

TABLE OF CONTENTS

OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RECERTIFICATION.....364

 NEW APPLICATION.....366

 REAPPLICATION.....370

 RECERTIFICATION.....372

DECISION AND NOTIFICATION.....374

 ACCEPTANCE.....376

 DENIAL.....378

 WITHDRAWAL OF APPLICATION.....379

 DISCONTINUANCE OR REDUCTION.....380

 TIMELY NOTICE.....382

DRUG AND ALCOHOL SCREENING, ASSESSMENT AND TREATMENT.....384

FINANCIAL MAINTENANCE.....386

OWNERSHIP AND AVAILABILITY.....388

AUTHORIZATION.....394

CARD ISSUANCE.....395

RECIPIENT RESTRICTION PROGRAM (RRP).....397

CO-PAY.....398

STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE.....400

DISTRICT OF RESPONSIBILITY (DFR).....402

ASSISTANCE TO PERSONS TEMPORARILY ABSENT.....409

ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE.....411

LIVING ARRANGEMENTS.....413

LIVING IN OWN HOME.....	416
MEDICAL FACILITIES.....	417
PUBLIC INSTITUTIONS.....	419
INFANTS RESIDING WITH INCARCERATED MOTHERS.....	421
IDENTITY.....	423
LEGALLY RESPONSIBLE RELATIVES (LRRs).....	424
SPOUSE.....	426
PARENTS AND CHILDREN.....	429
ABSENT PARENTS.....	432
EMANCIPATED MINOR.....	433
IV-D REQUIREMENTS.....	434
STEP-PARENTS.....	440
HOUSEHOLD COMPOSITION.....	443
LOW INCOME FAMILIES (LIF).....	444
ADC-RELATED HOUSEHOLD.....	445
HOUSEHOLD SIZE FOR POVERTY LEVEL PROGRAMS (PREGNANT WOMEN AND CHILDREN).....	447
SSI-RELATED.....	449
SINGLES/CHILDLESS COUPLES (S/CC).....	450
CITIZENSHIP AND ALIEN STATUS.....	451
CITIZENS.....	453
NATIVE AMERICANS.....	455
QUALIFIED ALIENS.....	456

BATTERED ALIENS.....461

U.S. ARMED FORCES ACTIVE DUTY AND VETERANS.....464

PRUCOL ALIENS.....465

UNDOCUMENTED/ILLEGAL ALIENS.....473

ALIENS ADMITTED ON A TEMPORARY BASIS.....475

RECOVERIES.....476

LIENS.....479

VOLUNTARY REPAYMENTS.....481

STATE AND FEDERAL CHARGES.....482

 NATIVE AMERICANS AND THEIR FAMILIES LIVING ON A RESERVATION.....484

 REFUGEES AND CUBAN-HAITIAN ENTRANTS.....485

 HUMAN SERVICES OVERBURDEN.....486

 OMH/OMR CHAPTER 621 ELIGIBLES.....487

 OFFICE OF MENTAL HEALTH (OMH).....489

 OFFICE OF MENTAL RETARDATION AND
 DEVELOPMENTAL DISABILITIES.....491

SOCIAL SECURITY ENUMERATION.....493

PRESUMPTIVE ELIGIBILITY.....495

 NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES.....496

 PREGNANT WOMEN.....501

IMMEDIATE MEDICAL NEED.....504

VETERANS' AFFAIRS REFERRAL.....505

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OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RECERTIFICATION

Description: The initial authorization and granting of Medicaid is based upon a written application, made on a state-prescribed form. The continuance of Medicaid is premised on a recertification of the A/R's eligibility for Medicaid. Department Regulations and the recipient's individual circumstances determine the frequency of recertification.

Policy: Medicaid is granted initially upon the determination of eligibility, based on a written application, made on a state prescribed form. An application may be made by the applicant, his/her authorized representative, or when the applicant is incompetent or incapable, by someone acting responsibly on his/her behalf, or an adult family member, or a person or agency acting on behalf of the applicant. Continuance of Medicaid is granted upon the recertification and redetermination of the recipient's eligibility. A separate Medicaid determination is made when a Public Assistance case is denied or closed and the household applied for or was in receipt of Medicaid. The only exception is when the reason to suspend, reduce or terminate Public Assistance is also a proper basis for reduction or termination of Medicaid. Any documentation contained in the case record is evaluated during recertification and/or reapplication. A separate Medicaid determination is also made when a SSI recipient loses eligibility for a SSI payment. Medicaid is continued until a determination can be made.

References:

SSL Sect.	366 366-a
Dept. Reg.	350.1 350.3 350.4 360-2.2 360-6.2
ADMs	OMM/ADM 97-2 82 ADM-5 80 ADM-19
INF	98 OMM/INF-02

OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RECERTIFICATION

Interpretation:

An A/R of Public Assistance applies separately for Medicaid by indicating that s/he wants a Medicaid eligibility determination as well. A SSI recipient is granted Medicaid based upon his/her certification for SSI. When a Public Assistance or SSI case is closed, Medicaid is continued until a separate Medicaid determination is made. The only exception to this is when the reason to suspend, or terminate Public Assistance is also a proper basis for the termination of Medicaid. In this case, a separate statement appears in the Notice of Intent advising the client of the action to be taken on his/her Medicaid case, the reasons for the action, the effective date of the action and the supporting regulations. The re-determination for Medicaid is completed by the end of the calendar month following the month in which Public Assistance is terminated. Similarly, for every SSI cash recipient whose case is closed, unless the closing is due to the death of the recipient or because the recipient moved out of state, a separate eligibility determination is made for Medicaid.

If an individual wishes to apply for Medicaid only, a separate application for Medicaid is filed and financial eligibility established using the standards of income and resources governing the Medicaid Program. To continue and re-authorize assistance, a periodic re-determination of eligibility is completed. This section deals with the application and certification as follows:

New application;

Reapplication; and

Recertification.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RECERTIFICATION**

NEW APPLICATION

Description: An application for Medicaid is a written, dated form prescribed by the State. It must be signed by the applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting responsibly for him/her.

Policy: An applicant requesting Medicaid must make application in person, through another person acting on his/her behalf, or by mail to the social services district. When an application is made by mail, a personal interview is conducted with the applicant or with his/her representative at a site designated to receive Medicaid applications.

References:

SSL Sect.	366 366-a
Dept. Reg.	360-2.2 360-2.3 360-2.4 360-6.2
ADMs	OMM/ADM 97-2 95 ADM-17 93 ADM-29 90 ADM-9 88 ADM-31
GIS	96 MA/015

Interpretation: An application for Medicaid may be made by the applicant in person, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting responsibly for him/her. The application must be signed in ink by the applicant or someone acting responsibly on the applicant's behalf. When both a husband and wife are applying for Medicaid, both spouses are required to sign the State-prescribed form. If only one spouse is applying, the non-applying spouse cannot be required to sign the application even though information concerning his/her financial circumstances is necessary to determine eligibility for the applying spouse.

OTHER ELIGIBILITY REQUIREMENTS

NEW APPLICATION

The date of application is the date that a signed State-prescribed application form, or a State-approved equivalent form or process is received by the local social services official. The application date for individuals who apply at outreach sites is the date on which the application is received at such sites. A local social services district cannot refuse an individual the right to apply for Medicaid. The applicant may be accompanied and assisted in the application process, if s/he wishes, by a person of his/her choice. If need be, the applicant may be assisted by a district staff member in the completion of the application.

A personal interview is conducted with the applicant or his/her representative. There is an exception. A personal interview is not required for any child who has been placed in the custody of the Office of Children and Family Services or the local social services commissioner. Generally, no decision or authorization may be made prior to the face-to-face interview, unless the interview is waived.

When the application is only for a pregnant woman and/or children under the age of 19, the personal interview may be conducted by an outreach provider's staff; a PCAP; or a qualified provider.

