed under penalty of perjury by the person making the affidavit, but need not be notarized. A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained must also be obtained.	C	YES	A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP. Note: Pregnant women are excluded from this requirement.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Collectively Naturalized Evidence that establishes U.S. Citizenship for Collectively Naturalized individuals.	Puerto Rico ►Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or ►Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain. U.S. Virgin Islands ►Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or ►The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or ►Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI]) ►Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or ►Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or ►Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.	C	YES	A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP. Note: Pregnant women are excluded from this requirement

Category 1: U.S. Citizens continued

Category	Identity Documents (One identity document must be used with secondary, third or fourth level citizenship documentation).	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)	►A driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used; ►School identification card with a photograph of the individual; ►U.S. military card or draft record; ►Identification card issued by Federal, State, or local government with the same information included on the driver's license; ►Military dependent's identification card; ►Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska native tribal document with photo or other identifying information; ►U.S. Coast Guard Merchant Mariner card; ►A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency's data system; ►If none of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable; ►Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator, on behalf of the individual in the facility, when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury but need not be notarized. ►Children under age 16 may have their identity documented using other means: ▪ Clinic, doctor or hospital record; ▪ School records including report card, day care or nursery school record. Records must be verified with the issuing school; ▪ Affidavit signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of the child's birth, if no other documents are available. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver's license is not available to the child until he or she is 18 years of age.	C	Not applicable to identity documents	Not applicable to identity documents

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

NATIVE AMERICANS

Policy:

Native Americans born in the United States are citizens of the United States and will have the same types of documentation of citizenship as do other U.S. citizens.

Native Americans born outside the U.S. are eligible for Medicaid without regard to immigration status restrictions, if they reside in New York State and are:

- ► A non-citizen member of a federally recognized tribe; or
- ► A Native American, who is at least fifty percent American Indian blood and was born in Canada;

A Native American born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if s/he is of at least one-half American Indian blood. As such, s/he is considered a U.S. citizen for the purposes of Medicaid eligibility and coding. This does not include a non-citizen whose membership in an Indian tribe or family is created by adoption unless such person is at least fifty percent Indian blood.

NOTE: The tribal membership card demonstrates membership in a U.S. Federally recognized Indian Tribe. For the purposes of Medicaid eligibility, Medicaid will accept a tribal membership card, with a date of birth, as proof of age, identity and citizenship status.

References:

SSL Sect.	122 131-k
Dept. Reg.	349.3 360.3.2(j)
ADM	04 OMM/ADM-7
GIS	08 MA/009 05 MA/ 028

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

NATIVE AMERICANS

Documentation: The following items can be used to verify Native American status or membership in a federally recognized tribe

NOTE: Tribal documents are considered to be as reliable as a U.S. passport and are to be treated as "primary" documents. Additional identity documentation is not required.

Native American Indians born in Canada:

► I-94 coded "S1-3";
► I-551 Permanent Resident Card stamped "S1-3";
►Temporary I-551 stamp in a Canadian passport coded "S1-3";
►Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA;
►Birth or Baptismal Certificate issued on a reservation or other satisfactory evidence of birth in Canada;

Member of federally recognized Native American tribe born outside of the U.S:

►A membership card or other tribal document demonstrating membership in a federally recognized Indian Tribe under Section 4 (e) of the Indian Self-determination and Education Assistance Act [25 U.S.C. §450b (e) and satisfactory evidence of birth outside the U.S].

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

NATIVE AMERICANS

Category	Documentation	WMS ACI CODE	Federal Financial Participation	SSN Requirement
Native Americans born outside the U.S. who belong to a federally recognized tribe	► A membership card or other tribal document demonstrating membership in a federally recognized Indian Tribe under Section 4 (e) of the Indian Self-determination and Education Assistance Act [25 U.S.C. §450b (e)] and satisfactory evidence of birth outside the U.S.	C	YES	YES
Canadian born Native Americans	►I-94 coded "S1-3"; ►I-551 Alien Registration Card stamped "S1-3"; ►Temporary I-551 stamp coded S1-3 in a Canadian passport; ►Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA; and satisfactory evidence of birth in Canada, such as a birth certificate or baptismal Certificate issued on a reservation;	C	YES	YES
Native Americans born in Canada	►I-94 coded "S1-3"; ►I-551 Permanent Resident Card stamped "S1-3"; ►Temporary I-551 stamp coded S1-3 in a Canadian passport; ►Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA; and satisfactory evidence of birth in Canada, such as the following: -a Birth certificate or Baptismal Certificate issued on a reservation; -Letter from Canadian Department of Indian Affairs; **or** -School Records.	C	YES	For the purpose of Medicaid, Native Americans are classified as U.S. citizens. A SSN is an eligibility requirement for all citizens applying for Medicaid of FHP. Note: Pregnant women are excluded from this requirement.
Native Americans belonging to a Federally recognized Tribe born outside the U.S.	-Membership card or other tribal document demonstrating (i.e., tribal card), membership in U.S. federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and satisfactory evidence of birth outside the U.S.	C	YES	

OTHER ELIGIBILITY REQUIREMENTS

SATISFACTORY IMMIGRATION STATUS

Description: Immigrants in satisfactory immigration status are otherwise eligible for Medicaid, Family Health Plus (FHPlus) and Child Health Plus (CHPlus) and include qualified aliens and persons permanently residing in the United States under color of law (PRUCOL).

Policy: All immigrants in satisfactory immigration status regardless of the date they physically entered into the United States can be eligible for Medicaid provided they meet all other eligibility requirements. The only difference is that Federal Financial Participation (FFP) should be claimed for some groups but must not be claimed for others or must not be claimed until the individual has resided in the United States as a qualified alien for five years (i.e., the Federal five-year ban).

- Qualified aliens who entered the U.S. prior to August 22, 1996 receive full Medicaid coverage with Federal Financial Participation (FFP);
- Certain qualified aliens who entered the U.S. on or after August 22, 1996 receive Medicaid coverage with FFP; and
- Certain qualified aliens who entered the U.S. on or after August 22, 1996, receive Medicaid coverage with State and local funds (FNP) until they have resided in the U.S. as a qualified alien for five years (five year ban).
- Persons permanently residing in the United States under color of law (PRUCOL) are eligible for Medicaid, provided they meet all other eligibility requirements. There is no Federal Financial Participation for this group. This means the federal government will not pay a share of their Medicaid costs. The shares are generally split 50% State/50% local. (Refer to the PRUCOL section of this document)

References:

Public Law	P.L. 100-202
SSL Sect.	122 131-k
Dept. Reg.	349.3 351.1 351.2 360-3.2(j)
ADMs	04 ADM 07 97 ADM-23 92 ADM-10

OTHER ELIGIBILITY REQUIREMENTS

SATISFACTORY IMMIGRATION STATUS

88 ADM-47
88 ADM-22
82 ADM-24

INF 06 OMM INF-5

GISs 09 MA/028
09 MA/009
98 MA/21
97 TA/DC022

Interpretation: Medicaid eligibility is based on whether the immigrant is in satisfactory immigration status and meets all the other requirements of the Medicaid program(s). Immigrants who are not in a satisfactory immigration status may be eligible for the treatment of an emergency medical condition.

Individuals who file United States Citizen Immigration Services (USCIS) applications and/or petitions at certain facilities have the option to receive an e-mail and/or text message informing them that USCIS has accepted their application or petition. The E-Notification does not constitute official notice of application acceptance; the A/R will receive an official notice of application acceptance (I-797) through the U.S. Postal Service. The e-mail or text message does not grant any type of immigration status or benefit and cannot be accepted or used as evidence that USCIS has granted the individual any immigration status or benefit. Receipt of the transmission cannot be used as supporting evidence of satisfactory immigration status for any Medicaid benefit.

SPECIAL NOTE: HOMELESS INDIVIDUALS

Homeless individuals often need assistance from the eligibility worker in obtaining acceptable proof of identity, citizenship or satisfactory immigration status. When the applicant is a homeless individual, it may be difficult for him/her to establish his or her identity, citizenship or immigration status. However, just because an individual is homeless, she/he still must be identified. Proving one's identity is a requirement of the Medicaid program. (See **OTHER ELIGIBILITY REQUIREMENTS** IDENTITY).

NOTE: If an individual is unable to verify his or her identity, citizenship or satisfactory immigration status, workers should not assume she/he is therefore eligible for coverage of an emergency medical condition.

OTHER ELIGIBILITY REQUIREMENTS

SATISFACTORY IMMIGRATION STATUS

"JOHN/JANE DOE"

A Medicaid application submitted by a "John/Jane Doe" individual (i.e., an individual who is unable to verify his or her identity) should be evaluated in the same manner as any other Medicaid applicant, that is, these individuals are required to meet the same documentation requirements as any other Medicaid applicant. A true "John/Jane Doe" individual is not eligible for Medicaid coverage for the treatment of an emergency medical condition. Verification of identity is a requirement for this coverage and all other covered services. (See **OTHER ELIGIBILITY REQUIREMENTS** IDENTITY).

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS

QUALIFIED ALIENS

Description: Immigrants considered "Qualified aliens" include the following:

- Persons lawfully admitted for permanent residence;
- Persons admitted as refugees;
- Persons granted asylum;
- Persons granted status as Cuban and Haitian entrants;
- Persons admitted as Amerasian immigrants;
- Persons whose deportation has been withheld;
- Persons paroled into the United States for at least one year;
- Persons granted conditional entry;
- Persons determined to be battered or subject to extreme cruelty in the United States by a family member;
- Victims of trafficking; or
- Veterans or persons on active duty in the Armed Forces and their immediate family members.

Policy:

QUALIFIED ALIENS WHO ENTERED THE U.S. PRIOR TO AUGUST 22, 1996:

A qualified alien who entered the United States prior to August 22, 1996, may receive all care and services available under the Medicaid program, provided he or she is determined to be otherwise eligible. This provision includes individuals who attained qualified immigrant status subsequent to August 22, 1996, and who can demonstrate to the district's satisfaction that they continuously resided in the United States until attaining qualified alien status. Federal Financial Participation (FFP) should be claimed for Medicaid provided to these qualified aliens.

QUALIFIED ALIENS WHO ENTERED THE U.S. ON OR AFTER AUGUST 22, 1996 AND ARE IN CERTAIN CATEGORIES EXEMPT FROM THE FEDERAL FIVE YEAR BAN ON MEDICAID:

The following qualified aliens who entered the United States on or after August 22, 1996, may receive all care and services available under the Medicaid program, provided they are determined to be otherwise eligible.

- Persons who have been granted asylum under Section 208 of the INA;

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS

QUALIFIED ALIENS

- Persons for whom deportation has been withheld under Section 243(h) or 241 (b) (3) of the INA;
- Cuban/Haitian entrants, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (P.L. 96-422);
- Qualified immigrants lawfully residing in the State who are on active duty in the armed forces, or who have received an honorable discharge from the armed forces and their spouses and unmarried dependent children, who are also qualified aliens.

NOTE: Non-citizen veterans and Active Duty Military personnel and their spouses and children are exempt from most of the immigration status related restrictions under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). For example they are eligible for Supplemental Security Income (SSI) and Food Stamps and are exempt from the five year ban.

- Refugees under Section 207 of the INA (including Amerasian immigrants admitted under the provisions of Public Law 100-202).
- Victims of a severe form of trafficking are qualified aliens who receive Medicaid to the same extent as refugees. A comprehensive discussion of this group is in the section "Victims of Trafficking" of this Reference Guide. Federal Financial Participation (FFP) should be claimed for Medicaid provided to these qualified aliens.

ALL OTHER QUALIFIED ALIENS WHO ARE NOT IN THE ABOVE TWO GROUPS:

This group of qualified aliens may receive all care and services available under the Medicaid program, provided s/he is determined to be otherwise eligible. However, for these individuals the date they physically entered the United States will determine whether or not Federal Financial Participation (FFP) is available. This date is called the "Date Entered Country" (DEC). During their first five years in the U.S. with a status as qualified alien, FFP is not available. The cost of their Medicaid coverage will be born solely by State and local shares (50% State/50% local). Once a qualified alien in this group has resided in the United States as a qualified alien for a period of five years, FFP will become available. This means the federal government will pay a share of their Medicaid costs.

Qualified aliens in this group include the following:

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS

QUALIFIED ALIENS

- Persons lawfully admitted for permanent residence (i.e. LPRs- "green card holders") under the Immigration and Nationality Act (INA);
- Persons paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
- Persons granted conditional entry pursuant to Section 203(a)(7) Immigration and Nationality ACT (INA); and
- Persons who have been determined by the social services district to be in need of Medicaid as a result of being battered or subject to extreme cruelty in the United States by a spouse, parent, or by a member of the spouse's or parent's family residing in the same household as the alien family member at the time of the battering or extreme cruelty. (Refer to the section of this Reference Guide entitled "Battered Qualified Alien")

References:

SSL Sect	122 131-k
Dept Reg.	349.3 351.1 351.2 360-3.2 (j)
ADMs	04 ADM 07 97 ADM 23 88 ADM 22 88 ADM 4 82 ADM 24
INFS	06 INF-5

Interpretation: Applicants who meet the criteria above are considered to be in satisfactory immigration status and, if otherwise eligible, may receive all care and services provided by the Medicaid program.

Documentation: The following chart indicates examples of acceptable USCIS forms/documentation for qualified aliens who are in satisfactory immigration status.

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS[1]

QUALIFIED ALIENS

Category 2: Qualified Aliens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Native Americans born in Canada	►I-94 coded "S1-3"; ►I-551 Permanent Resident Card stamped "S1-3"; ►Temporary I-551 stamp coded S1-3 in a Canadian passport; or ►Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA; and satisfactory evidence of birth in Canada, such as the following: - Birth certificate or Baptismal Certificate issued on a reservation; -Letter from Canadian Department of Indian Affairs; **or** -School Records.	C	YES	For the purposes of Medicaid, Native Americans are classified as U.S. citizens. An SSN is an eligibility requirement for all citizens applying for Medicaid or FHP. Note: Pregnant women are excluded from this requirement.
Native Americans belonging to a Federally recognized Tribe born outside the U.S.	-Membership card or other tribal document demonstrating (I.E., tribal card), membership in federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and satisfactory evidence of birth outside the U.S.	**C**	**YES**	
Refugees	►I-94 or foreign passport with annotation "Section 207" of the INA or "Refugee" RE1, RE2, RE3, or RE4; ►I-551 coded R8-6, RE6, RE-7, RE-8, or RE-9; ►I-571 Refugee Travel Document; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(3); **or** ►I-766 Employment Authorization Document annotated "A3".	**R**	**YES**	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
Asylees	►I-94 or foreign passport annotated "granted Asylum under Section 208" of the INA , "Section 208" or "Asylee"; ►I-551 coded AS1, AS2, AS3, AS6, AS7 or AS8; ►I-571 Refugee Travel Document; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(5); ►I-766 Employment Authorization Document annotated "A5"; **or** ►Grant letter/order from the USCIS[2] Asylum Office or Immigration judge granting asylum.	**A**	**YES**	

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS
QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Persons granted withholding of deportation or removal (Non-citizens whose deportation or removal has been withheld based on a finding that the person's life or freedom is threatened in the country of deportation based on race, religion, nationality, or membership in a particular social group or political opinion.)	►I-94 or foreign passport stamped "Section 243(h)" or "Section 241(b)(3)"; ►I-766 Employment Authorization Document annotated "A10"; ►Order issued by an immigration judge , the Board of Immigration appeals or a federal court showing the date that deportation was withheld under Section 243(h) of the INA, as in effect prior to April 1, 1997, or removal withheld under Section 241 (b)(3) of the INA.	**J**	**YES**	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
Cuban/Haitian Entrants	►I-94 with annotation "Cuban-Haitian Entrant" Section 212(d)(5) of the INA, or CU6, CU7 or any other notation indicating "parole" under 212 (d)(5) on or after 10/10/80; and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ►I-551 coded CU6, CU7, CH6, CN-P, LB-2, LB-6 or LB-7; ►Temporary I-551 stamp coded "CU-6" or "CU-7" in a foreign passport; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(c)(8), and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ►I-766 Employment Authorization Document annotated "C8" and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti;; ►Order to Show Cause (OSC), I-221S, or Notice to Appear (NTA), I-862, indicating pending exclusion, removal or deportation proceedings and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; **or** ►Any document indicating pending asylum application or filing of I-589 Application for Asylum with satisfactory evidence on the document that the person has been a citizen of Cuba or Haiti	**H**	**YES**	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS
QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Amerasians	►I-94 Arrival/Departure Record of Vietnamese passport or exit visa stamped "AM1, AM2, AM3, AM6, AM7, or AM8"; ►I-551 Permanent Resident Card coded "AM1, AM2, AM3, AM6, AM7, or AM8"; ►Temporary I-551 stamp in Vietnamese passport "AM1, AM2, AM3, AM6, AM7, or AM8"; **or** ►I-571 Refugee Travel Document.	**R**	**YES**	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
Victims of a Severe Form of Human Trafficking	►I-94 Arrival/Departure Record coded T1, T2, T3, T4 or T5 stating admission under Section 212(d)(5) of the INA if status is granted for at least one year; ►Certification letter (for adults) or eligibility letter (for children) from the Office of Refugee Resettlement. Must call 1-866-401-5510 for verification; **or** ►I-797 Notice of Action acknowledging receipt of I-914, Application for T non-immigrant status.	**D** Upstate **R** NYC	**YES**	
Veterans **(Immediate family members: documentation of relationship to veteran.)**	►DD Form 214 showing "Honorable" discharge; **or** ►Original or notarized copy of the veteran's discharge papers.	**V**	**YES**	
Persons on active duty in the Armed Forces and their immediate family members	►Military I.D. card -DD Form 2 (active); ►Original or notarized copy of current orders showing the person is on full-time duty in U.S. Armed Forces; (**Immediate family members must show documentation of relationship to the person on active duty**.)	**M**	**YES**	

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS
QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Please note**: Qualified Aliens who are Eligible for State Medicaid until becoming Eligible for Federal Medicaid after a 5 Year Waiting Period**: Qualified aliens listed below, who entered the U.S before August 22, 1996, are eligible for federal Medicaid, if otherwise eligible. However, qualified aliens in these four categories who entered the U.S. on or after August 22, 1996, are subject to the federal five year ban. This means that they are *not* eligible for federally funded Medicaid until they have resided in the U.S. for five years in a qualified alien status. Until becoming eligible for federally funded Medicaid, these qualified aliens are eligible for State funded Medicaid coverage of all medically necessary care and services, if they meet the program's other eligibility requirements. Districts must enter the appropriate State/federal charge codes to assure proper claiming of federal and State shares. For these individuals the date they physically entered the U.S. will determine whether or not Federal Financial Participation (FFP) is available. This date is called the "Date Entered Country" (DEC). During their first five years in the U.S the cost of their Medicaid coverage will be born solely by the State and local share (50% State/50% local). Once a qualified alien in this group has resided in the United States as a qualified alien for a period of five years, FFP will become available. This means the federal government will pay a share of their Medicaid costs.

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Lawful Permanent Residents (LPRs or "green card" holders)	►I-94 Arrival/Departure Record or foreign passport stamped I-551; ►I-551 Lawful Permanent Resident Card "green card"; ►I-327 Re-entry permit'; **or** ►I-181 Memorandum of Creation of Record of Lawful Permanent Residence with approval stamp.	**K** (without 40 quarters) **S** (with 40 quarters)	**YES** After 5 yrs in a qualified status	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
Parolees admitted into the U.S. for at least one year (Non-citizen who have been allowed to come into the U.S. for humanitarian or public interest reasons.)	►I-94 Arrival/Departure Record with annotation "Paroled Pursuant to Section 212(d)(5)" or "parole" or "PIP" or "public interest" with the date of entry and date of expiration indicating **at least one year**; ►I-688B Employment Authorization Card annotated " 8 C.F.R. 274a.12(a)(4) or 274a.12(c)(11)"; **or** ►I-766 Employment Authorization Document annotated "A4" or "C11".	**G**	**YES** After 5 yrs in a qualified status	
Conditional Entrants ***(Status granted to refugees before 1980.)***	►I-94 Arrival/Departure Record stamped Section 203(a)(7), or otherwise indicating status as a conditional entrant;; ►I-688B Employment Authorization Card annotated "8 C.F.R. 274a.12(a)(3)"; **or** ►I-766 Employment Authorization Document annotated "A3".	**F**	**YES** After 5 yrs in a qualified status	

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS

QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Victims of Battery/Abuse The term "battered qualified alien" includes the following immigrants described at 8 U.S.C. §1641(c): • an alien who has been battered or abused in the U.S. by a spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the alien; or • the parent of a battered or abused child; or • the child of a battered or abused parent. **A substantial connection must also exist between the battery or abuse and the need for public benefits such as Medicaid. The alien must no longer be living with the batterer or abuser**.	A variety of documents provide evidence that an alien meets this definition. ►I-797 Notice of Action indicating that the alien has an approved I-360 self petition (Do NOT refer to DVL); ►I-797 Notice of Action indicating that the alien has a pending I-360 self petition that has established a prima facie case (Do NOT refer to DVL); ►Order from the Executive Office for Immigration Review ("EOIR") granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal. (Do NOT refer to DVL); or ►I-797 Notice of Action indicating that the alien has a pending I-360 self petition AND credible evidence of battery or abuse (Request permission to refer to DVL); or ►I-797 Notice of Action indicating the alien is the beneficiary of a pending or approved I-130 petition and credible evidence of battery and/or abuse (Request permission to refer to DVL); or ►I-94 coded K3, K4, V1, V2 or V3 and credible evidence of battery or abuse(Request alien's permission to refer to DVL); or ►Any other USCIS document indicating the alien has a K or V visa and a pending or approved I-130 petition with credible evidence of battery or abuse. (Request permission to refer to DVL); or	B	YES After 5 yrs in a qualified status	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.

Continued on next page

OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS

QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
(from previous page)	(from previous page) ►I-94 or Foreign passport annotated CR1, CR2, CR6, CR7 with credible evidence of battery and/or abuse (Request permission to refer to DVL); or; ►I-688B Employment Authorization Card annotated:274a.12(a)(9)-spouse/children of USC or LPR (K or V visa); 274a.12(a)(15)-spouses and dependents of LPR (K or V visa); 274a.12(c)(10)-applicant for suspension of deportation with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or ; ►I-766 Employment Authorization Document annotated A9, A15 or C10 with credible evidence of battery and/or abuse (Request alien's permission to refer to DVL).			

NOTE: Referral to a domestic violence liaison (DVL): Medicaid-only offices may refer alien applicants and recipients who must demonstrate that they are credible victims of domestic violence to be considered qualified for Medical assistance as "battered aliens" to the DVL for a credibility assessment. Those applicants and recipients who cannot document eligibility in any other category and cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the alien has in fact been subject to battery or extreme cruelty will need to see the district/s DVL for a credibility determination. If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien's written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

REVISED 03/03/08

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

Description: An immigrant who, or whose child or parent, has been battered or subjected to extreme cruelty in the United States by a U.S. citizen or lawful permanent resident spouse or parent can be considered a qualified alien. An immigrant whose child has been battered/abused by the child's U.S. citizen or lawful permanent resident other parent is similarly eligible, as are immigrant children, whose parent has been abused by the parent's U.S. citizen or lawful permanent resident spouse residing in the same household. The immigrant can be considered a qualified alien when it is determined that there is substantial connection between the battery, abuse or cruelty and the need for benefits.

Policy: Battered immigrants are considered qualified aliens and are said to be in satisfactory immigration status.

