16.5 CATEGORICALLY NEEDY, MANDATORY - FOR FAMILIES AND/OR CHILDREN

NOTE: No Categorically Needy coverage group is subject to a spenddown provision.

A. AFDC MEDICAID RECIPIENTS (MAAR, MAAU)

Income: 185% Need Standard (1993 FPL) **Assets: $1,000**
100% Need Standard (1993 FPL)
Payment Level (24% 1994 FPL)

AFDC Medicaid provides for Medicaid coverage for those who would be eligible for AFDC, if the Program were still in effect. If so, AFDC Medicaid is approved; if not, eligibility under all other Medicaid coverage groups must be explored. Refer to Chapter 15 for a complete explanation of AFDC Medicaid.

NOTE: Receipt of a WV WORKS check has no bearing on Medicaid eligibility. Receipt of a WV WORKS check does not automatically qualify the client to receive Medicaid.

B. DEEMED AFDC RECIPIENTS

The following coverage groups are required by law to be treated as AFDC recipients for Medicaid purposes. This treatment automatically qualifies them for AFDC Medicaid. Therefore, the information in item A, above, is also applicable to these cases.

NOTE: Recipients of Extended Medicaid are not referred to nor required to cooperate with child support activities.

1. Extended Medicaid (ME C, ME S)

Income: N/A **Assets: N/A**

An AG is eligible for Extended Medicaid for 4 months when both of the following conditions are met:

- The AG lost eligibility for AFDC Medicaid due to the onset of new child or spousal support or an increase in child or spousal support; and

- The AG received AFDC Medicaid in any 3 or more months during the 6-month period that immediately precedes the 1st month of ineligibility for AFDC Medicaid.

Recipients of Extended Medicaid are not required to cooperate with, nor are they referred to BCSE.

2. Children Covered Under Title IV-E Adoption Assistance

Income: N/A **Assets: N/A**

Families which receive Title IV-E Adoption Assistance payments from West Virginia for an adopted child, receive a medical card for the child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Adoption Assistance and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Adoption Assistance from West Virginia, medical coverage is provided as a recipient of Title IV-E Adoption Assistance. The Worker must not provide medical coverage for the child as an SSI recipient.

- When the child receives Title IV-E Adoption Assistance from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

3. Children Covered Under Title IV-E Foster Care

Income: N/A **Assets: N/A**

Persons who receive Title IV-E Foster Care payments from West Virginia for a foster child, receive a medical card for the foster child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Foster Care and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Foster Care from West Virginia, medical coverage is provided as a recipient of Title IV-E Foster Care. The Worker must not provide medical coverage for the child as an SSI recipient.

- When the child receives Title IV-E Foster Care from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

C. TRANSITIONAL MEDICAID (TM) (ME I, ME T, ME D)

Income: Phase I - N/A **Assets: N/A**
Phase II - 185% FPL

This coverage group consists of families which lose eligibility for AFDC Medicaid because of earned income, the loss of earned income disregards or the number of hours worked. TM provides continuing medical coverage after AFDC Medicaid eligibility ends and occurs in 2 phases as described below.

There are no application procedures for Transitional Medicaid. Instead, when an AFDC Medicaid case becomes ineligible, the Worker must automatically determine eligibility for TM. If the case is closed in error instead of being converted to a TM case, the case must be reopened without reapplication by the client.

The periodic review letter (PRL) dates throughout this Section will vary due to adverse action deadline and non-work days. See Appendix A.

NOTE: Transitional Medicaid (TM) is not related in any way to DCA eligibility or ineligibility or the loss of WV WORKS eligibility. TM eligibility is related only to ineligibility for AFDC Medicaid.

NOTE: Recipients of TM are not referred to nor required to cooperate with child support activities.

NOTE: Loss of TM coverage must not affect 12 months of continuous Medicaid eligibility for the children in the AG. See Section 2.8.

NOTE: When a child loses eligibility as a Qualified or Poverty-Level child and his family is receiving Transitional Medicaid (TM), he is included in the AG, if otherwise eligible.