At the time of the personal interview the district staff gives the applicant material describing the program and informs the applicant or representative of: (1) the eligibility requirements for Medicaid; (2) the responsibility of the applicant to report all facts necessary for a proper determination of eligibility; (3) the joint responsibility of the district and the applicant to explore all facts concerning eligibility and the applicant's responsibility for securing, wherever possible, records or documents supporting his/her statements; (4) the types of verification needed; (5) the fact that any investigation essential to determine eligibility will be made; (6) the fact that the A/R may be reimbursed for paid Medicaid covered medical care and services received during the three months prior to the month of application and up until the actual date of application, if otherwise eligible; (7) the fact that after the date of application the A/R must use providers who accept Medicaid and who are Medicaid approved; and (8) the applicant's responsibility

to immediately notify the district of all changes in his/her circumstances.

UPDATED: AUGUST 1999		368
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OTHER ELIGIBILITY REQUIREMENTS

NEW APPLICATION

NOTE: Local social services districts that have selected the community coverage option contained in 95 ADM-17 inform the A/Rs of the application options available (full or limited asset review). The A/R's choice should be indicated on LDSS 4481. It is important that the applicant understands the eligibility determination process, including his/her responsibility to keep the district informed of any change in his/her income and/or resources. The applicant is advised of his/her right to have an agency conference or to request a fair hearing, as appropriate. The applicant is also notified of other services for which s/he may be eligible.

Verification Process: All factors relating to the eligibility determination are verified. These include, but are not limited to: identity; citizenship or alien status; family composition; residence; age; income from all sources; all resources, when appropriate, including savings and life insurance; and medical, accident and/or health insurance. If the applicant is unable to provide the district with acceptable proof of his/her eligibility, collateral sources are used to secure verification. By signing the application, the client agrees to an investigation confirming any information s/he provided. However, it may be necessary, due to district procedures or requirements of outside agencies, to have a separate consent form signed by the applicant before collateral sources are contacted and information verified.

If the applicant claims paid or unpaid medical bills for the three month period prior to the month of application, eligibility for that period is also established. This three month period is retroactive from the month in which the person applied.

NOTE: A person need not be living to have unpaid medical expenses covered by Medicaid. A representative may apply on behalf of the deceased person. Medical expenses may be paid for a deceased person, provided the person was eligible at the time the medical service was rendered.

Documentation: Sufficient to establish an audit trail:

Photocopies may be used. A primary source for eligibility documentation is any previous case record.

OTHER ELIGIBILITY REQUIREMENTS

NEW APPLICATION

When citing documents, the date, issuing authority, file number and such pertinent data as necessary to determine authenticity must be recorded in the applicant's file.

Disposition:

The interviewer, together with the applicant and/or his/her representative, reviews the application for completeness and accuracy. If the applicant has not provided all the required documents, the application is held until the district receives the documents. When the applicant fails or refuses to provide information essential to the eligibility determination, s/he is informed in writing that his/her application is denied, the reasons for the denial and his/her right to a fair hearing. The determination of eligibility is made promptly, generally within 45 days of the date of application. Determinations for persons eligible under the poverty-based programs (pregnant women and children under age 19) are completed within 30 days. Determinations of eligibility based on a disability are completed within 90 days. Under certain circumstances additional time may be required, such as when there is a delay on the part of the applicant, an examining physician or because of an administrative or other emergency that could not be controlled by the district.

NOTE: If the district is waiting for essential information, such as a birth certificate from another State and it will take more than the appropriate time, the reason for the delay is noted in the record. The applicant is notified by letter of the reason for the delay in his/her eligibility determination.

Exception:

When an applicant claims to have a disability or when it appears that an applicant may meet the criteria for disability, the district has 90 days from the date of application to make a determination of eligibility. This 90 day period is not used as a waiting period before granting Medicaid, if the applicant is eligible under a different category. Medicaid is authorized as soon as eligibility is established. A note is made in the record as a reminder to re-budget the recipient, adjust any spenddown amounts and claim FP coverage for the retroactive period when the A/R is certified disabled. When it is necessary to hold a potential disability case beyond the 90 day period, this is not a basis for denying Medicaid to an otherwise eligible applicant or for terminating assistance.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RECERTIFICATION**

REAPPLICATION

Description: A reapplication for Medicaid is an application made by a former recipient whose eligibility was terminated or an applicant whose previous application was denied by the district.

Policy: A reapplication for Medicaid must be as complete and accurate as a new application for Medicaid.

When an applicant is denied and reapplies within 30 days, a new written application on the state prescribed form is not required. In this situation, the date of application is the date that a written request for reapplication is received.

References:

SSL Sect	366 366-a
Dept. Reg.	360-2.2 350.4(a)(5)
ADM	93 ADM-29

Interpretation: When a reapplication is made, any previous application or record available in the local district is used for reference and documentation of eligibility factors not subject to change (e.g., date of birth). This includes verified information available through the Welfare Management Systems (WMS) in an active or closed case record. If documentation is available in the record, it can be used to verify or supplement data the applicant has available. In every case, the reapplication must be as complete and accurate as an original application, all factors relating to eligibility verified and documented. In all instances where there is a previous record or application, a cross-reference is made to verify accuracy and consistency with the current reapplication. When inconsistencies are apparent, the interviewer pursues the factual data to resolve such inconsistencies.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RECERTIFICATION**

REAPPLICATION

**Verification/
Documentation:**

Needed verification and documentation are identical to that of a new application, page 366.

NOTE: The case record is a primary source for documentation. A/Rs are not asked to provide information that is contained in the case record, unless such information is subject to change (e.g., work history).

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RECERTIFICATION**

RECERTIFICATION

Description: A recertification for Medicaid is a determination to continue or discontinue Medicaid based upon the eligibility of the recipient.

Policy: All active Medicaid cases, including those receiving both Medicaid and Public Assistance, are recertified periodically. The recipient must submit a written application (recertification) to continue Medicaid. Generally, a recipient is not reauthorized until a face-to-face interview with the recipient and/or his/her authorized representative is completed. There are two exceptions to this policy: children who have been placed in the custody of the Office of Children and Family Services or a local social services commissioner; and when the district has been granted a waiver by New York State. The re-authorization period may not exceed one year, regardless of the recipient's situation.

Individuals who receive Medicaid based on their eligibility for SSI are recertified for Medicaid by virtue of their recertification for SSI. SSI recipients need not be reauthorized yearly. Their authorization may be open-ended until December 31, 2049. Local districts use the SDX to confirm that an SSI recipient continues to be eligible for SSI and, therefore, Medicaid.

References:

SSL Sect.	366 366-a
Dept. Reg.	360.1 360-2.2(e) 360-6.2
ADMs	86 ADM-47 82 ADM-5 80 ADM-19
LCMs	94 LCM-84

Interpretation: The period covered by a recertification may vary by category and circumstances but may not extend beyond one year. Certain fixed income and chronic care cases may be recertified for the maximum allowable time span; however, when a recipient is unemployed or receives variable or seasonal income, s/he may

require more frequent recertification.

OTHER ELIGIBILITY REQUIREMENTS

RECERTIFICATION

Verification:

All factors relating to eligibility are reevaluated at recertification. Items which remain constant may be documented and verified from the A/R's record (including the use of WMS, when verified). Items which are reported as remaining the same are still verified. For example: when verifying employment status, the interviewer asks whether the recipient has a second or part-time job, whether any members of the family have obtained employment and/or whether income has been received from any other source.

The skill of the interviewer is of special importance when identifying items which may affect continued eligibility.

NOTE: All SSI recipients who enter a nursing facility who appear on the SDX with a "Pay Status Code" of EO1 (eligible - no payment), are sent a letter by the district informing them of their continued eligibility for Medicaid. In addition, the income of these individuals is reviewed to determine the amount, if any, of their net available monthly income (NAMI) to be contributed toward the cost of care.

OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

Description: A decision on an application, reapplication, or recertification is a determination that the applicant is either eligible or ineligible for Medicaid.

Policy: A decision as to the A/R's eligibility is made within specified time periods for each new application, reapplication and recertification. Upon reaching a decision, a written notification of acceptance, denial, withdrawal, discontinuance, reduction or change in the spenddown calculation is sent to the applicant.

The Notice of Intent sent to Public Assistance A/Rs who have also applied for Medicaid contains a separate statement concerning Medicaid eligibility. Where the reason for denying the PA case is also a valid reason for denying Medicaid, it is stated separately in the Notice of Intent.