References:

SSL Sect. 122
131-k

Dept Reg. 349.3
351.1
351.2
360-3.2(j)

ADMs 04 ADM-7
97 ADM-23
92 ADM-10
88 ADM-47
88 ADM-22
88 ADM-24

INFs 06 OMM-INF-5

GISs 08 MA/009

Interpretation: Battery or extreme cruelty is defined as including, but not limited to, being a victim of any act or threatened act of violence, including forceful detention, which results or threatens to result in physical or mental injury or psychological or sexual abuse or exploitation, including rape, molestation, incest, or forced prostitution.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

Immigrant victims of battery/abuse can be treated as a "qualified alien" for Medical Assistance benefit purposes if they meet the following four requirements:

1. Be a credible victim of battery/abuse or extreme cruelty, who or who's child or parent has been battered, abused or subject to extreme cruelty in the U.S., by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household; and
2. Be able to show a substantial connection between the need for benefits sought and the battery or extreme cruelty; and
3. No longer resides in the same household as the abuser, and
4. Have an appropriate immigration status including a pending or approved I-130 petition for a alien relative (K or V visa status), a pending or approved I-360 self petition, or Notice of Prima Facie Case determination (I-797 Notice of Action), or an Executive Office for Immigration Review (EOIR) order/letter granting suspension or cancellation under 8 U.S.C 1229b(b)(2) and 8 U.S.C. 1254(a)(3) or evidence that an application for suspension of deportation/cancellation of removal has been made with evidence that sets forth a prima facie case.

EVIDENCE OF ABUSE:
An applicant who has an approved petition or court order granting him/her protection from the abuser has already shown battery or extreme cruelty and a new determination should not be made by the eligibility worker. Other evidence of battery/abuse that immigrants may present includes, but is not limited to: reports or affidavits from police, judges, court officials, medical personnel, school officials, clergy, social workers; counseling or mental health personnel; proof of a domestic violence conviction, and proof of seeking safe-haven in a battered shelter.

SUBSTANTIAL CONNECTION:
There must be a substantial connection between the battery/abuse or extreme cruelty to which the immigrant, immigrant's child, or immigrant child's parent has been subjected to and the need for the medical assistance. The following list demonstrates circumstances in which a substantial connection exists between the battery and the need for medical assistance benefits:

- where the benefits are needed to enable the immigrant, immigrant's child, or an immigrant child's parent to become self-sufficient following separation from the abuser;

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

- where the benefits are needed to enable the immigrant, immigrant's child, or an immigrant child's parent to escape the abuser and/or the community in which the abuser lives and to ensure safety;

- where the benefits are needed due to a loss of financial support resulting from the immigrant's separation from the abuser;

- where the benefits are needed because the battery/abuser or extreme cruelty, separation from the abuser, work absences, or lower job performance resulting from the abuse or court-related proceeding cause the immigrant, the immigrant's child, or immigrant child's parent to leave or lose employment;

- where the benefits are needed because the battery/abuse or extreme cruelty has caused the immigrant, the immigrant's child, or immigrant child's parent to require medical attention/counseling or become disabled;

- where the benefits are needed because of the loss of a dwelling or source of income or because fear of the battery/abuse after separation diminishes the immigrant's, or immigrant child's parent's ability to care for the children;

- where the benefits are needed to alleviate nutritional risks and needs following battery/abuse and/or after separation;

- where the benefits are needed to provide medical care during pregnancy resulting from sexual assault or the relationship with the abuser; and

- where medical coverage or health care services for the immigrant, the immigrant's child, or immigrant child's parent are needed to replace the services provided while living with the abuser.

NON-RESIDENCY WITH THE BATTERER:

The following examples will serve as credible evidence to support the claim of non-residency with the batterer and include, but are not limited to:

- a civil protection order requiring the batterer to stay away from the battered immigrant, immigrant child, or immigrant child's parent;

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

- an eviction notice removing the batterer from the immigrant's residence;
- employment records;
- utility receipts;
- school records;
- hospital or medical bills;
- rental records from a building or property manager;
- affidavit from a staff member at a battered or homeless shelter
- affidavits from witnesses, including landlords and neighbors; and
- any other records establishing that the immigrant, immigrant's child, or immigrant child's parent no longer resides with the abusive abuser.

NOTE: Districts should be cautioned that they should not contact the abuser for any verification or documentation of living arrangements or other factors of eligibility.

Information with respect to victims of domestic violence must not be released to any outside party or other governmental agencies unless the information is required to be disclosed by law, or unless authorized in writing by applicant/recipient. Districts need to be concerned about how information is shared (i.e., insure that information pertaining to good cause or domestic violence is mailed to the victims' homes). Notices and other information may be mailed to an alternate mailing address (i.e., shelter) or held at district office. The client must decide the safest way to obtain the information.

REFERRAL TO A DOMESTIC VIOLENCE LIAISON (AVL):

Battered Immigrants are "qualified aliens" and may receive Medical Assistance benefits if all of the following criterions are met, including financial requirements: A battered qualified alien must be:

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

- an alien who has been battered or subjected to extreme cruelty ("abused") in the U.S. by a spouse or parent or by a member of the spouse's or parent's family residing in the same household as the alien; or
- the parent of a battered or abused child; or
- the child of a battered or abused parent.

Applicants and recipients who cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the immigrant has in fact been subject to battery/abuse or extreme cruelty will need to see the district's DVL for a credibility determination. These individuals must demonstrate that they are credible victims of domestic violence in order to be considered qualified for Medical Assistance as a "battered qualified alien". If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien's written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

VERIFICATION OF IMMIGRATION STATUS:
Battered or abused aliens will typically possess one or more of the following documents:

- I-797 Notice of Action indicating that the alien has an approved I-360 self-petition (entitled Petition for Amerasian, Widow(er) or Special Alien) under the Violence Against Women Act (VAWA) to obtain lawful permanent residence status as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident [Do not refer to the domestic violence liaison (DVL)]; or
- I-797 Notice of Action indicating that the alien has a pending I-360 self-petition under VAWA that has established the alien's prima facie eligibility for obtaining lawful permanent resident status as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident (Do not refer to the DVL); or
- Order from the Executive Office for Immigration Review (EOIR) granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal based on battery or abuse by a U.S. citizen or lawful permanent resident spouse or parent (Do not refer to the DVL); or
- I-797 Notice of Action indicating that the alien has a pending I-360 self-petition under VAWA to established lawful permanent resident status as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident and credible evidence of battery or abuse (Request alien's permission to refer to the DVL); or

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

- I-797 Notice of Action indicating that the alien is the beneficiary of a pending or approved I-130 Petition for Alien Relative as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL;); **or**
- I-94 Arrival/Departure Record stamped "K3", "K4", "V1", "V2", or "V3" and credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- Any other USCIS document indicating that the alien has a "K" or "V" visa and a pending or approved I-130 Petition for Alien Relative and credible evidence of battery or abuse (Request alien's permission to refer to the DVL;); or
- I-94 Arrival/Departure Record or foreign passport stamped "CR-1", "CR-2", "CR-6" or "CR-7" **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- I-688B Employment Authorization Card coded "274a.12(a)(9)," "274a.12(a)(15)" or "274a.12(c)(10)" **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- I-766 Employment Authorization Document coded "A9", "A15" or "C10" **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL).

Districts must determine if the USCIS or the EOIR has approved an applicant's I-360 self-petition or has found that an applicant's pending petition set-forth a prima facie case by reviewing the applicant's documents.

- The worker must carefully examine the documents provided by the immigrant applicant.

- If based on the documentation provided to show citizenship, immigration or qualified alien status the worker can conclude that the applicant is not a "qualified alien" (i.e. the applicant presents documents such as a tourist visa or other documents that do not make them eligible for Medical Assistance), the worker does not need to verify the applicant's status.

- If the documentation provided does not appear on its face to be genuine or does not appear to relate to the person presenting it, this should not serve as a basis to conclusively deny benefits without first checking with the USCIS. (Through SAVE or by filing a G-845 "Verification Request" [non-SAVE agencies] with USCIS. Refer to 04 ADM-7).

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED AIENS

BATTERED QUALIFIED ALIENS

- If the USCIS notifies the applicant that they have an immigration status that makes him/her a qualified alien the eligibility worker should accept the USCIS verification and proceed to determine whether the applicant satisfies the remaining program requirements. If the USCIS notifies the applicant that she/he does not have immigration status that makes him/her a qualified alien, the worker should notify the applicant of her appeal rights.

If the applicant is a battered immigrant and the documentation provided does not appear on its face to be genuine or does not appear to relate to the person presenting it, the worker should contact the Immigration Court that is handling the case or the USCIS Vermont Service Center at 75 Lower Welden Street, Saint Albans, Vermont, 05479.

THE FIVE YEAR BAN TO BENEFITS ACCESS:

Battered immigrants who first entered the United States after 8/22/96 and become "qualified aliens" are not eligible to receive federal Medical Assistance benefits until they have attained five years in a qualified alien status. This is called the federal "five year bar." This bar applies to all immigrants who entered the United States after 8/22/96.

New York State covers “battered” qualified aliens with State only funds until the five-year ban expires.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

BATTERED QUALIFIED ALIENS

SOCIAL SECURITY NUMBERS (SSNs) FOR BATTERED QUALIFIED ALIENS:
The Social Security Administration (SSA) does not routinely assign new SSNs. However, SSA will do so when evidence shows the immigrant is being harassed, a victim of family violence, abused or their life is endangered.

Qualified aliens must provide a social security number. If they do not have a SSN, they must apply for one. An exception applied to pregnant women. Pregnant women are not required to provide or apply for a SSN for the duration of the pregnancy and the sixty-day period that begins on the last day of the pregnancy and including, but not exceeding, the last day of the month in which the sixty-day post-partum period ends.

If a qualified alien applies for a SSN, but is denied a SSN based on immigration status, the alien is not required to reapply for a SSN until his or her status changes. In these situations districts are to use WMS Social Security Code N, “State Benefits Eligible Alien”.

ALIEN NUMBER (A#) REQUIREMENT FOR BATTERED QUALIFIED ALIENS:
Providing an alien registration number is no longer an eligibility requirement for Public Assistance, Medical Assistance or Food Stamp Assistance for battered aliens (ACI Code "B"). This change is a result of MKB litigation.

Although not required, if an alien number is presented by the applicant/recipient, the alien number should be entered into the Welfare Management System (WMS).

BATTERED QUALIFIED ALIENS DESK AID

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Victims of Battery/Abuse The term "battered qualified alien" includes the following immigrants described at 8 U.S.C. §1641(c): ▪ an alien who has been battered or abused in the U.S. by a spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the alien; or • the parent of a battered or abused child; or • the child of a battered or abused parent. A substantial connection must also exist between the battery or abuse and the need for public benefits such as Medicaid. The alien must no longer be living with the batterer or abuser.	A variety of documents provide evidence that an alien meets this definition. ►I-797 Notice of Action indicating that the alien has an approved I-360 self petition (Do not refer to DVL); ►I-797 Notice of Action indicating that the alien has a pending I-360 self-petition that has established a prima facie case (Do not refer to DVL); ►Order from the Executive Office for Immigration Review ("EOIR") granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal (Do not refer to DVL); or ►I-797 Notice of Action indicating that the alien has a pending I-360 self petition AND credible evidence of battery or abuse (Request alien's permission to refer to DVL); or ►I-797 Notice of Action indicating the alien is the beneficiary of a pending or approved I-130 petition and credible evidence of battery and/or abuse (Request alien permission to refer to DVL); or ►I-94 coded, K3, K4, V1 V2 or V3 and credible evidence of battery or abuse (Request alien's permission to refer to DVL); or ►Any other USCIS document indicating the alien has a K or V visa and a pending or approved I-130 petition with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or ►I-94 or Foreign passport annotated CR1, CR2, CR6, CR7 with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or ►I-688B Employment Authorization Card annotated 274a.12(a)(9)-spouse/children of USC or LPR (K or V visa), 274a.12(a)(15)-spouses and dependents of LPR (K or V visa), 274a.12(c)(10)-applicant for suspension of deportation with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or ►I-766 Employment Authorization Document annotated A9, A15 or C10 with credible evidence of battery or abuse (Request alien's permission to refer to DVL).	B	YES After 5 yrs in a qualified status	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.

NOTE: Referral to a domestic violence liaison (DVL): Medicaid-only offices must refer alien applicants and recipients who must demonstrate that they are credible victims of domestic violence to be considered qualified for medical assistance as "battered aliens" to the DVL for a credibility assessment. Those applicants and recipients who cannot document eligibility in any other category and cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the alien has in fact been subject to battery or extreme cruelty will need to see the district's DVL for a credibility determination. If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien's written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

REFUGEE MEDICAL ASSISTANCE (RMA)

Description: A refugee is an individual who comes to the United States because he/she faces persecution or fear of persecution in his/her home country. New York State provides the services of resettlement agency case workers to help refugees in applying for short-term cash and medical assistance upon arrival in the United States. The program under which this service/support is provided is known as Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA).

Policy: The Refugee Medical Assistance (RMA) Program is primarily limited to refugees who are single or childless couples (S/CCs) who are not living with a dependent child, are not pregnant, or certified blind or disabled and who:

- Are eligible for or receiving Safety Net Assistance (SNA); or
- Are financially ineligible for Medicaid Under the S/CC category of assistance or FHPlus; and
- Meet immigration status and identification requirements set forth below; and
- Provide the name of the resettlement agency which resettled them, if he/she is a refugee or entrant; and
- Are not full-time students in an institution of higher education, except where such enrollment is expected to be approved as part of an individual employability plan.

References:

SSL Sect. 358 (3)

Dept. Reg. 373-2

ADMs 05 OTDA/ADM-01

INFs 10 OHIP/INF-2
06 OMM/INF-5

Interpretation: The term refugee includes the following groups: Refugees, Asylees, Cuban and Haitian Entrants and Amerasians. Aliens who are considered “refugees” for the purpose of Medicaid eligibility also include federally certified victims of a severe form of human trafficking, certain family members of certified trafficking victims, and Special Immigrant Visa Holders (SIV) from Afghanistan and Iraq.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

REFUGEE MEDICAL ASSISTANCE (RMA)

Eligibility for RMA is based on the applicant's income on the date of application. The LDSS must NOT average income prospectively for the application-processing period to determine income eligibility for RMA. A sponsor's income (solely because the person is serving as a sponsor), in-kind services and shelter provided to an applicant by a sponsor or resettlement agency and any cash grant received by the applicant from the United States Department of State or Department of Justice during the initial 30-day Reception and Placement Program period are exempt in determining the applicant's eligibility. All other Medicaid rules and regulations apply in determining eligibility under RMA.

NOTE: Match grants provided to an applicant by a voluntary agency under direct agreement with the Office of Refugee Resettlement (ORR) must be counted in determining eligibility. However, a Match grant should not cause the individual to be ineligible for Medicaid.

Eligibility is first determined for S/CC. If the individual is not eligible as an S/CC, then eligibility under FHPlus is determined. If the applicant is not eligible as an S/CC or under FHPlus, an ADC budget is performed and the S/CC is allowed to spend-down to the Medically Needy Income Level.

If a refugee who is receiving RMA receives new or increased earnings from employment after eligibility for RMA has been determined, the increased earning will not affect his/her continued RMA eligibility.

If during the initial eligibility period an individual who is receiving "regular" Medicaid becomes ineligible for "regular" Medicaid due to increased earnings, the individual must be transferred to RMA without an RMA eligibility re-determination. This includes refugees receiving Medicaid through Family Assistance (FA) Program or under Low Income Family (LIF) category of assistance. However, before transferring the individual to RMA, the case must first be evaluated for eligibility under Transitional Medical Assistance (TMA).

Should earnings/income decrease during the initial eligibility period, eligibility must be redetermined. If the individual is now eligible under regular Medicaid or FHPlus, authorize coverage as appropriate. If the individual continues to be ineligible under regular Medicaid or FHPlus, as an S/CC, but the decrease in earnings/income results in a decrease

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

REFUGEE MEDICAL ASSISTANCE (RMA)

in the excess income amount under the ADC-related budget, notify the individual of his/her decrease in excess income.

NOTE: Refugee families with children can receive RMA during their first eight months in the U.S. only if they become ineligible for the State's "regular" State Plan Medicaid Program.

Disposition: The following refugees are eligible for RMA for the time periods specified:

- Refugees, Cuban/Haitian entrants and Amerasian immigrants are eligible for eight months from the date of arrival into the United States.
- Asylees are eligible for eight months from the date that asylum status is granted.
- Trafficking victims are eligible for RMA benefits for eight months from the date indicated in the certification letter (for adults) or eligibility letter (for children) issued by the ORR.
- Certain family members of victims of a severe form of human trafficking are eligible for eight months from the date they acquired the Derivative T-Visa status:
    - For family members who received the Derivative T-Visa in the United States, the date of eligibility for RMA benefits is the notice date found on the I-797 Notice of Action.
    - For family members who enter the United States with a Derivative T-Visa, the date of eligibility is the date the individual entered the country which is stamped on the individual's passport or I-94 Arrival/Departure Record.
- Iraqi/Afghan Special Immigrant Visa Holders' eligibility continues for eight months from the date they entered the U.S. or, if already in the U.S., for eight months from the date that they acquired their Special Immigrant Status.

Documentation: RMA applicants must provide proof of his/her immigration status including, as appropriate, Arrival/Departure Record (I-94), Permanent Resident Card (I-551), or a USCIS Notice of Action (I-797). The various immigration statuses that may be found on the immigration documents include:

- Admitted as a conditional entrant under Section 203 (a) (7) of the Immigration and Nationality Act (INA).
- Admitted as a refugee under Section 207 of the INA.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

REFUGEE MEDICAL ASSISTANCE (RMA)

- Granted asylum under Section 208 of the INA.
- Any national of Cuba or Haiti granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided.
- Any other national of Cuba or Haiti who:
    - Was paroled into the U.S. and has not been given any other status under the INA; or is facing exclusion or deportation proceedings under the INA; or has an application for asylum pending with the USCIS; and
    - With respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered.
- Amerasian immigrants (aliens who were born in Vietnam after January 1, 1962 and before January 1, 1976, and whose fathers were U.S. citizens and such alien's spouses or minor children) who are admitted to the U.S. as immigrants pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in Section 101 (d) of Public Law 100-202 and as amended by Public Law 100-461).
- Adjusted to permanent resident status from one of the previously held eligible statuses described above.
- Office of Refugee Resettlement documentation for trafficking victims, as described in 06 OMM/INF-5. There are two categories of trafficking victims:
    - Adult (18 years of age or older) victims of a severe form of human trafficking who are certified by ORR of the Federal Department of Health and Human Services. These individuals must submit the original certification letter to the LDSS. This letter is used instead of USCIS documents; and
    - Children younger than 18 years of age do not have to be certified but are issued an eligibility letter by the ORR stating that they are eligible for benefits as victims of a severe form of human trafficking.

  The ORR certification or eligibility letter is proof of the alien's immigration status. However, the Medicaid worker must call the Trafficking Verification Line (1-866-401-5510) to verify the document(s).

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

REFUGEE MEDICAL ASSISTANCE (RMA)

Certain family members of victims of a severe form of trafficking are also eligible for RMA benefits and services to the same extent as refugees. These individuals will have either a T-2, T-3, T-4 or T-5 visa, which is referred to as a Derivative T-Visa. Derivative T-Visas may be issued while the immigrant is in the U.S. or an individual may be issued a Derivative T-Visa upon entering the U.S.

- Iraqi and Afghan Special Immigrant Visa Holders (SIV) category/code "SI" will be stamped in the foreign passport or appear on the I-551-Lawful Permanent Resident Card ("green card").

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

U.S. ARMED FORCES ACTIVE DUTY AND VETERANS

Description: Qualified aliens who are on active military duty or who are veterans are eligible for Medical Assistance, if they are otherwise eligible.

Policy: Medicaid may be authorized for a qualified alien who is on active duty or who is a veteran of the U.S. Armed Forces, provided that s/he is otherwise eligible.

References: Balanced Budget Act of 1997

SSL Sect. 122

Dept Reg. 349.3
351.1
351.2
360-3.2(j)

ADMs 04 ADM-7

INF 06 INF-5

GISs 08 MA/009

Interpretation: Active Military Duty-The individual must be on full-time duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard. Active Duty for training and full time National Guard duty are not included in this interpretation.

Medicaid is also provided to the immigrant's spouse and unmarried dependent children who are qualified aliens.

Veterans - The veteran's discharge must have been characterized as "honorable", and not because of his or her immigration status. Medicaid is also provided to the veteran's qualified alien's spouse, including his or her un-married surviving spouse if the veteran is deceased, and any unmarried dependent children of the veteran who are qualified aliens.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

U.S. ARMED FORCES
ACTIVE DUTY AND VETERANS

NOTE: The Balanced Budget Act of 1997 provided that Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and have been lawfully admitted to the United States for permanent residence are to be considered veterans for the purpose of this provision.

Documentation: U.S. ARMED FORCES-ACTIVE DUTY AND VETERANS

Category 2: Qualified Aliens Continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Veterans (Immediate family members: documentation of relationship to veteran or person on active duty)	►DD Form 214 showing "Honorable" discharge; or ►Original or notarized copy of the veteran's discharge papers.	V	YES	YES Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
Persons on active duty in the Armed Forces and their immediate family members	►►Military I.D. card – DD Form 2 (active); ►Original or notarized copy of current orders showing the person is on full-time duty in U.S. Armed forces; (Immediate family members must show documentation of relationship to the person on active duty.)	M	YES	

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

VICTIMS OF TRAFFICKING

Description: The federally eligible immigration category, "victims of a severe form of trafficking", Section 107(b) of The Trafficking Victims Protection Act of 2000 (P.L. 106-386) makes victims of "a severe form of trafficking in persons" eligible for Medicaid and other benefits (if otherwise eligible) to the same extent as an alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act (INA).

Policy: Victims of "a severe form of trafficking in persons" (VOTs) are eligible for Medicaid and other benefits (if otherwise eligible) to the same extent as an alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. Individuals with letters of certification or eligibility as victims of severe forms of trafficking are eligible for medical assistance. They retain this eligibility for seven years from the date of certification contained in the letter.

References:

The Trafficking Victims Protection Act of 2000	Sect.107(B) P.L. 106-386
The Trafficking Victims Reauthorization Protection Act of 2003	P.L. 108-193
Chapter 74 of the Laws of 2007	
Dept. Regs.	360.3.2 (j)
ADMs	09 ADM-01(OTDA) 04-OMM/ADM-7 03-ADM-1(OTDA)
INF	06 OMM INF-5
GIS	10 MA/002 08 MA/009

Interpretation: A "victim of a severe form of trafficking in persons" means a person:

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

VICTIMS OF TRAFFICKING

1) Who has been subjected to a "severe form of trafficking in persons," which is defined as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery"; and

2) Who has not attained the age of 18 years or who is the subject of a certification issued by the federal government pursuant to Section 107(b)(1)(E) of the Act.

For individuals who meet the above criteria, the Office of Refugee Resettlement (ORR) will issue the certification letters for adults and the eligibility letters for children. To receive a certification or a letter, a victim of trafficking must be willing to assist with the investigation and prosecution of trafficking cases AND either:

(1) Have made a bona fide application for a "T" visa that has not been denied. **OR**
(2) Be an individual whose continued presence the Attorney General is ensuring to effectuate a Trafficking prosecution.

When a victim of trafficking applies for Medicaid, local districts must follow their normal procedures for establishing Medicaid eligibility for refugees. Local districts must also:

1. Accept the certification letter for adults, or eligibility letter for children in place of USCIS documentation. **Please note, as of November 6, 2001, certification letters for adults and eligibility letters for children no longer contain an eight-month expiration date.** Victims of severe forms of trafficking do not need to provide any other documentation of their immigration status. The local district must call the trafficking verification line at 1-866-401-5510 to verify the validity of the documentation.
2. Use the certification date as the "Date of Status" (DOS) for Medicaid purposes. The certification date is in the body of the certification letter or the eligibility letter for children.
3. Issue benefits to the same extent as other refugees, provided the victim of a severe form of trafficking meets other program eligibility criteria (e.g., income levels).

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

VICTIMS OF TRAFFICKING

4. Upstate WMS: Districts should use citizenship/alien code (ACI) "D"- Victim of Human Trafficking.
5. New York City WMS: Workers should use ACI code "R"- Person Admitted as a Refugee" for Victim of Human Trafficking.