1. Phase I Coverage

   a. Eligibility Requirements

      In order to be eligible for Phase I coverage, all of the following conditions must be met:

- The AG became ineligible for AFDC Medicaid due to hours of employment, amount of income from employment or from loss of the AFDC/U time-limited earned income disregards ($30 + 1/3 or $30 disregard).*

  NOTE: In determining ineligibility for AFDC Medicaid, the Worker must consider income of the AG and any individual who would normally be included in the AG, but who has been penalized.

- The AG received AFDC Medicaid in any 3 or more months during the 6-month period immediately preceding the 1st month of ineligibility for AFDC Medicaid.

  NOTE: Receipt of WV WORKS or a DCA payment does not meet this requirement. It is met only by receipt of AFDC Medicaid for at least 3 of the last 6 months.

- The AG did not receive AFDC Medicaid fraudulently during any of the 6 months prior to the 1st month of AFDC Medicaid ineligibility.

- The family has a dependent child who would be included in the AFDC Medicaid AG, if the family were eligible.

* When the AG becomes ineligible for AFDC Medicaid for a combination of reasons, the Worker must determine if the amount of earned income, hours worked or loss of time-limited disregards (or the addition of an individual with earnings who has received AFDC Medicaid in 3 of the past 6 months), had an effect on the ineligibility. Only when this is the case is the AG eligible for TM.

* The steps below are to be followed to determine if such factors had an effect on ineligibility for AFDC Medicaid:

* Step 1: Determine if the increase in income (or hours of employment or loss of the AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in AFDC Medicaid standards, etc.).

* If yes, the AG meets the requirement.

* If no, go to Step 2.

* Step 2: Determine if events other than the increase in income (or hours of employment or loss of the

AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if the income (hours or disregards) had stayed the same.

* If yes, the AG does not meet the requirement.

* If no, go to Step 3.

* Step 3: Determine if the AG is ineligible for AFDC Medicaid when all changes are considered.

* If yes, the AG meets the requirement. The increase in earnings (or hours of employment or loss of the AFDC/U earned income disregards) was essential to the loss of AFDC Medicaid eligibility. Without that increase, the AG would not have lost eligibility.

* If no, the AG is still eligible for AFDC Medicaid.

b. Loss of Eligibility Before Expiration of Full Phase I Coverage

The following circumstances will result in case closure (after proper notice) before the expiration of the Phase I coverage:

(1) No Dependent Child

When there is no child in the home who would be eligible for AFDC Medicaid, the AG loses eligibility. Eligibility ends at the end of the 1st month in which the AG no longer includes such a child.

EXAMPLE: Last dependent child leaves the home on February 10th. The case is closed effective February. Advance notice is required.

(2) Fraud

When it is determined that AFDC Medicaid benefits received in one or more of the 6 months prior to the start of Phase I coverage were received fraudulently, the AG is ineligible. Eligibility ends on the last day of the month when the advance notice period expires.

(3) Enrollment in Free Employer's Plan

When the person whose employment caused ineligibility for AFDC Medicaid does not enroll or maintain enrollment in the employer's health plan, provided such coverage is free to the client, the AG becomes ineligible. Eligibility ends on the last day of the month when the advance notice period expires. Benefits are not delayed pending compliance with this requirement. The client must be allowed 30 days to prove he has taken the steps necessary to comply.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: Failure, without good cause, to return a complete PRL3 by 1st work day after the 20th of the 4th month results in ineligibility to participate in Phase II of TM, but has no effect on Phase I coverage.

c. Eligible Situations

Provided the AG meets all of the eligibility requirements in item a above, it is eligible for Phase I TM in the following situations:

- The AG's gross income is above 185% or 100% of the AFDC/U Standard of Need or the countable income is above the payment level, and the beginning of employment or increase in hours or payment rate had an effect on AFDC Medicaid ineligibility.

- The earned income of an individual who received AFDC Medicaid in 3 of the last 6 months and who is added to the AG, has an effect on the AG's AFDC Medicaid ineligibility.