New SSI beneficiaries will receive a letter from New York State informing them that they are automatically eligible for Medicaid. This letter also requests the A/R to supply information concerning third party health insurance, and information on paid or incurred medical bills for the three months prior to the month of application.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5 360-2.8 360-2.9
ADM	89 ADM-21 82 ADM-5

Interpretation: A determination of eligibility is made within a 45 day time period. A determination of eligibility for persons eligible under the poverty based programs (pregnant women and children under age 19) is completed within 30 days. The only exception to this are cases awaiting a disability determination. A 90 day time limit is applied to situations when a disability determination is being made (see page 26). If the eligibility determination process for a disabled applicant takes more than 90 days, on or before the 90th day, the

A/R is sent a written statement stating the reasons

OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

for the delay. When the applicant is eligible under a different category, Medicaid is authorized for the interim period.

Each applicant for Medicaid is notified in writing of the local district's decision regarding his/her application. In the written notification, the applicant is informed of: the action taken, the effective date of the action, the specific reason(s) for the action whether positive or negative, including supporting regulations or laws; his/her right to a conference with a representative of the district; and of his/her right to a fair hearing including the method by which s/he may obtain a hearing. The applicant is also advised that s/he may be represented at any conference or fair hearing by someone such as legal counsel, or by a relative, friend or other person and of the availability of community legal services (Legal Aid), if any. A fair hearing request may be made on the basis of: denial of assistance; failure to determine the applicant's eligibility within the time period specified; inadequacy of the amount or manner of assistance; discontinuance or reduction of assistance; objection to State policy as it affects the applicant; or any other grounds affecting the applicant's entitlement to assistance. If a recipient requests a fair hearing within the time period specified in the notice, Medicaid is continued unchanged until a decision is issued on the Fair Hearing.

A separate Medicaid eligibility determination is completed for every PA case closed or denied where the A/R also applied for or was in receipt of Medicaid, except for cases when the reason for closing or denying PA is also a valid reason for closing or denying Medicaid. In all situations, the client is advised in a separate statement of the status of his/her Medicaid eligibility.

This section describes decision and notification in detail. It is organized as follows:

Acceptance;

Denial;

Withdrawal; and

Discontinuance or reduction.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

ACCEPTANCE

Description: When an application for Medicaid is accepted, Medicaid is authorized for a stated person(s) for a specific period of time. The applicant is notified as to who was accepted or denied and the period of authorization.

Policy: When an application is accepted and Medicaid is authorized, notification in writing shall be sent to the applicant.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5
ADMs	OMM/ADM 97-2 96 ADM-15 89 ADM-21 87 ADM-41

Interpretation: Written notification to the applicant includes a copy of the applicant's budget and an explanation of what care or services are authorized. If limitations are placed upon care or services, the limitations are explained in the letter. A copy of the notice is also sent to the medical provider (e.g., nursing home or hospital), as appropriate.

When only certain members of the applying household (group applying) are accepted for coverage, the coverage is explained in the notice to the applicant. The notice also advises the applicant of his/her responsibility to inform the district of any changes in his/her financial situation and/or any other changes affecting eligibility.

In addition to the standardized notice, an A/R with excess income (see page 239) is given a copy of the "Explanation of Excess Income Program" letter. When appropriate, a copy of the "Provider/Recipient Letter" and the "Optional Pay-In Program for Individuals with Excess Income" (see 96 ADM-15) is sent to A/Rs with excess income. The "Provider/Recipient Letter" lists incurred medical expenses for which the A/R is responsible or partially

responsible. A copy of the "Provider/Recipient Letter" is also sent

OTHER ELIGIBILITY REQUIREMENTS**ACCEPTANCE**

to the provider for billing purposes. When the medical expenses are for services from more than one provider, a separate form is completed for each provider to protect the A/R's confidentiality. When the A/R is a patient in a nursing facility or is approved for nursing home care, a letter of notification is sent to both the nursing home and the A/R clearly stating the A/R's liability toward the cost of care. When the A/R is an institutionalized spouse (see page 228), the community spouse is also sent a copy of the notice.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

DENIAL

Description: A denial is a determination that an applicant is not eligible for Medicaid.

Policy: When an application for Medicaid is denied, a written notification is sent to the applicant.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5 360-2.8 360-2.9
ADMs	OMM/ADM 97-2 96 ADM-15 89 ADM-21 87 ADM-4

Interpretation: An application may be denied because the applicant is ineligible or because the applicant's eligibility cannot be determined due to his/her failure to cooperate in establishing eligibility. When a decision is reached, a letter is sent to the applicant, including a copy of the budget, when applicable, informing him/her of the reason for the denial and of his/her right to: a conference with a representative of the local district; and a fair hearing as outlined on page 375, "Decision and Notification". A copy of the notice is also sent to the Medical provider (e.g. nursing home and hospital) as appropriate.

When an applicant is denied due to excess income and the applicant is ADC-related, SSI-related, a pregnant woman, or under 21, the letter explains how excess income may be utilized to "spend down" to the Medically needy income level or PA Standard of Need (whichever is higher) (see pages 114 and 121). The letter further explains local district procedures regarding the applicant's use of the excess income, including the Optional Pay-In Program for Individuals with Excess Income.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

WITHDRAWAL OF APPLICATION

Description: After the submission of a written application, but before the applicant is notified by the local social services district of his/her eligibility determination, the applicant may withdraw his/her request for Medicaid.

Policy: When an application is withdrawn by the applicant, the district registers it as withdrawn.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.1 358-3.3 358-4.1

Interpretation: The decision to withdraw an application can only be made by the applicant or by the person making the application on behalf of the applicant. When the withdrawal is made in person, the applicant or representative is asked to sign the application as appropriate or sign a statement declaring his/her desire to withdraw the application. When the request is by phone, a notation is made on the application. No further action is taken on the application, however, the applicant may reapply at any time. Original documents, such as birth certificates, are returned to the applicant, but any photostatic copies and the application remain with the district and are not returned to the applicant.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

DISCONTINUANCE OR REDUCTION

Description: A discontinuance of Medicaid is a termination of all benefits under the program. The reduction of Medicaid is a change of benefit coverage from more extensive coverage to less extensive coverage or to an increase in the client's liability (e.g. a change from full coverage to a spenddown).

Policy: A determination by the district to discontinue or reduce a recipient's Medicaid is communicated to the recipient in a letter of intent to discontinue or reduce Medicaid. Generally, the notice is sent at least ten days in advance of the proposed action. Under certain circumstances, it is not necessary to send a notice of intent ten days in advance of the action (see page 382). Where the A/R is in receipt of both Medicaid and Public Assistance, any notice to discontinue or reduce Public Assistance also includes a statement advising the client of the status of his/her Medicaid eligibility.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.6 360-2.7 360-2.8 360-2.9
ADMs	OMM/ADM 97-2 89 ADM-21 83 ADM-27 81 ADM-55 80 ADM-19

Interpretation: A Medicaid case is discontinued because of the recipient's ineligibility for continued assistance, failure to cooperate, permanent removal from the district or other factors which affect continued eligibility. Generally, a letter of notification is sent (see page 374), at least 10 days in advance of the proposed action, to the recipient advising him/her of: the action to be taken; the effective date of the action, the reason(s) why the action(s) is/are being taken; the supporting law or regulation; the client's right to

request a conference with a representative of the district; and the

(MRG)

OTHER ELIGIBILITY REQUIREMENTS

DISCONTINUANCE OR REDUCTION

right to a fair hearing. If the recipient requests a fair hearing between the date of the notification and the date of the proposed action, Medicaid is continued without reduction until the fair hearing decision is rendered.

A reduction in Medicaid coverage also requires that a letter of notification be sent at least 10 days in advance of the proposed reduction. The letter of notification advises the client: that his/her Medicaid is being reduced; the effective date of the action, the reason why the action is being taken, the supporting law or regulations, the recipient's right to a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of receiving the notice and the date of the proposed reduction, Medicaid is continued without reduction until the fair hearing decision is rendered.

