MANUAL MATERIAL TRANSMITTED					
MANUAL: Income Maintenance			CHANGE NUMBER: 94		
DELETE			INSERT OR CHANGE		
PAGES	CHAPTER	DATED	PAGES	CHAPTER	DATED
Table of Contents, Pages: iii and iv	19	1/96	Table of Contents, Pages: iii and iv	19	12/97
53 thru 76	19	1/96, 12/96	53 thru 76	19	12/97
		and 11/97			
DATE: December 1997		TO: ALL INCOME MAINTENANCE MANUAL HOLDERS			

This manual material contains NO policy revisions. It is being issed solely for the reason that the previous issuance dated November, 1997 was not properly paged. Therefore, it is necessary to reissue the entire section. This issuance contains the most previous revisions that were effective November, 1997 but contains NO OTHER REVISIONS.

Call Bob Kent at 558-8290 if you have any questions.

19.3 NON-EMERGENCY MEDICAL TRANSPORTATION

For example, a family may be in need of ongoing homemaker's service or money management counseling although the emergency has been eliminated or averted through the authorization of Emergency Assistance.

The Worker shall determine the appropriate social service via discussion with the applicant/recipient, and make a referral via the HS-1 form to the Social Service Unit.

19.3 NON-EMERGENCY MEDICAL TRANSPORTATION

A. Introduction

1. Funding Sources

Transportation for non-emergency medical purposes is funded through three different sources. These sources are:

- Title XIX funds for all Medicaid recipients including foster children,
- Title V funds for non-Medicaid eligible recipients of Handicapped Children's Services, and
- Agency administrative funds for applicants of financial or medical assistance who need a physical examination in order to complete the eligibility determination process.

2. Services Provided

Services provided under this program are:

- Transportation and certain related expenses necessary to secure medical and other services covered by the Medicaid Program including medical services under the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT).
- Transportation and certain related expenses necessary to secure medical services covered by the Handicapped Children' Program for non-Medicaid eligible children.
- Transportation and certain related expenses necessary to secure medical examinations required in the eligibility determination process for the financially needy and medical assistance only programs.

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.(note the clarifications and exceptions 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 are eligible for NEMT benefits including transportation needed to obtain the PASARR test (psychiatric evaluation) as necessary to obtain screening for admission to nursing homes.

  * 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.

An exception exists to the exclusion noted above for on-site school-based services. This applies to children receiving services under the Individuals with Disabilities Education Act (IDEA). However, this exception exists only when the following conditions are met:

1. The child receives transportation primarily to obtain a Medicaid-covered service, and

2. Both the Medicaid-covered service and the need for transportation are included in the child's Individualized Education Plan (IEP).

- Incur transportation and/or certain related costs for the round-trip to the medical vendor.

- Receive medical treatment or services covered by the Medicaid program. Transportation costs incurred only to obtain medicine, medical products or repairs to medical products are NOT covered.

- Receive pre-authorization in certain situations for the transportation costs as described on the application form and in this policy.

- Have an appointment or plan for the medical treatment or service.

- Comply with the 60-day application submittal deadline.

2. Specific Eligibility Requirements

a. Transportation Requests Which Require Prior Approval from the Bureau of Medical Services

All requests for out-of-state transportation and certain related expenses must have prior approval from the Bureau of Medical Services, Case Planning Unit. Certain medical providers residing in bordering states near the West Virginia state line have been

granted border status. These providers are considered in-state providers and should have a West Virginia Medicaid provider number as though they were physically located in West Virginia. If in doubt, please contact the Bureau of Medical Services, Provider Services, to determine if an out-of-state medical provider has been granted border status.

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 Bureau 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.

b. Transportation Requests Which Require Prior Approval from the Local or County Worker

- Transportation of an immediate family member to visit/stay with a patient at the medical facility. An immediate family member will be limited to a parent to visit/stay with a child(ren), a child to visit/stay with a parent(s) and a spouse to visit/stay with his/her spouse. The need to visit/stay must be based upon a medical necessity and be documented in writing by physician. In emergencies, verbal documentation may be accepted. In all situations, the physician must state why the visit/stay is necessary and the reason must be based upon a medical necessity. Exceptions to the definition of what constitutes family members may be granted after supervisory approval.