- The case becomes ineligible for AFDC Medicaid due to failure to report or provide verification of new earnings, provided that fraud is not indicated.

- The case becomes ineligible for 1 month only due to a temporary increase in hours worked or rate of pay.

d. Ineligible Situations

The AG is not eligible for Phase I coverage in the following situations:

- The AG becomes ineligible because of the earnings of an individual being added to the AG who has not received AFDC Medicaid in 3 of the last 6 months.

- The AG becomes ineligible for a reason other than those found in item 1,a above.

- There is an indication, with supporting evidence, that the AG received AFDC Medicaid fraudulently during at least 1 of the 6 months prior to the first month of AFDC Medicaid ineligibility. The Worker must determine from the case record if a referral has been made to IFM or if an IFM decision has been rendered on any fraud claim. If there is a substantive indication that fraud was involved, the AG is not eligible for Phase I coverage.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: There is no provision to discontinue Phase I coverage due to the AG's becoming eligible for AFDC Medicaid again. Instead, the AG is dually eligible for AFDC Medicaid and TM. See item 3 below for the significance of dual eligibility.

e. Beginning Date of Phase I Coverage

An AG is eligible for Phase I coverage beginning the month following the last month of AFDC Medicaid eligibility. When AFDC Medicaid is continued beyond the month ineligibility occurs because of an agency or client error, the beginning date of TM is the 1st month **after advance notice would have expired and the** client should have lost eligibility**.**

f. Client's Reporting Requirements

The client is required to report his gross earnings and day care costs for the first 3 months of Phase I coverage by the 1st work day after the 20th of the 4th month. He is also required to report

the earnings and day care costs of any person in the home who is included in the AFDC Medicaid Income Group. In addition, he must report his gross earnings and day care costs for the last 3 months of Phase I coverage by the 1st work day after the 20th of the 1st month of Phase II coverage.

RAPIDS letter PRL3, is mailed to the client by the 3rd Friday of the 3rd month.

If the client returns the completed PRL3 form, he has met one of the eligibility requirements for Phase II coverage.

Failure to return a completed form, without good cause, by the 1st work day after the 20th of the 4th month, automatically renders the AG ineligible to participate in Phase II, after proper notice. The client must be notified of the consequences of his actions when the form is not returned by the due date without good cause or is returned but is incomplete. The client has a right to a Fair Hearing on this issue since future eligibility is involved. The Worker must not wait until the end of Phase I coverage to notify the client of his ineligibility for Phase II. The process of determining eligibility or ineligibility, based on this reporting requirement, is completed prior to the end of Phase I coverage.

The PRL3 must be filed in the case record.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

A RAPIDS alert notifies the Worker when the form is due.

If the client provides the completed form within the 13-day notice period, this part of the eligibility requirement for Phase II is reestablished.

g. Special Agency Notification Requirements

During the 4th month of Phase I eligibility, the client is notified of the availability of Phase II coverage and what he must do to continue coverage.

2. Phase II Coverage

NOTE: When all eligibility factors for Phase II coverage are met, eligibility continues, without interruption, from Phase I to Phase II, unless the client has indicated he does not wish to continue such coverage.

a. Eligibility Requirements

In order to be eligible for Phase II coverage, all of the following conditions must be met:

- The AG received Phase I coverage for the entire 6-month Phase I period. The 6-month period includes months for which the client was dually eligible for Phase I and AFDC Medicaid, if applicable.

- The client completed and returned, in a timely manner, the PRL3 sent to him, or had good cause for not returning it. The form is considered to be returned in a timely manner when it is received within the advance notice period.

- The family has a dependent child who would be eligible for AFDC Medicaid.

- The earned income amount meets the financial test as described in Chapter 10. For Phase II coverage, information from the PRL3 is used. Information from the PRL3 determines eligibility for months 7 – 12 of Phase II TM coverage. Information from the PRL8 determines continued eligibility for months 9 – 12 of Phase II and the PRL9 determines eligibility for month 12 of TM.

- The client continues to have earnings, unless the lack of earnings is due to involuntary loss of employment, illness, or unless good cause is established.