When an A/R is in receipt of Public Assistance and Medicaid or SSI cash and the cash benefit is discontinued, a separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance is terminated. The Notice of Intent to Discontinue Public Assistance contains a separate statement advising the client of the status of his/her Medicaid: continued until a separate determination can be made; discontinued and the reasons why; or continued until the next recertification. When an SSI cash benefit is discontinued, and there is adequate information in the local district's records, the recipient's eligibility is determined without contacting the recipient. The recipient is notified of the eligibility decision. When Medicaid eligibility can not be determined due to inadequate information, the recipient is contacted and required to provide the necessary information. Medicaid is continued pending the receipt of the information. The recipient is given 30 days to provide this information.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION
DISCONTINUANCE OR REDUCTION**

TIMELY NOTICE

Policy:

When a recipient's Medicaid is terminated or reduced, the recipient is adequately notified in writing 10 days in advance of the action (see page 380). However, if one of the following conditions has resulted in the termination or reduction of Medicaid, it is not necessary to send a notice 10 days in advance of the action. Instead, the adequate notice is sent by the date of the termination. These conditions are:

1. Death of the recipient.
2. The recipient has provided a signed statement that s/he no longer wants Medicaid.
3. The recipient is admitted or committed to an institution that does not qualify for federal financial participation.
4. The recipient's whereabouts are unknown and his/her mail has been returned by the post office indicating no known forwarding address.
5. The recipient has been accepted for Medicaid by a different district.

References:

Dept. Reg.	360-2.7 358-3.3(d)
ADM	89 ADM-21

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RECERTIFICATION**

DRUG AND ALCOHOL SCREENING, ASSESSMENT AND TREATMENT

Description: Single persons under age 65, childless couples, who are not certified blind or disabled, or pregnant and who are at least age 21 but not yet 65, must comply with certain drug and alcohol screening, assessment and treatment requirements.

Policy: *Applicants must answer the questions on the Alcohol/Substance Abuse Screening Instrument, and comply with the assessment and treatment as appropriate, when they meet the following criteria:*

At least age 21, but not yet 65; and

Are not certified blind or certified disabled; and

Are not pregnant; and

Are single; or

Are a member of a childless couple; or

Are a husband/boyfriend of a pregnant woman with no other children in the household; or

Are a stepparent with no other children of his/her own in the household when the birth parent also lives in the household.

A copy of the completed Screening Instrument must be retained in the case file.

References:

SSL Sect.	132
Dept. Reg.	351.2(i)
ADMs	OMM/ADM 97-2
INF	98 OMM/INF-02 97 INF-16
GIS	00 MA/005

Interpretation: Screening

The required screening questions may be given verbally by

UPDATED: JUNE 2000

384

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RECERTIFICATION**

DRUG AND ALCOHOL SCREENING, ASSESSMENT AND TREATMENT

reading each question to the client and recording the 'yes' or 'no' response on the instrument or it may be handed to the client for completion. The client must sign and date the form either in the office or off site. When two or more "yes" responses are received, the individual is referred for an assessment. If the worker has reason to suspect alcohol or substance abuse through observation of the individual's behavior, the individual is referred for an assessment. A copy of the completed Screening Instrument is forwarded to the person conducting the assessment. If fewer than two "yes" responses are received there is no need for an assessment.

If the individual refuses to answer the questions on the Screening Instrument, the individual is ineligible for Medicaid. The individual and the individual's income and resources will continue to be considered in determining the eligibility of any remaining family members.

A drug/alcohol screening is completed once for each recipient. It may be required more than once but not more frequently than once every six months unless the district has reason to believe that the individual is abusing or dependent on alcohol or drugs. If no abuse or dependence is indicated, the A/R is not required to complete the screening form at each recertification.

Assessment

An assessment is required when two or more positive responses are received to the questions on the Screening Instrument, or when the worker has reason to suspect abuse of drugs or alcohol. The assessment is performed by an alcohol and substance abuse professional credentialed by the Office of Alcoholism and Substance Abuse Services (OASAS) and may include drug testing. A model assessment form has been developed for local use. The district may choose to use a counselor at the district or may use a contractor to perform the assessment.

The assessment determines whether the individual is abusing alcohol and/or drugs. If abuse is found, the assessment determines whether the individual is able to work. If the individual is not able to work, the recommended level of treatment is

determined and the individual is referred to and must comply with treatment.

UPDATED: JUNE 2000		385
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OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND CERTIFICATION

DRUG AND ALCOHOL SCREENING, ASSESSMENT AND TREATMENT

An individual referred for an assessment who fails to participate in the assessment without good cause is ineligible.

Treatment

If the results of the assessment indicate that an individual is unemployable and that treatment is required, the individual must comply. Treatment must be received from a program licensed or certified by OASAS. Failure to comply with recommended treatment without good cause results in ineligibility.

Disposition:

If the district is advised that the individual has failed to comply with available appropriate treatment, the individual is ineligible for Medicaid.

If the individual leaves a treatment program but returns to another appropriate treatment program, the individual may again receive Medicaid, if otherwise eligible.

If an individual is found to be in need of treatment, **but** s/he is already in a treatment program, s/he could continue in the existing treatment. As long as the treatment is considered appropriate, s/he is considered to be in compliance with this requirement. The local district may require an assessment to determine if the treatment is appropriate or may allow the treatment to continue and evaluate any additional treatment needs at the completion of the treatment.

After an applicant is found financially and otherwise eligible, Medicaid is authorized for an individual referred for assessment or treatment as long as the A/R is cooperating in the process. If the local district receives information that the individual A/R has not complied with completion of the assessment or with treatment, the individual A/R is not eligible for Medicaid.

NOTE: If an individual is ineligible for Medicaid for reasons unrelated to Drug and Alcohol Screening requirements, the screening instrument is not required to be completed.

OTHER ELIGIBILITY REQUIREMENTS**FINANCIAL MAINTENANCE**

Description: Financial maintenance refers to the manner in which the A/R meets basic needs and non-medical expenses. The local district evaluates the completeness and consistency of the A/R's statements regarding financial circumstances.

Policy: In evaluating the assets of the A/R, the picture of financial management which s/he presents at the time of application or recertification is carefully considered. S/he has the responsibility to report to the local district all information that is required for the determination of eligibility. The local district has the responsibility to evaluate this information for completeness and consistency in the eligibility determination process.

References: SSL Sect. 366-a.4
Dept. Reg. 360-2.2
360-2.3(c)

Interpretation: When the local district is presented with a set of facts by the A/R during the course of the application/recertification process, the local district has the responsibility of evaluating these facts against the program income/resource levels and against each other. Although the A/R may appear to be eligible on the basis of the comparison of his/her available assets against the applicable income/resource level, the financial maintenance picture may be unreasonable.

For example: The A/R declares information regarding income and resources which appears to make him/her eligible for Medicaid. However, s/he also declares a high shelter expense and the difference between the A/R's income and shelter expense is so small that it is unlikely s/he can live on it (income is \$550, shelter expense is \$540). In this instance, the A/R is asked to explain and document the way in which food, clothing and incidental expenses are met. It is possible that these expenses have been met from accumulated resources or the generosity of friends or relatives. If so, the A/R is asked to document this, as long as providing documentation is not expected to result in cessation of the informal support. ***A statement from the A/R may be sufficient.***

The local social services district obtains an explanation of assets declared in prior case records, but no longer declared by the A/R. If the assets (income and resources) were used for maintenance,

OTHER ELIGIBILITY REQUIREMENTS**FINANCIAL MAINTENANCE**

the A/R should document this. If the A/R cannot document how the assets (income and resources) were spent, the possibility of a transfer of assets for the purpose of qualifying for Medicaid is considered (see pages 353 through 363).

Disposition:

The information that is provided by an A/R concerning his/her living circumstances is used to assist in determining his/her assets (income and resources). An A/R can be denied or closed for failure to explain how s/he meets expenses.

If the local social services district believes that the A/R has undisclosed income/resources, the case is referred for further investigation.

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

Policy: The ownership and availability of income and resources are determined. Only those income and resources available to and owned by the A/R or a legally responsible relative are considered when determining eligibility for Medicaid.

References: New York Estates, Powers and Trust Law 7-3.1

Mental Hygiene Law Article 81

SSL Sect. 104
366.2
366.3

Dept. Reg. 351.2
352.16
352.23
360-4.3(f)
360-4.4
360-4.6

ADMs 96 ADM-8
89 ADM-47
82 ADM-6

Interpretation: Income:

Certain income, which is not actually available to the A/R, is counted when determining eligibility for Medicaid. Generally, money deducted from income to pay court-ordered support, income taxes, FICA and New York State Disability is budgeted as available when determining Medicaid eligibility. See page 95 for treatment of court-ordered support when deeming; and page 199 for treatment of work expenses for the blind when determining eligibility for an SSI-related A/R.