For purposes of Medicaid/Family Health Plus and/or Child Health Plus eligibility, victims of a severe form of trafficking, (holders of a T-visa/T-1, and holders of T-2, T-3, T-4 and T-5 ["Derivative" T-visas]) who are the minor children, spouses and in some cases the parents and siblings of victims of severe forms of trafficking in persons, may receive Medicaid benefits to the same extent as refugees. Recipients of a "T" visa are eligible for employment authorization. "T" visa recipients also may, if eligible, adjust their status to that of lawful permanent resident after three years. Victims may also apply for other immigration benefits such as an "S" visa (See section on **OTHER** VISA STATUSES) or asylum.

New York State "*Confirmed"* Victims of Human Trafficking:

Effective November 1, 2007 human trafficking was established as a crime in New York State. Under the law, a process to "*confirm*" victims of human trafficking as a means of providing assistance to such victims was established. State "c*onfirmed*" human trafficking victims who are citizens or aliens with a satisfactory immigration status who are otherwise eligible, are eligible for Medicaid benefits and services to the same extent as any other citizen or alien with satisfactory immigration status.

State "*confirmed"* human trafficking victims who do not have a satisfactory immigration status who are otherwise eligible for Medicaid may receive coverage and care necessary for the treatment of an emergency medical condition. (See **OTHER ELIGIBLITY REQUIREMENTS** CITIZENSHIP AND IMMIGRATION STATUS UNDOCUMENTED/ILLEGAL ALIENS TREATMENT OF AN EMERGENCY MEDICAL CONDITION) When the State "*confirmed*" adult or minor victim is an alien without satisfactory immigration status, local districts must contact the Office of Temporary and Disability Assistance (OTDA), Bureau of Refugee and Immigration Affairs (BRIA) Anti-Trafficking Program Coordinator. BRIA will refer the victim to a specific regional case management agency and/or other local resources that may be able to assist the victim.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

VICTIMS OF TRAFFICKING

At the time of application, the "*confirmed*" adult victim should have received a letter from OTDA indicating that she/he is a state "*confirmed*" victim of human trafficking. Each "*confirmed*" adult victim must present evidence of confirmation. Should the victim not present the letter to the intake worker or she/he does not appear to have a letter, or if additional information about the case is needed, the local district must contact the BRIA Anti-Trafficking Program Coordinator.

Minor children who are State "*confirmed*" trafficking victims who are otherwise eligible, may be provided medical coverage without regard to immigration status under the Child Health Plus program. BRIA will notify the LDSS by telephone and follow-up letter of any minor victims of human trafficking whether "*confirmed*" or "*not confirmed",* and whether a "victim" or "possible victim" of human trafficking.

State "*confirmed*" human trafficking victims who are pregnant and otherwise eligible may be provided Medicaid at any time without regard to immigration status.

NOTE: State "*confirmed*" victims of human trafficking are not to be confused with the federally "*certified*" alien victims of human trafficking. Federally "*certified*" adults will have a Certification Letter from the Office of Refugee Resettlement (ORR). Children victims of human trafficking (under age 18) will have a letter of eligibility from ORR.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS

VICTIMS OF TRAFFICKING

Documentation: Victims of Trafficking will have the following documentation:

Category 2: Qualified Immigrants Continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Victims of Trafficking	►I-94 Arrival/Departure Record coded T1, T2, T3, T4, or T5 stating admission under Section 212(d)(5) of the INA if status is granted for at least one year; ►Certification letter (for adults) or eligibility letter (for children) from the Office of Refugee Resettlement. Must call 1-866-401-5510 for verification; or ►I-797 Notice of Action acknowledging receipt of I-914, Application for T non-immigrant status.	D- Upstate or R-NYC	YES	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

Description:

The United States Citizenship and Immigration Services (USCIS) (formerly the Immigration and Naturalization Services [INS]), or Immigration and Customs Enforcement (ICE), under the umbrella of the Department of Homeland Security (DHS), and/or the Executive Office for Immigration Review (EOIR), under the Department of State, are collectively referred to in this document as "the federal immigration agency" or "agency".

PRUCOL is an acronym for persons Permanently Residing Under Color Of Law. The federal immigration agency does not determine whether an alien is PRUCOL and does not grant PRUCOL status. This is because PRUCOL is not a federal immigration status. Rather, PRUCOL is a public benefits eligibility status. Immigrants who are PRUCOL for Medicaid eligibility purposes and who may be eligible for Medicaid are any immigrants who are permanently residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the United States the federal immigration agency does not contemplate enforcing.

An immigrant will be considered as one whose departure the agency does not contemplate enforcing if:

a. Based on all the facts and circumstances in that particular case, it appears that the federal immigration agency is otherwise permitting the immigrant to reside in the United States indefinitely; or

b. It is the policy or practice of the federal immigration agency not to enforce the departure of immigrants in a particular category.

Policy:

The Medicaid eligibility worker must determine whether the alien is PRUCOL based upon the documentation that the alien, or the alien's representative, presents. An alien who establishes that he or she is PRUCOL is eligible for State Medicaid and FHPlus benefits if the alien meets the programs' financial and other eligibility requirements, regardless of the date the immigrant entered the U.S. (Aliessa v. Novello, 06/01). There is no longer a five-year waiting period.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

Previously, Section 122 of the Social Services Law (SSL) provided an exception for certain PRUCOL immigrants who, on August 4, 1997, were residing in certain residential settings or who were diagnosed with AIDS and receiving Medicaid. Such individuals will continue to be provided Medicaid coverage to the extent they are otherwise eligible. The settings included are:

- Residential health care facilities licensed by the NYS Department of Health;
- Residential facilities licensed, operated or funded by the NYS Office of Mental Health (OMH), including psychiatric centers; residential treatment facilities; family care; community residences; teaching family homes; family based treatment; and residential care centers for adults; and
- Residential facilities licensed, operated or funded by the NYS Office for People with Developmental Disabilities (OPWDD), including: developmental centers and small residential units; intermediate care facilities for the developmentally disabled; family care; community residences; individual residential alternatives; and OPWDD certified schools for the mentally retarded.

References:

SSL Sect.	122 131-k
Dept. Reg.	360-3.2(j)(1)(ii)
ADM	04 OMM/ADM-7
INFs	07 OHIP INF-2 08 OHIP INF-4
GISs	08 MA/009 04 MA/014 04 MA/002 02 MA/016 02 MA/002 01 MA/033 01 MA/030 01 MA/026

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

Interpretation: Some aliens are PRUCOL because the federal immigration agency has granted them a particular immigration status or relief. These aliens are permanently residing in the U.S. with the "knowledge and permission" of the federal agency. Examples include, but are not limited to, aliens paroled (admitted) into the U.S. for less than one year, aliens residing in the U.S. under an order of supervision, aliens granted an indefinite stay of deportation and aliens granted voluntary departure, deferred action or temporary protected status. A more complete list is included in the "Documentation Guide to Citizenship and Immigrant Eligibility for Health Coverage in New York State," pages 9-10, issued on March 26, 2008, as part of GIS 08 MA/009. Each of these aliens will have a form of documentation, as listed in this desk guide, issued by the federal immigration agency that shows that the agency has granted the alien a particular status or relief.

Other aliens may be PRUCOL because they have applied for or otherwise requested a particular immigration status or relief from removal and are awaiting the federal immigration agency's decision. The federal agency has received their application or request for relief and has not yet approved or denied the request. Under certain circumstances, and as further explained in this document, these aliens are PRUCOL pending the federal immigration agency's determination. Until the agency has adjudicated the application or request, these aliens are residing in the U.S. with the "knowledge and acquiescence" of the federal immigration agency.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

Verification: **PRUCOL CATEGORIES**

a. Immigrants Paroled into the United States pursuant to Section 212 (d)(5) of the Immigration and Nationality Act (INA) showing status for less than one year, except Cuban/Haitian entrants.

   (1) Immigrants in this category are admitted to the United States for similar reasons as a refugee, i.e. humanitarian. However, this category, unlike refugee, does not grant legal residence status.

   (2) Parole status allows the immigrant temporary status until a USCIS determination of his/her admissibility has been made, at which time another status may be granted.

   (3) Immigrants in this category will have an Arrival/Departure Record (Form I-94) indicating that the bearer has been paroled pursuant to Section 212 (d)(5) of the INA. Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.

b. Immigrants residing in the United States pursuant to an Order of Supervision.

   (1) Immigrants in this category have been found deportable; however, certain factors exist which make it unlikely that the federal immigration agency would be able to remove the immigrant. Such factors include age, physical condition, humanitarian concerns, and the availability of a country to accept the deportee.

   (2) Immigrants in this category are required to report to USCIS periodically; if the factors preventing deportation are eliminated one of the federal immigration agencies will initiate action to remove the immigrant.

   (3) Immigrants in this category will have USCIS Form I-94 or I-120B.

c. Deportable immigrants residing in the United States pursuant to an Indefinite Stay of Deportation.

   (1) Immigrants in this category have been found to be deportable, but the federal immigration agency may defer deportation indefinitely due to humanitarian reasons.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

(2) Immigrants in this category will have a letter and/or a Form I-94 showing that the immigrant has been granted an indefinite stay of deportation.

d. Immigrants residing in the United States pursuant to an Indefinite Voluntary Departure.

(1) Immigrants in this category will have a letter and/or Form I-94 indicating that the immigrant has been granted voluntary departure for an indefinite time period.

e. Immigrants in this category on whose behalf an Immediate Relative Petition (Form I-130) has been approved and their families covered by the petition, who are entitled to voluntary departure and whose departure the agency does not contemplate enforcing.

NOTE: An immediate relative for USCIS purposes is: husband, wife, father, mother, or child (unmarried and under age 21).

(1) Immigrants in this category are the immediate relatives of a United States citizen or lawful permanent resident (LPR) and have had filed on their behalf a Form I-130 petition for issuance of an immigrant visa.

(2) If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.

(3) Immigrants in this category may have a Form I-94 and/or Voluntary Departure Letter (I-210 Letter). These documents, or others, indicate that the immigrant is to depart on a specified date (usually 3 months from date of issue); however, USCIS expects the immigrant's visa to be available within this time. If it is not, extensions may be granted until the visa is ready.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

f. Immigrants who have filed applications for Adjustment of Status pursuant to section 245 of the INA that USCIS has accepted as "properly filed" or has granted and whose departure the agency does not contemplate enforcing.

(1) Immigrants in this category have filed for lawful permanent resident status.

(2) Immigrants in this category may have Form I-94 or Memorandum of Creation of Record of Lawful Permanent Residence (Form I-181). Form I-181 or their passports will be stamped with either of the following: "Adjustment application" or "employment authorized during status as adjustment applicant."

g. Immigrants granted Stays of Deportation by court order, statute or regulation, or by individual determination of the federal immigration agency pursuant to section 243 of the INA whose departure the agency does not contemplate enforcing.

(1) Immigrants in this category have been found to be deportable, but the agency may defer deportation for a specified period of time due to humanitarian reasons.

(2) Immigrants in this category will have a letter or copy of the court order and/or a Form I-94.

h. Immigrants granted Voluntary Departure pursuant to section 242(b) of the INA whose departure the agency does not contemplate enforcing.

(1) Immigrants in this category are awaiting a visa.

(2) Such immigrants are provided Forms I-94 and/or Form I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.

i. Immigrants granted Deferred Action Status pursuant to agency operating policy. Immigrants in this category will have a Form I-210 or a letter indicating that the immigrant's departure has been deferred.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

j. Immigrants who entered and have Continuously Resided in the United States since before January 1, 1972. Immigrants in this category are presumed by the federal immigration agency to meet certain criteria for lawful permanent residence. Obtain any documentary proof establishing entry and continuous residence.

k. Immigrants granted Suspension of Deportation pursuant to section 244 of the INA whose departure the federal immigration agency does not contemplate enforcing.

   (1) Immigrants in this category have been found deportable, have met a period of continuous residence and have filed an application for the agency to suspend deportation, which has been granted.

   (2) Immigrants in this category will have a letter/order from an immigration judge and a Form I-94 showing suspension of deportation granted. After lawful permanent residence is granted, the immigrant will have a Lawful Permanent Resident Card (Form I-551 "green card").

l. Any other immigrant living in the U.S. with the knowledge and permission or acquiescence of the federal immigration agency and whose departure that agency does not contemplate enforcing.

   (1) Immigrants in this category may be in a status not listed above. But, based on a determination by one of the federal immigration agencies or documentation supplied by the immigrant or his or her representative that indicates the immigrant is present in the U.S. with the knowledge of the federal immigration agency and with the permission or acquiescence of the agency, local districts may find them to be PRUCOL. Examples include, but are not limited to:

   - Applicants for adjustment of status to Lawful Permanent Residence (LPR), asylum, suspension of deportation or cancellation of removal or requesting deferred action; or
   - Deferred Enforced Departure (DED) due to conditions in their home country; or
   - Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands); or
   - Persons granted Temporary Protected Status (TPS); or
   - Applicants for Temporary Protected Status; or
   - Persons having a "K", "V", "S" or "U" visa.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

DETERMINING PRUCOL STATUS

The following paragraphs describe the Department's policy regarding the PRUCOL status of aliens who:

1. have filed official applications with the federal immigration agency, typically USCIS or EOIR, for a particular immigration status or to obtain other relief; or
2. have submitted letters or other correspondence to the federal immigration agency, typically ICE, for relief, such as deferred action, for which no official application form exists.

I. Applications filed on federal immigration agency forms

There are many types of immigration statuses or relief for which an alien may apply by submitting an official application to the federal immigration agency on its application forms. Examples include applications to USCIS for adjustment of status to that of a lawful permanent resident (Form I-485), asylum and withholding of removal (Form I-589), or temporary protected status (Form I-821). An alien in removal proceedings may also apply to EOIR for suspension of deportation (EOIR-40), cancellation of removal (EOIR-42A) and for certain other forms of relief. It is the Department's understanding that the federal immigration agency generally confirms its receipt of an official application by issuing an I-797 Notice of Action.

It is the Department's policy, as stated in 04 OMM/ADM-7, 07 OHIP/INF-2, and 08 OHIP/INF- 4 that the alien is PRUCOL during the period of time that the federal agency is determining whether to approve the application by granting the requested immigration status or other relief. Local departments of social services should continue to follow the procedures described in these directives when the alien, or the alien's representative, presents documentation that an application has been submitted to the federal immigration agency on the agency's forms. In particular, the district should

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

attempt to verify whether the application remains pending or whether the federal immigration agency has adjudicated the application by granting or denying the requested status or relief. There are a few ways that the district can verify the current status of an application. The alien may have an I-797 Notice of Action, employment authorization document or other federal immigration agency document that contains a 13 character receipt number. If so, the district worker can access the USCIS website at www.uscis.gov and follow the instructions for checking the case status online. This on-line search can confirm the accuracy of the information in the document as well as whether the agency has approved the request.

However, if the alien does not have a document with a receipt number, or the district worker does not have access to the USCIS website, the worker should send a Document Verification Request, Form G-845, (also known as a Systematic Alien Verification for Entitlements (SAVE) request) to USCIS. The worker should include copies of all documentation that the alien has submitted to, or received from, the federal immigration agency, and request that it verify the alien's current status. As a general rule, the district worker should also send a G-845 Document Verification Request when the documentation does not clearly indicate a particular immigration status, the alien has presented expired documents or the worker has reason to believe that the documentation may be questionable in any respect.

The Medicaid worker should find the alien to be PRUCOL if the alien's application remains pending with the federal immigration agency, not having yet been approved or denied, unless contradictory evidence indicates that the federal immigration agency is contemplating enforcing the alien's departure from the U.S.

The alien would be PRUCOL from the date that the federal immigration agency received the application. The I-797 Notice of Action indicates the date of receipt. If the alien does not have an I-797 Notice of Action, the date of receipt can be verified from a U.S. Postal Service return receipt, a "signature confirmation" or a "delivery confirmation."

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

If the federal immigration agency denies the application or otherwise indicates that it is not permitting the alien to remain in the U.S., the alien is not PRUCOL. The alien would be eligible only for Medicaid coverage for the treatment of an emergency medical condition, if otherwise eligible.

II. Other letters or requests for relief from removal

There are various forms of relief from removal or deportation for which no formal application form or process exists. Two examples are deferred action and voluntary departure.

An alien whom the federal immigration agency would regard as illegal, and thus subject to removal, may still, under certain circumstances, be PRUCOL for purposes of eligibility for State Medicaid benefits and Family Health Plus (FHPlus).

DEFERRED ACTION/VOLUNTARY DEPARTURE

Deferred action is a form of relief that the Department of Homeland Security, in its' discretion, may afford to an otherwise removable alien whom DHS has decided not to prosecute for removal before the immigration courts, whether for humanitarian or administrative reasons. According to DHS estimates, the vast majority of cases in which deferred action is granted involve medical grounds. The former INS had operating instructions for making deferred action determinations under which the INS would consider the age or physical condition affecting an alien's ability to travel as well as the presence of sympathetic factors. Although the INS withdrew these operating instructions in 1997, deferred action continues to be available, according to DHS.

Voluntary departure permits an otherwise removable alien to depart the U.S. at his or her own expense, thus avoiding the stigma of being subjected to a removal proceeding. It is available both during and prior to removal proceedings. An alien may request voluntary departure to return to his or her home country or another country, if he or she can secure entry there.

Because no formal application process exists for these types of relief, the federal immigration agency might not timely respond to, or even acknowledge receipt of, the alien's letter requesting relief. Several months may pass before the agency responds to the informal request, if it responds at all. It is also

more difficult for local departments of social services to verify the current status of the federal immigration agency's review of a request for deferred action or other relief made by letter rather than the current status of a formal application filed on official USCIS or EOIR application forms. However, an alien who has made a letter request for deferred action or other relief from removal may still be PRUCOL under certain circumstances.

Sections A through C of this document, which follow, present guidelines for local departments of social services to apply when determining the PRUCOL status of an otherwise removable alien who has requested, by informal letter, the federal immigration agency to grant relief from removal including, but not limited to, deferred action, voluntary departure or any other relief that may reasonably be construed as humanitarian relief.

A. Initial contact with the federal immigration agency

The letter or other correspondence to the federal immigration agency must clearly state the type of relief sought, which must be a recognized form of relief from removal or a recognized immigration status. The letter should summarize pertinent facts and circumstances of the alien's case that would support the granting of the relief. For example, if the alien is requesting deferred action or other humanitarian relief from removal based on the alien's medical condition, this information would include such factors as the following: date of birth and nationality; address in the U.S.; family ties in the U.S., if any; immigration history; criminal history, if any; and, in particular, the alien's current medical condition with a rationale for why the federal immigration agency should grant deferred action relief based on the alien's medical condition. If the alien is requesting voluntary departure, the alien must be capable of departing the U.S. if the federal immigration agency grants voluntary departure under the applicable federal regulations at 8 C.F.R. § 240.25 or § 1240.26. If the alien is represented by an attorney, the attorney should include an executed copy of the "Notice of Appearance as Attorney or Representative."

The alien, or the alien's representative, must present documentation sufficient to show that the letter was mailed to, and received by, the federal immigration agency. There is more than one way to establish mailing and receipt. A letter sent via the U.S. Postal Service by certified mail proves that the letter was mailed on a certain date. A

certified letter, return receipt requested, is proof not only of mailing but also of receipt. A U.S. Postal Service "signature confirmation" or "delivery confirmation" also verifies receipt. In addition, a letter that is properly addressed, stamped and mailed by regular first-class mail is presumed to have been received, although this presumption can be rebutted.

B. Affording the federal immigration agency a "reasonable period of time" to adjudicate the request for relief

The alien is not considered PRUCOL immediately upon mailing of the initial letter requesting relief. Before the alien may be considered PRUCOL, the federal immigration agency must be afforded a "reasonable period of time" to consider and act upon the request. This is consistent with 04 OMM/ADM-7, in which the Department stated that an alien may be PRUCOL when the federal immigration agency, despite having been notified of the alien's presence in the U.S., fails after "a reasonable period of time" to respond to the alien's letter requesting relief or fails to take any action to enforce the alien's departure from the U.S.

Under federal law, the federal immigration agency is required to conclude matters presented to it "within a reasonable time" (5 U.S.C. § 555). There is no hard and fast rule that defines a "reasonable time." What is "reasonable" depends on all the facts and circumstances of a case. However, local departments of social services may consider that a "reasonable period of time" is six months. This six-month period is measured from the date that the alien, or the alien's representative, mailed to the federal immigration agency the initial letter requesting relief.

C. Subsequent contacts with the federal immigration agency within the six-month period

A single letter or other piece of correspondence requesting relief from the federal immigration agency does not establish PRUCOL status. (An exception applies to applications to USCIS or EOIR that are filed on official application forms, as previously discussed.) It is reasonable to expect that any alien who has submitted a good faith request for relief to a federal immigration agency would take steps to follow-up on the status of the original request. The same principle applies here.

The Medicaid applicant, or the applicant's representative, must make reasonable efforts to follow-up with the federal immigration agency on

the status of the request for deferred action or other relief. These efforts to monitor the status of the initial request must occur during the six-month period that begins with the date that the alien, or the alien's representative, mailed to the federal immigration agency the initial letter requesting relief. If the applicant, or the applicant's representative, fails to make any effort to follow-up on the request within this period, this indicates that the request was not a "good faith" effort to seek relief.

This policy is consistent with court cases that have found otherwise removable aliens to be PRUCOL when the federal immigration agency was made aware on numerous occasions of the alien's presence in the U.S. but neither responded to the alien's letters nor took any action to enforce the alien's departure.

Applying these guidelines, local departments of social services should determine that the alien is PRUCOL when, based on all the facts and circumstances of the particular case, it appears that the federal immigration agency is acquiescing, at least for now, to the alien's presence in the U.S. Three examples of circumstances in which the local department of social services should conclude that federal acquiescence to the alien's presence exists, and the alien is thus PRUCOL, are illustrated below:

1. The federal immigration agency does not respond to the alien's initial or subsequent letters within six months after mailing and made no effort within that six-month period to enforce the alien's departure from the U.S.

In this example, the alien would be PRUCOL effective on the date that is six months after the alien, or the alien's representative, mailed the initial letter requesting relief provided that the alien, or the alien's representative, made reasonable and good faith efforts to follow-up on the status of the initial request during this six-month period. An exception applies if other evidence indicates that the federal immigration agency contemplates enforcing the alien's departure from the U.S.

2. The federal immigration agency responded to the alien's initial letter within six months after mailing by referring the matter to another entity and the entity to which the letter was referred did not respond within that same initial six-month period.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

For example, ICE responded to the alien's initial letter within six months of the date it was mailed by referring the matter to another wing of the Department of Homeland Security, namely USCIS, and USCIS did not respond within that same initial six-month period.

In this example, the alien would be PRUCOL effective on the date that is six months after the alien, or the alien's representative, mailed the initial request that was then referred to another entity. This presumes, however, that the alien, or the alien's representative, made reasonable and good faith efforts to follow-up on the status of the request for relief during this six month period. Again, an exception applies if other evidence indicates that the federal immigration agency is contemplating enforcing the alien's departure from the U.S.

3. The federal immigration agency responds to the alien's initial letter within six months of mailing and the agency's response can be reasonably interpreted as indicating that the agency does not contemplate enforcing the alien's departure from the U.S. at this time.

In this example, the federal immigration agency has responded within six months after the alien, or the alien's representative, mailed the initial letter. If the agency had granted the alien's request for relief, the alien would be PRUCOL effective on the date of the agency's response. However, the alien may still be PRUCOL if the agency's response, although not granting the requested relief, also does not show that the agency intends to enforce the alien's departure from the U.S. For example, the federal immigration agency may have responded that the alien is not in any form of formal expulsion proceedings or is not under a final order of removal and that the agency is returning the request for deferred action or other relief without adjudicating the request; that is, without determining whether to grant or deny the requested relief. In that example, the alien would be PRUCOL effective on the date of the federal immigration agency's response.

NOTE: As a general rule, the Medicaid worker should determine that an alien is not PRUCOL when the federal immigration agency denies the alien's request for relief from removal or indicates that it is not permitting or acquiescing to the alien's continued presence in the U.S. or, from all the facts and circumstances of the particular case, it appears that the agency is contemplating enforcing the alien's departure from the U.S.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

For example, the federal agency might respond to an alien's letter seeking deferred action or other relief by stating that the alien has been placed in formal removal proceedings or is under a final order of removal. In that case, the alien is not PRUCOL and is eligible only for Medicaid coverage for the treatment of an emergency medical condition, if financially and otherwise eligible.

