EXAMPLE:

Date	Recording	Worker	Data Transmission
10/10/95	Client applied. All elig. req. met except spdwn. DFA-6 and 6A given for medical bills	Jones	N/A See case comments of 10/10/95
11/6/95	Medical bills received ($432). Not enough to meet spenddown.	Jones	N/A
11/8/95	More bills received ($617). Spdwn met approval notice sent	Jones	

For all Medicaid applications, the documentation on CMCC and/or the appropriate RAPIDS Screens must include, but is not limited to, the following:

- Date of application. This is on RAPIDS Screen ACPA.

- Date the verification checklist or DFA-6 and 6A were mailed or given to the client. This appears on RAPIDS Screen CNHS.

- Date medical bills submitted by the client were received in the local office. This appears on RAPIDS Screen ANMR.

- Date medical expenses were added to RAPIDS. This appears on Screen AGTM.

- The result of each 30-day review found on CMCC (instructions in item 2 below).

- All actions related to the MRT process, when applicable, which include, but are not limited to:

  - Date initial medical reports are requested

  - Date of follow-up activity required to obtain initial reports

  - Date medical reports are received in the county office

- Date additional medical information, as indicated on the initial medical report or as requested by MRT, is requested
- Date of follow-up activity required to obtain the additional medical information
- Date additional medical reports are received in the county office
- Date material is referred to MRT
- Date the Worker is notified of the final MRT decision

This information appears on RAPIDS Screen ANMR.

2. Procedure For Review Of Pending Applications

Applications that have not been entered in the data system must be reviewed at least each 30 days.

The county office must establish procedures to ensure that each pending application is reviewed a minimum of once every 30 days. The results of the review must be documented in the case record. CMCC must document the reason the application has not been acted on. If this reason is not beyond the control of the Department, the Worker must immediately take any actions are necessary to process the application. If the application has not been acted on within the required time limit, the Worker must send an **DFA-20** or RAPIDS notice NMRL to the applicant informing him of the information which has not been received by the Department. The **DFA-20** or NMRL is sent to the client at the time of the expiration of the maximum allowable time for acting on the application.

D. DETERMINING REASONABLE PERIOD OF TIME FOR SPENDDOWN ENTRY

Cases that meet spenddown should be entered in the data system in the 30 day application period.

E. PRIOR ELIGIBILITY FOR CASES NOT CURRENTLY ELIGIBLE

When it is established that eligibility requirements for prior Medicaid coverage were met, but the case is not currently eligible, the procedures are as follows:

1. Approvals

The application is approved for Medicaid to cover the prior period. The medical card is mailed to the local office and is rewritten for the correct POE and mailed to the client. For a spenddown case, verified medical expenses, old unpaid bills prior to the POC, or paid and unpaid bills incurred during the POC, are used as spenddown expenses.

A manually written medical card for the correct POE is mailed to the client.

2. Denials

When the Worker determines that the case does not meet spenddown in the prior period, the application is denied and the client notified using the ES-NL-A.

3. Closures

Advance notice requirements apply. When the 13-day advance notice of closure is not required, the procedure is as follows:

If a card will be generated, the address of the county office is entered in ACCH.

A closure is transmitted immediately following the approval or spenddown transaction.

When the card is received in the county office, the Worker must destroy it and manually issue a medical card to reflect the prior POE. The Supervisor initials the card and either mails it or gives it to the client. It is the client's responsibility, or that of the individual who is acting on his behalf, to take the card to medical providers.

F. CHANGING COVERAGE GROUPS AND REDETERMINATION PERIOD

When one coverage group is closed and another opened, the original redetermination period is kept.

EXCEPTION: When a WV CHIP AG is closed for **a reason(s) listed in Section 7.3,A** and a Medicaid evaluation results in an approval, the child receives a new Medicaid certification and redetermination period.

1.25 WV WORKS

When WV WORKS applicants are also SNAP and/or Medicaid applicants, requirements in 1.2 and 1.4 also apply to the SNAP portion of the case and the requirements in Sections 1.2, 1.6 - 1.22 apply to the Medicaid portion.

A. APPLICATION FORMS

A DFA-2 is used.

NOTE: When an application has been made for WV WORKS and/or Medicaid and the application is denied, withdrawn or approved for DCA, the AG or non-recipient Work-Eligible Individual must not be required to make an additional application for SNAP. SNAP eligibility must be determined based on the information provided for the other programs.

B. COMPLETE APPLICATION

The application is complete, when the client signs a DFA-2 or DFA-5 which contains, at a minimum, his name and address.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed DFA-2. The DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

An application is considered incomplete when the client chooses not to sign the DFA-2. It is a withdrawal, and appropriate data system action and client notification must be completed. The recording in Case Comments must specify that the client did not want to sign the application and the reason for his decision. The client must be encouraged to sign the application so there is no misunderstanding that he was denied the right to apply.

C. DATE OF APPLICATION

The date of application is the date that the DFA-2, which contains, at a minimum, the applicant's name and address, is signed. Benefits are prorated from the date of application when all other eligibility requirements are met.

If a household which became ineligible due to a lump sum payment requests recomputation, the date of application is the date of the request.