Generally, when an A/R is due income, but the income is not being paid and is not within his/her control or the control of a fiduciary owing a duty to the A/R, the income is considered unavailable and not counted when determining eligibility. However, an A/R is required to apply for entitlement benefits, which would reduce or eliminate the need for assistance and care.

Unemployment Insurance (UIB) and Social Security (RSDI) are

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

examples of entitlement benefits. The local district has a responsibility to assist the A/R, as needed, in obtaining such entitlement benefits.

Garnisheed income is generally considered available and is included when determining the A/R's gross income. Local districts may assist the A/R in attempting to have a garnishment removed.

When a legally responsible relative, not living in the A/R's household, is determined able to support an A/R, the contribution is not budgeted until and unless it is actually received.

When an A/R is living with a person to whom s/he is not married, the ability and willingness of the person to support the A/R is evaluated. If the A/R is actually receiving income from this person, that income is considered.

When an A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district considers the funds available for the A/R's care. If the A/R has a guardian or other fiduciary who is not meeting his/her obligations, it may be appropriate for the local district to take legal action to compel him/her to utilize funds for the A/R's medical care and services, to have him/her replaced, or to seek a money judgment against the fiduciary or an order of contempt.

Currently unavailable income from any source is reviewed to determine the likelihood of its affecting the continued eligibility of a recipient. For example, if the recipient is expected to receive income in six months, the situation is reviewed after six months.

Ownership:

In order to determine whether or not resources are available to the A/R, it is necessary to determine who owns the resource.

When the A/R and one or more persons jointly own a resource (financial institution accounts, real estate, stocks, bonds, etc.) the general rule is that such property is considered available to the A/R to the extent of his or her interest in the property. In the

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related A/Rs concerning the availability of financial institution accounts. Generally, for such SSI-related A/Rs it is presumed that all of the funds in a joint account belong to the SSI-related A/R (see page 252 for details).

It is not unusual for non-legally responsible relatives to own life insurance on the life of an A/R. A parent may own a policy on the life of an adult child. When someone other than the A/R owns the policy and has the redemption rights, the life insurance is not considered an available resource of the A/R. See page 264 for further details on the treatment of insurance.

Availability:

All resources owned by the Medicaid A/R are considered available unless there is a legal impediment that precludes liquidation. If there is a legal impediment to the disposal of the resources, the resources are not counted in determining resource eligibility until the legal impediment does not exist.

A legal impediment exists when an A/R is legally prohibited from, or lacks the authority to liquidate the resource. For example, a legal impediment exists when an A/R needs the consent of a co-owner of a jointly owned resource in order to sell the resource, and the co-owner refuses to give consent.

When an A/R is living with a legally responsible relative (LRR), the LRR's income and resources are generally considered available to the A/R.

When an **A/R is residing** in the community **with an LRR** and the LRR asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the LRR provides financial information; or (b) the LRR refuses to provide the requested financial information.

(a) When the LRR provides information, but refuses to make his/her income/resources available to the A/R, eligibility for the A/R is determinable. When completing a budget, only the

income/resources actually available to an A/R are counted.

UPDATED: AUGUST 1999		391
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OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

- (b) When the LRR refuses to provide financial information, eligibility is generally indeterminable. However, if the A/R provides complete information concerning his/her own income and resources, including any jointly held resources, eligibility is determined based on the available information. If an LRR refuses to make his/her income and/or resources available for the A/R's medical care a dollar amount is budgeted for any non-medical needs that the LRR is meeting. For example, the LRR may be providing the A/R with food, shelter, and clothing. The value of these items would be considered income. The non-contributing LRR is not included in the household size.

The resources of a legally responsible relative, residing with the A/R, are considered in the eligibility process. However, if the legally responsible relative refuses to make his/her resources available to the A/R, Medicaid is provided to the A/R, if s/he is otherwise eligible. The provision of assistance to such persons creates an implied contract with the legally responsible relative and the local social services district may initiate legal action to recover the cost of medical care provided. For childless couples (S/CC), the resources of the LRR living in the same household are considered available to the A/R whether or not they are being made available (see page 388).

For married couples, at the time of initial eligibility, when one is an institutionalized spouse (see page 228), all countable resources are combined and considered available to the institutionalized spouse, regardless of which spouse owns the resource. The community spouse is allowed to retain resources up to the maximum community spouse resource allowance. The resources, which comprise the community spouse resources allowance are then transferred to the community spouse. These resources are no longer considered available to the institutionalized spouse. After the month eligibility is established for the institutionalized spouse, none of the community spouse's resources are considered available to the institutionalized spouse.

When the value of an A/R's countable resources exceed the appropriate resource level, the A/R is ineligible for Medicaid. See page 339 for the treatment of excess resources.

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

Generally, no grant or loan to an undergraduate student for educational purposes is considered an available resource. There are some variations on this policy according to the category of the A/R. (See pages 129, 150, 174 and 210.)

When an A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district reviews the terms of the trust or other agreements/documents to assure that the A/R's resources are actually available for his/her care. If a trust was created from the A/R's funds, and, if the trustee has any discretion to expend any of the trust income for the benefit of the A/R, then all of the trust principal which could be expended in any way to benefit the A/R is considered available. In instances where the client has a formal fiduciary and the fiduciary is uncooperative, the local district commences a recovery proceeding under SSL 104.

If an A/R is alleged to be incapable of managing his/her own finances and there is no one with the legal authority to make decisions concerning the A/R's income/resources, the A/R's income/resources are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian. The income and resources are considered unavailable to the A/R prospectively and for a retroactive period of three months.

Where there is a question of availability, the local social services district documents why the resource is not considered available and any actions taken to secure the resource for the A/R.

If the A/R jointly owns a home, but s/he is out of the home due to an informal separation and the spouse in the home refuses to sell, the A/R's share is an unavailable resource.

- When to Verify Status:**
- (a) The A/R indicates that s/he has a joint financial institution account;
 - (b) When the A/R indicates joint ownership of assets;
 - (c) When the A/R indicates that an LRR has available assets;

OTHER ELIGIBILITY REQUIREMENTS**OWNERSHIP AND AVAILABILITY**

- (d) When a child in the household has assets in his/her own name;
- (e) When someone other than the A/R pays the mortgage.

Documentation:

Sufficient to establish an audit trail:

Copies of financial institution account statements from the bank, mortgagor or insurer, or statements of availability from the LRR.

All efforts to obtain unavailable income and/or resources are documented in the case record.

OTHER ELIGIBILITY REQUIREMENTS

AUTHORIZATION

Description: Medicaid is granted to an eligible person on the basis of a signed authorization. The authorization is initiated by the district. In addition to initial eligibility determination, authorizations are required for recertifications, reauthorizations, changes and closings.

Policy: An authorization is initiated for all persons determined eligible for Medicaid. A reauthorization is initiated to continue Medicaid previously authorized. No authorization or reauthorization, except those done for SSI recipients, may exceed a period of one year beyond the date of application or recertification. When retroactive coverage is appropriate, a case may be authorized for up to 15 months, 3 months retroactive and 12 months prospective.

References: SSL Sect. 366.1(a)
Dept. Reg. 360-6.2
354.1

Interpretation: An authorization is completed for all persons determined eligible for Medicaid. Common Benefit Identification Cards or rosters are issued for all eligible individuals (see page 395). Authorizations are initiated to grant Medicaid and affect changes, such as suspension or termination of Medicaid and changes in information affecting eligibility.

When an authorization is used to change eligibility information, such as family composition, marriage, change of name, death of a member of a family, living arrangements, address or limitations on care or services, it is not necessary to use more than one authorization to make changes which take place at the same time. For example, at recertification, a case can be reauthorized for another year and an address change made on the same form.

In all situations, the authorization is signed and a copy kept in the record.

