17.17 THE APPLICATION/REDETERMINATION PROCESS

A. APPLICATION PROCESS

The application/redetermination process is the same as for SSI-Related Medicaid found in Chapter 1, with the following exceptions:

The Worker is responsible for the following:

1. Accepting form DHS-2.FRM, with an attached copy of the last page of the PAS from the contract agency which determines medical necessity. The DHS-2.FRM must not be dated older than 60 days. The PAS must not be older than 1 year minus 1 day unless the case is in hearing status or an extension has been granted by the Office of Home and Community-based Services in BMS due to circumstances beyond the individual's control. Both forms must be presented.

   The DHS-2.FRM referral will originate from one of the following.

   - Take Me Home West Virginia
   - A case management agency, when the client chooses to use one; or
   - The WV Bureau of Senior Services (WV BoSS), when the client chooses self-directed case management.

   The DHS-2.FRM has 2 versions. The same information is contained on both, but one includes a third line in the form title which states "Self-Directed Case Management" and the distribution list includes WV BoSS, instead of the case management agency.

   NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the HCB Waiver group, but must be evaluated for any or all DFA programs.

   EXAMPLE: John Bumgardner applies for HCB Waiver which requires a medical eligibility decision by the HCB Waiver Program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DHHR Office and applies for SNAP. Although his medical eligibility for HCB Waiver has not been determined and a financial determination cannot be made by the Worker for HCB Waiver, his pending status for this program does not prevent his evaluation for all other Medicaid groups for which he may qualify.

2. Processing the application as for any other Medicaid AG, presuming that medical eligibility has been determined. The date of application is the date that the client or his representative contacts the local office by phone, fax, mail, e-mail or in person to inquire about making an application.

NOTE: The applicant has only 60 days to establish financial eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical. The Community Services Manager (CSM) will be notified by Bureau for Medical Services (BMS) of medically-eligible clients. The CSM will distribute the list to field supervisors so Workers are aware HCB Waiver applicants will be contacting the county office for an application.

If a face-to-face interview is requested, the appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his representative. Case management agencies who chose to represent clients have been instructed by BMS to request an application within 7 days of the date the medical approval is received.

SSI, Deemed SSI and all other full coverage Medicaid AG's must provide the DHS-2.FRM and a copy of the medical necessity information. A shortened application, the DFA-LTC-5, is required to determine eligibility for payment of Waiver Services for these groups. See Section 17.12.

The beginning date of Medicaid eligibility is the later of the following:

- The first day of the month of application; or
- The first day of the month in which the individual is eligible for payment of HCB Waiver services after a transfer of resources penalty expires. See Section 17.25.

NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the HCB Waiver group, but must be evaluated for any or all DFA programs.

3. Completing the Asset Assessment at the individual's or authorized representative's request after receiving the approved PAS.

4. Instructing the individual that HCB services will only be paid on or after the HCB approval date.

B. REDETERMINATION PROCESS

A redetermination of eligibility is completed once a year; a face-to-face interview is not required. Medical necessity must be verified annually at redetermination

with a copy of the last page of a PAS completed within the past 12 months unless the case is in current hearing status or the individual was granted an extension by the Office of Home and Community-based Services. Once the redetermination is complete, the same criteria and procedures used for applications is used. Medicaid eligibility is established and the medical eligibility for services is monitored by BMS.

The Worker receives an alert in RAPIDS when a redetermination is due.

C. TAKE ME HOME, West Virginia, A Money Follows the Person (MFP) Initiative

Take Me Home, West Virginia assists individuals residing in long-term care facilities, transition home or into the community, and retain long-term care and support services.

The following procedure needs to be applied when the Department is contacted by a Waiver Case Management Provider, Bureau of Senior Services or APS Healthcare for the purpose of an HCB or TBI Waiver financial eligibility determination of a Take Me Home, WV participant and indicates probable transition from a nursing home to an approved facility.

The Department will be notified within two business weeks of the client's projected date of discharge from a Waiver Case Management Provider, Bureau of Senior Services or APS Healthcare with a DHS-2 form. The Worker will evaluate the client's financial eligibility based on the current information in the case record. If financially eligible, the Worker completes the DHS-2 with the effective (projected discharge) date and submits the DHS-2 to the appropriate agency indicating the client's financial eligibility. This may be by:

- Fax
- Scan; or
- Mail

The Worker records in eRAPIDS the action taken in the case record. The completed DHS-2 is valid for 30 days after the effective date of discharge. When the DHS-2 expires the entire process is void and the procedure is repeated as needed.

The nursing home will contact the Department when the actual discharge occurs. The worker will then place the actual discharge date in the eRAPIDS system and run eligibility to complete the procedure and again comment the action taken.

Information about Waiver Services, such as self-directed and personal options, is found on the Bureau of Senior Services website at **www.wvseniorservices.gov**. A listing of case management agencies by county is also found on this site.