- One parent is employed, and his working hours preclude participation in the interview during the agency's normal working hours.

- He is physically/mentally unable to participate in the interview and this is established by a written or verbal statement of a physician, social worker, attorney or other responsible person.

When the specified relative with whom the child lives has a legal committee, the committee must be interviewed.

When the child is living with only one specified relative, and that relative is unable to participate in the interview, a representative may be interviewed. A written statement, signed by the relative, which gives the representative authority to apply on his behalf, is required.

F. WHO MUST SIGN

The individual(s) who is interviewed must sign the DFA-2.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the following must be discussed in the interview:

- BCSE: When the adult relative is applying for or receiving Medicaid, explain assignment of support rights, redirection requirements, good cause, penalties for failure to cooperate without good cause, possible referral to BCSE for signature of paternity acknowledgment, and obtain the signature on the DFA-AP-1 of the relative with whom the child lives. See 1.6,G.

- That any child under age 18 may be evaluated for SSI-Related Medicaid based on blindness or disability.

- The spenddown process.

- **The specific months which will constitute the Period of Consideration (POC) based on the 6 month POC that will most benefit the client. The beginning date of eligibility may be backdated up to 3 months prior to the month of application when all eligibility requirements are met and the client has medical expenses for which he seeks payment.**

- The MRT process, if applicable.

- They may receive more than one medical card if a child(ren) has income or there is income deemed to a parent.

- TPL: Explain Third-Party Liability procedures.

H. DUE DATE OF ADDITIONAL INFORMATION

Additional information is due 30 days from the date of application.

I. AGENCY TIME LIMITS

Data system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

EXCEPTION: When delay is a result of factors outside the control of the Department and the applicant, e.g., inability to obtain medical reports. This must be documented on each case as specified in Section 1.24, regarding documentation for pending applications.

J. AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 and OFS-6A, if applicable, to request it. He must inform the client that the application is being held pending. When the verification or information is received and the client is eligible, medical coverage is retroactive to the date eligibility would have been established, had the Department acted in a timely manner.

Reimbursement for out-of-pocket expenses may apply. See Chapter 2.

K. PAYEE

The parent or other specified relative who is the caretaker relative is the payee. When both parents are in the home, either parent may be the payee.

L. REPAYMENT AND PENALTIES

An individual who is sanctioned for failure to cooperate with BCSE is not included in an AFDC-Related Medicaid AG.

M. BEGINNING DATE OF ELIGIBILITY

This date may be backdated up to 3 months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

1. Non-Spenddown

The beginning date of eligibility is the first day of the month of the POC.

2. Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on Screen AGTM, are not paid by Medicaid.

N. REDETERMINATION SCHEDULE

1. Non-Spenddown

Non-spenddown AG's are redetermined in the 6th month of the POC. The 6-month period begins with the month of application, unless the POC is backdated. The date the next redetermination is due is automatically coded in the data system.

2. Spenddown

Spenddown AG's are not redetermined and are closed at the end of the 6th month of the POC. The client must reapply for a new POC.

O. EXPEDITED PROCESSING

There is no expedited processing requirement.

P. CLIENT NOTIFICATION

See Chapter 6.

Q. DATA SYSTEM ACTION

Each application requires data system action to approve, deny or withdraw.

R. REDETERMINATION VARIATIONS

The redetermination process is the same as the application process with the following exceptions:

1. Non-Spenddown

a. The Redetermination List.

AFDC-Related Medicaid AG's are redetermined every 6 months in the last month of the current POC. The data system alerts the Worker when a redetermination is due and sends a letter to the client.

b. The Date of the Redetermination

The Worker, after receipt of the above, is responsible for scheduling the redetermination so that it is completed prior to or during the month in which it is due.

c. Scheduling the Redetermination

An appointment letter is generated by RAPIDS to notify the client of the redetermination and the date the interview is scheduled.

d. Completion of the Redetermination

When the redetermination is completed and the AG remains eligible, the new POC must begin the month immediately following the month of the redetermination. The new beginning POC is automatically coded in the data system.

2. Spenddown AG's

a. The Redetermination List

There is no redetermination list.

b. The Date of the Redetermination

Spenddown AG's may come into the office at any time to reapply for a new POC.

c. Scheduling the Redetermination

These AG's are not scheduled for redetermination. The client must reapply for a new POC.

d. Client Notification

Spenddown AG's are mailed a computer-generated letter at adverse action notice deadline of the 6th month of the POC. This letter informs the client that his eligibility will end on the last day of the month and that he must reapply for Medicaid coverage.