OTHER ELIGIBILITY REQUIREMENTS**CARD ISSUANCE**

Description: There are three types of Common Benefit Identification Cards (CBIC): permanent plastic photo; permanent plastic non-photo; and temporary paper replacement. A temporary Medicaid Authorization (DSS-2831A) form may also be issued in cases of immediate medical need. Any of these cards may be presented to a medical care provider for the purpose of verifying eligibility and coverage.

Policy: Photo and non-photo cards are plastic and issued on a permanent basis. A recipient generally uses the same card for his/her entire period of eligibility. Adults applying for or in receipt of Medicaid must comply with CBIC photo requirements unless specifically exempted.

The following Medicaid A/Rs are exempt from the photo CBIC requirements:

1. All cash SSI recipients;
2. Current SSI-related recipients not required to have a face-to-face recertification;
3. All children under 21 living with a responsible relative (including foster parents and guardians);
4. All persons who apply through the hospital or Pre-natal Care Assistance Program (PCAP) application process, until their first recertification. Those who come in to recertify after their initial period of eligibility are photographed at that time, unless otherwise exempt;
5. Homebound persons including those receiving personal care, home health care, or long-term home health care;
6. All persons in nursing facilities or in institutional foster care;
7. Person residing in living arrangements operated by the Office of Mental Health (OMH), or residing in living arrangements certified or operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD);
8. Person enrolled in the OMRDD Home Community Based Services Waiver (HCBS Waiver); and

OTHER ELIGIBILITY REQUIREMENTS**CARD ISSUANCE**

9. Persons who have their Medicaid eligibility determined by OMH or OMRDD in conjunction with the NYS Department of Health (i.e., districts 97 and 98).

When two or more adults reside in the same household, each receives his/her own card.

When an applicant is determined eligible and has an immediate medical need, the district may issue a temporary Medicaid authorization (DSS-2831A) pending his/her receipt of a permanent CBIC. The DSS-2831A is intended to be used between the time of determination and actual delivery of the permanent card, and is valid only for a specific number of days.

Interpretation:

A CBIC is issued to each: (1) individual in receipt of SSI; (2) needy child in foster care; or (3) individual determined eligible for Medicaid. Cards are not issued for periods of retroactive coverage. Certain recipients, such as those in nursing homes or voluntary child care institutions do not receive a CBIC. Rather, their names are placed on a roster of eligible individuals. Rosters are generated from principal provider codes and sent to each facility.

Disposition:

Persons, who are required to have a photo CBIC, but fail or refuse, may be denied or discontinued from Medicaid. All other eligible family members continue to be entitled to Medicaid.

All photo identification cards must be signed. A card may be signed by the recipient, the recipient's authorized representative, the recipient's caretaker relative, or an authorized representative of the local social services agency. Children, age 13 and older, may sign their own cards.

OTHER ELIGIBILITY REQUIREMENTS**RECIPIENT RESTRICTION PROGRAM (RRP)**

Policy: When an individual's utilization of Medicaid services is considered excessive, following a NYS claims review, the A/R is restricted to only primary providers. The individual is given the opportunity to select which physician, clinic, or pharmacy etc. s/he wishes to use.

References: SSL Sect. 366
Dept. Reg. 360-6

Interpretation: Through the RRP, certain Medicaid recipients are restricted to one physician, dentist, inpatient hospital, pharmacy and/or clinic for receipt of medical care or services. A provider inquiring on the Electronic Medicaid Eligibility Verification System (EMEVS), concerning a recipient's Medicaid coverage, will be informed of any limitations including the recipient's restriction status. Information in the EMEVS provider manual expands on this information. The restriction message on EMEVS will change each time a recipient either enters the RRP or is removed from the program. Further information on the RRP may be obtained from the individual in your district who administers the program or from the State Department of Health.

OTHER ELIGIBILITY REQUIREMENTS

CO-PAY

Description: Medicaid recipients age 21 or older may be asked to pay part of the cost of some medical care/items. This is called a Co-payment or Co-pay.

Policy: Health care providers may ask for a co-payment for certain services from Medicaid recipients age 21 or older. There is a maximum of \$100.00 per recipient per twelve (12) months for all co-payments. The provider cannot refuse to give medical services or goods because the recipient indicates that s/he is unable to pay the co-payment.

References: SSL Sect. 366
Dept. Reg. 360-7.12

Interpretation: A Medicaid recipient age 21 or older may be asked to pay part of the cost of some medical care/items in accordance with the following schedule:

<u>SERVICE</u>	<u>AMOUNT (\$)</u>
Inpatient Hospital	\$25.00 per stay upon discharge
Outpatient Hospital and Clinic	\$3.00 per visit
Non-emergency/Non-urgent ER	\$3.00 per visit
Prescription drugs	
(branch name)	\$2.00
(generic)	\$.50
Over-the-Counter Drugs	\$.50
Drugs to treat Mental Illness or Tuberculosis	NO CO-PAYMENT
Family Planning	NO CO-PAYMENT
Enteral/Parenteral	\$1.00 per
Formulae/Supplies	order/prescription
Medical/Surgical Supplies	\$1.00 per order
Laboratory	\$.50 per procedure code
X-ray	\$1.00 per procedure code

OTHER ELIGIBILITY REQUIREMENTS

CO-PAY

Recipients exempt from co-payment include the following:

Recipients under the age of twenty-one (21)

Pregnant women (This exemption continues for 2 months after the month in which the pregnancy ends.)

Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

Recipients enrolled in Medicaid Managed Care Plans.

Residents of OMH and OMRDD certified community residences and recipients enrolled in a Comprehensive Medicaid Care Managed Program (CMCM) or in an OMRDD Home and Community Based Services (HCBS) waiver program.

Services Exempt from Co-Payment include the following:

Emergency Services

Family planning services and supplies (birth control pills or condoms)

Tuberculosis Directly Observed Therapy

Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, alcohol and substance abuse clinic services

NOTE: Co-payments are not charged by private physicians and dentists or, for home health and personal care services.

OTHER ELIGIBILITY REQUIREMENTS**STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

Description: The state of residence of an A/R is where s/he is domiciled. A person's domicile, or legal residence, is the principal and permanent home to which the person, wherever temporarily located, always intends to return.

Policy: Medicaid is provided to otherwise eligible persons domiciled in New York State, regardless of the length of their residence. Local districts rely on a person's intent in determining the state of legal residence, unless the person's actions are inconsistent with that intent.

References:

SSL Sect.	62
Dept. Reg.	349.4(b) 360-3.2(g)
ADM	OMM/ADM 97-1 93 ADM-34 87 ADM-22

Interpretation: An A/R's State of residence is determined by a preponderance of factors, including, but not limited to: the address where the A/R is currently residing; the address from which s/he is registered to vote; his/her mailing address; the abandonment of any prior residence; and his/her health when s/he entered the district. The state that is responsible for providing Medicaid is the state where the A/R is domiciled.

Generally, when an SSI cash recipient enters New York State with the intent to remain, the district where s/he resides is responsible for providing him/her with Medicaid beginning with the date s/he entered New York State (provided the recipient was not placed in New York by another state). When an SSI recipient moves into New York State and continues to be eligible for SSI, the Social Security Administration (SSA) will change the state responsible for making state supplement payments to the recipient. The date of this change is the first of the month following the month in which the recipient moved. The date of the change will appear on the SDX in field 74 "Date Residency Began".

If an SSI recipient incurs a bill after entering New York State, but prior to the date in field 74 "Date Residency began" Medicaid is provided by the local district where the recipient resides. Medicaid

coverage begins on the first of the month prior to the month of the

OTHER ELIGIBILITY REQUIREMENTS

STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

"Date of Residency". The SDX is adequate documentation for determining when the recipient became a resident of the State. When an SSI recipient indicates that s/he moved to New York State prior to the first of the month preceding the "Date of Residency" further investigation is required. If the SSI recipient can document that s/he became a resident of New York State at an earlier date, Medicaid is authorized from that date.

Children who are adopted or receive foster care under Title IV-E of the Social Security Act receive Medicaid from the state in which the adoptive or foster parents reside. When a family including a IV-E eligible child moves to a different state, the new state become responsible for providing Medicaid. Families of IV-E adopted children must bring documentation of IV-E eligibility to the new state of residence for Medicaid to be authorized.