Also as a general rule, Medicaid applicants are responsible for providing information and documentation necessary to establish their eligibility for Medicaid. This obligation includes providing information and documentation necessary to establish eligibility for Medicaid as a PRUCOL alien. Among other factors, an applicant who asserts that the federal immigration agency has a policy or practice of not enforcing the departure of aliens in a particular category, and that he or she falls within that category, is responsible for establishing that the federal immigration agency has such a policy or practice.

The desk aids that follow this section describe the documentation that a PRUCOL individual may present.

Category 3: Persons who are Permanently Residing in the U.S. Under Color of Law (PRUCOL)*

*PRUCOL is not an immigration status. PRUCOL is not granted by the federal immigration agency. PRUCOL is a public benefits eligibility category.

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
a. **Persons paroled into the U.S. for less than a year**. (Non-citizens allowed to come into the U.S. without being granted admission.)	►I-94 Arrival/Departure Record with annotation "Paroled Pursuant to Section 212(d)(5)" of the INA or "parole" or "PIP"; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(4) or 274a.12(c)(11); or ►I-766 Employment Authorization Document annotated "A4" or "C11".	T	NO	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
b. **Persons under an Order of Supervision.** (Non-citizens who have been found deportable; however certain factors exist which make it unlikely that they will be deported.)	►I-94 Arrival/Departure Record annotated "Order of Supervision"; ►I-220B Order of Supervision; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12 (c)(18); or ►I-766 Employment Authorization Document annotated "C18".	O	NO	
c. **Persons granted indefinite stay of deportation** (Non-citizens who have been found deportable, but deportation is deferred indefinitely due to humanitarian reasons.)	►I-94 Arrival/Departure Record coded 106 "granted Indefinite Stay of Deportation"; or ►Letter/order from the immigration agency, immigration judge or a federal court granting indefinite stay of deportation.	O	NO	
d. **Persons granted indefinite voluntary departure** (Status that was granted before April, 1997 to non-citizens who have been found deportable, but deportation is deferred indefinitely due to humanitarian reasons.)	►I-94 Arrival/Departure Record or letter/order from the immigration agency or immigration judge granting voluntary departure for an indefinite time period.	O	NO	
e. **Persons on whose behalf an immediate relative petition has been approved and family members covered by the petition.** (Non-citizens who are immediate relatives (spouse, father, mother, or unmarried child under 21) of a U.S. citizen/LPR who has filed an I-130 Relative Petition on their behalf.)	►I-94 Arrival/Departure Record or I-210 indicating departure on a specified date, however, the USCIS expects the non-citizen's visa will be available within this time; or ►I-797 indicating I-130 Relative Petition has been approved.	O	NO	

REVISED 03/03/08

Category 3: PRUCOL continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
f. **Persons who have filed applications for adjustment of status to lawful permanent resident under Section 245 of the INA that the USCIS has accepted as "properly filed".** (Non-citizens who filed for legal permanent resident status.)	►I-94 Arrival/Departure Record or foreign passport with annotation "adjustment application" or "employment authorized during status as adjustment applicant"; ►I-688 Temporary Resident Card or I-688A Employment Authorization Card annotated "245A"; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12 (c)(22); or ►I-766 Employment Authorization Document annotated "C22".	O	NO	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
g. **Persons granted stays of deportation** (Non-citizens who have been found deportable, but the federal immigration agency may defer deportation for a specified period of time due to humanitarian reasons.)	►I-94 Arrival/Departure Record or letter/order from the immigration agency, immigration judge or court granting stay of deportation.	O	NO	
h. **Persons granted voluntary departure under Section 242(b).** (This section of the INA has been repealed.)	►I-797 Notice or form showing grant of extended voluntary departure; ►I-688B Employment Authorization Card annotated 274a.12(a)(11); or ►I-766 Employment Authorization Document annotated A11.	O	NO	
i. **Persons granted deferred action status**.	►I-797 or any document from the federal immigration agency granting deferred action status; ►I-688B Employment Authorization Card annotated 8 C.F.R 274a.12 (c)(14); or ►I-766 Employment Authorization Document annotated "C14".	O	NO	
j. **Persons who entered and continuously resided in the U.S. before January 1, 1972.** (Non-citizens are presumed by the USCIS to meet certain criteria for legal permanent residence.)	►Any documentary proof establishing entry and continuous residence; or ►I-688B or I-766 coded 274a.12(c)(16) or C16; or ►I-797, letter/notice from the USCIS or court indicating registry application is pending.	O	NO	
k. **Persons granted suspension of deportation pursuant to Section 244 of the INA; the USCIS does not contemplate enforcing departure** (Non-citizens in this category have been found deportable, have met a period of continuous residence and have filed an application for the USCIS to suspend deportation, which has been granted.)	►I-797, letter/notice from an immigration judge or court; and ►I-94 Arrival/Departure Record showing suspension of deportation granted. (After Lawful Permanent Residence is granted the person will have a "green Card" Form I-551).	O	NO	

REVISED 03/03/08

Category 3: PRUCOL continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
I. **Other persons living in the U.S. with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the agency does not contemplate enforcing:** Examples include, but are not limited to: ►Applicants for adjustment of status to LPR[1], asylum[2], suspension of deportation or cancellation of removal[3] or requesting deferred action; or ►Persons granted Deferred Enforced Departure (DED)[4] due to conditions in their home country; or ►Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands[5]; ►Persons granted Temporary Protected Status[6]; or ►Applicants for Temporary Protected Status[7] (TPS); or ►Persons having a K, V, S or U Visa.[8]	►I-94 Arrival/Departure Record coded K1, K2, K3, K4, V1, V2, or V3, U, or S; ►I-688B Employment Authorization Card annotated 8 C.F.R.274a.12(c)(9)[1], 274a.12(c)(8)[2] 274a.12(c)(10)[3], 274a.12(a)(11)[4] 274a.12(a)(8)[5], 274a.12(a)(12)[6] or 274a.12(c)(19)[7], 274a.12(a)(9)[8], 274a.12(a)(13)[8], 274a.12(a)(15)[8], 274a.12(c)(21)[8],and 274a.12(c)(24)[8] ►I-766 Employment Authorization Document annotated C9[1], C8[2], C10[3], A11[4], A8[5], A12[6], C19[7], A9[8], A13[8], A15[8], C21[8] or C24[8]. ►I-797 indicating the USCIS has received an application or petition or request for change of status; or ►Postal Return Receipt addressed to the federal immigration agency* or a copy of a cancelled check to the federal immigration agency, and a copy of the application, petition or request submitted to the federal immigration agency. (* USCIS-United States Citizenship and Immigration Services; ICE-Immigration and Customs Enforcement; EOIR-Executive Office of Immigration Review.)	O	NO	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.

REVISED 03/03/08

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES rev. 09/15/08

PRUCOL: (Permanently Residing in the United States Under Color Of Law) are any aliens who are residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency (formerly the Immigration and Naturalization Services [INS]), now the United States Citizenship and Immigration Services (U.S.C.I.S.), or the United States Immigration and Customs Enforcement (I.C.E) or the Executive Office of Immigration Review (EOIR) and whose departure from the United States the agency does not contemplate enforcing.

ALIEN CATEGORIES	GENERAL INFORMATION		DOCUMENTATION/FORMS
a) Aliens paroled into the United States pursuant to Section 212(d)(5) of the INA showing status for less than one year, except for Cuban/Haitian entrants.	Aliens in this category are admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this category, unlike refugee status, does not grant legal residence status.	Parole status allows the alien temporary status until USCIS determination of his/her admissibility has been made; at which time another status may be granted.	Aliens in this category will have a FORM I-94 indicating that the bearer has been paroled pursuant to Section 212 (d)(5) of the INA. Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.
b) Aliens residing in the United States pursuant to an Order of Supervision.	Aliens in this category have been found deportable; however, certain factors exist which make it unlikely that the federal immigration agency would be able to remove the alien. Such factors include age, physical condition, humanitarian concerns, and the availability of a country to accept the deportee.	Aliens in this category are required to report to the federal immigration agency periodically; if the factors preventing deportation are eliminated, the agency will initiate action to remove the alien.	Aliens in this category will have an USCIS Form I-94 or I-220B.
c) Deportable aliens residing in the United States pursuant to an indefinite stay of deportation.	Aliens in this category have been found to be deportable, but the federal immigration agency may defer deportation indefinitely due to humanitarian reasons.		Aliens in this category will have a letter and/or FORM I-94 showing that the alien has been granted an indefinite stay of deportation.
d) Aliens residing in the United States pursuant to an indefinite voluntary departure.			Aliens in this category will have a letter and/or Form I-94 indicating that the alien has been granted departure for an indefinite time period.
e) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure and whose departure the federal immigration agency does not contemplate enforcing.	NOTE: An immediate relative for USCIS purposes is: husband, wife, father, mother, or child (unmarried and under 21). Aliens in this category are the immediate relatives of an American citizen/LPR and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa.	If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.	Aliens in this category may have a Form I-94 and/or I-210 letter. These documents, or others, indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, USCIS expects the alien's visa to be available within this time. If it is not, extensions may be granted until the visa is ready.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES continued

ALIEN CATEGORIES	GENERAL INFORMATION		DOCUMENTATION/FORMS
f) Aliens who have filed applications for adjustment of status pursuant to Section 245 of the INA that USCIS has accepted as "properly filed" or has granted and whose departure the federal immigration agency does not contemplate enforcing.	Aliens in this category have filed for lawful permanent resident status.		Aliens in this category may have Form I-94 or Form I-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant".
g) Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the federal immigration agency pursuant to Section 243 of the INA whose departure BCIS does not contemplate enforcing.	Aliens in this category have been found to be deportable, but the federal immigration agency may defer deportation for a specified period of time due to humanitarian reasons.		Aliens in this category will have a letter or copy of the court order and/or a Form I-94.
h) Aliens granted voluntary departure pursuant to Section 242(b) of the INA whose departure the federal immigration agency does not contemplate enforcing.	Aliens in this category are awaiting a visa.	NOTE: N/A SECTION 242 (b) OF THE INA HAS BEEN REPEALED	Such aliens are provided Forms I-94 and/or I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.
i) Aliens granted deferred action status pursuant to the federal immigration agency's operating policy.			Aliens in this category will have Form I-210 or a letter indicating that the alien's departure has been deferred.
j) Aliens who entered and have continuously resided in the United States since before January 1, 1972.	Aliens in this category are presumed by the federal immigration agency to meet certain criteria for lawful permanent residence.		Obtain any documentary proof establishing entry and continuous residence.
k) Aliens granted suspension of deportation pursuant to Section 244 of the INA whose departure the federal Immigration agency does not contemplate enforcing.	Aliens in this category have been found deportable, have met a period of continuous residence and have filed an application for the federal immigration agency to suspend deportation, which has been granted.		Aliens in this category will have a letter/order from an immigration judge and a Form I-94 showing suspension of deportation granted. After lawful permanent residence is granted the alien will have a Form I-551.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES continued

ALIEN CATEGORIES	GENERAL INFORMATION		DOCUMENTATION/FORMS
l) Any other aliens living in the U.S. with the knowledge and permission or acquiescence of the federal immigration agency and whose departure that agency does not contemplate enforcing.	Aliens in this category may be in a status not listed above, but based on a determination by the federal immigration agency or documentation supplied by the alien or his or her representative that indicates the alien is present in the U.S. with the knowledge of the agency and with the permission or acquiescence of the agency, local districts may find them to be PRUCOL.	Examples include, but are not limited to: Applicants for adjustment of status to LPR, asylum, suspension of deportation or cancellation of removal or requesting deferred action; or Persons granted Deferred Enforced Departure (DED) due to conditions in their home country; or Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands); Persons granted Temporary Protected Status; or Applicants for Temporary Protected Status (TPS); or Persons having a K, V, S or U Visa.	Aliens in this category may have: I-94 Arrival/Departure Record; or I-688B Employment Authorization Card; or I-766 Employment Authorization Document; or I-797 “Notice of Action” indicating the USCIS has received an application or petition or request for change of status; or a Postal Return Receipt addressed to the federal immigration agency* or a copy of a cancelled check to the federal immigration agency, and a copy of the application, petition or request submitted to the federal immigration agency. (* USCIS-United States Citizenship and Immigration Services; ICE-Immigration and Customs Enforcement; EOIR-Executive Office of Immigration Review.)

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS
TEMPORARY PROTECTED STATUS (TPS)

Description:

"Temporary protected status (TPS)" is a temporary immigration status granted under federal law at 8 U.S.C. 1254a to aliens who are physically present in the United States and who are from certain countries designated by the U.S. Secretary of Homeland Security as unsafe to accept their return because of ongoing environmental disasters or other extraordinary and temporary conditions. At present, the following countries have TPS designation: Angola, Burundi, El Salvador, Honduras, Liberia, Montserrat, Nicaragua, Sierra Leone, Somalia, and Sudan. [A list of countries designated for TPS is located at the United States Citizenship and Immigration Services' (USCIS) (formerly the Immigration and Naturalization Service-INS), website, at: http://*www.uscis.gov*]

NOTE: The Department of Homeland Security (DHS) has designated Haiti for Temporary Protected Status beginning January 21, 2010 and ending January 18, 2011. TPS will apply only to those Haitians who were in the United States on or before January 12, 2010, even if such individuals were illegally in the United States. TPS protects these individuals from deportation until January 18, 2011 and allows them to work in the U.S. Haitians who attempt to travel into the U.S. after January 12, 2010, will not be eligible for TPS.

Policy:

Immigrants who have been granted Temporary Protected Status ("TPS") may be eligible for Medicaid, Family Health Plus (FHP) or Child Health Plus (CHPlus) based on their status as permanently residing in the United States under color of law (PRUCOL), if they meet such programs' requirements.

Immigrants who have applied for TPS may also be considered to be PRUCOL and may thus be eligible for Medicaid, Family Health Plus or Child Health Plus, if otherwise eligible.

References:

ADMs 04 ADM-7

GISs 10 MA/019
10 MA/005
08 MA/009

Interpretation:

Immigrants Granted Temporary Protected Status (TPS): These immigrants should be treated as PRUCOL for purposes of their eligibility for Medicaid, FHP or CHPlus "Persons granted TPS are authorized to remain in the United States for a specific limited period; the U. S. Secretary of Homeland Security can extend it for a further specified period. Prior to 1990, a similar status called "Extended Voluntary Departure" was used in the same way to provide relief to

particular nationalities.

Immigrants who have been granted TPS will have the following documentation:

- Form I-688B; or
- Form I-766 EAD coded 274a.12(a) (12) or A12; or
- A letter, verification or correspondence from USCIS, such as a Notice of Action (I-797) indicating temporary protected status has been granted.

Immigrants who have *applied* for Temporary Protected Status (TPS): These immigrants should be treated as PRUCOL for purposes of their eligibility for Medicaid, Family Health Plus or Child Health Plus if it reasonably appears, based on all the facts and circumstances of the case, that they are present in the United States with the **knowledge** and **permission** or the acquiescence of the federal immigration agency and that such agency is not presently contemplating deporting them. Social services districts should request proof from the immigrant that he or she filed the Application for Temporary Protected Status (Form I-821) and the Application for Employment Authorization (Form I-765) to the USCIS or its predecessor, the INS. For example, the immigrant may have a receipt or letter from the federal immigration agency that shows that such agency received these documents. However, the immigrant does not need to have written confirmation from the federal immigration agency acknowledging its receipt of these documents. An immigrant can be considered PRUCOL if the immigrant can prove that he or she mailed these documents to the federal immigration agency on a certain date. When the federal immigration agency has not acted on the application after a reasonable period of time after mailing, the district may reasonably presume that the applicant is PRUCOL.

Documentation: Immigrants applying for temporary protected status will have one of the following types of documentation:

- Receipt or notice showing filing of Form I-821 (Application for Temporary Protected Status) and Form I-765 (Application for Employment Authorization); or
- Form I-688B; or
- Form I-766 EAD codes 274a.12 (c) (19) or C19; or
- Any letter, verification or correspondence from USCIS or a U.S. Postal Return Receipt.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

TEMPORARY PROTECTED STATUS (TPS)

Category 3: Persons who are Permanently Residing Under Color of Law (PRUCOL)*
***PRUCOL is not an immigration status. PRUCOL is not granted by the USCIS. PRUCOL is a public benefits eligibility category.**

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
I. Other persons living in the U.S. with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing: Examples include, but are not limited to: ►Applicants for adjustment of status to LPR[1], asylum[2], suspension of deportation or cancellation of removal[3] or requesting deferred action; or ►Persons granted Deferred Enforced Departure (DED)[4] due to conditions in their home country; or ►Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands[5]); ►Persons granted Temporary Protected Status[6]; or ►Applicants for Temporary Protected Status[7] (TPS); or ►Persons having a K, V, S or U visa.[8]	►I-94 Arrival/Departure Record coded K1, K2, K3, K4, V1, V2, or V3, T, U, or S; ►I-688B Employment Authorization Card annotated 8 C.F.R.274a.12(c)(9)[1], 274a.12(c)(8)[2], 274a.12(c)(10)[3], 274a.12(a)(11)[4], 274a.12(a)(8)[5], 274a.12(a)(12)[6] or 274a.12(c)(19)[7], 274a.12(a)(9)[8], 274a.12(a)(13)[8], 274a.12(a)(15)[8], 274a.12(c)(21)[8], and 274a.12(c)(24)[8] ►I-766 Employment Authorization Document annotated C9[1], C8[2], C10[3], A11[4], A8[5], A12[6], or C19[7], or A9[8], A13[8], A15[8], C21[8] and C24[8]. ►I-797 indicating the USCIS has received an application or petition or request for change of status; or ►Postal Return Receipt addressed to federal immigration agency* or a copy of a cancelled check to the federal immigration agency, and a copy of the application, petition or request submitted to the federal immigration agency. (* USCIS-United States Citizenship and Immigration Services; ICE-Immigration and Customs Enforcement; EOIR-Executive Office of Immigration Review.)	O	NO	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

OTHER VISA STATUSES

Visa Statuses: K, S, T, U, and V

There have been several new visa categories issued by the United States Citizenship and Immigration Services (USCIS) [formerly the Immigration and Naturalization Services (INS)] over the past several years.

Some categories of non-immigrant status allow the status (visa) holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for adjustment to Lawful Permanent Resident (LPR) status after he or she has had the nonimmigrant status for a period of time.

Such visa statuses include, for example:

K status: For the spouse, child, or fiancé (e) of a U.S. citizen
S status: For informants providing evidence for a criminal investigation. Also known as the "Snitch Visa".
T status: For victims of Trafficking.*
U status: For victims or witnesses of specified crimes (who have suffered substantial physical or mental abuse and agrees to cooperate with the government)
V status: For spouses and children of LPR's whose visa petitions have been pending for at least three years.

[Law found at 8 U.S.C. section 1101 (a)(15)(K), (S), (T), (U), and (V).]

*Victims of Trafficking receive benefits to the same extent as refugees (06 OMM INF-5). (See **OTHER ELIGIBILITY REQUIREMENTS** VICTIMS OF TRAFFICKING)

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OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

"NON-IMMIGRANTS"
NON-IMMIGRANTS ADMITTED ON A TEMPORARY BASIS

Description: **TEMPORARY NON-IMMIGRANT:** A temporary non-immigrant is an individual who has been allowed to enter the United States for a specific purpose and for a limited period of time. Examples include tourists, foreign students, and visitors on business or pleasure. For the purpose of Medicaid eligibility, non-immigrants may be eligible only for the treatment of an emergency medical condition.

Policy: Immigrants admitted on a temporary basis are "non-immigrants" and if otherwise eligible, are limited to Medicaid coverage for the care and services necessary for the treatment of an emergency medical condition.

References:

SSL Sect 122
366(1)(b)

Dept. Reg. 360.3.2(j)

ADMs 04 ADM-07
92 ADM-10
88 ADM-47
88 ADM-22
88 ADM-4

GISs 09 MA/017
08 MA/015
08 MA/012
08MA/009
04 MA/016
04 MA/002
03 MA/005

Interpretation: Certain immigrants may be lawfully admitted to the United States temporarily for a specific purpose and for a specified period of time. Foreign students, visitors, tourists, some workers and diplomats are admitted but restricted due to the temporary nature of their admission status. Thus, although these individuals may be residing in the United States with the knowledge and permission of the USCIS, they are not qualified aliens.

Otherwise eligible non-immigrants who are admitted on a temporary basis and who require immediate medical care which is not otherwise available may receive

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

"NON-IMMIGRANTS"
NON-IMMIGRANTS ADMITTED ON A TEMPORARY BASIS

Medicaid coverage for the care and the treatment of an emergency medical condition only. Such non-immigrants may receive this coverage, provided that they have not entered the State for the purpose of obtaining medical care.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

"NON-IMMIGRANTS"
NON-IMMIGRANTS ADMITTED ON A TEMPORARY BASIS

Verification: Non-immigrants admitted on a temporary basis will have the following types of documentation:

Category 4: Temporary Non-Immigrants

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Temporary Non-immigrants include but are not limited to the following visa types: A –Foreign government representatives on official business; B-1 or B-2 – Visitors for business or pleasure; D – Crewmen on shore leave; E – Treaty Traders and investors; F – Foreign students; G – Representatives of international organizations; H – Temporary workers (including agricultural workers); I - Members of the foreign press; J – Exchange visitors, L- Intra-company transferee; O – Persons with extraordinary ability or achievement; P – Artists, Entertainers and Athletes; Q – Cultural Exchange Visitors; and R – Religious workers.	►I-94 Arrival/Departure record or foreign passport stamped with non-immigrant code; ►I-185 Canadian Border Crossing Card*; ►I-586 Mexican Border Crossing Card*; ►I-444 Mexican Border Visitor's Permit; or ►I-95A Crewmen's Landing Permit. ►I-688B Employment Authorization Card ►I-766 Employment Authorization Document *B-1/B-2 Visa/Border Crossing Card (BCC) is now issued in place of these documents (Temporary non-immigrants are lawfully admitted to the U.S. for a temporary or specified period of time.)	E Only eligible for the treatment of an Emergency medical condition	YES	**NOT Required** However, may be assigned an SSN if USCIS/DHS has granted permission to work.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

"SPECIAL NON-IMMIGRANT"

Description: **SPECIAL NON-IMMIGRANT:** Some categories of "special" non immigrant statuses allow the status (visa) holder to work in the United States and eventually adjust to Lawful Permanent Resident (LPR) status. These categories allow the individual to apply for adjustment to Lawful Permanent Resident (LPR) status after he or she has had the non-immigrant status for a period of time. These statuses are included in the category defined as: "other persons living in the U.S. with the knowledge and permission and acquiescence of USCIS and whose departure USCIS does not contemplate enforcing."

Such statuses include, for example:

K status: For the spouse, child, or fiancé(e) of a U.S. citizen.

S Status: For informants providing evidence for a criminal investigation. Also known as the "Snitch Visa".

U Status: For victims or witnesses of specialized crimes (who have suffered substantial physical or mental abuse and agrees to cooperate with the government).

V Status: For spouses and children of LPR's whose visa petitions (Form I-130) have been pending for at least three years.

Policy: Immigrants granted a "K", "V", "S", or "U" visa category, if otherwise eligible should be authorized for Medicaid, Family Health Plus and Child Health Plus as a person who is Permanently Residing in the U.S. Under Color of Law (PRUCOL).

Interpretation: Non-immigrant visas V (Visa codes V-1, V-2 and V-3) and K (Visa codes K-3 and K-4) are two new categories of "special" non-immigrant visas that were created by the Legal Immigration and Family Equity Act (LIFE Act) and are issued to persons intending to live permanently in the United States. The V visa may be issued to alien spouses and minor children of lawful permanent residents whose family petitions (the I-130) have been pending for some time. The V visa is intended to permit family reunification while the immigration cases of the lawful permanent resident's spouse and children are pending. The K visa allows the spouse and minor children of United States citizens to enter the United States legally and obtain work authorization. Individuals issued any of these visas may enter the United States as non-immigrants to complete the immigration process.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

"SPECIAL NON-IMMIGRANT"

Holders of the S (Visa codes S-5, S-6 and S-7) or U visas (Visa codes U-1, U-2, U-3, and U-4) are considered PRUCOL and, if otherwise eligible, may receive Medicaid, FHPlus or CHPlus.

