23.3 APPLICATION/REDETERMINATION PROCESS

A. APPLICATION FORMS

A DFA-2 is used.

A reapplication is treated as any other application except in situations when a new form is not required. See Section 1.3.

B. COMPLETE APPLICATION

The application is complete when the client or his representative signs a DFA-2 or DFA-MA-1 which contains, at a minimum, the client's name and address.

C. DATE OF APPLICATION

The date of application is the date the applicant submits a DFA-2, DFA-MA-1 in person, by fax or other electronic transmission or by mail, 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.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed DFA-2. The DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed. No DFA-2 is required when the requirements in Section 1.3 are met.

D. INTERVIEW REQUIRED

No interview is required.

E. WHO MUST BE INTERVIEWED

Although no interview is required, when an interview is conducted, it is with the applicant or his representative.

A representative may make the application on behalf of the individual if it is established that he is physically/mentally unable to participate in the interview.

F. WHO MUST SIGN

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The application must be signed by the applicant or his representative.

G. CONTENT OF THE INTERVIEW

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

- Advantages and disadvantages of health coverage through other Medicaid groups when the applicant is eligible for both M-WIN and another group, including but not limited to: the existence of medical bills to apply against a spenddown, monthly premiums, and the need for backdated medical coverage. The client's choice is documented.

NOTE: If an applicant chooses M-WIN instead of coverage through another Medicaid group for which he is eligible, and later makes a different choice, once the AG is confirmed and he has received the M-WIN benefit, unless approved in consultation with the Policy Unit, payment of an enrollment fee or premium is not refunded by the contract agency.

- That health coverage may continue during a temporary period(s) of involuntary unemployment or when the individual's medical condition improves and applicable requirements are met.

- The MRT process, if applicable

- Information regarding payment of the enrollment fee and monthly premiums including:

  - If eligible for M-WIN, the enrollment fee must be paid within 60 days of the eligibility notification letter date or coverage is denied.

  - An explanation of the need to pay the enrollment fee as early as possible prior to 60 days, since the first month of M-WIN coverage begins the month following the month the enrollment fee is received.

  - An explanation that with the enrollment fee notification letter an enrollment fee payment stub is included and must be separated from the letter and enclosed with the method of payment.

  - An explanation that each month after the first month's coverage, a premium payment due letter is sent with a premium payment stub that must be enclosed with the recipient's method of payment for ongoing enrollment.

- That the individual indicates his identifying information, i.e., name, SSN, PIN, etc., on his method of payment.

- Medicaid will stop after advance notice, if the premium payment is not received by the 26th of the coverage month or the payment is returned for insufficient funds.

- The premium amount is decreased the month following the month a decrease in income is reported.

- The premium amount is not increased between reviews.

- The name of the client's M-WIN Worker.

H. DUE DATE OF ADDITIONAL INFORMATION

Additional information is due 30 days from the date of application.

I. AGENCY TIME LIMITS

1. Application Processing Limits

Agency time limits for these AG's differ, depending upon a number of factors which include establishing financial and/or medical eligibility and payment of the enrollment fee.

- Disability Determined by SSA

  - When a withdrawal or denial is indicated for a reason other than non-payment of the enrollment fee, data system action must be taken within 30 days.

  - When the client meets all requirements except payment of the enrollment fee, data system action to approve the application in accordance with Section 23.2 is taken within 30 days from the date of application.

  - When a client fails to submit the enrollment fee, data system action to deny the application must be taken within 60 days from the date of the initial eligibility.

- Disability Determined by MRT

  - When a withdrawal or denial is indicated for a reason other than non-payment of the enrollment fee, data system action must be taken within 90 days.

- When the client meets all requirements except payment of the enrollment fee, data system action to approve the application in accordance with Section 23.2 is taken within 90 days from the date of application.

- When a client fails to submit the enrollment fee, data system action to deny the application must be taken within 60 days from the date of the initial eligibility.