Transfer of Medicaid for IV-E foster care children is accomplished with the assistance of the State's IV-E Foster Care Compact Coordinator. When a IV-E foster care child is placed in another state, once the new placement is approved by the new state, that state opens up a Medicaid case. Until the new state of residence approves the foster care placement, New York State is responsible for arranging Medical care. While a New York State Medicaid case may remain open, Children and Family Services is responsible for working with foster parents in arranging for medical care out of state.

Specific residence topics are considered in detail in the following sections:

Persons Temporarily In the State;

District of Fiscal Responsibility; and

Persons Temporarily Out of State.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Policy: Generally, each local social services district is responsible for furnishing Medicaid to otherwise eligible A/Rs who are residents of New York State (NYS) and who reside within the district.

References:

SSL Sect.	62.5 365.5
Dept. Reg.	311.3 311.4 360-3.5 360-3.6
ADMs	OMM/ADM 97-1 94 ADM-20 90 ADM-9 86 ADM-40 80 ADM-4
INF	90 INF-45
GIS	97 MA/028

Interpretation: Where Found Rule

When a person enters New York State with the intent to remain permanently or indefinitely and has a need for medical care, before a living arrangement is established, the local district where the person is found is responsible for providing Medicaid, if the A/R is otherwise eligible.

When a person has not abandoned his/her residence in another state, but is unable to return to the home state due to illness, eligibility for benefits from the home State is explored. If, the home state does not agree that the individual is a resident of that state for Medicaid purposes, the local district where s/he is found at the time that the person can no longer return to his/her home state is the district responsible for providing Medicaid, regardless of where the applicant is found at the time of application. If the A/R subsequently is moved to a medical facility in another district, the first district remains responsible. For example: While visiting his sister in Essex County from another state, Mr. Smith becomes ill and cannot return to his home state. He is hospitalized in

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

on his behalf for Medicaid in Essex County. If the home state does not agree that the individual is a resident of that state for Medicaid purposes, Mr. Smith is authorized for Medicaid by Essex County. Subsequently Mr. Smith is moved to a nursing facility in Franklin County. Essex County remains fiscally responsible for Mr. Smith's Medicaid.

When a person applies for Medicaid while in a district other than his/her local district of residence, the local district in which the person is found contacts the local district of residence before assuming that district will accept and process an application. The district where the A/R is found assists in processing the application as a courtesy. This acknowledgment of fiscal responsibility is confirmed and noted in the record, prior to forwarding the courtesy application. Without such an agreement, the district in which the applicant is found accepts and processes the application. If otherwise eligible, Medicaid is authorized by the district where the applicant is found. The district may then request a fair hearing to determine the district of responsibility.

EXCEPTIONS TO THE “WHERE FOUND” RULE

NOTE: Unless one of the following ten exceptions applies, the “where found” district is fiscally responsible for the A/R. The burden of proof is on the “where found” district to establish that an exception applies.

Temporary Absence from Legal Residence

The local social services district where a person has his or her legal residence continues to be responsible for providing Medicaid when the person is temporarily absent from the district. A person's legal residence, or domicile, is the principal and permanent home to which the person, wherever temporarily located, always intends to return. Districts rely on a person's expression of intent in determining the district of legal residence, unless the person's actions are inconsistent with the expressed intent. When a person capable of indicating intent leaves his/her district of legal residence, the person will be considered to be temporarily absent from such district if:

- (a) the person enters another district for a specific purpose (such

as rehabilitation for alcohol or substance abuse, training, schooling, or vacation); and

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

- (b) the person intends to return to the “from” district when the specific purpose is accomplished and
- (c) the person’s actions are not inconsistent with this purpose. In this situation, the “from” district continues to be responsible for providing Medicaid as long as the recipient continues to engage in the activity which prompted the temporary absence.

This responsibility continues only until the temporary purpose ends. At that point, the recipient:

returns to his/her district of legal residence; or

is considered to have established a new legal residence and is transitioned from the “from” district to the “where found” district; or

becomes a transient (a homeless person without a legal residence) and immediately becomes the responsibility of the “where found” district.

When an A/R chooses to receive care or treatment in a medical facility outside his/her district of residence, the district of residence retains responsibility for the cost of the A/R's care.

Transition Rule

In the event that a non-institutionalized recipient moves from one district to another, the local district from which s/he moved continues Medicaid for at least 10 days or until the end of the month in which the recipient moved, whichever is later. The local district may authorize assistance until the last day of the month following the month in which the recipient moved. The former district informs the recipient of his/her need to apply for Medicaid in his/her new district of residence, if s/he wants to continue receiving Medicaid. The client must complete the full eligibility process in the new local district.

Medical Facility Rule

The local district of legal residence continues to be responsible for

providing Medicaid to a person who has entered a medical facility in another district if the person is in need of Medicaid upon admission to the facility, or becomes in need during the inpatient

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

stay, or upon discharge from the facility. This responsibility continues indefinitely until there is a break in the recipient's need for Medicaid.

When applying these provisions to a Title XIX facility operated or certified by OMH or OMRDD, regardless where the facility is located, the district of legal residence ("from district") remains responsible until there is a "break in need".

A "break in need" is defined as one calendar month without financial eligibility. As long as an individual remains financially eligible for Medicaid, there is no break in need. If the individual has excess income and submits paid or incurred expenses totaling the amount of excess or pays the excess directly to the district, there is no break in need. If in any month, the individual becomes resource ineligible and is unable to spend down the excess resources or does not meet an excess income liability, there is a break in need. When a break in need occurs, the district of fiscal responsibility may close the case with adequate and timely notice.

District Placement Rule

When the A/R's district of residence arranges or participates actively in arranging for care in another local district, that district is assuming responsibility for the continuing care of that A/R, regardless of the type of facility the person enters. The A/R's district of legal residence continues to be, or becomes responsible for providing Medicaid when: a district (either the local district of legal residence or any other district) was involved in placing the eligible person into a formal residential care setting in another district. District involvement in a placement includes both direct and indirect involvement by any county agency or official governmental entity of the county including courts, mental health departments, probation departments, etc.

Homeless Rule

in another district, the placing district continues to be responsible for providing Medicaid during the individual's/family's stay in temporary housing. When a district places a homeless individual/family in temporary housing Medicaid during the individual's/family's stay in the temporary housing. If the homeless recipient

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

subsequently moves into permanent housing, the placing district retains responsibility for the month of the move and may continue to authorize Medicaid for the following month.

NOTE: When a homeless A/R relocates from one district to another and does not wish to return to the first district, s/he is treated as any other A/R moving from one district to another.

Domestic Violence

When an eligible person enters an approved Shelter for Victims of Domestic Violence located in another district following an incident of domestic violence, the district in which the person legally resided at the time of the incident is fiscally responsible for that person while s/he resides in the approved shelter. This rule applies to persons who had been receiving Medicaid prior the incident as well as to persons who become eligible due to lack of available income and resources while residing in the approved shelter.

This responsibility continues until the person leaves the approved shelter. If the recipient chooses not to return to the former district of legal residence, such district is responsible for providing Medicaid during the month the recipient leaves the shelter and may continue Medicaid for the following month. The "where found" district is responsible thereafter.

A/R under 21

Children under age 21 generally retain the residence of their parents or legal guardian, regardless of the circumstance under which they move.

Medical Parole

The DFR for an inmate released on medical parole is the district from which the inmate was sentenced. This responsibility continues indefinitely until there is a break in need.

The DFR for non-medical parolees released into a non-medical residential setting such as a halfway house will follow the placement rule. The Board of Parole is considered to be acting on behalf of the court who is considered to be acting on behalf of the

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

district. Therefore, the district where the parolee legally resided prior to incarceration will continue to be responsible for providing Medicaid to the parolee until there is a break in need.

Infants Residing with Incarcerated Mothers

The DFR for an infant residing with an incarcerated mother is the mother's district of legal residence prior to incarceration.

Assisted Living Program (ALP)

The DFR for an individual residing in an ALP is determined as follows:

for an individual who is Medicaid eligible at the time of admission to an ALP, the district that is fiscally responsible for the individual immediately prior to his or her admission to the ALP will retain fiscal responsibility; and

for an individual who is not Medicaid eligible at the time of admission to the ALP but later becomes Medicaid eligible, the individual's district of legal residence prior to admission to the ALP is the fiscally responsible district.

