must inquire if the Special Pharmacy applicant is receiving medical coverage through CAS. If the Worker believes the individual may be dually eligible through both FACTS and RAPIDS, the Worker must electronically notify the DFA Economic Services Policy Unit with the following information:

- Applicant/Recipient's Name
- Date of Birth
- Social Security Number
- Client's FACTS ID, if known

Upon receipt, the Policy Unit will contact CAS to establish if coverage already exists or if further eligibility determination is necessary.

Once the eligibility decision is made, the county office is notified by DFA. The Worker must then provide the client with all necessary information to obtain the drug(s). The DFA Economic Services Policy Unit will notify the Worker that the Special Pharmacy recipient's coverage is about to end. The Worker must contact the client regarding reapplication prior to the termination of the coverage.

B. SPECIAL PHARMACY, CLOZAPINE/CLOZORIL, DRUG MANAGEMENT AND TESTING

Individuals for whom Clozapine/Clozoril has been prescribed and who are not eligible for Medicaid due solely to failure to meet a spenddown may have the cost of this medication paid by the Department. To qualify, it must be established that the cost of the Clozapine/Clozoril, if paid by the client, would reduce the family income to at or below 100% of the FPL for a family of the same size. Because lab work is not covered under Special Pharmacy for Clozapine/Clozoril, incurred lab costs are used as a deduction in income calculations. The individual must have been denied Medicaid for the above reason within six months of the date of the client's request for payment. In addition, the Worker must review the previous application to determine if the client's circumstances have changed. If he continues to be ineligible for Medicaid, due solely to failure to meet a spenddown, at the time he requests payment for the medications, Special Pharmacy is considered. To have the client considered for this program, the Worker must submit a memorandum to Director, DFA. The memorandum must have "Special Pharmacy" at the top of the page or the Special Pharmacy Consideration form must be submitted and contain all of the information specified in item A above with the following additions:

- Average monthly cost of Clozapine/Clozoril

- Average monthly cost of lab tests

- Name of facility which will perform the lab tests.

No verification of the information submitted is required unless the client does not know the information or the Worker has reason to doubt the client's statement.

NOTE: Certain recipients of the Division of Children and Adult Services (CAS) are eligible to receive coverage for immunosuppressant drugs through FACTS. During the application or renewal process, the Worker must inquire if the Special Pharmacy applicant is receiving medical coverage through CAS. If the Worker believes the individual may be dually eligible through both FACTS and RAPIDS, the Worker must electronically notify the DFA Policy Unit with the following information:

- Applicant/Recipient's Name

- Date of Birth

- Social Security Number

- Client's FACTS ID, if known

Upon receipt, the DFA Economic Services Policy Unit will contact CAS to establish if coverage already exists or if further eligibility determination is necessary.

Once the eligibility decision is made, the county office is notified. The Worker must then notify the client and provide him with all necessary information to obtain the services. The DFA Economic Services Policy Unit will notify the Worker that the Special Pharmacy recipient's coverage is about to end. The Worker must contact the client regarding reapplication prior to the termination of the coverage.

C. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS

Provided they are legally able to do so, all adult Medicaid applicants and recipients must assign to the department any rights to medical support and to payments for medical care from any third party.

When the adult receives Medicaid under any coverage group, under any case number, the assignment of medical support rights is a condition of eligibility and he must cooperate in identifying and providing information to use in pursuing third parties, unless good cause is established for not cooperating. This includes providing accurate health insurance information at application and redetermination. See Section 4.2,H for verification requirements. Good cause is determined by DFA, based on written information obtained by the Worker.

NOTE: All other adults who have the legal ability to do so, but who are not Medicaid recipients, must assign medical support rights as well.

When an otherwise eligible individual cannot legally assign his own rights, and the person legally able to do so does not cooperate, the individual remains eligible.

EXAMPLE: A mother refuses to assign benefits for herself and her children, for whom she can legally make an assignment. The mother is ineligible and the children remain eligible for Medicaid.

NOTE: Poverty-Level Pregnant Women are not penalized for failure to cooperate with this requirement until the expiration of the postpartum period.

An applicant for SSI is required to assign third-party rights to the Department as part of his application for SSI. If he refuses to assign these rights, he is ineligible for Medicaid.