- Lodging plus meals as required with lodging.

- Transportation via common carrier. If the applicant, during the interview, insists upon incurring transportation costs and certain related expenses beyond that which is offered or approved by the Department, the Worker will share with the applicant that such costs will not be reimbursed by the Department.

- Request for two round trips for two appointments to the same medical provider on the same date. Each request must be individually evaluated before approval may be given.

  Note: Prior approval is NOT necessary for transportation requests within the state but beyond the nearest resource.

c. Routine Automobile Transportation Requests

Routine automobile transportation requests plus meals and turnpike fees may be received by eligible Medicaid recipients WITHOUT pre-authorization. If the applicant meets the NEMT eligibility guidelines as verified by the submission of an application after the trip is taken, he may be found eligible to receive these benefits. Routine automobile transportation requests plus meals and turnpike fees may be defined as any request for travel NOT as part of or in conjunction with requests that require pre-authorization as set forth in a or b above.

If the applicant incurs more costly transportation costs than the private auto mileage rate without prior approval, he will receive reimbursement at the current private auto mileage rate unless he can show that less expensive transportation could NOT be obtained.

d. Advance Payment

Applicants approved for benefits under the Non-Emergency Medical Transportation Program are reimbursed for allowable expenses incurred for round-trip travel. However, situations may occur when the recipient/vendor may request payment in advance because of insufficient resources. The Worker is permitted to evaluate and make the decision to approve such requests. After a careful evaluation of the situation, the Worker must document the decision to deny or approve such requests by making a recording in the case record.

e. Transportation for Emergency Room Services

Situations may occur when the Medicaid recipient requests transportation to an emergency room to receive medical treatment. THE USE OF AN EMERGENCY ROOM AS A PHYSICIAN'S OFFICE IS NOT COVERED. When such requests are approved, it must be thoroughly

documented in the case record that emergency room treatment was medically necessary.

f. Handicapped Children's Services Recipients

Recipients of Handicapped Children's Services receive reimbursement of transportation and certain related expenses in order to obtain planned medical services. Transportation services are limited to those patients whose family income falls within the Handicapped Children's Services' financial guidelines.

(1) Medicaid Eligible Handicapped Children's Service Recipients

Handicapped Children's Services patients may also be Medicaid eligible (i.e. they are foster children or members of an AFDC/U, Medicaid or SSI benefit group). Medical services provided by Handicapped Children's Services for these patients are billed to the Medicaid program. Transportation services for these patients are also charged to the Medicaid program. Services provided due to Medicaid eligibility must meet the requirements in item B. Requests for transportation that require approval from the Bureau of Medical Services are submitted to Handicapped Children's Services staff for approval.

(2) Transportation Requests which Require Prior Approval from Handicapped Children's Services staff (Local or office staff)

In all situations when the child must secure medical care outside the state, Handicapped Children's Services staff must approve the necessary transportation and certain related expenses.

(a) Medicaid-Covered and Non-Medicaid covered Handicapped Children's Services:

In ALL situations when the child must secure medical care outside the state, Handicapped Children's staff must approve the necessary transportation and certain related expenses.

(b) Non-Medicaid covered Handicapped Children's Services:

Prior approval must be obtained from Handicapped Children's Services for routine appointments to a physician's office, a clinic or to receive therapy and hospitalization UNLESS the applicant can submit written verification that the service has been approved by Handicapped Children's Services.

(3) Advance Payment

In certain situations, advance payment may be requested by the applicant. For example, certain types of medical care such as organ transplant services may require that the patient travel long distances with very little advance notification. All requests for advance payment must be carefully evaluated and justified by the Worker via recording on the application form. If the Worker feels that sufficient justification exists for an advance payment, approval may be made by the Worker. When the client fails to verify the trip, **NO** additional advance payments may be made.

All inquiries regarding the eligibility for transportation and certain related expenses for recipients of Handicapped Children's Services must be directed to Handicapped Children's Services, Division of Maternal and Child Health.

g. Applicants who Require Medical Examinations

Applicants who apply for benefits under certain programs in which a medical examination is required may request transportation benefits for the trip.

