MANUAL MATERIAL TRANSMITTED					
MANUAL: Income Maintenance			**CHANGE NUMBER:** 23		
DELETE			INSERT OR CHANGE		
PAGES	**CHAPTER**	**DATED**	**PAGES**	**CHAPTER**	**DATED**
49 - 50	19	1/96	49 - 50 a	19	4/96
55 - 58	19	1/96	55 - 58	19	4/96
DATE: April 1996			**TO: ALL INCOME MAINTENANCE MANUAL HOLDERS**		

A. EMERGENCY ASSISTANCE

The policy added to Section 19.2, page 49 - 49a was omitted in error during a previous Manual revision. This policy, which describes the application of the time limitation policy as it relates to determining who shall be included in the benefit group, is being restored to the Emergency Assistance policy and the narrative has not been changed in any way.

B. NEMT

The policy added to the general eligibility requirements on page 55 (19.3) clarifies that SLIMB and QDWI cases can be ineligible for NEMT benefits or dually eligible for Medicaid and therefore eligible for NEMT.

this person is the head of the household or the person who has accepted responsibility for and is knowledgeable about other members of the benefit group.

Situations will occur when the person who should apply for benefits is unable or unwilling to do so. In these situations, the Worker must use judgement to determine if someone else in the benefit group can apply. Consideration should be given to the nature of the crisis and if a suitable person is available to apply. In most situations, the spouse of the head of the household would be the best choice.

4. The Benefit Group

The benefit group will consist of one or more persons who are living together. The only exception to this policy is when a person is paying for the privilege of living in the household. When this occurs, that person and his income will not be considered in determining eligibility of the benefit group. However, the payment being made for the privilege of living in the household will be added to the total income of the benefit group. This payment must be consistent with that amount which is locally usual and customary for the privileges covered. The worker may decide to request written verification of these situations. Written verification must consist of a statement having the amount of payment and what it covers, the time period covered by the payment and the dated signature of the person to whom payment is made.

Benefit group members will always receive a communal benefit from the Emergency Assistance Payment. This simply means that everyone in the group benefits from the payment even when payment is made for such items as pharmacy or medical treatment for individual assistance. No one who has benefitted from an Emergency Assistance Payment during the time limitation period may be included in the benefit group for individual assistance nor in determining eligibility for the entire benefit group. For example, an individual was a member of a benefit group that received an Emergency Assistance Payment. Six months later, this person is a member of a second household (or

The failure to return information or the return of incomplete or incorrect information that prevents a decision from being made on the case will be considered failure to provide verification and will result in a denial of the application. THEREFORE, ALL REQUESTS FOR VERIFICATION AND/OR TO RETURN CERTAIN INFORMATION MUST BE MADE VIA ES-6 FORM. If the applicant fails to return the ES-6 form by the date entered on the form, the Worker would deny the case via code E09. A computer-generated denial letter will be sent to the applicant and the ES-NL-A letter will not be necessary.

6. Decision on the Application

After the Worker has thoroughly reviewed with the applicant his current situation, consideration should be given to the following items:

a. Has the benefit group received (or received on it's behalf) an authorization for Emergency Assistance or IV-A Homeless benefits within the last twelve consecutive months including the current month of application (except for authorizations based upon natural or man-made disasters or fire)? If so, the application will be denied.

b. Has the applicant met the general eligibility requirements?

c. Has the applicant met the specific eligibility requirements for whatever item(s) of need he has requested?

d. Has the applicant been referred to an available community resource and has the applicant followed through to obtain the resource? Did the applicant actually receive (or receive on his behalf) the benefits in time to eliminate or prevent the emergency?

After giving careful consideration to the above, the Worker will approve or deny the application by entering the appropriate code on the ES-CHET-1 form. (Please refer to Section 19.4, item c-5.)

A decision must be rendered on all Emergency Assistance applications as soon as possible if the

B. Eligibility Requirements

1. General Eligibility Requirements

In order to be eligible for non-emergency medical transportation and certain related expenses, one must:

- Be a Medicaid recipient except as noted below:

  * Individuals who are designated a Qualified Medicare Beneficiary (QMB), or Specified Low Income Medicare Beneficiary (SLIMB), or Qualified Disabled Working Individuals (QDWI) only are **NOT** eligible for NEMT benefits. However, these cases may also be dually eligible for Medicaid by qualifying both as a QMB, SLIMB, or QDWI and under another category listed in the State Plan. Dually eligible cases ARE eligible for NEMT benefits since they are entitled to the full range of Medicaid services.

  * All Medicaid patients designated as TEFRA are eligible for NEMT benefits.

  * All Medicaid patients designated as LTC and Alternative LTC when transportation is required to obtain the PASARR test (psychiatric evaluation) as necessary to obtain screening for admission to nursing homes ARE eligible for NEMT benefits.

  * All Medicaid public school patients being transported to schools for the primary purpose of obtaining an education even though Medicaid-reimbursable school-based health services are received during normal school hours are NOT eligible for NEMT. If such services are provided off-site from the school or at school during other than normal school hours, NEMT benefits would be available.

though they were physically located in West Virginia. If in doubt, please contact the Office of Medical Services, Provider Services.

Requests to the Case Planning Unit should be made in writing if sufficient time exists. If sufficient time does not exist, the request may be made by telephone. ALL REQUESTS MUST INCLUDE THE FOLLOWING INFORMATION:

- The Medicaid recipient's name, address and Medicaid case number.

- The physician's order for the service including any necessary documentation and the following related items:

  * Specific medical service requested.

  * Where the service is to be obtained, who will provide it, and the reason why an out-of-state medical provider is being used. (This is especially important if the medical service is available in the State.)

  * The Medicaid recipient's diagnosis, prognosis, and the duration of the medical service.

  * A description of the total round trip cost for transportation and any certain related expenses that must be included and if advance payment is required. When the request is approved by the Office of Medical Services, necessary related expenses such as food and lodging are also considered as approved. Food and lodging requirements can often be coordinated through the Social Service Departments at the hospital.