The S visa status is given to aliens who assist U.S. law enforcement to investigate and prosecute crimes and terrorist activities. S visa holders are allowed to adjust status to permanent resident under Section 245(j) of the Immigration and Nationality Act.

The U visa status is given to aliens who are victims and/or witnesses of certain crimes who are assisting an investigation or prosecution. This status allows the non-immigrant to remain in the U.S. and to work. After three years in this status, a U status holder can apply to adjust their status.

With respect to the U visa status, the USCIS has directed that individuals who satisfactorily demonstrate to USCIS that they are eligible for a U visa are to be granted Deferred Action status. As such, holders of U visas are to be considered PRUCOL and, if otherwise eligible, may receive Medicaid, FHPlus or CHPlus.

OTHER ELIGIBILITY REQUIREMENTS
CITZENSHIP AND IMMIGRATION STATUS

"SPECIAL NON-IMMIGRANT"

Category 4: Special Non-Immigrants

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Special Non-immigrants: Some categories of non-immigrant status allow the status holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for the adjustment to LPR status after he or she has had the non-immigrant status for a period of time. As SPECIAL NON-IMMIGRANTS, (K), (S), (T)*, and (V) visa holders are PRUCOL and are eligible for Medicaid/FHPlus/CHPlus. * Victims of Trafficking (T visas) receive benefits to the same extent as refugees (04 OMM/ADM-7).	►I-94 Arrival/Departure Record coded K3, K4, V1, V2, or V3, T*, U, or S; ►I-797 indicating the USCIS has received, taken action on or approved an application or petition; ►Postal Return Receipt addressed to the USCIS or copy of cancelled check to the USCIS and a copy of the of the enclosed documents submitted to the USCIS, or ►Correspondence to or from the USCIS, showing that the person is living in the U.S. with the knowledge and permission or acquiescence of the USCIS, and the USCIS does not contemplate enforcing the person's departure from the U.S.	O PRUCOL* ***Except for Victims of Trafficking**	NO	LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirement for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

Description: An immigrant is here illegally or is undocumented if s/he entered the United States in a manner or in a place so as to avoid inspection, or was admitted on a temporary basis (certain non-immigrants) and the period of authorized stay has expired.

Policy: Medicaid shall be provided for the care and services necessary for the treatment of emergency medical conditions to otherwise eligible illegal or undocumented aliens.

References:

SSL Sect	122 131-k
Dept. Reg.	360.3.2(f)(2)
ADMs	04 ADM-7 92 ADM-10 88 ADM-47 88ADM-22 88 ADM-4 88ADM-1
GISs	10 MA/012 08 MA/009 07 MA/ 017

Interpretation: If otherwise eligible, an A/R cannot be denied Medicaid coverage for treatment of an emergency medical condition because of his/her immigration status.

The term emergency medical condition is defined as: "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(a) placing the patient's health in serious jeopardy;
(b) serious impairment to bodily functions; or
(c) serious dysfunction of any bodily organ or part."

Care and services related to an organ transplant procedure are not included in the federal definition of treatment for an emergency medical condition.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

Medicaid is available for emergency services provided to undocumented/illegal or certain non-immigrants from the time that the individual is first given treatment for an emergency medical condition until such time as the medical condition requiring emergency care is no longer an emergency. If an eligible individual receives treatment for an emergency medical condition and continues to receive care after the emergency ceases, Medicaid coverage for such care is not available.

When an enrollee is eligible for Emergency Services Only, Medicaid no longer covers the costs for or the transportation to rehabilitation services (including physical, occupational and speech therapies). This is because these services do not fall under the definition of treatment of an emergency medical condition.

NOTE: Until formally notified to do otherwise, chemotherapy and radiation therapy are to be considered as emergency medical services.

Current Medicaid policy states that certain types of care provided to chronically ill persons are beyond the intent of the federal and State laws which allow Medicaid to pay for the treatment of medical emergencies. Such care includes:

- alternate level of care in a hospital,
- nursing facility services, and
- home-care (including but not limited to, personal care services, home health services and private duty nursing).

NOTE: A women with a medically verified pregnancy is not required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends.

Verification: Temporary non-immigrants and undocumented aliens applying for coverage for the treatment of an emergency medical condition must complete the appropriate MEDICAID APPLICATION and sign the DOH 4471, “Certification of Treatment of Emergency Medical Condition”.

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

The DOH-4471 certification form must be signed by the A/R. If the A/R is unable to sign, his or her authorized representative may sign on the behalf of the A/R. The form is not valid without the required signature of the A/R or his/her authorized representative. Signing the form authorizes the local department of social services to request information regarding the emergency medical treatment. It also gives the physician or facility permission to provide such information.

The treating physician must complete the DOH-4471 and sign and date the form. The physician must, in all cases, make the decision as to whether or not the medical treatment is for an emergency medical condition. The physician must complete the entire form, sign and date the certification and return it to the local department of social services.

The local district maintains this certification form in the applicant's case record, the local district notifies the provider of the acceptance/denial of the application, and furnishes the provider with the individual's CIN number when appropriate.

The DOH-4471 has space to accommodate up to four coverage periods ("FROM_____TO_____ Date(s)" of Treatment/Hospital Stay) that may be entered by the provider. A new DOH-4471 certification form must be completed, dated and signed by the A/R, or the A/R's authorized representative, and by the treating physician and submitted for subsequent or continuing treatment of an emergency medical condition.

Each person's "emergency" is unique and the coverage period under the definition of emergency medical condition is limited and date specific. Therefore, Medicaid coverage for the emergency care must be a specific period of time in the past (i.e., at least one day prior to the initial Medicaid application date or one day prior to the Transaction Date for recipients in need of continuing care for the treatment of the emergency medical condition).

Medicaid payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services exists (e.g., the date of admission through the date of discharge from the hospital).

OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

The DOH-4471 form has space to accommodate up to four coverage periods (From-To Date(s) of Treatment/Hospital Stay). Each "From-To" date(s) must be entered in the Welfare Management System (WMS) as a separate coverage period, and each coverage period requires a separate Client Notification System (CMS) note (upstate). For any subsequent treatment/hospital stay or continuing treatment for an emergency medical condition, a new DOH-4471, form must be completed, dated, and signed by the A/R, or the A/R's authorized representative, and by the treating physician.

The maximum period of time for which "emergency treatment" (coverage code "07") may be entered from one submission of the DOH-4471 is 90 days. This can be a combination of retroactive, current, and prospective coverage. A new DOH-4471 must be obtained from a physician at least once 90 days, in order to continue the Medicaid coverage. Future (prospective) coverage may not exceed 60 days.

Category 5: Undocumented Aliens

Category	Documentation	WMS ACI code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Undocumented Aliens: (Undocumented aliens do not have the permission of the USCIS to remain in the U.S. They may have entered the United States legally but have violated the terms of their status, e.g. over-stayed a visa, or they may have entered without documents.)	Undocumented aliens are unable to provide documentation of immigration status; therefore, absent any documentation they are eligible only for the treatment of an emergency medical condition. Undocumented children may be eligible for CHPlus. Undocumented pregnant women continue to be eligible for pre-natal care.	E Only eligible for treatment of an emergency medical condition	YES	**NOT Required**

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

Description: Recovery is the repayment or taking back of funds expended for Medicaid.

Policy: A recovery may be made:

- from the estate (including non-probate assets) of a permanently institutionalized individual of any age;
- from the estate (including non-probate assets) of an individual who was 55 years of age or older when s/he received Medicaid;
- from a personal injury award or settlement;
- based upon a court judgment, for Medicaid incorrectly paid (including Family Health Plus);
- from a legally responsible relative who fails or refuses to make his/her income and resources, as appropriate, available to the Medicaid recipient (See **OTHER ELIGIBLITY REQUIREMENTS** OWNERSHIP AND AVAILABILITY);
- from the sale of real property of a permanently institutionalized individual (See **RESOURCES** PERSONS IN MEDICAL FACILITIES TREATMENT OF REAL PROPERTY) when a lien had been placed against the real property of such person pursuant to SSL 369(2)(a)(ii); or
- from a non-custodial parent who has a court order to pay cash medical support to the LDSS.

A recipient may elect to voluntarily reimburse a district for Medicaid correctly or incorrectly paid.

References: SSL Sect. 366(3)(a)
369

NYS Finance Law 18 (4&5)

General Business Law 453

Social Security Act 1917(b)

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

Dept. Reg. 360-1.4
360-4.4
360-4.7
360-7.2
360-7.4
360-7.11

ADMs 09 OHIP/ADM-3
02 ADM-03
96 ADM-08
94 ADM-17
92 ADM-53
92 ADM-45
89 ADM-47
89 ADM-45

LCMs 94 LCM-89

GISs 10 MA/008
08 MA/031
06 MA/018
06 MA/022

Interpretation: Medicaid paid on behalf of a recipient age 55 or older or a permanently institutionalized individual of any age is recoverable from the recipient's estate (including non-probate assets) with certain exceptions (See **OTHER ELIGIBILITY REQUIREMENTS** RECOVERIES ESTATE RECOVERIES).

Medicaid/Family Health Plus which has been paid for an ineligible recipient is incorrectly paid and may be recovered. This may be done by:

- requesting voluntary repayment from the recipient for any incorrect payment; or.
- going to court to obtain a judgment that the payment was incorrectly made.

The amount of Medicaid/Family Health Plus incorrectly paid is calculated from the first day the recipient became ineligible for Medicaid, (including any Medicaid paid during the notice period, and pending a fair hearing decision). Medicaid paid prior to the day the

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

recipient became ineligible is Medicaid correctly paid.

For federally-participating (FP) individuals, when Medicaid has been incorrectly paid because the recipient had excess income and, in the case of SSI-related individuals excess resources, that were not considered in the eligibility determination, the amount of Medicaid incorrectly paid is limited to the amount of the recipient's excess income/resources liability. The overpayment is restricted to the amount of the spenddown liability. In any event recovery cannot exceed the amount that Medicaid paid.

The overpayment for federally non-participating (FNP) individuals is the total amount of Medicaid payments (fee-for-service or Managed care premiums) expended. The overpayment for Family Health Plus recipients is the total amount of premiums paid during the period of ineligibility.

When Medicaid is provided to a person with a legally responsible relative (LRR) who refuses or fails to make his/her income available to the A/R, an implied contract is created with the non-contributing LRR. The LRR may be responsible for Medicaid paid. Recovery for Medicaid paid may be pursued through court action. The LRR can be offered the opportunity to voluntarily reimburse the district before a court action is initiated. By clearly explaining the district's procedures, a court action may be avoided.

NOTE: Recoveries are not pursued from the parents of: children participating in one of the home and community-based waiver programs; pregnant minors; certified blind or certified disabled children who are 18 years of age or older; children under age 18 who are expected to be living separately from their parents' household for at least 30 days; and from the parents of a disabled child for Medicaid furnished for school-based medical care and services provided to such child under the IDEA as part of a free and appropriate education.

If a district has a legal basis for making a Medicaid recovery from a recipient of his or her estate, it may commence a court action pursuant to the Debtor and Creditor Law to undo transfers of assets by the recipient and have those assets returned to the recipient or his/her estate so that sufficient assets will be available to satisfy the district's claim. The Debtor and Creditor Law cannot be used to attempt to have assets returned to a Medicaid recipient for the purpose of making the recipient ineligible for Medicaid prospectively.

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

The cost effectiveness of pursuing recoveries for Medicaid paid must be determined. Cost effectiveness is based on a variety of factors, including but not limited to: the administrative cost of a court action; the amount of overpayment; the availability of income or assets from which to recover; and previous experience with the court.

Cash medical support court ordered to be paid by the non-custodial parent to the LDSS can be recovered from the non-custodial parent by using the Non-custodial Parent Billing Notice, OHIP-0029. Such recovery can be made administratively through the accounting or Medicaid unit. The Medicaid Medical Support Transmittal, OHIP-0030 must be sent to the CSEU for further action. Additional court appearances to recover money may be indicated if cost-effective.

See **OTHER ELIGIBLITY REQUIREMENTS** RECOVERIES LIENS for a discussion of recovery from the real property of an institutionalized individual. An institutionalized individual is an inpatient in a nursing facility, intermediate care facility for the

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

mentally retarded, or other medical institution, who is not reasonably expected to be discharged from the medical institution to return home.

Limitations on recoveries from Personal Injury Settlements/Awards (effective for recoveries made on or after May 1, 2006):

- Only the portion of the personal injury settlement or award specifically allocated to compensate the Medicaid recipient for past medical expenses arising out of the personal injury is available to satisfy a 104-b lien. Any portion allocated to compensate the Medicaid recipient for pain and suffering, lost wages, and other non-medical damages is not available to satisfy a l04-b lien. A minor's personal injury settlement or award is also subject to this policy.
- To the extent that the lien amount exceeds the portion of the personal injury award or settlement specifically allocated to repayment of past medical expenses, the district's recovery of the lien will be reduced.
- 104-b liens are paid prior to funds being transferred to a supplemental needs trust for the benefit of the Medicaid recipient, insofar as the lien is partially or fully satisfied out of the portion of the personal injury settlement or award specifically allocated to compensate the Medicaid recipient for past medical expenses. Any other amounts of the settlement or
- awards are the Medicaid recipient's personal property and should be evaluated in accordance with resource and supplemental needs trust policies.

Medicaid Managed Care and Family Health Plus capitation payments made during a time after a recipient has either reported a change that makes him/her ineligible or requests his/her case closed may be recovered ONLY if the recipient accessed services from the managed care plan during that time.

NOTE: The extent to which liens may be imposed and recoveries pursued with respect to Medicaid recipients who are Qualified Partnership Policyholders (QPPs) depends on the type of plan chosen by the QPP.

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

Total Asset Protection Plans (TAP) - No liens may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP nor may recoveries made from the estate of a TAP QPP.

Dollar-for-Dollar Asset Protection (DDAP) Plans- Since homes of DDAP QPPs must be evaluated for their exempt/countable status, a lien shall be placed on the real property of the permanently institutionalized individual DDAP QPP in an amount equivalent to his/her unprotected resources, if any.

The sections that follow discuss these forms of recoveries:

- Estate Recoveries
- Confinement and Pregnancy Related Expenses
- Liens; and
- Voluntary Repayments.

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

Description: Estate recovery is when the cost of Medicaid provided to an individual who was after age 55 or older, or when the recipient was permanently residing in a medical institution, is recovered from the assets in the recipient's estate.

Policy: Medicaid correctly paid for any recipient who was age 55 or older, or regardless of age, was permanently institutionalized, is recoverable from the estate of the recipient. Non-probate assets of the recipient that generally pass directly to another individual upon death, including: jointly owned financial institution accounts, jointly held real property, life estate interests, interests in certain trusts and annuities regardless of whether there is a named beneficiary or right of survivorship are considered part of the decedent's estate.

References:

SSL Sect. 366(3)(a)
369

Social Security Act 1917(b)

NYS Finance Law 18 (4&5)

General Business Law 453

Dept. Reg. 360-1.4
360-4.4
360-4.7
360-7.2
360-7.4
360-7.11

ADMs 11 OHIP/ADM-8
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96 ADM-08
94 ADM-17
92 ADM-53
92 ADM-45
89 ADM-47
89 ADM-45

LCMs 94 LCM-89

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

GISs 10 MA/008
08 MA/031
06 MA/018
06 MA/022

Interpretation: Effective September 8, 2011 assets subject to estate recovery include all property in which the deceased Medicaid recipient has any legal interest including jointly owned real and personal property, retained life estates, interests in trusts and other assets.

Medicaid Recoveries are prohibited:

- During the lifetime of the surviving spouse, or at any time when the recipient has a surviving child who is under age 21 or a child of any age who is certified blind or certified disabled. This prohibition applies to all assets of the recipient including those that pass directly upon the recipient's death to individuals other than a surviving spouse or minor child, or blind or disabled child.
- From the income, resources and property belonging to an American Indian or Alaskan Native.
- From government reparation payments paid to special populations.
- From Workers' Compensation, volunteer firemen's benefits, Social Security, SSI or other such benefits.
- From the recipient's personal injury action that was filed against a nursing home. This prohibition runs for the lifetime of the recipient.
- From the personal account of a veteran who died in a Veteran's Administration (VA) nursing facility. If a veteran was transferred from a non-VA facility to a VA facility (e.g. a VA hospital) for treatment and died while in the VA facility no recovery from the personal account maintained by the non-VA facility is pursued. Similarly if the VA contracted for the care of a veteran in a private nursing facility at VA expense recovery is not sought from the personal account maintained by the private nursing facility.
- From payments made through the Office of Mental Health Comprehensive Outpatient Program (COPs).

Medicaid Recoveries involving a homestead are prohibited:

- When a sibling with an equity interest in the home of a

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

deceased Medicaid recipient lived in the home for at least one year immediately before the recipient was institutionalized and who has lawfully resided in the home continuously since that time;

- When an adult child who lived in the home of a deceased Medicaid recipient for at least two years immediately before the recipient was institutionalized, who provided care that may have delayed the recipient's institutionalization and who has lawfully resided in the home continuously since that time;
- From the real property of a permanently institutionalized individual if the value of the property when counted in determining eligibility results in the applicant having to spend down excess resources. An example is a permanently institutionalized individual who does not intend to return home and does not have a relative that would allow the homestead to be exempt from recovery (as described above). In such instances, the home is treated as a countable resource.

If the prohibited period ends (e.g., the spouse dies or a minor child reaches the age of 21) or in the case of a decedent's home, the sibling or adult child no longer resides in the home or the property is to be sold, a recovery can then be pursued.

Recoveries and Liens-Qualified Partnership Policy Holders

The extent to which liens may be imposed and recoveries pursued with respect to Medicaid recipients who are Qualified Partnership Policyholders (QPPs) depends on the type of plan chosen by the QPP.

- Total Asset Protection Plans (TAP) - No liens may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP nor may recoveries be made from the estate of a TAP QPP.

- Dollar-for-Dollar Asset Protection (DDAP) Plans- Since homes of DDAP QPPs must be evaluated for their exempt/countable status, a lien shall be placed on the real property of the permanently institutionalized individual DDAP QPP in an amount equivalent to his/her unprotected resources, if any.

Recovery of Expanded Probate Assets

- Jointly Owned Bank Accounts and Securities - the Medicaid

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

recipient's per capita interest in a joint bank account as well as jointly owned securities (e.g., stocks, bonds, mutual funds) at the time of his/her death is subject to recovery from the person(s) who is named as the joint owner on the account.

NOTE: If the case record does not contain evidence that rebuts the presumption of 100% ownership by the decedent or the decedent was not subject to a resource test for Medicaid eligibility purposes and the joint owner claims the funds in the joint account were not wholly assets of the decedent, the joint account owner must be allowed the opportunity to provide documentation of his/her interest in the account through verifiable deposits and withdrawals.

- Jointly Held Real Property - real property owned jointly by a Medicaid recipient and one or more other individuals may not have been considered available as a resource during the eligibility process. Whether the property was considered available or unavailable, recovery must be pursued against the deceased recipient's interest in such property. A post death lien must be filed.

  Life Estate Interest - A life estate interest that was created by a recipient or his/her spouse in property in which the recipient or spouse held interest at the time the life estate was created, or a life estate interest that was created for the benefit of a recipient or the recipient's spouse in property in which the recipient or spouse held any interest within five years prior to the creation of the life estate is subject to estate recovery. The value of the life estate interest is an actuarial computation based on the age of the recipient and the fair market value (FMV) of the property immediately prior to the recipient's death. Effective September 08, 2011, the Internal Revenue Service (IRS) actuarial table, "Table S, Single Life Factors", in accordance with the most recent mortality table, "Table 2000CM", and interest rates under IRS code 7520, "Section 7520 Interest Rates", must be used for this computation. These tables and rates are found on the IRS website.

  Example:

  Step 1. Determine the IRS code 7520 interest rate that applies to the month and year of the recipient's death.

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

Step 2. Determine the interest rate factor from "Table S".

Step 3. Multiply the FMV of the property by the interest rate factor from "Table S" to arrive at the life estate value.

NOTE: If the life estate was jointly owned by the recipient, the district must file a post death lien on the real property using the "Notice of Post Death Medical Assistance Lien".

- Trusts - Any interest the recipient had in a living trust at the time of death must be included in the estate recovery.
  - Revocable living trusts – when created by the recipient or the recipient's spouse, the entire value of the principal and accumulated interest is considered an available resource at the time of death and is included in the individual's estate for purposes of estate recovery.
  - Irrevocable trusts – when funded in whole or in part with the assets of the recipient or the recipient's spouse, any principal and accumulated interest that was required to be paid to or for the benefit of the recipient are included in the decedent's estate for recovery.

NOTE: Exception trusts created for the benefit of a certified disabled individual under age 65, and exception trusts created for the benefit of a certified disabled individual of any age (pooled trusts) are disregarded as available income and resources when determining eligibility. However, these trusts must include provisions giving the Medicaid program a remainder interest of all amounts remaining in the trust, or in the case of a pooled trust, all amounts not retained by the trust, up to the total value of all Medicaid paid on behalf of the disabled individual, payable at the time of the recipient's death.

- Annuities - The remaining balance or income distribution from an annuity purchased by or with assets of the decedent or the decedent's spouse is included in the Medicaid recipient's estate and is subject to recovery regardless of a designated beneficiary. A "payable on death" clause does not alter the status of these funds from being subject to estate recovery as the investment is considered an asset of the recipient at the time of death.

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

An annuity purchased on or after February 8, 2006 by an SSI-related Medicaid recipient is required to have the State named as the remainder beneficiary if the annuity is not treated as a countable resource (considered countable income only).

- Life Insurance – Generally, life insurance policies are not part of a decedent's estate. However, if the beneficiary of the policy is the estate, or there are no surviving beneficiaries, the payout is recoverable as part of the estate.

Hardship

No recovery of Medicaid correctly paid will be pursued against any portion of an estate if it will result in undue hardship. Examples of undue hardship include:

- the sole income-producing asset of the beneficiary (ies), such as the family farm or family business and income produced by the asset is limited, or
- real property of modest value (i.e., having a value no higher than 50% of the average selling price in the county where the home is located, as of the decedent's date of death) and the home is the primary residence of the beneficiary (ies), or
- other complying circumstances.

Undue hardship is not considered to exist based on the inability of the beneficiaries to maintain a pre-existing lifestyle or when the alleged hardship is the result of Medicaid or estate planning methods involving divestiture of assets.

Waiver of Estate Recovery

The estate claim may be waived in whole or in part if the recovery against the decedent's interest in the asset will result in undue hardship as described above.

Deferral of Estate Recovery

Recovery against a deceased Medicaid recipient's estate must be deferred:

- during the lifetime of the recipient's surviving spouse; or
- during any period in which the recipient has a surviving child under 21 years of age; or
- during the lifetime of a recipient's surviving child of any age who is certified blind or certified disabled; or

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

- with respect to the home of a deceased Medicaid recipient, when one of the relatives, adult child or sibling as described above, is lawfully residing in the home.

Upon the death of the surviving spouse, or blind or disabled child, or upon the minor child reaching 21 years of age, or in the case of a decedent's home, upon the adult child or sibling ceasing to reside in the home or the home being put up for sale, the estate claim against the estate that was previously prohibited must be pursued. The claim against such individual for the receipt of such property by distribution or survival is limited to the value of the property received from the estate of the deceased Medicaid recipient or the amount of medical assistance otherwise recoverable, whichever is less.

Deferral of estate recovery on real property is subject to a post death lien if:

- undue hardship has not been found to exist;
- the heir or survivor has lawfully and continuously resided in the real property, beginning prior to the deceased Medicaid recipient's death, and is unwilling to sell the real property;
- the Medicaid claim cannot be paid in full unless the property is liquidated;
- the heir or survivor is able to demonstrate the inability to obtain financing to pay the estate claim; AND
- a written agreement has been entered into between the Medicaid program and the dependent, heir or survivor whereby the Medicaid program holds a lien on such real property and the dependent, heir or survivor agrees to pay the amount of the claim in accordance with a reasonable payment schedule, subject to reasonable interest.