In determining eligibility for these requests, the Worker should consider the following:

- The required medical examinations MUST be only for the purpose of determining eligibility for a program operated by the Department (such as AFDC-Incapacity).

- The Worker will apply the eligibility guidelines outlined under B, Eligibility Requirements, with the exception of the first and third items since the applicant is not yet a Medicaid recipient.

C. Transportation Providers

The transportation providers listed below must be used according to the priority in which they are listed. THIS MEANS THAT THE LESS EXPENSIVE METHOD OF TRANSPORTATION MUST ALWAYS BE CONSIDERED AND, IF POSSIBLE, USED FIRST:

- The patient or a member of his family, friends, interested individuals, foster parents, adult family care providers or Volunteers.

- Volunteers or paid employees of community-based service agencies such as Community Action Programs and Senior Citizen Programs.

- Common carriers (bus, train, taxi or airplane).

- An employee of the Department with Supervisory Approval ONLY AFTER IT HAS BEEN DETERMINED THAT THE PROVIDERS INDICATED ABOVE ARE NOT AVAILABLE.

Whenever patients/applicants use more expensive transportation than the private auto mileage rate without prior authorization, they must show that only

the more expensive transportation was available when the trip was taken. If the patient/applicant, for example, uses a taxi to make the trip but is unable to show that automobile transportation was not available, reimbursement will be at the current mileage rate instead of the taxi fare.

1. Determining the Amount of Payment for Transportation

   Determining the amount of payment for transportation depends upon the method of transportation used and the round-trip distance to the medical facility.

   WHEN TRANSPORTATION REQUESTS ARE RECEIVED FROM RECIPIENTS OF HANDICAPPED CHILDREN'S SERVICES AND/OR MEDICAID ELIGIBLE CHILDREN FOR THE PURPOSE OF INPATIENT HOSPITALIZATION ADMITTANCE, REIMBURSEMENT IS MADE FOR UP TO THREE ROUND TRIPS PER ADMISSION. This will include one round trip on the day of admission, one round trip for the parent to be present for surgery, and one round trip on the day of discharge.

   - Automobile - Mileage is paid at the current mileage rate for one round trip. If more than one patient is being transported, the Worker will make payment for only one round trip. Whenever the transportation provider is NOT the patient or someone living in the patient's household, the total cost of the round trip mileage to the medical facility will be computed from the provider's point of departure (his residence) to pick up the patient for the trip to the medical facility. The round trip will be made over that route which constitutes the SHORTEST DISTANCE IN MILEAGE. The worker may adjust the total mileage when it is believed the provider/patient has charged excessive mileage. However, the worker must be able to justify such an adjustment with a road map or certified odometer reading. When a Department employee is the provider, the employee will be reimbursed at the rate permitted in the state travel regulations.

   - Common Carrier - When a common carrier is the provider, the established round-trip fare

will be paid. The cost of waiting time will be included in the payment when inter-city travel is required (travel from city to city). The patient and taxi driver must be aware that waiting time is allowed ONLY TO SECURE MEDICAL SERVICES. Prior to making payment for transportation in which the cost of waiting time is included, the Worker must obtain from the taxi company a dated and signed statement indicating the rate, elapsed time, and total charges for waiting time.

When intra-city travel is required (travel within the city limits), the cost of waiting time will not be included in the payment, and the patient(s) and taxi driver must be aware of this.

2. Car Pool

Car pooling will be maintained for all recipients when appointment dates at the same medical facility coincide for more than one patient. However, the Worker should use judgement and input from the transportation provider in determining the safe number of persons to be included in each vehicle.

In special situations, car pooling may not be appropriate for certain clients. For example, various types of physical infirmity may prohibit car pooling in order to maintain the appropriate level of safety and comfort for all involved. Judgement, and if required, verbal or written medical certification must be exercised by the Worker in determining when car pooling is appropriate.

3. Use of Volunteers as Transportation Providers

a. Definition of a Volunteer

In order to maintain the records for volunteer transportation providers, a "volunteer" will be defined as anyone who provides assistance to clients or recipients of the Department without compensation or with reimbursement of expenses only.

b. Limitations on the Use of Volunteers as Transportation Providers

In the case of Burnsville Community Cab, Inc. vs. Alice Knicely and the Department of Human Services, the Public Service Commission has made the following adjustment in regard to the use of volunteers as transportation providers.