2. MRT Time Limits

To ensure that the 90-day limit is met for MRT cases, the following time limits apply to the MRT process:

REQUIRED ACTION	TIME LIMIT
Request medical records and reports	By the 7th calendar day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request, and each 30 days thereafter
Submission to MRT	By 7 days after initial request, and each 30 days thereafter
Receipt of file and logged in by MRT	By 2 days after receipt by MRT
Initial review by MRT staff	By 7th day after receipt
Physician's initial review	By 14th day after receipt
Additional medical information requested, if required, by physician	By 7th day after initial physician review
Physician's final review	By 7th day after receipt of additional medical information
Final decision and completion of ES-RT-3	By 7th day after final physicians review
File returned to county office	By 3rd day after final review decision
Notice to the client	By 7th day after receipt of final decision at county office

NOTE: The 90-day processing time limit concludes with the date client notification is mailed, not the date of the data system action.

J. AGENCY DELAYS

If the Department failed to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 to the client and note that the application is pending. When the information is received, coverage may be considered back to the date eligibility would have been established had the Department acted in a timely manner. See Beginning Date of Eligibility below.

If the Department delayed acting on the information already received, benefits are retroactive to the date eligibility would have been established had the Department acted in a timely manner.

The Worker must process an M-WIN applicant's Medicaid application as soon as possible rather than by the maximum allowable time since the benefit is delayed until the month after the enrollment fee is received.

If an application has not been acted on within a reasonable period of time unless the delay is due to factors beyond the control of the Department, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses. See Section 2.4.

EXAMPLE: Samantha Reynolds applies for M-WIN on December 5th and explains she is scheduled for surgery January 2nd. The Worker explains the importance of paying the enrollment fee in December to provide Medicaid coverage for January and Samantha pays her enrollment fee December 28th. The Worker returns January 5th and approves M-WIN effective February without backdating M-WIN to include January. The Worker corrects the case; however, Ms. Reynolds filled prescriptions January 1st totaling $121. The pharmacy refuses to bill Medicaid. The agency error was within the control of the Department, therefore Ms. Reynolds is eligible for direct reimbursement for out-of-pocket medical expenses.

K. PAYEE

The recipient is the payee.

L. REPAYMENT AND PENALTIES

This does not apply to M-WIN benefits.

M. BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the 1st day of the month following the date the enrollment fee is received.

NOTE: Coverage for this group can never be backdated prior to the month following the month the enrollment fee is submitted, unless it is done in consultation with the Policy Unit and is due solely to agency error.

N. REDETERMINATION SCHEDULE

All AG's are redetermined for disability and financial eligibility in the 6th month of the eligibility period. See item M above. The 6-month period begins with the 1st month of eligibility. The premium amount is redetermined and adjusted, if applicable.

O. EXPEDITED PROCESSING

There is no expedited processing requirement. See Agency Delays above.

P. CLIENT NOTIFICATION

Two eligibility notices must be sent when the client is determined to meet all program requirements. The Worker must first notify the client that he meets all requirements except payment of the enrollment fee. See Section 23.2. This notice contains an enrollment fee payment stub which is returned with the individual's method of payment. If the enrollment fee is not received, the Worker must send a denial notice. For all other notice requirements see Chapter 6.

Q. DATA SYSTEM ACTION

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

R. REDETERMINATION VARIATIONS

NOTE: RSDI COLAs are disregarded in determining income eligibility until the new FPL limits become effective.

The redetermination process is the same as the application process with the following exceptions:

1. The Redetermination List

   M-WIN AG's are redetermined every 6 months in the 6th month of eligibility. The Worker must set an alert and schedule the redetermination.

2. The Date Of The Redetermination

The Worker is responsible for scheduling the redetermination so that it is completed prior to or during the month in which it is due.

3. Scheduling The Redetermination

An appointment letter must be requested by the Worker to notify the client of the redetermination and the date the interview is scheduled.

4. Completion Of The Redetermination

When the redetermination is completed and the AG remains eligible, the new eligibility period begins the month immediately following the month of the redetermination. The Worker must set a control/alert for the next redetermination.

The new beginning eligibility period is automatically coded in the data system.

S. THE BENEFIT

A medical card is issued for each eligible individual.

1. Ongoing Benefits

Effective April 2015 the Medicaid card issuance process will change from a monthly to a yearly issuance. The Medicaid card will not include any date parameters since eligibility may terminate.

Each January, beginning with the 2016 issuance, Medicaid recipients will receive one Medicaid card per case.

In situations where retroactive eligibility is established, the Medicaid card will be validated appropriately for each back-dated month.

2. Ending Date Of Eligibility

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