D. TYPES OF CHANGES

1. Change In Case Name

The case name may be changed from one individual to another at the request of the individuals involved or when a change in circumstances requires it.

A new application must be completed and signed by the new payee unless his signature is on the most recent application.

If the client's name changes, no new application is necessary.

For QMB, SLIMB or QI-1 a new application must be signed by the spouse, if he becomes eligible, even though he will be added to the existing case.

2. Change Of Address

A change of address is made in the data system as soon as the client reports it. Any other changes which the client reports, in addition to the address change, are also acted on at the same time when notice requirements permit. A change made prior to the deadline date is effective the following month. See Section 2.8 for children's Medicaid groups.

When the address change is made after the deadline date, the change is effective 2 months after the change is made. See item below for instructions for returned medical cards.

3. Change In The Assistance Group, Needs Group Or Income Group

When there is an addition to or a deletion from the AG and/or Needs Group, individual eligibility for each member must be reevaluated. See Chapter 9. This change(s) may require data system action.

When a family reports that a child is born or a child moves into the home and there is an existing Medicaid or WV CHIP AG, the Worker must evaluate the child's eligibility for all coverage groups and WV CHIP without requiring an application. Information to evaluate the child's eligibility may be obtained from the existing case information, from a phone **contact** or by requesting information using a RAPIDS verification list or DFA-6.

When there is an addition to or deletion from the Income Group or a change in the income of the existing group, financial eligibility must be

In no instance is Medicaid Coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. A child is also evaluated for WV CHIP eligibility. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is evaluated based on case record information. The client may be required to visit the office only for completion of a Social Summary for a MRT referral. The AG does not remain active while the MRT decision is pending.

See Section 2.11 for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

**EXCEPTION:** Changes in income do not affect the eligibility of Poverty-Level and Deemed Poverty-Level pregnant women. Also, regardless of any changes, except those specified in Section 2.8, a child determined eligible for Medicaid must have 12 months of continuous QC or FPL coverage. See Section 2.8.

**NOTE:** An AG which meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individual is an AG member.

- A member(s) of the Income Group experiences an increase in income; or

- An individual(s) with income is added to the Income Group; or

- An individual(s) is removed from the Needs Group

If the AG loses eligibility for another reason, such as no eligible child or no deprivation factor, the AG is closed after proper notice before the POC ends.

**NOTE:** For QMB, SLIMB and QI-1, the RSDI COLA's are disregarded in determining income eligibility for January and any subsequent months prior to the effective month of the state's FPL updates for the year.

5. Cost-Of-Living Increases In Federal Benefits

Recipients of federal benefits such as RSDI, SSI, Black Lung or VA Benefits may receive periodic cost-of-living increases (COLA's). RSDI/SSI increases are handled in accordance with instructions in Appendix B of this Chapter. All other federal benefit cost-of-living increases are treated as any other change, except that the client is not required to report the change.