The Department will not reimburse any individual volunteer who provides transportation under the Non-Emergency Medical Transportation Program for eligible patients in any amount greater than 6,000 miles in any calendar year at the current rate of reimbursement.
The following EXCEPTIONS will apply to the policy above:

In areas of the state where no public transportation is available, there will be no limitation on the mileage ceiling referred to above.

On every occasion in which (1) no public transportation is available at the time of a patient's medical appointment and (2) no volunteer who has not yet provided 6,000 miles worth of reimbursable transportation during the calendar year is available to provide transportation to that patient, the Department is permitted to use a volunteer who has already exceeded the 6,000 mile ceiling in order to provide the necessary transportation to that patient.

There will be no limitation on the amount of reimbursement received by the family members or friends of individual patients who have been selected by the patient to provide the transportation.

In situations where a patient is in need of frequent regular medical treatment (such as, but not limited to, kidney dialysis or chemotherapy), there will be no limitation to the vendor who routinely provides transportation to that patient for medical treatment. THIS EXCEPTION WILL BE GRANTED ON A CASE-BY-CASE BASIS BY LOCAL STAFF AND ONLY UPON REQUEST OF THE PATIENT.

The policy statement regarding the limitation will not apply to Transportation Remuneration Incentive Program tickets or to the reimbursement of common and contract carriers operating under the authority of the Public Service Commission.

4. Use of Employees of Entities That Provide Medicaid Services During Their Hours of Employment.

Employees of entities that provide Medicaid services (such as but not necessarily limited to Homemaker agencies, Behavioral health center, Behavioral health rehabilitation providers) may not be reimbursed as NEMT providers when providing transportation while they "are on the clock" or otherwise during their official hours of employment.

D. Certain Related Expenses

1. Allowable Expenses

Certain related expenses will be limited only to the following items:

- Meals
- Lodging
- Turnpike Fees

2. Determining the Amount of Payment for Certain Related Expenses

a. Meals

Necessary meals at the rate of $5.00 per meal per person will be considered only in the following circumstances:

- When the time of the appointment and the length of the round trip extend through meal hour(s) during the trip **AND** the single day round trip is not less than 100 miles. Meal hours of noon for lunch and 6:00 p.m. for dinners will be observed. Breakfast is permitted only when lodging has been approved, or otherwise obtained.

- When lodging has been approved, meals will be permitted for the patient when out-patient treatment is received and/or for one person who was approved to accompany or visit the patient plus the driver.

- Meals are permitted for the driver only when a private automobile is used.

- Meals are permitted for the patient(s) regardless of the type of transportation used.

- When an employee of the Department is the provider, the employee will observe agency regulations regarding travel and meals.

b. Lodging

IT IS MANDATORY THAT THE MOST ECONOMICAL RATE OR FACILITY BE OBTAINED FOR LODGING. Resources such as McDonald Houses and other facilities recommended by the medical facility must be used whenever possible. This will include hospital "rooming in" facilities. Therefore, necessary lodging at the MOST economical rate may be considered only in the following circumstances:

- When approval has been given for someone to stay with the patient.

- When the hour of the appointment and the length of the trip require that the patient/provider have overnight lodging to prevent undue hardship. For example, an early a.m. appointment prior to 9 a.m. and a travel time of NOT LESS THAN 4 HOURS. Lodging will be permitted in these circumstances for ONE patient and ONE provider. In most situations, this would normally involve a child who receives Handicapped Children's Services and the parent who is also the provider.

- When approval for lodging has been given by the State Office staff of Handicapped

Children's Services or the Bureau of Medical Services.

- When lodging is required for the patient and one person (which must be verified in writing by the attending physician to accompany the patient) for the completion of outpatient treatment plans.

  In any of the situations above, when the driver prefers to return and not obtain lodging, the cost of the double round trip may not exceed the cost of the driver's lodging plus meals.

NOTE: When an employee of the Department is the provider and overnight lodging is required, the employee will observe for his expenses only the state travel regulations.

