NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents printing the DFA-2, form DFA-5 must be signed by the applicant and filed in the record with the DFA-2 after it is printed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

2. Right To General Information

All those who have applied for benefits, or who inquire about the requirements for receiving benefits, must have the requested information provided to the county office Worker. This includes a basic explanation of the eligibility requirements and answers to general questions. If the Worker does not know the answer to the general question, he must consult with his Supervisor. If the answer is unknown to the Supervisor, they may submit the question to the DFA Economic Services or Family Support Policy Unit. Applicants, potential applicants or their representative must not be referred to the DFA Policy Unit for a direct response.

NOTE: The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation.

3. Right To Consideration For All Programs

a. Applying for Programs with the Department

It is the Worker's responsibility to explain and make available all of the Department's programs for which the applicant could qualify. Certain programs, such as CDCS, I/DD, TBI and HCB Waiver, require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs. Unless the applicant specifically states he is not interested in being considered for WV WORKS, including DCA; SNAP benefits; Medicaid; or SCA, during the appropriate time period, the Worker must evaluate potential eligibility for each of these. The evaluation of eligibility is accomplished in eRAPIDS.

All applications for any program must be evaluated for all other programs based on the available information.

When an Evaluated AG passed and is confirmed, a client notice is issued from eRAPIDS to inform the applicant that he may be eligible for a benefit for which he did not apply and that he must contact his local office for information or to apply.

b. Applying at the Federally-Facilitated Marketplace (FFM)

Individuals may apply at the Marketplace for insurance affordability programs and MAGI Medicaid including Parents/Caretaker Relatives, Adult, Pregnant Women and the Children Under Age 19 Group and WV CHIP. When the individual's income is at or below the income limits for Medicaid, the Marketplace will determine the applicant's eligibility for Medicaid or WV CHIP and forward the data file to eRAPIDS. The system will determine the specific Medicaid or WV CHIP coverage group through which Medicaid will be issued without delay.

The Marketplace's responsibility of determining eligibility for Medicaid is limited to Medicaid coverage implemented through the Affordable Care Act in WV effective October 1, 2013 and includes MAGI groups only. The Marketplace is not responsible to assess or determine eligibility for other Medicaid or other Department Programs, benefits or services. When the Worker identifies the individual's potential eligibility, the Worker notifies the individual of the application process for any other programs or services.

NOTE: The Adult MAGI Medicaid group begins January 1, 2014.

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may receive Marketplace benefits. If approved for other non-MAGI Medicaid coverage, the Marketplace is electronically notified. See Section 1.24,G.

6. Redeterminations Submitted by Mail

Recipients of some Medicaid coverage groups, WV CHIP and other Programs receive an instruction letter and redetermination form which is submitted by mail, along with appropriate verifications. The client must complete, sign and mail or bring the form and other required information to his local DHHR office or the Customer Service Reporting Center as directed by the letter. See below for redeterminations submitted by inROADS. The client may always request a face-to-face interview. See Program Sections for specific information about the redetermination process.

7. Redeterminations Submitted by inROADS

Recipients of some Medicaid coverage groups, WV CHIP and other Programs receive an instruction letter and redetermination form. The client may choose to return the completed form and information by mail or complete the redetermination online by use of inROADS. The recipient receives certain information in the letter which must be entered online to use the inROADS redetermination process. See program sections for specific information about the redetermination process.

No signature page is required and the redetermination is considered electronically signed when the recipient uses this process and enters information from the letter and other identifying information requested.

The online process is available for use through the end of the month the redetermination is due. Redeterminations submitted in inROADS are processed by use of eRAPIDS Inbox screen or the Worker's dashboard.

The client may also submit an application for another benefit(s) at the time of the inROADS redetermination.

8. Hospital-Based Presumptive Eligibility

Individuals receiving services at a qualified hospital who are interested in applying for Medicaid may apply with the assistance of an Authorized Hospital Employee (AHE). Hospitals may elect to provide Hospital-Based Presumptive Eligibility (HBPE) determinations to individuals who are without any other form of health coverage. Presumptive financial eligibility (PE) is not permitted for any other program. It is unrelated to Presumptive Medical decisions for the Medical Review Team (MRT). Eligibility is established on date of determination. Back-dating does not apply to this provision.

Categories Eligible For PE:

- Children under age 19
- Pregnant Women
- Parents/Caretaker Relatives
- Adult Group
- Former WV Foster Children
- Breast and Cervical Cancer Women Receiving Current Treatment

a. Duties of the AHE

The AHE makes a PE decision based on preliminary information provided by the individual seeking treatment, or someone with the patient who would reasonably be expected to know about the individual seeking benefits. They can attest to the individual's US Citizenship or satisfactory immigration status. The AHE is prohibited from requiring any other verification prior to approval. Additional information gathered includes name, household size, income limit, sex, address, and prior approval for PE in the last 12 months. Using the same inROADS portal as Community Partners, the AHE Worker sends the information electronically to the data system and issues a medical card with a PE Medical ID. The period of eligibility begins on the date of determination and ends on the last day of the next month, or when a full Medicaid application determination is made, whichever occurs earlier. The decision is not subject to fair hearing rights and advance notice is not required.