When such deferrals of estate recovery are made, a lien must be filed in the county clerk's office in the county where the property is located and remain on file to protect the interest of the Medicaid program to the extent of the claim against the recipient's estate, less any payments actually received toward such claim. Recovery is deferred until:

- the death of the dependent, heir or survivor; or
- the sale, refinance, transfer or change in title of the real property; or
- the determination by the Medicaid program that the dependent, heir or survivor is in breach of the repayment agreement.

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

Amount of the Lien

A claim may be asserted against the estate of a deceased Medicaid recipient for the amount of Medicaid paid from the date the recipient reached 55 years of age or the date of permanent institutionalization, whichever occurs first.

Effective January 1, 2010, Medicaid payments for Medicare cost sharing expenses made on behalf of any individual receiving benefits through the Medicare Savings Program, including: Medicare Part A and Part B premiums; Medicare deductibles, coinsurance and co-payments are exempt from estate recovery. Medicaid payments for all other services not related to Medicare cost sharing continue to be subject to estate recovery. In addition, Medicare cost sharing payments made on behalf of individuals who are not enrolled in the Medicare Savings Program continue to be subject to estate recovery.

If a recipient who is not permanently institutionalized (non PI) was 65 years of age prior to October 1, 1993, a claim may be made against the estate for the amount of Medicaid paid from the date the recipient became 65 until his/her death. If such recipient was less than 65, but more than 55 years of age as of October 1, 1993 then a claim may be made against the estate for the amount of Medicaid paid from the date the recipient became 55 years old or October 1, 1993, whichever is later

The local social services district is a preferred creditor of the estate. After the payment of funeral and burial expenses, the recovery of Medicaid is subject to the funds remaining in the estate including: probate assets, non-probate assets, excess revocable burial funds and payments for burial space items that are not used after the payment of funeral. After all debts of the estate are satisfied, including Medicaid, the remainder goes to the beneficiary or beneficiaries designated by will or by law if no will exists.

Social services districts must notify affected heirs when an estate claim is made and give the individuals an opportunity to request an undue hardship waiver.

Districts must evaluate the cost effectiveness of pursuing Medicaid recoveries. Cost effectiveness is based on factors including but not

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES
ESTATE RECOVERIES

limited to: the administrative cost of court action, the amount of Medicaid paid, the availability of assets from which to recover, and previous experience with the court.

Notice of Claim

Upon notification of the death of the Medicaid recipient or the surviving spouse of such individual, the local department of social services shall issue "Notice of Claim-Non Probate Assets" reproduced on district letterhead, "Medicaid Estate Recovery Questionnaire", and "Important Information Regarding Medicaid Estate Recovery" to the fiduciary of the decedent's estate, and, if applicable, to the person in possession of property or assets in which the decedent had any legal title or interest at the time of death.

NOTE: For estates with a fiduciary, the district should file its claim within seven months from the date the fiduciary is first appointed to probate the decedent's will. If the district files its claim after this seven month period, the fiduciary will not be liable if he or she has in good faith paid other claims or distributed the estate.

OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES

CONFINEMENT AND PREGNANCY RELATED EXPENSES

Policy: Confinement recoveries are not pursued during a woman's pregnancy, during the 60-day period beginning on the last day of the pregnancy or during the remainder of the calendar month in which the 60th day occurs.

The father's liability for confinement expenses depends on his legal relationship with the mother and child and on the father's financial circumstances as described in below:

When the father is married to the mother, he is not liable for payment of confinement expenses for the mother and child if:

1. the father's income was considered available in determining the pregnant woman/mother's Medicaid eligibility; or

2. the father's income was at or below Medicaid standards at the time of birth of the child; or

3. the father was in receipt of TANF or Medicaid at the time of birth of the child.

If any of the above circumstances apply, the father is not liable for confinement expenses.

When the father is not married to the mother, his liability for the mother's confinement expenses may be determined by the court at a hearing to establish paternity and support. However, no confinement expenses are pursued when the local district determines that the father currently has income at or below the applicable Medicaid standard or is currently in receipt of TANF or Medicaid. When paternity and responsibility for prospective medical support have already been established and the father's financial circumstances do not warrant pursuit of confinement expenses, the A/R is not referred to Child Support Enforcement Unit (CSEU).

Where the father, regardless of marital status, is not in receipt of Medicaid or TANF and his income is unknown and cannot be determined for the relevant period of time, the local district may pursue confinement expenses. This allows the court to conduct an inquiry into the father's financial circumstances.

OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES

CONFINEMENT AND PREGNANCY RELATED EXPENSES

When the father is not married to the mother his liability for the child's expenses is evaluated in the same manner as explained in (1) through (3).

References: LCM 04 OMM/LCM-4

GIS 08 MA/031

Interpretation: The following chart summarizes the legal relationship of the father to the mother and the time period for which the father's income is considered.

Marital status:	Expenses of:	When ability to pay measured:
Married	Mother	Time of Birth
Married	Child	Time of Birth
Unwed	Mother	Time of Hearing
Unwed	Child	Time of Birth

NOTE: This chart only deals with the recovery of Medicaid furnished for the mother's confinement expenses and the child's birth related expenses paid for the child before the child leaves the hospital. Regardless of marital status, there is legal authority to pursue an order of medical support prospectively against the absent father of a child receiving Medicaid.

Documentation: When an eligibility worker refers a case to the CSEU for reasons that include recovery of confinement or pregnancy related expenses, the referral includes documentation of such expenses in a format that is acceptable as evidence to the court. When testimony is needed to establish liability for, or the amount of, confinement costs, the local district arranges for qualified staff to testify regarding the Medicaid expense records. These Medicaid expense records are not needed to establish paternity or pursue prospective medical support.

OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES

LIENS

Description: A lien is a legally filed claim against property as security for the payment of a debt.

Policy: Generally a lien may be placed against a recipient's:

- exempt real property if the individual is permanently institutionalized; and
- personal injury claim or suit for Medicaid expenditures related to the injury.

A claim may be placed against a recipient's:

- estate including non-probate assets, if the deceased recipient was 55 years of age or older when he or she received Medicaid; and
- estate including non-probate assets, if the deceased recipient of any age was permanently institutionalized.

References:

SSL Sect. 104
106
366.3(a)
369

Dept. Reg. 360-7.11

ADMs 11 OHIP/ADM-8
09 OHIP/ADM-3
02 ADM-03
92 ADM-53

Interpretation: When a recipient is permanently institutionalized and has an interest in real property that is exempt for purposes of Medicaid eligibility, is anticipating a court award, settlement, or claim that resulted from a personal injury or has died and left an estate, a lien is placed against the exempt real property, award, settlement, claim or estate. An award, settlement or claim may result from, but is not limited to insurance payments and lawsuits. Generally, liens against real property and estates are for the amount of Medicaid correctly paid on behalf of the individual, while liens for personal injury are for the cost of medical care provided to treat the personal injury.

Incorrectly paid Medicaid is any Medicaid furnished to a recipient at a

time when s/he was ineligible. Only by instituting a court action pursuant to SSL Section 369 (2)(a)(i) can a district place a lien on a recipient's real property to recover Medicaid incorrectly paid.

NOTE: If an institutionalized individual is discharged and returns to the community, any liens against his/her real property are removed. If the individual wants to continue Medicaid coverage, his/her eligibility is determined based on his/her new circumstances.

Liens May Not Be Imposed

- Against an A/R's homestead

    - o When a sibling with an equity interest in the home of a Medicaid recipient lived in the home for at least one year immediately before the recipient was institutionalized and who has lawfully resided in the home continuously since that time;

    - o When an adult child who lived in the home of a Medicaid recipient for at least two years immediately before the recipient was institutionalized, who provided care that may have delayed the recipient's institutionalization and who has lawfully resided in the home continuously since that time;

    - o Against the real property of a permanently institutionalized individual if the value of the property when counted in determining eligibility results in the applicant having to spend down excess resources. An example is a permanently institutionalized individual who does not intend to return home and does not have a relative that would allow the homestead to be exempt from a lien (as described above). In such instances, the home is treated as a countable resource.

    Institutionalized individuals are given an opportunity to transfer his/her homestead to a specified relative, before a lien is imposed. (See **RESOURCES** TRANSFER OF ASSETS for lists of who an A/R may transfer his/her homestead to without penalty.) Generally, the transfer is made within 90 days of the eligibility determination. A longer period may be allowed if necessitated by delays

OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES

LIENS

beyond the institutionalized individual's control.

NOTE: A lien may be imposed on a mobile home only if the mobile home is on land owned by the institutionalized individual, and the mobile home has been permanently affixed to the land (e.g., a basement, foundation, or other immovable structure ties the mobile home to the land).

- Against any asset(s) of the recipient including those that pass directly upon the recipient's death to individuals other than a surviving spouse or minor child, or blind or disabled child during the lifetime of the surviving spouse, or at any time when the recipient has a surviving child who is under age 21 or a child of any age who is certified blind or certified disabled.

- Against the income, resources and property belonging to an American Indian or Alaskan Native.

- Against government reparation payments paid to special populations.

- Against Workers' Compensation, volunteer firemen's benefits, Social Security, SSI or other such benefits.

- Against the recipient's personal injury action that was filed against a nursing home. This prohibition runs for the lifetime of the recipient.

- Against the personal account of a veteran who died in a Veteran's Administration (VA) nursing facility. If a veteran was transferred from a non-VA facility to a VA facility (e.g. a VA hospital) for treatment and died while in the VA facility no recovery from the personal account maintained by the non-VA facility is pursued. Similarly if the VA contracted for the care of a veteran in a private nursing facility at VA expense recovery is not sought from the personal account maintained by the private nursing facility.

- Against payments made through the Office of Mental Health Comprehensive Outpatient Program (COPs).

If the prohibited period ends (e.g., the spouse dies or a minor child reaches the age of 21) or in the case of a decedent's home, the sibling or adult child no longer resides in the home or the property is to be sold, a recovery can then be pursued.

OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES

LIENS

Liens and Qualified Partnership Policyholders

The extent to which liens may be imposed and recoveries pursued with respect to Medicaid recipients who are Qualified Partnership Policyholders (QPPs) depends on the type of plan chosen by the QPP.

Total Asset Protection Plans (TAP) - No liens may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP nor may recoveries be made from the estate of a TAP QPP.

Dollar-for-Dollar Asset Protection (DDAP) Plans - Since homes of DDAP QPPs must be evaluated for their exempt/countable status, a lien shall be placed on the real property of the permanently institutionalized individual DDAP QPP in an amount equivalent to his/her unprotected resources, if any.

Real Property Post Death Lien

If not otherwise prohibited (as described above), a post death lien may be placed on real property that passes outside the probate estate to a joint owner, heir, dependent or survivor to secure their obligation to pay the Medicaid estate claim up to the value of the property received. Such liens should be imposed against real property as soon as practicable after the individual's death to put mortgage lenders and prospective purchasers of the property on notice of the Medicaid program's claim against the property.

Notices

- "Informational Notice to Institutionalized Individuals with Real Property" is provided to the individual at the time of application.
- LDSS 4466 "Notice of Intent to Impose a Lien on Real Property" is provided when the district has determined that a lien will be filed on specified real property.
- "Notice of Medical Assistance Lien" is a sample notice of lien that may be adapted for purposes of filing a SSL Section 369 lien against real property.

OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES

VOLUNTARY REPAYMENTS

Disposition: A voluntary repayment is a payment made by a recipient, without coercion, to the local district for Medicaid correctly or incorrectly paid.

Policy: A client may elect to reimburse a local social services district for Medicaid correctly or incorrectly paid. Reimbursement for Medicaid correctly paid is always voluntary. The record clearly documents that the decision to reimburse the district was totally voluntary and that the client fully understood that s/he had no obligation to provide reimbursement. An SSI-related recipient who receives a lump sum payment, placing him/her over the resource limit, may choose to reimburse the district for previously paid medical bills and continue his/her eligibility uninterrupted.

See **OTHER ELIGIBILITY REQUIREMENTS** RECOVERIES for recovery and voluntary reimbursement or repayment of assistance incorrectly paid.

References: Dept. Reg. 360-7.11

ADM 02 ADM-03

Documentation: A statement from the A/R or his/her representative that the repayment was voluntary. The statement should include the amount of the repayment and when appropriate, the services or time period covered by the repayment.

When the repayment is for assistance correctly paid, the statement clearly indicates that the decision to reimburse was totally voluntary and that the A/R understands s/he is under no obligation to reimburse the district.

OTHER ELIGIBILITY REQUIREMENTS

STATE AND FEDERAL CHARGES

Description: Generally the cost of any care provided through federally reimbursable (FP) Medicaid is shared by the federal, State and local government at a rate of 50/25/25. Under certain circumstances, the federal and/or State government assumes responsibility for a greater share or the full cost of care provided by the Medicaid program. For example: the federal government is responsible for approximately 50%, the State for about 40% and the local government around 10% of the cost of care provided to recipients of certain long term care services.

Federal charge refers to care fully reimbursed by the federal government; there is no local or State share. State charge refers to care reimbursed by both the federal and State governments or by the State alone. There is no local share in the cost of care provided to a recipient entitled to State or federal charge status.

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time limited waiver was granted pursuant to Section 1115 of the Social Security Act.

Policy: The cost of Medicaid may be borne completely by the State government, or it may be shared with the federal and local governments. The cost of care for a specified time period for refugees and Cuban-Haitian entrants is totally reimbursable by the federal government. The cost of care is fully reimbursed by the State and/or federal government for: Native Americans and their families residing on reservations; and individuals who have been patients in an Office of Mental Health (OMH) or Office for People with Developmental Disabilities (OPWDD) facility for five or more continuous years under Chapter 621 of the Law of 1974.

NOTE: The New York State Veteran's Home at Oxford is a State-operated facility for New York State veterans and their dependents. The State and federal government are financially responsible for veterans and their dependents who are patients at the Oxford Home. Local districts are administratively responsible for determining MA eligibility and processing the eligibility for these A/Rs.

New York State also operates other nursing facilities for veterans. These facilities include the New York City Veteran's Home at St. Albans, the New York State Veteran's Home at Batavia and

OTHER ELIGIBILITY REQUIREMENTS

STATE AND FEDERAL CHARGES

the Long Island Veteran's Home. Local districts share in the administrative and fiscal responsibility for residents of these facilities.

NOTE: To assure proper claiming special coding is available through WMS.

References:

SSL Sect.	2.19 62.4(c) 153 365
ADMs	97 ADM-2 OMM/ADM 97-1 96 ADM-7 82 ADM-24 81 ADM-47
INFs	89 INF-43 88 INF-67
LCM	95 LCM-92

Interpretation: This section discusses: A/Rs for whom local districts retain only the administrative responsibility of providing Medicaid, but no fiscal responsibility; and A/Rs for whom local districts have no responsibility (eligibility is determined by the State). It is organized as follows:

Native Americans and their families living on a reservation;

Refugees and Cuban-Haitian entrants;

Human Services Overburden;

OMH/OMR Chapter 621 eligibles.

Office of Mental Health (OMH);

Office for People with Developmental Disabilities (OPWDD).

OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES

NATIVE AMERICANS AND THEIR FAMILIES LIVING ON A RESERVATION

Policy: There is no local participation in the cost of Medicaid provided to Native Americans and their families living on reservations in New York State. When such a person is eligible (See **OTHER ELIGIBILITY REQUIREMENTS** NATIVE AMERICANS), the cost of his/her care is shared by the State and federal government.

NYS will receive 100% Federal Financial Participation (FFP) when Medicaid services are provide through an Indian Health Services facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization, to Native Americans living on a reservation.

References:

SSL Sect.	2.19(b)
	368-a(1)(c)
SSA	1095 (b)

Interpretation: Although there is no local share in the cost of Medicaid provided to Native Americans and their families living on reservations, local districts remain administratively responsible for processing the cases of such persons. For Native Americans not living on reservations and receiving Medicaid, the local share of the cost of care is the usual percentage. (See **OTHER ELIGIBILITY REQUIREMENTS** STATE AND FEDERAL CHARGES)

Disposition: Local districts determine Medicaid eligibility for Native Americans and their families living on reservations using the appropriate category. The cost of care for such persons is fully reimbursed by the State or by the State and federal government.

OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES

HUMAN SERVICES OVERBURDEN

Policy: The State will reimburse 100% of the local share for Medicaid expenses paid on behalf of an overburden-qualifying mentally disabled person.

References: INFs 89 INF-43

Interpretation: The local share of Medicaid expenditures for qualifying mentally disabled recipients is 100% reimbursable by the State. For Human Services Overburden funding, a person defined as mentally disabled meets one of the following criteria:

(1) resides in a Residential Treatment Facility certified by the New York State Office of Mental Health or in an Intermediate Care Facility for the Developmentally Disabled certified by the New York State Office for People with Developmental Disabilities;

(2) was discharged from a New York State Office of Mental Health Psychiatric Center or New York State Office for People with Developmental Disabilities Developmental Center from April 1, 1971 to December 31, 1982 and has 90 or more cumulative days of inpatient treatment;

(3) resides in a community-based facility as certified by the New York State Office of Mental Health or the New York State Office for People with Developmental Disabilities. This includes A/Rs who:

have received services in certified Community Residences (CR) or Individual Residential Alternatives (IRA);

are residents of schools certified by the New York State Office for People with Developmental Disabilities;

are inpatients in Terrance Cardinal Cook (Flower Hospital); or

(4) receives a minimum of 45 visits in any calendar quarter of day or continuing day treatment programs (including Subchapter A day treatment).

OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES

OMH/OPWDD CHAPTER 621 ELIGIBLES

Description: Full State and federal reimbursement is available for the cost of care provided to A/Rs who meet the requirements for State charge funding under the provisions of Chapter 621 of the Laws of 1974. These A/Rs are frequently referred to as 621 eligibles.

621 eligibles are A/Rs who: are discharged from a psychiatric center operated by the Office of Mental Health (OMH) or a developmental center being operated by the Office for People with Developmental Disabilities (OPWDD) (including stays in Family Care); and have spent five or more continuous years in these facilities.

Policy: Local districts are responsible for determining Medicaid eligibility for 621 eligibles residing within the geographic boundaries of the district regardless of other residency rules (See **OTHER ELIGIBILITY REQUIREMENTS** DISTRICT OF FISCAL RESPONSIBILITY). There is no local district financial participation in the cost of care for 621 eligibles.

NOTE: 621 eligibility is determined solely by OMH or OPWDD and is transmitted to the Department in an automated file that is loaded onto eMedNY which is then used in paying claims.

References:

SSL Sect.	62 131 365
ADMs	97 ADM-1 82 ADM-72 75 ADM-28 74 ADM-134
INFs	11 OHIP/INF-1 89 INF-43
LCMs	95 LCM-92

Interpretation: 621 eligible persons have their eligibility for Medicaid determined by the local social services district in which they are found. The local district determines eligibility and processes the A/R's case, regardless of other residency issues. Full reimbursement for the cost of medical care for 621 eligibles is available from the State and federal government.

OTHER ELIGIBILITY REQUIREMENTS

OMH/OPWDD CHAPTER 621 ELIGIBLES

Verification: 621 status is verified by the "OMR/OMH 621 Eligibles Discharge Date" field on eMedNY.

When to Verify: When an A/R or his/her representative indicates that s/he was a resident in an OMH or OPWDD facility;

- when an A/R or his/her representative states that s/he is 621 eligible; or
- when an A/R is living in an OMH or OPWDD community facility.

Disposition: Local social services districts are responsible to determine Medicaid eligibility for 621 eligible persons living within their district. The cost of care for these persons is fully reimbursed by the State and federal government.

OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES

OFFICE OF MENTAL HEALTH (OMH)

Policy: The Office of Mental Health (OMH) is responsible for providing care to persons with mental illness, as defined in Mental Hygiene Law.

References: ADM 97 ADM-1

INF 89 INF-43

LCMs 93 LCM-40
92 LCM-119

Interpretation: The following are living arrangements, operated or certified by OMH, with which local districts have the greatest contact:

(1) Psychiatric Centers (PC) (Adult, Children, and Forensic) - The State Department of Health (SDOH) in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in PCs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;

(2) Family Care (FC) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Family Care (SOFC) facilities. Local districts are responsible for determining Medicaid eligibility for A/Rs in Voluntary Operated Family Care (VOFC) facilities. Medicaid funding is shared jointly (50/50) by New York State and the federal government;

(3) Residential Treatment Facilities for Children and Youth (RTF) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in RTFs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;

(4) Community Residence (CR) - Generally, the SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Community Residences (SOCR). (See 89 INF-43 for exceptions.) Local districts are responsible for determining Medicaid eligibility for A/Rs in a Voluntary Operated Community Residence (VOCR). Generally for SOCRs, Medicaid funding is shared jointly (50/50) by New York State and the federal government. For A/Rs in VOCRs, Medicaid funding is shared (50/25/25) by the

OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES

OFFICE OF MENTAL HEALTH (OMH)

federal government, New York State and local districts. For all categories, except S/CC, local districts receive reimbursement of the local share through overburden (See **OTHER ELIGIBILITY REQUIREMENTS** STATE AND FEDERAL CHARGES HUMAN SERVICES OVERBURDEN);

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time-limited waiver was granted pursuant to Section 1115 of the Social Security Act.

(5) Residential Care Centers for Adults (RCCA) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Residential Care Centers for Adults (SORCCA). Local districts are responsible for determining Medicaid eligibility for A/Rs in Voluntary Operated Residential Care Centers for Adults (VORCCA). For A/Rs in SORCCAs, funding is shared jointly (50/50) by the federal government and New York State. For A/Rs in VORCCAs, funding is shared (50/25/25) by the federal government, New York State and local districts. Local districts receive reimbursement of the local share through overburden (See **OTHER ELIGIBILITY REQUIREMENTS** STATE AND FEDERAL CHARGES HUMAN SERVICES OVERBURDEN and NOTE above);

(6) Family Based Treatment (FBT) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in FBT. Medicaid funding is shared jointly (50/50) by the federal government and New York State.

(7) Teaching Family Homes (TFH) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in TFH. Medicaid funding is shared jointly (50/50) by the federal government and New York State.

OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Policy: The Office for People with Developmental Disabilities (OPWDD) is charged with the responsibility of caring for persons who are developmentally disabled as defined in Mental Hygiene Law.

References:

ADM	97 ADM-1
INFs	92 INF-33 89 INF-43
LCMs	94 LCM-24 93 LCM-62 92 LCM-170

Interpretation: The following are living arrangements operated or certified by OPWDD, with which local districts have the greatest contact:

(1) Developmental Centers (DC) - The State Department of Health (SDOH) in conjunction with OPWDD is responsible for determining Medicaid eligibility for A/Rs in DCs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;

(2) Small Residential Units (SRU) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for A/Rs in SRUs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;

(2) Family Care (FC) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for A/Rs in State or Voluntary Operated Family Care homes. For A/Rs in State and Voluntary Operated FCs, Medicaid funding is shared jointly (50/50) by the federal government and New York State.

(3) Community Residence (CR) and Individual Residential Alternative (IRA) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for 621 eligible individuals in State Operated Community Residences (SOCRs) and State Operated Individual Residential Alternatives (SOIRAs). Local districts are responsible for determining Medicaid eligibility for all other A/Rs in VOCRs or VOIRAs and non-621 individuals in SOCRs. For State

administered cases and 621 eligible local district cases, Medicaid funding is shared jointly (50/50) by the federal government and New York State. For all categories except S/CC, non-621 eligible A/R's Medicaid funding is shared (50/25/25) with the local share reimbursable through overburden funding. (See **OTHER ELIGIBILITY REQUIREMENTS** STATE AND FEDERAL CHARGES HUMAN SERVICES OVERBURDEN)

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time-limited waiver was granted pursuant to Section 1115 of the Social Security Act.