Ronald McDonald Houses and NEMT -

At the present time, only three Ronald McDonald Houses exist in West Virginia:

Charleston - CAMC (346-0279)
Huntington - Cabell-Huntington Hospital and St. Marys Hospital (529-1122)
Morgantown - Chestnut Ridge Hospital, Monongalia General Hospital, Ruby Memorial Hospital and Mountaineer Rehabilitation Center (598-0050)

Certain Medicaid-eligible clients arrive at Ronald McDonald Houses without being pre-approved for NEMT at the county office. These clients are referred to by Ronald McDonald staff as "emergencies." Income Maintenance personnel stationed at any of the facilities listed above will take the NEMT applications for Medicaid-eligibles designated as "Emergency" and in need of lodging benefits from the Ronald McDonald Houses. All other benefits available from NEMT, such as food and transportation, can be evaluated as well.

Otherwise, the local worker may contact the Ronald McDonald Houses listed above when referrals need to be made for NEMT patients.

c. Turnpike Fees

Turnpike fees for round-trip travel will be permitted for private automobiles only. Receipts are not necessary.

E. Application Process

The application process consists of obtaining sufficient information required to make a decision regarding the applicant's eligibility for benefits. The application form (ES-NEMT-1) has been designed to permit the applicant to complete it without Worker assistance. This is important when the patient is requesting routine automobile transportation benefits. These requests do not require pre-authorization and may be handled through the mail.

1. Completion of Form ES-NEMT-1, Application Verification Form

Form ES-NEMT-1 must be completed for all requests for transportation (except when the DF-67-B may be used) and certain related expenses in order to determine eligibility for NEMT benefits. (Refer to item 2 below to determine when the DF-67-B may be used.)

The form is divided into Sections A - Identifying Information, B -Applicant and/or Patient Responsibilities Signatures, C - For Agency Use only and D - Verification of Attendance/Travel Costs.

The form contains sufficient space to obtain verification for up to four trips per application. However, when the patient is making more than ONE TRIP PER WEEK, up to five trips/week may be verified. Each trip date must be entered in the space entitled "Date Patient Attended." In this way, a maximum of twenty round trips can be approved on one application since four verification spaces exist per application. Regardless of the number of trips included on the form, ALL trips must have occurred within the 60-day deadline (refer to "d." below).

The form is to be completed as follows:

a. Identifying Information and Form Origination

The identifying information of the person who is completing the application will be entered in this section. Case numbers will be obtained for the patient who needs the travel. Additional spaces for case numbers are provided in situations where additional cases with different numbers exist in one household.

The form must originate from the county in which the Medicaid card was issued. If foster children are placed in foster homes located in other counties, the completed application form can be mailed by the foster parent to the Worker in the county in which the Medicaid card was issued.

b. Applicant/Patient Responsibilities/Signatures

ALL statements must be checked either "yes" or "no" and the applicant's signature and date must be entered before an eligibility decision can be rendered.

c. For Agency Use only

The Worker will use the recording space to enter any and all information as appropriate.

A space to enter the transportation vendor number is located in the upper right corner. If different vendors are used, the Worker may enter the vendor number(s) and label it/them as such on the appropriate trip. (Refer to the verification of travel page.) Finally, the Worker must sign and date the form.

The actual verification form now requests the social security number of the patient and the NEMT vendor (or tax I.D. number of the vendor). Check mark blocks for case approval or denial are provided to permit the worker to approve or deny each verification form. A space is also provided for the entry of an

appointment time when eligibility for food comes into question or for some other reason.

d. Verification of Attendance/Travel Costs

The instructions are self-explanatory and are provided to assist the applicant in completing the verification form(s).

Upon receipt of the complete application form, the Worker must carefully review the verification of travel. All items that pertain to the claim must be completed. Incomplete applications must be returned to the applicant with instructions for making corrections.

Finally, the completed application which includes verification of attendance, must be submitted to the Department no later than 60 days from the date of the trip(s) for which the applicant is requesting benefits. Benefits will be DENIED if this deadline is not met. All trip dates must meet the 60-day deadline requirement.