- The client applies for and maintains enrollment in his employer's health plan, provided such coverage is free to the client

b. Beginning Date of Phase II Coverage

An AG is eligible for Phase II coverage beginning the 1st month immediately after Phase I coverage ends. When Phase II coverage

is, in error, not begun in the correct month, coverage begins upon discovery of the error and is backdated to the date coverage should have begun. In no instance is Phase II coverage extended beyond 6 months past the end of Phase I coverage.

c. Client's Reporting Requirements

The client is required to report his gross earnings, the gross earnings of other Income Group adults in the home, and actual out-of-pocket day care costs. This information is used to determine financial eligibility for Phase II coverage. The PRL3 is mailed by the 3rd Friday of the 3rd month and must be completed and returned by the 1st work day after the 20th of the 4th month, unless the client establishes good cause.

The PRL8 is mailed by the 3rd Friday of the 6th month and the completed form is due by the 1st work day after the 20th of the 7th month. The PRL9 is mailed by the 3rd Friday of the 9th month and the completed form is due by the 1st work day after the 20th of the 10th month. All PRL forms must be returned by the due date, unless the client establishes good cause.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

The PRL forms must be filed in the case record. A RAPIDS alert notifies the Worker that the forms are due.

d. Automatic Termination of TM

The data system will automatically terminate TM eligibility at the end of 8th month if the PRL8 is not returned by the due date.

RAPIDS will automatically terminate TM at the end of the 11th month if the PRL9 is not returned by the due date.

At the end of the TM Phase II, the data system will automatically terminate coverage.

NOTE: When TM eligibility ends for any reason other than expiration of the time period, the Worker must evaluate eligibility of the AG for all other Medicaid coverage groups.

3. Return To AFDC Medicaid, Phases I and II

If an AG returns to AFDC Medicaid during Phase I or Phase II, but otherwise meets the requirements for TM, the AG is dually eligible for AFDC Medicaid and TM. If the AG again becomes ineligible for AFDC Medicaid, Worker action depends upon the case circumstances at the time of the subsequent case closure as follows.

a. Otherwise Eligible for TM

If the AG meets all of the eligibility requirements found in item 1,a above, the family is eligible for a new TM period, beginning with Phase I for 6 months and continuing through Phase II, if the Phase II requirements are met.

b. Not Otherwise Eligible for TM

When either of the two following conditions are met at the time of the subsequent case closure, the AG is eligible only for the remainder of the original TM period.

- The AG loses eligibility for a reason not related to employment; or

- The AG loses eligibility for a reason related to employment, but does not meet the requirement of having received AFDC Medicaid in 3 of the preceding 6 months.

EXAMPLE: An AFDC Medicaid AG becomes ineligible when the parent obtains full-time employment. The family receives TM for 7 months, from March through September, but returns to AFDC Medicaid for 2 months, October and November. At the time the parent's job starts again, at the end of November, he has no longer received AFDC Medicaid in 3 of the 6 months prior to ineligibility. One of the eligibility requirements for TM is no longer met. However, because the AG was dually eligible for TM and AFDC Medicaid, TM coverage continues for December, January and February.

D. QUALIFIED CHILDREN (QC), BORN ON OR AFTER 10-1-83 (MQCA)

NOTE: For Qualified Children born before 10/1/83, see Section 16.7,E.

Income: N/A **Assets: N/A**

NOTE: If a Qualified Child is receiving inpatient services on the date eligibility ends due to attainment of the maximum age limit, eligibility must continue until the end of that inpatient stay.

A child is eligible for Medicaid coverage as a Qualified Child (QC) when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The child was born on or after 10-1-83.
- The child is under age 19, regardless of school attendance or course completion date.
- The income eligibility requirements described in Chapter 10 are met.

QC's are not required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

E. POVERTY-LEVEL PREGNANT WOMAN

A pregnant woman is eligible for Medicaid coverage as a Poverty-Level Pregnant Woman or as a Deemed Poverty-Level Pregnant Woman as follows. In certain situations, eligibility may be backdated more than 3 months. See Chapter 1.