(5) Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for 621 eligible A/Rs in State or Voluntary Operated ICF/DDs. Local districts are responsible for determining Medicaid eligibility for non-621 eligible A/Rs in State or Voluntary Operated ICF/DDs. For 621 individuals, Medicaid funding is shared jointly (50/50) by the Federal government and New York State.

For non-621 individuals, Medicaid funding is shared 50/25/25 with the local share being reimbursed through Overburden funding for all categories, except S/CC.

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

Policy: With certain exceptions, all applicants must tell the local social services district what their Social Security Number (SSN) is or apply for an initial or replacement Social Security card.

NOTE: There are three exceptions to this policy:

- An undocumented alien, applying for Medicaid coverage of care and services necessary for the treatment of an emergency medical condition, is not required to apply for or provide an SSN.

- A pregnant woman is not required to apply for or provide an SSN. Districts cannot require a pregnant woman to provide an SSN until the end of the month in which the sixtieth (60th) day following the end of her pregnancy occurs. (See **CATEGORICAL FACTORS** MEDICAID EXTENSIONS/CONTINUATIONS) However, some pregnant women may want to provide a SSN and may do so.

- An SSN is not required for a child, born to a woman eligible for and receiving Medicaid, at the time of the child's birth for up to one year. **NOTE**: Deemed newborns are required to provide an SSN upon reaching one year of age. (See **CATEGORICAL FACTORS** MEDICAID EXTENSIONS/CONTINUATIONS)

References: Taxpayer Relief Act of 1997

SSL Sect.	131-c
Dept. Regs.	369.2(b)(1) 370.2(c)(3)
ADMs	10 OHIP/ADM-8 OMM/ADM 97-2 97 ADM-23 93 ADM-4 90 ADM-9 89 ADM-12 88 ADM-47 88 ADM-4 87 ADM-25 83 ADM-29

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

80 ADM-75
80 ADM-42

INFs 08 OHIP/INF-1
90 INF-14

GISs 00 TA/DC-008
03 MA/008
98 TA/DC-014
07 MA/010

Interpretation: With some exceptions, all Medicaid applicants regardless of age, who fail, or in the case of a child under 21 whose parent or caretaker relative fails, to tell the local social services district what their SSN is, or apply for an initial SSN, are ineligible for Medicaid. A Medicaid application for benefits must not be denied or delayed pending issuance of a social security number. Local district staff must follow up with the recipient if the SSN has not been provided within four months after the SSN application is filed.

See **NOTE** above for the three exceptions.

- The Taxpayer Relief Act of 1997 requires the SSN of each parent to be on the application for an original SSN for a child under 18.

- Effective June 30, 2000, all applications for original SSNs and replacement cards must be made directly to the applicant's local SSA Office. The local SSA office will issue a SSA-5028 (Receipt for Application for a Social Security Number) if the applicant requests verification that s/he has applied for an SSN.

- Except for S/CC, a non-applying legally responsible relative (spouse or parent) of an A/R is not required to furnish a Social Security number. The local district may request the non-applying spouse or parent to provide an SSN, but the individual is informed that the disclosure is voluntary and how the number will be used.

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

Aliens with work authorization are required to apply for a Social Security Number and card.

NOTE: If the alien with work authorization has an individual Taxpayer Identification Number (ITIN) from the Internal Revenue Service, the ITIN is considered a tax processing number and is not an equivalent to an SSN. In such situations, the alien with work authorization must provide or apply for an SSN.

Aliens without work authorization who appear to meet all eligibility requirements for federal or State funded Medicaid/Family Health Plus, except for the SSN requirement, must be provided with a letter addressed to the Social Security Administration. This letter must be provided by the district to each immigrant who lacks work authorization and is otherwise eligible for benefits. The applicant is directed to submit the letter to the Social Security Administration along with the social security number application (SS5). The district must assist the immigrant with the social security number application if necessary. The required letter formats are found in 08 OHIP/INF-2.

Verification:

Districts must continue to confirm that the SSN provided is correct. The Welfare Management System (WMS) uses two processes; verification and validation that help districts confirm the SSN.

Verification: Verification is the process in which an individual's SSN and demographics are matched to information contained in WMS. Verification is done when a case is in application status. Districts are alerted of any problems through the Resource File Integration (RFI) process.

Validation: Validation is the process in which WMS sends a SSN and certain other individual data to the Social Security Administration (SSA) for comparison. If the SSN and demographic data associated with an individual on WMS match the information on file with the SSA, that individual's SSN is

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

validated as correct on WMS. Validation occurs after the case is opened or whenever a change in demographics occurs.

Medicaid A/Rs no longer have to provide documentation of their SSN, except in those cases where either the verification or the validation process fails to confirm the SSN. A copy of the A/R's Social Security card is always acceptable. The district may accept a printed pay stub indicating the SSN, or W-2 Form as documentation.

If the SSN does not validate through this process, the A/R must be notified to provide documentation of the SSN within 10 days (14 days NYC) from the date of notification. If the A/R does not provide documentation of the SSN, Medicaid benefits must be discontinued or denied.

Form SSA-2853 (message from Social Security), verification that an application was made through the Enumeration at Birth (EAB) process, or a copy of the birth certificate indicating enumeration at birth are the primary evidence that a newborn has applied for an SSN. An SSN is not required for a child born to a woman eligible for, and receiving Medicaid, at the time of the child's birth for up to one year.

OTHER ELIGIBILITY REQUIREMENTS

PRESUMPTIVE ELIGIBILITY

Policy: Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

References:

SSL Sect. 364-i 4. (a)(e)
364-1
368-a

Dept. Reg. 360-3.7
Part 531

ADMs 08 OHIP/ADM-2
97 ADM-10
90 ADM-9

Interpretation: A/Rs can apply for Medicaid through the presumptive eligibility process if they meet one of the following certain conditions:

- a pregnant women who applies for Medicaid at an Article 28 Pre-natal Care Provider or other entity designated by the State Department of Health, who has been trained to perform presumptive eligibility and perform application assistance ;

- a child under the age of 19 who applies for Medicaid with a Qualified Entity (QE) that has a signed Memorandum of Understanding (MOU) with the State Department of Health, or

- a patient in an acute care hospital awaiting discharge but needing the type of medical care provided by a Certified Home Health Agency, Long Term Home Health Care Program, nursing facility or hospice.

The sections that follow discuss these forms of presumptive eligibility:

- Nursing facility, hospice or home health care services,
- Children up to age 19
- Pregnant women.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

Policy:

Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

Presumptive eligibility for nursing facility, hospice or home health care services is available to persons meeting the following criteria:

(1) the applicant is receiving care in an acute hospital at the time of application;

(2) a physician certifies that the applicant no longer requires acute hospital care, but requires the type of medical care provided by a Certified Home Health Agency (CHHA), a Long Term Home Health Care Program (LTHHCP), nursing facility or hospice;

(3) the applicant or his/her representative states that there is insufficient insurance coverage for this type of care and that the applicant would not otherwise be able to pay for that required care;

(4) it appears that 65% of the cost of care provided by the nursing facility or hospice, would be less than the cost of continued hospital care computed at the Medicaid rate (alternate care rate); and

(5) the applicant appears to meet all the criteria, financial and non-financial, for Medicaid. A screening checklist is used to eliminate those cases from the presumptive eligibility process which require in-depth reviews to determine eligibility.

Persons applying for presumptive eligibility for home health care services are budgeted as community cases. They are not considered to be in chronic care.

A period of presumptive eligibility begins on the date of discharge from the hospital and continues for sixty (60) days or until the standard eligibility determination is completed, whichever is earlier.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

During a period of presumptive eligibility, all Medicaid services are covered except:

(a) hospital-based clinic services;

(b) hospital emergency room services;

(c) acute hospital inpatient services (except when provided as part of hospice care); and

(d) bed hold for an individual determined presumptively eligible for Medicaid coverage of nursing facility services.

References: SSL Sect. 364-i

Dept. Reg. 360-3.7
531.1

ADM 97 ADM-10

Interpretation: When an application is being made for presumptive eligibility, the local district:

(1) determines that the applicant meets the above criteria;

(2) makes an eligibility determination by reviewing the application package;

(3) notifies the applicant of his/her presumptive eligibility determination within five working days of the receipt of the presumptive eligibility application package or by the discharge date if that date is later. The local social services district sends the “Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services” or “Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care”, whichever is appropriate. The local social services district sends the notice of the client’s eligibility to the applicant (in care of the hospital

if there is no authorized representative), the hospital, and the proposed provider, if presumptively eligible. In addition, the provider is advised of the client's liability toward the cost of care, if applicable.

NOTE: See 97 ADM-10 for copies of the Notices.

(4) authorizes the applicant for up to sixty days of presumptive eligibility from the date of discharge from the hospital if the stated conditions are met; and

(5) processes a routine, complete and fully documented eligibility determination.

Documentation: The DOH-4220, completed by the applicant or authorized representative, is submitted to the local social services district, with the physician's statement that the patient no longer requires care in an acute care hospital, but does require nursing facility, CHHA, LTHHCP, or hospice services. Included with the application package is the completed Screening Checklist (Attachment I to 97 ADM-10), the medical documentation from the hospital of the type of care and, in the case of CHHA services, the amount of care required.

Upon receipt of the application for presumptive Medicaid eligibility, the local social services district must review the application package, including the Screening Checklist, to determine if the applicant meets the basic qualifying conditions to participate in the presumptive Medicaid eligibility program.

The local social services district may ask questions to resolve conflicting information, particularly for items on the Screening Checklist. However, documentation cannot be required to determine presumptive Medicaid eligibility. Attestation of facts is sufficient to determine if an individual is presumptively eligible for assistance.

The local social services district or its agent must agree that the CHHA or LTHHCP services recommended are appropriate. The local social services district agent providing the evaluation of medical need might be a Community Alternative Systems Agency (CASA) or staff in the Medicaid or Long Term Care Unit. The local

social services district is neither expected to or required to visit or converse with the applicant or hospital staff at this time to evaluate medical need. The evaluation is performed from the written material provided by the hospital to explain the care required.

The hospital submits medical documentation of the type of care required. The hospital may use the suggested Medical Documentation Transmittal Form (Attachment II to 97 ADM-10) to transmit this information to the local social services district. Documentation of the type of care required should be sufficiently detailed to enable a local social services district to evaluate the appropriateness of LTHHCP or CHHA services. In addition, documentation needs to be sufficiently detailed to enable the local social services district to determine cost effectiveness of CHHA services.

1. Home Care

   If the applicant will be receiving the services of a CHHA, the local social services district multiplies the hourly or visit rate for each home health service by the number of hours or visits the patient requires per month. This monthly amount is then divided by 30 days to determine the average daily cost. Sixty five percent of the average daily cost is then compared to the hospital's Medicaid alternate level of care rate to determine cost effectiveness.

   No cost comparison is required for persons who will receive their care through a LTHHCP, since in order to participate in the LTHHCP the cost of care in that program must be less than the cost of care in a skilled nursing facility.

2. Nursing Facility and Hospice Services

   If the applicant will be receiving nursing facility services, the local social services district compares 65 percent of the average regional Medicaid nursing facility rate with the appropriate (Upstate or New York City/Metro Region) Medicaid alternate level of care rate to determine cost effectiveness.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

To determine cost effectiveness of hospice services (whether provided to an individual residing in the community or to an institutionalized individual), the local social services district compares 65 percent of the average regional Medicaid nursing facility rate with the appropriate alternate level of care rate.

NOTE: Presumptive eligibility is not available for S/CC.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

PREGNANT WOMEN

Policy: Presumptive eligibility is a means of immediately providing Medicaid services for prenatal care pending a full Medicaid determination. All Article 28 Pre-Natal Care providers and others as designated by the SDOH who have been trained must perform a preliminary assessment of a pregnant woman's income and provide application assistance if requested. Then, based upon guidelines established by the Department, s/he determines whether or not the woman is presumptively eligible for a limited array of medical services, based on income.

References:

PHL	2529
Dept. Reg.	360-3.7(d)
ADM	90 ADM-9
INF	90 INF-45
LCM	95 LCM-106
GISs	00 MA/024 97 MA/028 95 MA/034 94 MA/016 91 MA/007

Interpretation: A pregnant woman is presumed eligible for limited Medicaid coverage when it is determined that the woman's income does not exceed 200% of the federal poverty level. The information used in the presumptive eligibility determination does not have to be verified. Pregnant women have the benefit of a larger “family size” by counting other family members (parents, stepparents, siblings, stepsiblings and half-siblings), whether or not they are applying. The income of such family members residing in the household is counted when determining the eligibility of pregnant women and children under the federal poverty levels, with two exceptions:

1. Public Assistance and SSI cash recipients and their income are invisible; and

2. The income/resources of parents are not considered in determining the income/resources available to a pregnant minor.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

PREGNANT WOMEN

The following deductions from income are allowed: $90 from earned income; child care from employment income; $100 from child support received; and health insurance premiums, if not already deducted from the wages. (See I**NCOME** LIF BUGETING METHODOLOGY $90 WORK EXPENSE DISREGARDS and **INCOME** ADC-RELATED BUDGETING METHOLDOLOGY CHILD/INCAPCITATED ADULT CARE COST and INCOME ADC-RELATED DISREGARDS and **INCOME** HEALTH INSURANCE PREMIUMS) All resources are disregarded.

When the pregnant woman's family income is equal to or less than 100% of the federal poverty level, she is presumptively eligible for all care, services and supplies available under the Medicaid program.

When the pregnant woman's family income exceeds 100% of the poverty level, but does not exceed 200%, she is presumptively eligible for Medicaid covered ambulatory prenatal services only.

The Article 28 Pre-Natal Care provider or others designated by SDOH:

- completes the screening checklist at the first visit to determine the applicant's presumptive eligibility;
- assists the pregnant woman in completing the standard application for assistance and assist her with choosing a health plan;
- advises a presumptively eligible woman of her responsibility to complete the Medicaid application process;
- forwards screening checklist and Medicaid application to the appropriate local social services district within five working days; and
- provides the pregnant woman with a copy of the checklist and notice of presumptive eligibility determination.

Outreach sites that are not Article 28 Pre-Natal Care providers or other providers designated by the SDOH are not able to authorize presumptive eligibility.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

PREGNANT WOMEN

The local social services district will authorize Medicaid for the presumptively eligible woman. If the woman does not submit the required documentation by the date specified on the documentation checklist, without good cause, her presumptive case may be closed after appropriate notification.

Eligibility for pregnant women is determined as follows:

(a) If the net household income is equal to or less than 100% of the federal poverty level, the Medicaid level or Medicaid Standard (whichever is most beneficial), the woman and any infant under age one are fully eligible for all Medicaid services.

(b) If the net household income is above 100% of the federal poverty level and does not exceed 200% of the federal poverty level, the woman is eligible for ambulatory Medicaid prenatal care services and any infant under age one is fully eligible for all Medicaid services. If the net household income exceeds 200% of the federal poverty level, the pregnant woman is referred to the local social services district to determine eligibility for Medicaid under the "spenddown" provisions.

Disposition: A pregnant woman may be determined presumptively eligible for Medicaid. The provider completes a preliminary assessment of the woman's income and establishes her eligibility based on Department guidelines. If the woman's income is less than 100% of the federal poverty level, she is eligible for all ambulatory Medicaid services. When the income is above 100% but less than or equal to 200% of the poverty level, the pregnant woman is eligible for ambulatory prenatal care Medicaid services only. For the pregnant woman to continue her coverage past the period of presumptive eligibility, she submits the required documentation to the local social services district. Only one period of presumptive eligibility is allowed per pregnancy.

Presumptive Medicaid eligibility begins on the date the provider determines presumptive eligibility. This is usually the date of the pregnant woman's first visit or the date services were first rendered to her. This is also the date of application for on-going Medicaid. Presumptive eligibility continues until a finding of eligibility is made or if the woman does not file a Medicaid application, until the last day of the month following the month after the woman was first found to be presumptively eligible.

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

Policy: Presumptive eligibility is a means of immediately providing Medicaid covered care and services to children under the age of 19. A Qualified Entity (QE) performs a preliminary assessment of the child's eligibility based upon guidelines established by the Department. If the child is found to be presumptively eligible for Medicaid s/he is provided full Medicaid care and services for a limited period of time during which a full determination of eligibility is performed.

References: SSL Sect. 364-i4. (a)-(e)

ADM 08 OHIP/ADM-2

Interpretation: A child under the age of 19 is presumed eligible for full Medicaid coverage when a Qualified Entity determines that the child's household income does not exceed the appropriate federal poverty level (133% for children ages 1-5; 100% for children ages 6-18; and 200% for children under the age of 1).

The information used in the presumptive eligibility determination may be attested to and does not have to be verified in order to authorize presumptive coverage.

The household size is determined by counting the child and the mother of the applying child, and, if she is pregnant, count as 2 (mother plus the unborn child). Count the legal spouse and/or father of the child, if they live in the household. Count as 1 the Caretaker Relative (if no parents live in the household) and if the Caretaker Relative will also be applying for Medicaid. Count all of the children under age 21 in the household whether or not they are applying. Do not count persons who receive Temporary Cash Assistance or SSI cash assistance.

The following deductions from monthly gross income of the household (including the income of the caretaker relative, if they are part of the household count and are applying for Medicaid) are allowed: $90 from earned income (See **INCOME** ADC, LIF, AND S/CC-RELATED BUDGETING METHODOLOGY $90 WORK EXPENSE DISREGARD); child care from employment income (See **INCOME** ADC, LIF, AND S/CC-RELATED BUDGETING METHODOLOGY CHILD/INCAPACITATED ADULT CARE COST);

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

$100 from child support received (See **INCOME** ADC, LIF, AND S/CC-RELATED DISREGARDS); and health insurance premiums (See **INCOME** ADC, LIF, S/CC AND SSI-RELATED BUDGETING METHODOLOGY HEALTH INSURANCE PREMIUM), if not already deducted from the wages. Do not count grants, loans, or student wages or grants of Temporary Assistance (TA) and Supplemental Social Security Income (SSI). All resources are disregarded.

When the child under age 19's family income is equal to or less than the appropriate federal poverty level, s/he is presumptively eligible for all Medicaid covered care and services.

The qualified entity who has a signed MOU with SDOH:

- completes a personal screening interview with the A/R using the DOH-4441, "Medicaid Presumptive Eligibility for Children Screening Form";
- contacts the designated toll-free number to determine whether the screened eligible child is entitled to PE (**NOTE**: a child is entitled to only ONE period of PE in a 12 month period);
- provides the applying household a determination letter on the approved form, "Presumptive Eligibility for Children Screening Determination Letter", OHIP-0012 indicating their findings, and advises the applying household of the next steps in the process, which includes mandatory completion of a full application for Medicaid (DOH 4220, ACCESS NY Application) if eligible for PE, and/or referrals to the LDSS, or to a Facilitated Enroller if ineligible for PE.
- informs the applicant/representative of his/her rights and responsibilities as well as issuing required informational materials and brochures;
- assists the PE eligible applicant/representative with the "Access NY Health Care Application", DOH-4220 which must be completed, signed and properly documented in order for the LDSS to determine ongoing Medicaid eligibility. Responsibilities including requesting and compiling necessary documentation are delegated to the QE;

NOTE: QE's may enter into formal agreements with Facilitated Enrollers (FEs) to assist them in the Medicaid application,

documentation requirement and collection process. However, the QE continues to be responsible for the PE screening process and issuance of the PE screening determination form.

- forwards the completed application package (the PE for Children Screening form; PE for Children Determination letter; DOH 4220 application form; and, all documentation needed to determine eligibility) within 21 days from the date of initial screening (or within a reasonable extended timeframe if the applicant is making a good-faith effort to secure necessary documentation).
- QEs are not to forward completed PE screening forms to the LDSS for children who do not screen as PE eligible. The QE should provide the ineligible household with the DOH-4220 application form to complete and submit to a Facilitated Enroller or to the LDSS. Children are to be referred to FEs and/or Child Health Plus health plans.

The local social services district:

- designates one or more staff as a liaison to the designated QEs;

- accepts completed PE/MA application packets from the QE and processes them in a timely manner, but in no event later than 30 days from the date of the QE screening/assessment for pregnant women and children, and within 45 days for all other applications not requiring a disability determination;

- allows for a reasonable extension of time and extends PE coverage so that the applying household and/or the QE/FE can obtain required documentation;

- determines eligibility for the 3-month retroactive period as appropriate **NOTE**: Retroactive eligibility cannot be provided to children who are eligible for presumptive coverage only ;

- provides notice of the results of the final Medicaid eligibility determination simultaneously to the applicant and the QE including the CIN for billing purposes;

- documents in the case record delays in the receipt of completed applications from the QE that result in untimely determinations of eligibility;

OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

- open and maintain Medicaid case (s) including all undercare and renewals for individuals found eligible for ongoing coverage for a period of no less than 12 months from the date of screening/application. If the PE-only eligible child turns age 19 during the PE authorization period, authorizes the PE-only case to the last day of the month in which the child turns age19;

Disposition:

Parents/guardians of children up to age 19 may attest to basic information including citizenship, identity, residency, household size and composition and income during a brief interview with a Qualified Entity. The QE may provide services under Medicaid presumptive eligibility when the screened child's estimated family income (after applying simple disregards), does not exceed the applicable income standards. The PE eligible child may receive all care, services and supplies covered by the Medicaid program, from any Medicaid enrolled provider, prior to a full Medicaid determination by the LDSS. A CBIC card will not be issued for the PE period. Cards will be issued only for fully eligible MA children.

Children screened eligible for PE may receive ONE presumptive coverage authorization period in a 12-month period. Children found fully eligible will be authorized for no less than 12 months of Medicaid coverage OR through the last day of the month in which their 19th birthday occurs, whichever is earlier.

A completed MA application, DOH 4220, must be submitted by the QE along with the PE screening form and supporting documentation.

OTHER ELIGIBILITY REQUIREMENTS

IMMEDIATE MEDICAL NEED

Policy: An A/R with an immediate medical need is referred to a hospital and/or advised to seek medical care.

References: ADM 86 ADM-7

Interpretation: Applicants who indicate that they have a medical need are advised to seek medical care. When a local district believes that an A/R requires immediate medical care, i.e., a life-threatening situation, the A/R is referred to a hospital. Under 10 NYCRR Part 405, hospitals are obligated to provide care to the individual regardless of the source of payment. An applicant may advise his/her medical provider that s/he has applied for Medicaid and that if s/he is eligible, reimbursement may be available for care and services provided up to three months prior to the month of application.

The application is processed as quickly as possible. When primary sources of documentation are not available, secondary sources are used as appropriate.

OTHER ELIGIBILITY REQUIREMENTS

VETERANS' AFFAIRS REFERRAL

Policy: Veterans and/or their dependents explore and utilize all available veterans' benefits. Veterans and their dependents must agree to be referred to a State or county veterans' office so that their eligibility for veterans' related benefits can be assessed.

References: Dept. Reg. 360-7.4

ADMs 93 ADM-21

Interpretation: When an A/R indicates on the application/ recertification that s/he is a veteran or may be eligible for veterans' benefits, the local district advises him/her of potential benefits available through Veterans' Affairs (VA). When the A/R states on the application/recertification that s/he is not a veteran nor eligible for veterans' benefits, the local district clarifies that the A/R has not had military experience in the Armed Forces or as a merchant seaman.

An A/R who has served in the military files for benefits at the appropriate State/local VA office. Eligibility for family members can not be denied based on the veterans' failure to file.

Verification/ Documentation: Referrals to the VA office may be in writing or by telephone. When made in writing, the LDSS-2640, "Request for Action/Services" may be used. When the referral is made by phone, a notation is made and kept as part of the case record.

OTHER ELIGIBILITY REQUIREMENTS

CONSOLIDATED OMNIBUS BUDGET RECONCILATION ACT (COBRA)

Policy: COBRA allows certain persons who lose their health insurance coverage, provided through an employer, to continue coverage by paying the entire premium himself or herself. The premium is paid at the group rate paid by the employer. Generally, COBRA continuation election must be made within 60 days of the date coverage ends or the date of notice of the coverage option from the plan administrator, whichever is later. The plan must allow no less than 45 days from the date of the initial election to pay for the premium for the period beginning the day coverage would otherwise have ended. Coverage can continue for 18 to 36 months depending on the circumstances.