2. Completion of Form DF-67-B as the Application Form for EPSDT, Handicapped Children's and Other Approved Clinics

It is permissible to use Form DF-67-B, Non-Emergency Medical Transportation Voucher at the medical vendor's locale as an application form for applicants who request transportation to obtain the following services:

- Handicapped Children's Clinics
- EPSDT clinics
- Non-clinic EPSDT services
- OTHER approved clinics

The reason for permitting this procedure is to reduce the amount of paperwork for a routine function in which larger numbers of persons can be served in a group setting. This may be especially important for the local County office which is

responsible for handling the paperwork or making other arrangements for approved clinics. The DF-67-B form may be used at the office's option as the transmittal document for CHET entries. Therefore, the instructions for completing the form as an application will include data that is needed to transmit the CHET entry.

The form should be completed as follows:

FACILITY AND ADDRESS - Enter the name and address of the facility in which the EPSDT, Handicapped Children's or other approved clinic is being held.

DATE OF SERVICES - Date on which the clinic is being held.

CASE NAME, ADDRESS AND SOCIAL SECURITY NUMBER - Enter the case name, address and Social Security number of the person who is the case name.

VENDOR'S NAME/ADDRESS/NUMBER - When the vendor has previously been entered in the CHET system, a VENDOR NUMBER will be the only entry required in this column. Otherwise the name and full address must be entered.

PATIENT'S NAME(S) - Enter the name of the PATIENT(S) who is attending the clinic.

NOTE: At this point on the DF-67-B form, the application has been completed. The completed DF-67-B form (or a copy) must be returned to the patient's home for processing of payment. For example, if a patient residing in Clarksburg attended a clinic in Morgantown, the Clarksburg office would make payment to the transportation provider based upon information received at the Morgantown clinic. Completing the remainder of the form is necessary to make payment for transportation and other related expenses. This is described below in item F, Payment Process.

3. Categorical Identification

The categorical identification illustrates the type of assistance being received by the recipient of NEMT benefits. THE DEPARTMENT MUST REPORT THIS IDENTIFICATION WHEN REQUESTING REIMBURSEMENT OF

FEDERAL FUNDS. Therefore, the identification is entered upon the OIM-NEMT-1 application/verification form. Ultimately, the identification must be entered into the CHET system in order to make payment.

The following instructions apply in determining the correct identification to be used for each type of assistance. All Medicaid patients will be categorically identified by matching the letter prefixes or codes listed below on the left with the categorical program identification listed in the column on the right:

M prefix	=	MAO
C prefix	=	AFDC
U prefix	=	AFDCU
A prefix	=	SSI-A
B prefix	=	SSI-B
D prefix	=	SSI-D
E prefix	=	EPSDT
H prefix	=	Handicapped Children's Patients
G prefix	=	Medicaid Eligible Handicapped Children's Patients
P prefix	=	Pending Medical Examination Case
F prefix	=	Foster children who do not come under any of the codes listed above.

4. Completion of Form ES-6, Notice of Information Needed

Whenever the applicant has failed to include necessary information during the intake interview or upon the application form, the Worker should complete form ES-6 by writing clear and concise instructions about what is needed. In addition, the Worker should enter on the form a specific date by which the information is to be returned. A copy of the completed form should be attached to the application form.

5. Notification

After the Worker has made a decision on the application, the applicant must be notified about the decision.

a. Approval

Notification of approval is fulfilled when:

- Payment is made to or on behalf of the client for routine automobile transportation requests (approvals made after the trip is made), or

- The Worker approves the application prior to the trip and instructs the client to obtain verification of attendance.

b. Denial

Notification of denial is fulfilled when form letter ES-NL-A is completed and given (or mailed to) the applicant.

F. Payment Process

The payment or reimbursement of transportation and certain related expenses can be generated via CHET or generated by the Financial Clerk when advance payment is required. THE PAYMENT PROCESS BEGINS WITH THE COMPLETION BY THE WORKER OF FORM DF-67-B REGARDLESS OF THE METHOD IN WHICH PAYMENT IS TO BE MADE. After the form is completed by the Worker, it must be approved by the Worker's supervisor and then checked and approved by the Financial Clerk. If advance payment (or payment otherwise generated by the Financial Clerk) must be made, the Clerk will write the check based on the information contained on the DF-67-B form.

