The date entered by the Worker is 60 days from the date of application. When the AG is denied for failure to provide information required to determine eligibility and subsequently provides the requested information within 60 days of the original application, a new DFA-2 is not required. If the information is not provided by the date requested, an ES-NL-A must be sent for denial.

2. WV WORKS

The Worker and the applicant must agree upon the date entered. If the form is mailed to the client, the Worker must use his judgment about a reasonable amount of time required for the client to provide the information. The date entered must be at least 10 days from the date of issuance and no later than 30 days from the date of application. If the information is not provided by the date indicated, and the client has not contacted the Worker, the application is denied, if an eligibility factor is involved. The client must be notified by an ES-NL-A. If eligibility is established, but the client does not provide proof of entitlement to a deduction, the deduction is not allowed. The AG is approved, and the client is notified by an ES-NL-A.

3. Medicaid

The date entered must be at least 10 days or a time agreed upon with the applicant. See Due Date of Additional Information in Chapter 1, 1.4,H.

Spenddown

The date entered here must be 30 days from the date of application when it is determined that the client will be required to meet a spenddown. The DFA-6A must be attached to the DFA-6. In addition, the DFA-6 must indicate that medical expenses must be provided by the deadline date shown on the form, and the amount required to meet the spenddown must be specified. This is in addition to any other verification which may be needed.

If the AG does not appear to be subject to a spenddown when the DFA-6 was issued, but verification of or a change in income results in a spenddown prior to approval, a new DFA-6 is issued to obtain medical bills to establish eligibility. However, the time limit for providing medical expenses remains 30 days from the date of application.

Evaluation for Non-MAGI Coverage

Information regarding potential eligibility for non-MAGI coverage groups and the benefits and services afforded to the applicant in the non-MAGI

coverage groups will be provided to the applicant in the MAGI notice. Information regarding additional information needed to determine eligibility and how to apply will be provided to the applicant. The information should be sufficient to enable the applicant to make an informed choice.

Evaluation for MAGI Coverage – Special Circumstances for Medical Frailty

If an individual attests they are medically frail, such as having a physical, mental or emotional health condition or a chronic substance abuse, physical, behavior, intellectual or developmental condition in which assistance is needed, the client is given an option to choose the benefit package that best fits their health needs.

The choices are:

- Traditional Medicaid Benefits Package
- Alternative Benefits Package

Self-attested medically frail individuals will receive an additional option notice with the approval letter giving the beneficiary the ability to opt for **the Traditional Medicaid Benefit Package**. The form is to be filled out and returned to **the county office**. Otherwise, the client will be enrolled in the Alternative Benefits Package.

B. DFA-NL-6, NOTICE OF WITHDRAWAL OF APPLICATION

If the applicant withdraws his application, the Worker must give or mail him a DFA-NL-6.