The AHE Worker must assist the applicant or his representative in completing the SLA for MAGI Medicaid and forward the application to the Department.

b. DHHR Worker Responsibilities

Upon receipt of a completed application, the DHHR worker begins processing the application which should include the PE Medicaid Identification Number. This process combines the two applications together, and closes the PE period upon approval or denial of the Medicaid application. The Worker must establish whether the client was eligible at the time of the PE determination, as well as ongoingl Medicaid eligibility. Income is verified by the same method as any other application. Medicaid eligibility begins on the first day of the month of the PE determination. Retroactive back-dating is allowed with the Medicaid application, if the client is eligible.

NOTE: PE is limited to once every twelve months, with the exception of pregnant women, who are eligible for once per pregnancy.

L. CLIENT NOTIFICATION, WRITTEN AND VERBAL

The client must be notified in writing of the final decision on his application and the reason for it. Notification must be provided for each Program for which the client applied, but notification for more than one Program may be included on one form letter.

NOTE: There is specific, court-ordered client notification policy which must be followed. There are also specific forms which must be used and detailed procedures to follow. See Chapter 6.

During the intake interview or during some other client contact prior to written client notification, the Worker may know whether or not the client is eligible and, if so, the amount of the benefit. The Worker may tell the client the status of his application and/or benefit level, if he so chooses. However, even if the client has been told his status and/or benefit level, he must still receive the information in writing.

Under some circumstances, the data system automatically generates notification to the client. See the eRAPIDS User Guide.

M. COMPLETION OF THE APPLICATION PROCESS

The application process is completed when all of the following have occurred:

- Action is taken as follows:

  - To approve the application when all eligibility requirements are met; or

  - To deny the application when at least one eligibility requirement is not met or the client has failed to establish eligibility.

    - The client is notified of the action taken.

EXCEPTION: When eRAPIDS determines a LIS/MPA applicant is a current MPA recipient, no notice is sent.

- The client receives his initial benefit, if eligible.

N. COMMUNICATION WITH SOCIAL SECURITY ADMINISTRATION (SSA)

Each CSM is responsible for appointing a contact person to communicate with a contact person in the local SSA Office. This contact person does not interpret policy, but works out communication problems and any problems dealing with the completion and forwarding of forms, including those involved in the joint application process for SNAP benefits. The Department's contact works directly with the contact from SSA.

Any matters that cannot be worked out between the local office and the SSA contact person are referred to a DFA Policy Unit and to the SSA District Office by the appropriate staff.

NOTE: The Worker must not contact the SSA regarding LIS files received through data exchange. Different eligibility criteria are used by the SSA and the Department. The Worker may issue a eRAPIDS verification checklist or a DFA-6 if information in the LIS file and the Department's records differ and must be reconciled.

O. DOMESTIC VIOLENCE ASSISTANCE

Information about community resources that address the issue of domestic violence must be readily available in each waiting room of each county office. The information must be written and must be available for the client to take with him discreetly, without having to ask for it. In addition, the Worker must provide such information when it is requested and must offer it to any person who, in the Worker's judgment, could benefit. When possible, this must be accomplished during the office interview. In order to insure the safety of the individual to whom information about domestic violence is given, it is suggested that the domestic violence information be part of a packet which contains a variety of information. If, during the interview, the Worker observes language or other behavior which is threatening and discussion of such matters could pose a possible threat to the person who is judged to be in need of information the Worker must avoid direct discussion with the client. In those instances, a referral to the local domestic violence program, other available community resource or to Social Services is in order so that a contact can be made without the threat of additional harm to the client.

Each CSM is responsible for coordinating efforts between DFA staff, Division of Children and Adult Services, and available community resources. The CSM is also responsible for making sure that up-to-date information about domestic violence services is available at all times.

See Section 4.1 regarding allowances in the verification process for MAGI Medicaid and WV CHIP when the applicant attests to being a victim of domestic violence.

P. DETERMINING RACE AND ETHNICITY FOR FEDERAL REPORTING

It is the Worker's responsibility to determine the client's appropriate race and ethnic category and correctly enter the information in eRAPIDS.

1. Race

When a client identifies himself as being of a single race or a combination of races, the appropriate race is entered in eRAPIDS. The following are the races with which he may identify.

- Asian Indian
- Black or African American
- American Indian or Alaska Native
- White
- Native Hawaiian or other Pacific Islander
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Guamanian or Chamorro
- Samoan
- Other Asian

2. Ethnicity

The client must be placed in an ethnic category, regardless of the race with which he identifies.

- Hispanic or Latino
- None of the above

If Hispanic or Latino

- Mexican
- Mexican American
- Chicano/a
- Puerto Rican
- Cuban
- Other

EXAMPLE: The client identifies his race as Black, with some Hispanic ancestry. His ethnicity is entered as “Hispanic or Latino.”

EXAMPLE: The client identifies his race as White, with no Hispanic background. His ethnicity is entered as “None of the above.”

When the client refuses to identify his race and/or ethnicity, the Worker must use his best judgment when entering the information in eRAPIDS.