D. DATA SYSTEM INTERACTION

When health insurance information is entered by BCSE, RAPIDS alert 191 "Ins. Info. Check OSCAR'S INSU", is sent to the Worker. Since BCSE and BMS data systems do not interface, the Worker must enter the health insurance information on RAPIDS screen AFMC which will interface with BMS.

The Bureau for Medical Services must verify health insurance with the carrier before entering it in the BMS data system. The Worker is notified by RAPIDS alerts when BMS updates Third-Party Liability (TPL) information, there is an insurance carrier or policy number mismatch or the TPL information is not verified. See the RAPIDS User Guide for specific Worker actions required. If the Worker has any information which conflicts with the BMS-verified information, he must provide the information to the Third-Party Liability (TPL) Unit by e-mail or fax so that BMS can clear up any discrepancy. This insures accurate information is entered in both data systems.

E. CERTIFICATE OF COVERAGE WHEN MEDICAID COVERAGE ENDS

All Medicaid recipients who so request, must be issued a Certificate of Coverage DFA-HIP-1, when Medicaid benefits stop.

This applies to all individuals whose Medicaid benefits stopped on or after July 1, 1996. See Section 2.1,B.

F. CHILD SUPPORT REQUIREMENTS AND PROCEDURES

Federal law mandates that efforts be made to locate absent parents, establish paternity and obtain medical support for dependent children who receive Medicaid.

The responsible adult included in any Medicaid coverage group must cooperate with BCSE.

EXCEPTION: Recipients of TM cannot lose eligibility for failure to cooperate with BCSE. However, BCSE services must be explained and a voluntary referral made when appropriate.

When the responsible adult is not a Medicaid recipient under any coverage group, he must be informed of the availability of BCSE services and encouraged to accept a voluntary referral. Voluntary BCSE referrals do not sign the DFA-AP-1. There is no penalty when a voluntary referral subsequently fails to cooperate with BCSE.

The major responsibility for this effort rests with the Bureau for Child Support Enforcement (BCSE) through its staff of Legal Assistants.

In addition, the Worker has the following responsibilities:

- To explain the requirements and benefits of BCSE services, including the right to claim good cause for refusal to cooperate
- To refer appropriate cases to the Legal Assistant. Referral is accomplished by data system exchange or DHS-1.
- To evaluate evidence presented if the client claims good cause
- To determine if good cause for failure to cooperate with BCSE exists
- To apply the penalty for refusal, without good cause, to cooperate or provide information about medical support to adults included in any Medicaid AG who can legally assign support rights.

- **To respond to RAPIDS alert 191. See Section 16.1,D for the required action.**

The following information provides details about the responsibilities of the Worker, the Legal Assistant, and the client in the child support process.

1. DFA-AP-1, Acknowledgement Of Automatic Assignment Of Support Rights And Of Cooperation Requirements

   The purpose of the DFA-AP-1 is to assure that affected clients understand the benefits, requirements and rights associated with BCSE. It also advises them of the requirement to redirect child support, should the child become a cash assistance recipient.

6. Communication Between The Worker And The Legal Assistant

Communication between the Worker and the Legal Assistant continues until the case is closed, the child whose parent(s) is absent is removed from the benefit group, or, if applicable, the deprivation factor changes to unemployment, incapacity or death.

The Worker must notify the Legal Assistant, in writing, of the following:

Communication between the Worker and the Legal Assistant continues until the case is closed, the child whose parent(s) is absent is removed from the benefit group, or, if applicable, the deprivation factor changes to unemployment, incapacity or death.

The Worker must notify the Legal Assistant, in writing, of the following:

- A good cause determination is being made and the Legal Assistant's comments and recommendations are being requested prior to a final decision.

- The client has requested a Fair Hearing as the result of the Department's finding that good cause for non-cooperation is not established.

- Should the Worker become aware of information which could help the Legal Assistant in establishing paternity and/or obtaining medical support, this information must be shared.

The Legal Assistant must notify the Worker, in writing, of the following:

- The client refuses to cooperate in BCSE activities related to establishing paternity and/or obtaining medical support and the reason for the refusal.

- Information which affects eligibility or the amount of the payment.

- Change of address.

- Paternity is established.

- Information regarding a change in the deprivation factor or cause of absence, if applicable, is secured.

When health insurance information is entered by BCSE, an interface between OSCAR and RAPIDS occurs and RAPIDS alert 191 is sent to the Worker.

Changes in case circumstances are automatically referred to BCSE through RAPIDS.