The payment process is the same for ALL transportation vendors or providers. THIS MEANS THAT DEPARTMENTAL STAFF WHO HAVE PERFORMED AS TRANSPORTATION PROVIDERS WILL NOT CHARGE ALLOWABLE EXPENSES ON THE IN-STATE TRAVEL EXPENSE ACCOUNT FORM. INSTEAD, THE WORKER WILL RECEIVE REIMBURSEMENT VIA THE NEMT PAYMENT PROCEDURE AS ANY OTHER TRANSPORTATION PROVIDER.

1. Function of the DF-67-B Form in the Payment Process

In addition to serving as an application and verification form for approved clinics, the DF-67-B form continues its multi-purpose in the payment process:

- Voucher - The form serves as a voucher from which checks may be written by the Financial Clerk for advance payment or in other unusual situations when payment is not made via CHET.

- Authorization Record - The form serves as an excellent record of individual trip authorizations as posted from the ES-NEMT-1 forms. This becomes important when the costs of several trips are often combined into a single payment or one check. When it becomes necessary to audit, the detail is sufficient to resolve any questions about check amounts, what trips were covered, etc.

- CHET Transmittal - The form contains space for the necessary items required for making a transmittal for payment via the CHET system (please refer to 19.4, item C-8). The local office may opt NOT to use the DF-67-B form for this purpose. However, it will be necessary to complete the OIM-CHET-1 form in addition to the DF-67-B form in order to make payment via CHET (please refer to Section 19.4, item C-2 b.).

2. Completion of Form DF-67-B

Please refer to Section 19.4, item c-8 for complete details in completing the DF-67-B form. This will include advance payment (or payment otherwise made by the Financial Clerk) payment generated by CHET and instructions concerning the use of Form DF-67-B (or ES-CHET-1) as the CHET transmittal document.

- Voucher - The form serves as a voucher from which checks may be written by the Financial Clerk for advance payment or in other unusual situations when payment is not made via CHET.

- Authorization Record - The form serves as an excellent record of individual trip authorizations as posted from the ES-NEMT-1 forms. This becomes important when the costs of several trips are often combined into a single payment or one check. When it becomes necessary to audit, the detail is sufficient to resolve any questions about check amounts, what trips were covered, etc.

- CHET Transmittal - The form contains space for the necessary items required for making a transmittal for payment via the CHET system (please refer to 19.4, item C-8). The local office may opt NOT to use the DF-67-B form for this purpose. However, it will be necessary to complete the OIM-CHET-1 form in addition to the DF-67-B form in order to make payment via CHET (please refer to Section 19.4, item C-2 b.).

2. Completion of Form DF-67-B

Please refer to Section 19.4, item c-8 for complete details in completing the DF-67-B form. This will include advance payment (or payment otherwise made by the Financial Clerk) payment generated by CHET and instructions concerning the use of Form DF-67-B (or ES-CHET-1) as the CHET transmittal document.

19.4 CHET SYSTEM

A. Introduction and Purpose

The CHET system was developed to computerize the application and payment process of the Emergency Assistance and Homeless Person programs. In addition, CHET includes the computerization of the Non-Emergency Medical Transportation Program (NEMT) payment process. Finally, a computer-generated notification letter is featured for the Emergency Assistance Program.

The purpose of the CHET system is to obtain greater control over the three program processes referred to above. This can only be accomplished with the capability to disseminate client and vendor information with speed and accuracy. Not only does this include the ability to write checks but also the ability to obtain past client and vendor information in order to make eligibility decisions on current applications.

General Features of the CHET System:

The CHET system incorporates the features referred to below. Letter codes E, H, and/or T in parentheses indicate whether the feature applies to Emergency Assistance (E), Homeless (H), or NEMT (T).

* (EHT) A separate client and vendor file.

* (EHT) The computer can write up to 75 separate checks per case for all three programs combined over a 12-month period.

* (EHT) The ability to permit checks to be written manually by the Financial Clerk when necessary.

* (E) Computer-generated notification letters.

* (EHT) The Social Security number of the applicant will be the case certificate number.

* (EHT) When no Social Security number exists for the applicant, an automatic calendar "julian day" case certificate number is provided by the computer.

* (EH) Automatic designation of Title IV-A eligibility upon entry of benefit group data.