1. Categorically Needy, Deemed Poverty-Level Pregnant Woman

Income: N/A **Assets: N/A**

Any woman who is pregnant when she is an eligible Categorically Needy, Medicaid recipient, remains eligible for Medicaid throughout her pregnancy and through a 60-day postpartum period when both of the following conditions are met:

- The woman receives Medicaid under any mandatory or optional Categorically Needy coverage group. See Sections 16.5, 16.6 and 16.7. Those women who apply for such coverage groups after the birth of the child, are not eligible as Categorically Needy, Deemed Poverty-Level Pregnant Women, but may be eligible as a Poverty-Level Pregnant Woman. See item 3 below.

- The pregnant woman becomes ineligible for the Categorically Needy coverage group due solely to a change in income.

The pregnant woman's coverage must continue under the same Categorically Needy coverage group through the end of the postpartum coverage.

If the pregnant woman does not meet these requirements, the requirements in item 3 below must be met to continue eligibility based solely on her pregnancy.

NOTE: A Poverty-Level Pregnant Woman cannot have Medicaid terminated or denied for failure to cooperate with QC until the end of the postpartum period. After the postpartum period, the sanction is applied, even if she qualifies under another coverage group.

2. Medically Needy, Deemed Poverty-Level Pregnant Woman

Income: N/A **Assets: N/A**

Any woman who is pregnant when she is an eligible Medically Needy recipient, remains eligible for Medicaid through the end of the current Period of Eligibility (POE), when the woman has no spenddown or the spenddown has been met.

At the end of the original POE, the pregnant woman's eligibility ends and reapplication is required. Eligibility is determined as for any other Medically Needy case, with pregnancy having no effect on eligibility. If the spenddown is met in the new POC, or it is met and another spenddown must be met due solely to a change in income, the pregnant woman is again guaranteed medical coverage only until the end of the POE. Only when the Medically Needy pregnant woman gives birth to the child during a Medically Needy POE, she is guaranteed medical coverage through the 60-day postpartum period.

If the pregnant woman does not meet these requirements, the requirements in item 3 below must be met to continue eligibility based solely on her pregnancy.

NOTE: A Poverty-Level Pregnant Woman cannot have Medicaid terminated or denied for failure to cooperate with QC until the end of the postpartum period. After the postpartum period, the sanction is applied, even if she qualifies under another coverage group.

3. Poverty-Level Pregnant Woman (MFPP)

Income: 150% FPL **Assets: N/A**

a. General Requirements

A pregnant woman is eligible for Medicaid coverage as a Poverty-Level Pregnant Woman when all of the following conditions are met:

- The pregnant woman is not receiving:

  - AFDC Medicaid
  - SSI

  and is not eligible as a Deemed AFDC Recipient or a Deemed Poverty-Level Pregnant Woman.

- The income eligibility requirements described in Chapter 10 are met. Changes in income after eligibility has been established have no effect on continuing eligibility.

Poverty-level pregnant women are not required to have a deprivation factor and there is no asset test.

NOTE: A Poverty-level pregnant woman is not referred nor required to cooperate with child support activities while pregnant nor during the postpartum period.
NOTE: A Poverty-Level Pregnant Woman cannot have Medicaid terminated or denied for failure to cooperate with QC until the end of the postpartum period. After the postpartum period, the sanction is applied, even if she qualifies under another coverage group.

b. Postpartum Coverage

This coverage applies only to the mother, not the child. The child may be covered as a Continuously Eligible Newborn. Refer to item I below.

A woman who received coverage as a pregnant woman while living in another state or who is a recipient of postpartum coverage from another state, is not eligible for postpartum coverage in WV, unless she is determined eligible for Poverty-Level Pregnant Woman coverage in WV.

A woman continues to be eligible for Medicaid for 60 days postpartum, and the remaining days of the month in which the 60th day falls, provided that during the pregnancy or within 3 months of the end of the pregnancy, the woman met all of the following requirements:

- She applied for Medicaid (any coverage group)

- She was eligible for Medicaid (any coverage group)

- She received Medicaid services (any covered service, not limited to pregnancy services).

