1.6 PARENTS/CARETAKER RELATIVES

A. APPLICATION FORMS

The Single-Streamlined Application (SLA) or DFA-2 is used. See Section 1.3 for reapplications when a new form is not required.

B. COMPLETE APPLICATION

When the applicant signs an SLA or DFA-5 which contains, at a minimum, his name and address, his application is complete.

An application is considered incomplete when the client chooses not to sign the SLA, DFA-2, or DFA-5. When this occurs, 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 should always 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 the applicant submits an application, which contains, at a minimum, his name and address and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address and signature is received in the local office.

NOTE: When a faxed copy or other electronic transmission of an application is received that contains a minimum of the applicant's name, address and signature, it is considered an original application and no additional signature is required.

D. INTERVIEW REQUIRED

No interview is required.

E. WHO CAN BE INCLUDED ON THE SAME APPLICATION

1. Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or step child; parent - biological, adopted or step parent; sibling - biological, adopted, half or step sibling.)

2. Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

EXCEPTION: A non-custodial parent cannot apply for Medicaid or WV CHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), or siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.

3. Individuals who are under age 19 may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

F. CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements found in Section 1.2 are applicable. In addition, the following specific requirements apply and must be discussed with the applicant even when an interview is not conducted.

- BCSE: When the adult relative is applying for or receiving Medicaid and there is a child with an absent parent, 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 acknowledgement.

  When an AG includes a child with an absent parent(s) and the adult relative is not included in a Medicaid AG, a referral to BCSE is made only when the adult relative requests BCSE services. These services must be explained to him and a voluntary referral encouraged.

- Eligibility: Explain beginning date of eligibility and that it can be backdated.

- Pregnancy: Explain the need for the client to report immediately when anyone in the household who receives Medicaid becomes pregnant.

- TPL: Explain Third-Party Liability procedures.

G. DUE DATE OF ADDITIONAL INFORMATION

The client and the Worker agree on the date by which additional verification must be obtained.

H. AGENCY TIME LIMITS

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

EXCEPTION: When the delay is a result of factors outside the control of the Department and the applicant; e.g., inability to obtain medical reports.

I. AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send the eRAPIDS verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received and the client is determined eligible, medical coverage is retroactive to the date eligibility would have been established.

When the application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay.

The Medicaid client is eligible to receive direct reimbursement for out-of-pocket medical expenses if the Department has not acted on the application within a reasonable period of time. See Chapter 2.

J. PAYEE

The payee is the individual in whose name the medical card is written.

K. REPAYMENT AND PENALTIES

See Section 20.4.

L. BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. However, eligibility may be backdated up to 3 months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

When the client is eligible for backdated coverage, the system must be coded with the month, year on which the backdated period begins.

This date is always the first day of the month of backdated coverage.

M. REDETERMINATION SCHEDULE

Cases are normally redetermined annually. The redetermination schedule is set automatically by the data system.

N. EXPEDITED PROCESSING

There are no requirements for expedited processing. Cases are approved in the order in which eligibility is established.

O. CLIENT NOTIFICATION

The client must be informed that he is eligible for Medicaid coverage and the date that his coverage begins.

See Chapter 6.

P. DATA SYSTEM ACTION

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

Q. REDETERMINATION SCHEDULE AND SPECIAL PROCEDURES

1. Redetermination Schedule

Redeterminations occur annually. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by eRAPIDS which matches current information with the hub. The Reasonable Compatibility Provision applies each time this occurs. See Section 4.1. If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, eRAPIDS sends a pre-populated form containing case information and require the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated auto renewal verification checklist form provides the following information:

- That the AG(s) for the individual(s) listed is due for redetermination,
- The address to which the form is returned, if submitted by mail,
- The date by which the information must be submitted,

- Specific information necessary to complete the redetermination,

- The opportunity to report changes,

- That the AG may receive a verification checklist for completion and return, if reported changes require follow-up,

- That the AG(s) will be closed after proper notification, if the redetermination is not completed, and

- Instructions for submitting the pre-populated auto renewal verification checklist form online by using inROADS. A phone number to call if the individual has questions about submitting the pre-populated auto renewal verification checklist online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to 3 months.

2. Special Procedures – Rolling Renewals

When a change is reported during the certification period which affects eligibility, the Department must only request the information on the change reported. When the information is received, the client is evaluated for rolling renewal. If the agency has enough information available to renew eligibility with respect to all the eligibility criteria, the agency must begin a new 12-month certification period.

EXAMPLE: A client is determined eligible from February 1, 2014 through January 31, 2015. On June 2, 2014 the client calls and reports a change in income. The information is provided to the Department on June 6, 2014. The Worker evaluates and determines enough information is available to renew eligibility. The benefit is given a new certification period effective July 1, 2014 through June 30, 2015.

EXAMPLE: A redetermination for SNAP benefits is completed on May 14, 2014. The certification period is April 1, 2014 through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to recertify. The Medicaid certification period is renewed from June 1, 2014 through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination. See the eRAPIDS User Guide.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

R. THE BENEFIT

1. Retroactive Benefits

The first medical card generated by the data system shows eligibility through the end of the current month. In situations where retroactive eligibility is established, a separate card is used for each retroactive month.

2. Ongoing Benefits

The initial medical card shows the eligibility dates for the current month. After the initial month's medical card, a new card is issued monthly which shows the month's eligibility dates.

3. Ending Date Of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

S. PERSONAL RESPONSIBILITY CONTRACT (PRC)

The PRC is not used for Medicaid purposes.

T. ORIENTATION

Attending WV WORKS orientation is not an eligibility requirement for Medicaid.