

23.3 APPLICATION/REDETERMINATION PROCESS

A. APPLICATION FORMS

An OFS-2 is used.

A reapplication is treated as any other application except in some 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 an OFS-2 which contains, at a minimum, the client's name and address.

C. DATE OF APPLICATION

The date that the client or his representative signs the OFS-2 which contains, at a minimum, his name and address.

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

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

The interview is conducted 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

The application must be signed by the individual who is interviewed.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the following must be discussed in the interview:

- The MRT process, if applicable
- Information regarding payment of the enrollment fee and monthly premiums including:
 - Coverage begins the month following the month the enrollment fee is received.
 - A coupon for the enrollment fee will be included with the approval letter.
 - The enrollment fee must be paid within 60 days of the eligibility notice letter date or coverage is denied.
 - Medicaid will stop after proper 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 may be decreased if income decreases.
- That coverage may continue during temporary periods of involuntary unemployment or when the individual's medical condition improves and applicable requirements are met.

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: The client must be notified within 30 days of the date of application when he meets all requirements except payment of the enrollment fee. Data system action to approve the application is taken in accordance with

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Section 23.2,D,1. Data system action to deny the application for failure to submit the enrollment fee is take 60 days from the date of the initial eligibility notification letter.

Data system action to deny or withdraw the application for a reason, other than non-payment of the enrollment fee, must be taken within 30 days.

- Disability Determined by MRT: The client must be notified within 90 days of the date of application when he meets all requirements except payment of the enrollment fee. Data system action to approve the application is taken in accordance with Section 23.2,D,1. Data system action to deny the application for failure to submit the enrollment fee is taken 60 days from the date of the initial eligibility notification letter. Data system action to deny or withdraw the application for a reason, other than non-payment of the enrollment fee, must be taken within 90 days.

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
Interview client and 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

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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 ES-6 to the client and note that the application is being held 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 item M below.

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

For these cases, timely processing may mean acting faster than the maximum allowable time. If an application has not been acted on within a reasonable period of time and the delay is not due to factors beyond the control of the Department, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses. See Chapter 2.

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 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.

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. This notice must inform him of the amount of the enrollment fee, when it must be paid and the amount of the monthly premium. This notice contains an enrollment fee coupon which is returned for identification with the 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 COLA's are disregarded in determining eligibility through March of the year they 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.

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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. Initial Eligibility

The first medical card generated by the data system shows eligibility through the end of the coverage month. See Section 23.3,M.
 2. Ongoing Eligibility

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly which shows that month's eligibility dates.
 3. Ending Date Of Eligibility

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