NOTE: The post partum period begins with the child's date of birth. In some instances, the post partum period extends into the third calendar month after the month of birth to assure the recipient receives proper notice.

EXAMPLE: A woman with a pregnancy due date of August 7, 2009 reports on September 9, 2009 that her child was born on July 28, 2009. The redetermination date remains October 2009 to assure she receives proper notice of her scheduled eligibility redetermination. This also assures proper closure notice if she fails to complete the eligibility redetermination.

If the mother is determined, after the end of the pregnancy, to have been eligible in a month prior to the end of the pregnancy, she is eligible for postpartum coverage. This is true even if income increases above the income eligibility limits in any month after she is determined eligible.

NOTE: Postpartum coverage is required if the pregnancy ends in a live birth, miscarriage, abortion, or if the child is stillborn.

The last day of pregnancy is counted as day one of the 60-day postpartum period, and a redetermination is completed in the 2nd month of the postpartum period. If eligible for other Medicaid, or WV CHIP, that coverage must not begin until expiration of the postpartum period.

If no review takes place, Medicaid coverage will automatically close after the adverse notice period.

F. POVERTY-LEVEL CHILDREN UNDER AGE 1 (MFPI)

Income: 150% FPL **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child under the age of 1 is eligible for Medicaid coverage as a Poverty-Level Child Under Age 1 when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- The income eligibility requirements described in Chapter 10 are met.

A Poverty-Level Child Under Age 1 must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

G. POVERTY-LEVEL CHILDREN, AGES 1-5 (MFPC)

Income: 133% FPL **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 6, eligibility must continue until the end of that inpatient stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child at least age 1, but not yet age 6, is eligible as Poverty-Level Child Ages 1-5 when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The income eligibility requirements described in Chapter 10 are met.

Poverty-Level Children Ages 1-5 must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

H. POVERTY-LEVEL CHILDREN, AGES 6-18 (BORN ON OR AFTER 10-1-83) (MFPN)

Income: 100% FPL **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of the maximum age, eligibility must continue until the end of that inpatient stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child at least age 6, but not yet age 19 is eligible as a Poverty-Level Child, Ages 6-18, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The child was born on or after 10-1-83.
- The child is under age 19, regardless of school attendance or course completion date.
- The income eligibility requirements described in Chapter 10 are met.

A Poverty-Level Child, Age 6-18, must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

I. CATEGORICALLY NEEDY (MN) CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN),

NOTE: See Section 16.8,A for Medically Needy CEN coverage.

Income: N/A **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

A Continuously Eligible Newborn Child (CEN) (birth - 12 months) is eligible for Medicaid until he reaches age 1, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- A Medicaid application was made, or considered to have been made, and approved. The application may be made up to 3 months after the child's birth. If the child's mother was eligible for and receiving Medicaid from West Virginia in the month the child was born, an application is considered to have been made for the child.

- The child resides continuously in West Virginia during the entire CEN period. If the child leaves WV and returns, CEN coverage cannot be reinstated.

NOTE: Under SSI, a child born to an institutionalized woman is eligible on the date of birth only. Eligibility under all other Medicaid coverage groups must be explored immediately for these children.

- The mother remains eligible for any Categorically Needy Medicaid coverage group or would be eligible for Categorically Needy Medicaid if she were still pregnant. Changes in the mother's family income never affect the child's eligibility as a CEN, because changes in income never affect the eligibility of a Poverty-Level Pregnant Woman. Refer to item E above. In addition, failure of the child's mother to complete a redetermination does not result in ineligibility for the CEN.

CEN's must not be required to have an AFDC/U deprivation factor or to live with a specified relative (other than the mother), and there is no income or asset test for such children. Enumeration requirements are not to be applied.

NOTE: There is no requirement that the CEN be evaluated as a QC. He must remain a CEN until he reaches age 1, as long as all CEN eligibility requirements are met.