References:

SSL	104 367-a (1) (d)
Dept Reg	360-3.2 360-4.6(a) 360-4.7(b) 360-7.5(h)
ADMs	91 ADM-53 91 ADM-27 87 ADM-40
GISs	09 MA/024 97MA/001

Intrepretation: To be a COBRA Continuation Beneficiary (CCB), the individual must meet the following conditions:

1. Be an employee, spouse, or dependent child (ren) of the employee, or a retiree and/or his/her dependents or surviving spouse.

2. Have lost group health insurance coverage because of one of the following:

   - Death of the covered employee
   - Termination of covered employee's employment (except due to gross misconduct) or reduction in hours
   - Divorce or legal separation of covered employee from the employee's spouse

OTHER ELIGIBILITY REQUIREMENTS

CONSOLIDATED OMNIBUS BUDGET RECONCILATION ACT (COBRA)

- Covered employee's entitlement to Medicare
- Dependent child loses dependent status under the requirements of the group health plan
- For a covered retiree, the filing of Chapter 11 bankruptcy by the employer under certain circumstances.

A CCB may be eligible for Medicaid to pay the COBRA premium when they meet the following criteria:

- Coverage is available through an employer with 75 or more employees
- The insurance is cost effective
- The A/R's income, using SSI budgeting (See **INCOME** SSI-RELATED DISREGARDS) does not exceed 100% of the Federal Poverty Level
- The A/R's resources, using SSI budgeting (See **RESOURCES** SSI-RELATED DISREGARDS) do not exceed twice the SSI resource level
- The A/R meets all other non-financial requirements for Medicaid eligibility.

When a member of the household, other than the former employee, is eligible for the COBRA Continuation Program Coverage, Medicaid may pay for family coverage. For example: A mother and her 3 children apply for coverage. The mother is receiving Unemployment benefits and her oldest child is receiving child support. The income of the mother and the second child is below 100% of the FPL. The oldest child has income above 100% of the FPL and is not eligible for Medicaid payment of COBRA COVERAGE. However, because the youngest child is eligible for COBRA Continuation Program coverage, Medicaid will pay the premium for family coverage. If it is determined cost effective, the mother and both children will receive health insurance coverage.

Medicaid pays the health insurance premium only. The recipient incurs any co-payments.

OTHER ELIGIBILITY REQUIREMENTS

CONSOLIDATED OMNIBUS BUDGET RECONCILATION ACT (COBRA)

Medicaid payments for premiums may be made to the insurance company, employer, or recipient. Payments are only made to the recipient to reimburse for self-payment or when the employer/insurance company refuses to accept Medicaid payments.

The decision to continue coverage is to be made within 60 days after coverage ends or date of notice of coverage option from plan administrator. Premium payment is to be made within 45 days after election is made to continue coverage. If payment is not made in a timely manner, coverage will end.

Verification: The following information is verified:

- Group health insurance plan coverage, including COBRA coverage effective date, exclusions to enrollment, services covered and premium amounts;
- That the A/R is CCB eligible;
- The dates of the 60 day enrollment period; and
- All other appropriate eligibility criteria are met.

OTHER ELIGIBILITY REQUIREMENTS

COMPUTER MATCHING

Policy: All eligibility factors must be documented to substantiate an A/R's eligibility for assistance. When a computer match is used to document factors of eligibility without further verification, the information must be "verified upon receipt". "Verified upon receipt" means that the information from the computer match is coming from a primary source, is timely, and is not questionable.

References: GIS 06 OMM/INF-4

Interpretation: The Department of Labor (Unemployment Insurance Benefits (UIB)), Social Security Administration (RSDI or SSI), etc., are primary sources; there is no need for the district to independently verify the information provided through the match as long as the data is current (within 60 days of the date of case action) and there is no reason to believe that the information from the match is not valid. No further verification is required.

When a computer match involves a secondary source (for example, a contractor that provides information), the case record should be reviewed to determine if the information is already documented. When the information is not documented in the case record, the district needs to verify the accuracy of the information with the client or primary source before initiating any case action.

OTHER ELIGIBILITY REQUIREMENTS

WAIVERS

CARE AT HOME WAIVERS

Description: Section 366.6 & .7 of Social Services Law authorizes the Care At Home (CAH) program. The CAH Medicaid waiver programs were established and began enrolling children December 1, 1985. Currently there are 5 CAH waivers administered by the SDOH; CAH I & II are overseen on a daily basis by the LDSS and CAH III, IV & VI are overseen on a daily basis by the Office for People with Developmental Disabilities (OPWDD) and the Developmental Disabilities Services Office (DDSO) in twelve regional offices.

The CAH programs are 1915(c) Home and Community Based Medicaid waivers that enable children to access Medicaid for medically necessary State Plan services as well as waiver services such as case management and respite. In order to be enrolled in the CAH waiver, the child must meet several criteria. For example, to enroll in CAH I & II the child(ren) must be: under the age of 18, physically disabled based on SSI program criteria, require the level of care provided by a skilled nursing facility or hospital, and be capable of being cared for safely in the community. For CAH III, IV & VI the children must be disabled based on SSI program criteria and in addition have a developmental disability. The disability certification for any of the waivers can be done by the State or LDSS Disability Review Team. The Social Security Administration determines disability for CAH I and II children who are also in receipt of SSI.

NOTE: Applicants no longer require a 30 day inpatient stay.

Each LDSS has a designated CAH coordinator who can be contacted for information regarding the CAH program. It is important for all staff in the LDSS to be aware of the CAH program as applicants may be referred to them from the LDSS CAH coordinator as well as from various other outside sources, such as DDSOs, hospitals, physicians, case management agencies and parents.

Policy: The Medicaid eligibility determination for participants in the CAH waiver is different for CAH I & II and CAH III, IV and VI. Effective 12/01/2008 for CAH I/II, children who are Medicaid eligible based on their parent's income and, if applicable, resources, as well as children who are ineligible for Medicaid based on their parent's income and/or resources, may apply for enrollment in the waiver if they meet the qualifications stated above. For OPWDD CAH waivers (III, IV and VI) only children who are ineligible for Medicaid based on their parent's income and/or resources, may apply for enrollment.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

CARE AT HOME WAIVERS

For CAH III, IV & VI, and the CAH I/II children who are not otherwise Medicaid eligible based on their parent's income and/or resources, the eligibility determination is made for the child counting only their own income and resources and excluding the income and resources of the parent/legal guardian. The child is considered a household of one and the child's income and resources are compared to the medically needy level for one. If the child is receiving services paid for by a public program (i.e. Early Intervention, School Supportive Health), these services can be used to spend down the child's excess income/resources. (See **INCOME** EXCESS and **RESOURCES** EXCESS RESOURCES)

Enrollment in the CAH waivers ends on the child's 18th birthday. Prior to turning 18 the child may file an application for SSI.

References:

SSL Sect.	366.6 & .7
ADMs	86 ADM-4 91 ADM-11
GIS	11 OLTC/001 09 OLTC/04

Interpretation:

CAH III, IV and VI: When making an eligibility determination for a CAH III, IV and VI applicant, the child must be found ineligible for Medicaid when parental income and resources are budgeted and found eligible when deeming is not applied.

CAH I/II: When making an eligibility determination for a CAH I/II applicant, the child may be:

- found ineligible for Medicaid when parental income and resources are budgeted, but found eligible when deeming is not applied, OR
- be Medicaid eligible when parental income and resources are budgeted.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

NURSING HOME TRANSITION AND DIVERSION WAIVER (NHTD)

Description: Section 366 (6-a) of the Social Services Law authorizes the Nursing Home Transition and Diversion Waiver (NHTD). The NHTD waiver is overseen on a daily basis by 9 Regional Resource Development Centers (RRDCs) under contract with the New York State Department of Health.

The NHTD is a 1915 (c) Medicaid Home and Community Based Services Waiver (HCBS) authorized by the federal government. This waiver provides a community based alternative for providing care to seniors and persons with physical disabilities who are at least 18 years of age and require nursing home level of care. The waiver allows individuals to access Medicaid for medically necessary State Plan services as well as NHTD waiver services.

Policy: An individual participating in the NHTD waiver must be:

• Assessed to be eligible for nursing home level of care, using the Patient Review Instrument (PRI) (DOH-694) and SCREEN (DOH-695), which must be performed by a certified assessor who can conduct a PRI/SCREEN;

• In receipt of Medicaid coverage for Community Based Long Term Care services OR Outpatient Coverage for Community-Based Long Term Care;

• Capable of living in the community with the assistance of available informal supports, Medicaid State Plan services and one or more waiver service;

• At least eighteen years of age with a physical disability or aged 65 and older; and

• Part of an aggregate group that can be cared for at less cost in the community than in a nursing home.

An individual cannot be enrolled in the NHTD waiver and any of the other HCBS waivers at the same time (i.e. the Long Term Home Health Care Program waiver, the Traumatic Brain Injury waiver, and the Office for People with Developmental Disabilities HCBS waiver). Nor can an individual be enrolled in NHTD and Program of All Inclusive Care of the Elderly (PACE). If an individual is determined to be eligible for more than one waiver, a choice between the NHTD waiver and other HCBS waivers must be made by the applicant and/or legal guardian.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

NURSING HOME TRANSITION AND DIVERSION WAIVER

Due to the many roles the LDSS has in the NHTD waiver, it is important for all staff in the LDSS to be aware of the NHTD program. The Regional Resource Development Specialist (RRDS) and Service Coordinator must collaborate with LDSS staff to have an understanding of the applicant's history, if any, of participation in Medicaid State Plan community- based services or adult protective services. This collaboration furthers the RRDS and Service Coordinator's understanding of the strengths and needs of the applicant, as well as the availability of informal and formal supports. This knowledge and understanding will enhance the development of the waiver Service Plan and support the applicant's health and welfare if s/he is approved for the NHTD waiver.

The LDSS and/or State DOH retain responsibility for all prior authorizations/approvals of Medicaid State Plan services such as the Personal Care Services Program (PCSP), the Consumer Directed Personal Assistance Program (CDPAP), Personal Emergency Response Services (PERS) or private duty nursing (PDN). It is anticipated the RRDS/Service Coordinator will be in contact with LDSS home care staff when applicants require referrals for assessment and authorization of these services. LDSS home care staff may be asked to participate in team meetings, convened by waiver Service Coordinators, related to development or reassessment of the participant's waiver Service Plan.

In addition, the LDSS is responsible for determining financial eligibility for NHTD A/Rs.

References:

SSL Sect. 366 (6-a)

ADMs 11 ADM-06
08 OLTC-1

GISs 11 LTC007
11 LTC004
08 OLTC-03

Interpretation: Individuals interested in participating in the NHTD waiver will be applying for Medicaid coverage for Community-Based Long-Term Care. The RRDS will send a Letter of Introduction to the LDSS for such individuals and will also give a copy of the letter to the individual to bring with him/her when he/she meets with the LDSS to file the application. The LDSS will determine financial eligibility and return the letter, along with the appropriate form(s) and notices, to the applicant and RRDS.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

NURSING HOME TRANSITION AND DIVERSION WAIVER

Individuals who request Medicaid coverage of NHTD waiver services must provide proof of current income and resources and be otherwise eligible for Medicaid. See **INCOME** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS) and **INCOME** SSI-RELATED BUDGETING METHODOLOGY and **RESOURCES** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY BASED WAIVERS (HCBS).

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

BRIDGES TO HEALTH (B2H)

Description: Effective January 1, 2008, the federal government authorized the Bridges to Health (B2H) Waiver. The B2H is a federal Home and Community Based (HCBS) Medicaid waiver for children in foster care up to 21 years of age.

B2H provides community based services to children who are in the care and custody of a local department of social services (LDSS) or the Office of Children and Family Services (OCFS) and who have significant mental health care needs, developmental disabilities or medical fragility and who require an institutional level of care.

B2H is administered as three separate targeted 1915(c) Medicaid waivers providing Medicaid State Plan services, and the following waiver services: Health Care Integration, Skill building, Family care giver supports and services, Day habilitation, Prevocational services, Supported employment, Planned respite, Special needs community advocacy and support, Crisis avoidance, management and training, Immediate crisis response services, Intensive in-home supports crisis respite, Accessibility modifications and Adaptive and Assistive equipment.

Policy: Children must be in foster care and categorically eligible for Medicaid to be considered for enrollment in the B2H waivers. B2H participants who are discharged from foster care may remain in the B2H waiver if they meet the waiver and Medicaid eligibility criteria.

References: ADMs 08 OLTC/001

Interpretation: Health Care Integration Agencies (HCIA's) are voluntary child care agencies responsible for the operational and administrative functions of the B2H waivers. The Waiver Service Provider (WSP) networks operate throughout the State to ensure the delivery of comparable B2H services regardless of the location of a child's residence. The existing OCFS regions form the basis for the B2H regional designations. The B2H and OCFS regional designations are identical, with one exception: OCFS Region V is divided into the Lower Hudson Valley and Long Island B2H regions. Please refer to OCFS's website, www.ocfs.state.ny.us/main/b2h/ for specific information regarding the OCFS and B2H regions.

A B2H participant who has been discharged from foster care will have her/his Medicaid eligibility determined based on a household of one, and her/his own income and resources will be compared to the

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

BRIDGES TO HEALTH (B2H)

Medically Needy level. If a child's income and/or resources exceed the Medically Needy level, s/he may spenddown. Either ADC-related budgeting or SSI-related budgeting may be used, whichever is most beneficial to the child. However, if SSI-related budgeting is used, a disability review must be completed. Medicaid and waiver eligibility must be renewed annually. The LDSS will approve children for a B2H waiver based on their qualifying diagnosis; significant mental health care needs, developmental disabilities or medical fragility.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

TRAUMATIC BRAIN INJURY (TBI) WAIVER

Description: On March 23, 1994, the Medicaid Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (HCBS/TBI Waiver) was approved by the Federal Government. This waiver is one component of a comprehensive strategy developed by New York State to repatriate and de-institutionalize individuals with TBIs who reside in nursing facilities (NF) either in or out-of-state and to offer an alternative to NF placement for others currently living in the community who are at significant risk of NF placement. The HCBS/TBI Waiver is designed to provide the necessary services and supports to achieve these objectives.

The TBI Waiver is overseen on a daily basis by 9 Regional Resource Development Center (RRDCs) under contract with the New York State Department of Health. The RRDCs employ Regional Resource Development Specialists (RRDSs) who are responsible for the administration of the daily activities of the TBI Waiver.

Policy: An individual participating or seeking application in the HCBS/TBI Waiver must be:

- Between the ages of 18 and 65 with a primary diagnosis of Traumatic Brain Injury or other related acquired brain injury upon application to the waiver;
- Assessed to be eligible for nursing home level of care as a direct result of the brain injury. Nursing home eligibility is determined by using he Patient Review Instrument (PRI) (DOH-694) and SCREEN (DOH-695), which must be performed by a certified assessor who can conduct a PRI/SCREEN;
- In receipt of Medicaid coverage for Community Based Long Term Care services or Outpatient Coverage for Community Based Long term Care; and
- Capable of living in the community with the assistance of available informal supports, Medicaid State Plan services and one or more waiver services; and
- Part of an aggregate group that can be cared for at less cost in the community than in a nursing home.

An individual cannot be enrolled in the TBI waiver and any of the other HCBS waivers at the same time (i.e. the Long Term Home Health Care Program waiver, the Nursing Home Transition and Diversion

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

TRAUMATIC BRAIN INJURY (TBI) WAIVER

Waiver, and the Office for People with Developmental Disabilities HCBS waiver). If an individual is determined to be eligible for more than one waiver, a choice between the TBI waiver and other HCBS waivers must be made by the applicant and/or legal guardian.

Under the waiver, waiver participants may receive existing MA services and waiver services including: service coordination, independent living skills training and development, structured day programs, substance abuse programs, positive behavioral interventions and support services, community integration counseling, home and community support services, environmental modifications, respite care, special medical equipment and supplies, community transitional services and transportation.

Local departments of social services (LDSS) are responsible for determining the financial eligibility of the TBI Waiver A/Rs.

References: LCMs 96 LCM 37
95 LCM 70

Interpretation: Individuals apply through the RRDC for participation in the TBI waiver. The RRDS will provide the potential waiver participant with a list of available Service Coordination agencies. The applicant will choose a service coordinator who will assist in the development and compilation of all documentation needed to establish the individual's financial and non financial eligibility for the waiver. The individual and the service coordinator develop a comprehensive service plan which will include informal supports, necessary State Plan Medicaid services, any other federal or state programs and specific waiver services necessary to support the individual's health and welfare in the community.

If the individual has not been determined to be MA eligible and/or certified disabled, the RRDS will send a Letter of Introduction which is presented to the LDSS. The LDSS will determine financial eligibility and return the letter, along with the appropriate form (s) and notices, to the applicant and RRDS.

To determine eligibility of TBI A/Rs see **INCOME** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS) and **INCOME** SSI-RELATED BUDGETING METHODOLOGY and **RESOURCES** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY BASED WAIVERS (HCBS).

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

Description: The Long Term Home Health Care Program (LTHHCP) also known as the "Nursing Home Without Walls" or "Lombardi Program" is a federal 1915 c Home and Community Based Services waiver (HCBS). It is administered by local departments of social services and overseen by the State Department of Health (SDOH).

This Medicaid waiver was first authorized by the federal government in 1979 and became operational in 1983. It is designed to serve seniors and individuals with physical disabilities who: are medically eligible for nursing facility (NF) level of care; chose to remain at home; have assessed service needs that can be met safely in the home and community; and, have a service plan with Medicaid costs for services which fall within the participant's county of residence expenditure cap for nursing facility level of care. LTHHCP is available in all counties of New York State with the exception of: Chenango, Essex, Hamilton, Lewis, Livingston, Schoharie and Schuyler.

Pursuant to a written authorization from the State Health Commissioner, LTHHCP services may be provided by a certified home health agency (public or voluntary non-profit organization) or a residential health care facility or a hospital currently certified under Article 28 of the Public Health Law.

The AIDS Home Care Program (AHCP) instituted in 1992 to meet the challenge of the high incidence of AIDS in New York State is a subset of the LTHCCP. Certain LTHHCP agencies are approved by the federal government and New York Department of Health to provide the AHC.

LTHHCP services include: nursing, home health aide services, medical supplies and equipment, therapies (e.g. physical therapy, occupational therapy, speech therapy,), and personal care services including homemaker and housekeeper. In addition there are waiver services including: medical social services, respiratory therapy, nutritional counseling, home maintenance tasks, environmental modifications (home improvement services) and vehicular modifications, respite care both at home or in an institution, social day care, transportation to social day care, home delivered or congregate meals, assistive technology that includes Personal Emergency Response System (PERS), home and community support services, community transitional services, moving assistance, home and community support services, community transitional services and assistive technology.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

Policy:

An individual participating in the LTHHCP waiver (including AHCP participants) must fulfill requirements in three categories:

1. Be medically eligible for placement in a residential health care facility or hospital for an extended period of time;

2. Have total expenditures for health and medical services described in a comprehensive plan of care that do not exceed, on an annual basis, 75% of the monthly cost of care in a RHCF or 100% of the monthly cost when determined as special needs or 50% of the monthly cost when residing in an Adult Care Facility; and

3. Be determined eligible for Medicaid.

An important feature of the LTHHCP is the use of a comprehensive and coordinated assessment process to formulate a summary of the required services and a plan of care. Two distinct assessment processes are required for each individual prior to the development of a summary of services requirements for the individual; these are a medical assessment and a home assessment.

Individuals participating in the LTHHCP are assessed prior to enrollment in the program and must be reassessed for continued participation in the program every 180 days through the use of a joint assessment process between the local department of social services and a certified LTHHCP provider.

References:

ADMs
- 11 OLTC/ADM-1
- 09 OLTC/ADM-01
- 02 ADM-04
- 85 ADM-27
- 83 ADM-74
- 78 ADM-70

GISs
- 11 LTC005
- 11 LTC008
- 11 LTC009
- 10 LTC001
- 09 OLTC003
- 09 OLTC002
- 08 OLTC-008
- 06 MA-011
- 05 MA-37
- 01 MA-035

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

LCM 07 OHIP/LCM-1

Interpretation: Persons who request participation in the LTHHCP must be determined eligible for Medicaid, if Medicaid is to cover such services. Such persons must comply with the eligibility requirements of the appropriate category of assistance. See: **INCOME,** PERSONS IN MEDICAL FACILITIES, CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES and **INCOME** SSI-RELATED BUDGETING METHODOLOGY; and **RESOURCES** PERSONS IN MEDICAL FACILITIES.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD) HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)

Description:

The Office for People with Developmental Disabilities (OPWDD) Home and Community Based Services waiver (HCBS) is administered by OPWDD in conjunction with the State Department of Health (SDOH). The waiver is operated on a daily basis by OPWDD Developmental Disabilities Services Offices (DDSOs).

This Medicaid waiver was authorized by the federal government in September 1991 and provides a community based alternative for providing care to adults and children with developmental disabilities who live at home, in Family Care (FC), Community Residences (CRs), or in Individualized Residential Alternatives (IRAs). The HCBS waiver allows individuals to access Medicaid for medically necessary State Plan services as well as waiver services such as: Residential Habilitation, Day Habilitation, Respite, Prevocational Services, Supported Employment, Adaptive Technologies and Environmental Modifications.

Policy:

An individual participating in the OPWDD HCBS waiver must:

- Have a developmental disability as defined by MHL 1.03.(22);
- Require an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care;
- Reside in a qualifying living arrangement: (FC, CR or IRA, or their own home);
- Submit a waiver application to the DDSO and be approved by the DDSO for waiver services; and,
- Be Medicaid eligible.

Local districts are responsible for determining Medicaid eligibility for individuals seeking enrollment in the waiver who are not already in receipt of Medicaid. Districts are also responsible for the maintenance of new and existing Medicaid cases.

References:

LCMs 94 LCM-137
93 LCM-62
92 LCM-170

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)
HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)

Interpretation: For individuals who are not Medicaid eligible at the time the Waiver application is filed with the DDSO, a referral letter will be given to the Waiver applicant/enrollee to present to the LDSS.

Local districts must utilize the most advantageous eligibility option available to the family including a determination of disability, if necessary, as well as a determination of eligibility for the three month retroactive period, if appropriate, with the following exceptions:

- Children who are certified blind or certified disabled, under the age of 18, who live at home, may have Medicaid eligibility determined by disregarding parental income (and resources) and applying the child's income and resources to the Medically Needy level for a household of one.
- Certified blind or certified disabled children under the age of 18 who are expected to live outside the parental household (in a Waiver qualifying living arrangement) may have eligibility determined by disregarding parental income (and resources) and applying only the child's income and resources to the Medically Needy (or appropriate congregate care) level for a household of one.

NOTE: If the family of a certified blind or certified disabled Waiver child chooses not to apply for Medicaid for other household members, eligibility is to be determined for the Waiver child alone.

Children under the age of 18, who live at home, will be identified to the local district through a referral letter, completed by the local OPWDD Revenue Support Field Office, so the local district will be aware of the authority to waive parental deeming.

When Medicaid eligibility is determined by waiving parental deeming, a child support referral is not pursued.

HCBS Waiver applicants are required to document current resources, so that Community Coverage with Community-Based Long Term Care (coverage code 19) (or Outpatient Coverage with Community-Based Long Term Care, coverage code 21) can be authorized.

OTHER ELIGIBILITY REQUIREMENTS
WAIVERS

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD) HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)

Under Community Transition Services (CTS), an OPWDD HCBS Waiver participant may receive a payment to enable the individual to establish a basic household when transitioning from an institutional or provider-operated living arrangement to private residence living. These payments may include items such as security deposits, essential household furnishings and set-up fees or deposits for utility or service access. CTS payments are not considered income when determining Medicaid eligibility.

(See **INCOME** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSE IN SPECIFIED HOME AND COMMUNITY-BASED WAIVERS (HCBS) and I**NCOME** SSI-RELATED BUDGETING METHODOLOGY and **RESOURCES** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY–BASED WAIVERS (HCBS)