Children Eligible for Continuous Medicaid Coverage

If a child moves to another district during a period of continuous coverage, the child remains the responsibility of the originating district until such time as a Medicaid application is made for the child, and the child is determined eligible in the new district. At that time, a new period of continuous eligibility begins, and the new district becomes responsible for the child's Medicaid. If a Medicaid application is made for the child in the new district, and the child is determined ineligible for Medicaid, the child remains the responsibility of the originating district until the 12 month period of continuous eligibility ends.

In rare situations, however, it may be necessary for the new district to assume responsibility for a child's continuous coverage, to avoid a circumstance in which household members have Medicaid coverage from different districts. For example, a family with a two year old child in receipt of Medicaid moves. They advise the district, which makes the necessary systems changes

OTHER ELIGIBILITY REQUIREMENTS**DISTRICT OF FISCAL RESPONSIBILITY (DFR)**

to give the child continuous coverage. When the family applies in the new district, their net income now exceeds 133% of the FPL; therefore, the child cannot be determined fully eligible. A month later, the mother applies because she is pregnant, and is found eligible under 185% of the FPL. The new district adds the child to the mother's case using a "continuous coverage" categorical code for the balance of the continuous coverage period.

If a child turns age 19 during a period of continuous eligibility, the guarantee of continuous eligibility will end as of the last day of the month of the child's nineteenth birthday. However, if the child is receiving medically necessary inpatient services at that time, Medicaid coverage continues through the end of the hospitalization.

Disposition:

When the district of fiscal responsibility for the A/R has been established, that district authorizes Medicaid, if the A/R is otherwise eligible.

If a dispute based on residency occurs between local districts for an otherwise eligible A/R, either district may request a fair hearing to determine the district of fiscal responsibility. The district where the A/R is found provides Medicaid until the fair hearing decision is rendered. The district found to be responsible, if necessary, reimburses the district that assumed responsibility for the A/R prior to the fair hearing decision.

Generally, a person cannot gain residence in a district while receiving care in a Title XIX facility or a public institution.

When a pregnant woman is determined presumptively eligible for Medicaid, the district she states is her residence is fiscally responsible for care provided during the period of presumptive eligibility. Her documented district of residence may be different when a full eligibility determination is completed.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS TEMPORARILY ABSENT

Policy: Medicaid may be authorized for a resident of the New York State who is temporarily absent from NYS if the A/R remains in the United States (including Puerto Rico, the Virgin Islands, Northern Mariana Islands, or Guam) or in Canada, and s/he meets one of the following conditions:

- (1) the residents of the A/R's district customarily use medical facilities in another state or Canada; or
- (2) there are limited medical services available in the A/R's local district and the local social services district gives prior approval; or
- (3) an emergency situation arises.

References:

SSL Sect.	62 365
Dept. Reg.	360-3.2(g) 360-3.5
ADM	OMM/ADM 97-1

Interpretation: An A/R is temporarily absent from the State, if before the absence s/he: was a resident of the district; has an intent to return to the State; and has not shown an intent to establish a permanent residence elsewhere.

Residents of New York State may be eligible for Medicaid coverage of medical services provided in another state if residents of the A/R's district customarily use the medical facilities in another state, or if the type of medical service required is not available in New York State and the local social services district has given prior approval. Medicaid coverage may also be authorized, if while temporarily in another state, the A/R requires emergency medical attention. The assistance of that state is sought in the application process.

NOTE: New York Medicaid will only make payment to out-of-state providers who are enrolled in New York's Medicaid program. For situations involving medical expenses incurred/paid during the three month period prior to the month of application, see page 239.

OTHER ELIGIBILITY REQUIREMENTS**ASSISTANCE TO PERSONS TEMPORARILY ABSENT**

If an individual is placed in a medical institution in another state, the district which placed him/her continues to be responsible for all covered necessary medical expenses incurred outside the state, since the local district arranged for the placement in a medical institution. If, however, an individual voluntarily placed him/herself in a chronic care facility in another state, abandoning his/her former residence, s/he may be considered a resident of the state to which s/he moved.

NOTE: Generally, in cases involving a question of state residence, the intent of the client to establish a permanent dwelling is the primary consideration, as long as the A/R's action is consistent with his/her intent.

Disposition:

When an A/R is found to have established a legal residence (domicile) outside of New York State, a timely and adequate notice is sent to the A/R that s/he is no longer eligible for Medicaid in New York State and that s/he should apply for assistance in the State to which s/he moved.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE

Policy: The state of residence is fiscally responsible for providing Medicaid to otherwise eligible A/Rs.

When an application is made by a person temporarily in New York State (NYS), the local district in which s/he is found assists the appropriate agency in the applicant's state of residence with the investigation to determine eligibility and make arrangements for care.

However, if the Medicaid available to the client in his/her state of residence is limited in scope and duration, NYS may authorize care after the A/R utilizes any Medicaid available from his/her home state, providing the A/R did not enter the NYS for the purposes of obtaining such care and s/he is otherwise eligible.

Persons who are placed in medical institutions in NYS by another state remain the responsibility of that State which made the placement.

References:

SSL Sect	365.1(b) 366.1(b)
Dept. Reg.	360-3.2(g) 360-3.6
ADM	OMM/ADM 97-1
LCM	93 LCM-12

Interpretation: When an A/R is temporarily absent from his/her state of residence, that state continues to be responsible for the A/R's Medicaid (see page 400 for a discussion of state of residence). If the state of residence does not agree that the individual is the responsibility of that state for Medicaid purposes, then NYS Medicaid is authorized for an otherwise eligible A/R provided that the A/R did not enter NYS for the purpose of obtaining medical care.

When a person is found in NYS and is medically unable to return to his/her home state, the district where the person is found at the

time s/he becomes unable to return to his/her home state is

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OTHER ELIGIBILITY REQUIREMENTS**ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE**

responsible for providing his/her Medicaid, if the person is otherwise eligible and assistance is denied by the home state because of residency.

When to Verify: When an applicant indicates a recent entry or an address outside NYS, the local district establishes the client's actual State of residence. If s/he has recently entered New York State, the local district establishes that the entry was not for the purpose of receiving medical care.

Verification: When there is a question as to the A/R's state of residence, a determination of residence is based on a preponderance of the following factors: (1) the address from which s/he is registered to vote; (2) his/her mailing address; (3) the abandonment of any prior residence; and (4) his/her health.

NOTE: When there is a question as to the A/R's state of residence, generally the intent of the A/R to establish a permanent residence is the primary consideration, as long as the A/R's actions are consistent with his/her intent.

Disposition: When an A/R entered New York State for the purpose of obtaining medical care, his/her application is denied. If the A/R is a resident of another state, the local district in which s/he is found assists the state of residence in the investigation of his/her eligibility and/or the arrangement for his/her care (see page 400).

OTHER ELIGIBILITY REQUIREMENTS**LIVING ARRANGEMENTS**

- Description:** This section describes where Medicaid may be provided. A recipient may reside in his/her own home or a medical institution/facility. Medicaid may also be given to residents of certain public institutions/facilities. Federal reimbursement is not always available, however.
- Policy:** Care and services under Medicaid may be provided to an otherwise eligible A/R residing in: his/her own home; a general or chronic disease hospital; or an institution used primarily for the care of the mentally ill, when the A/R is under age 21, under age 22 if the A/R turned 21 while residing in the institution, or is age 65 or over. Generally a person residing in a public institution may not receive Medicaid unless the public institution is: a medical facility; a community residence, not on the grounds of a major institution, serving 16 or fewer residents; a child care institution for 25 or fewer children; an emergency shelter for the homeless; a home for adults operated by a local social services district; or an OMH residential care center for adults (RCCA).
- References:**
- | | |
|------------------|---|
| SSL Sect. | 365
366 |
| Family Court Act | 454 |
| Dept. Reg. | 360-3.4
360-6.6 |
| ADMs | OMM/ADM 97-1
90 ADM-18
89 ADM-2
88 ADM-50
86 ADM-23 |
- Interpretation:** The term **his/her own home** is broad in scope. Such living arrangement may include the person's own house or apartment, a private home for adults, an approved home for the aged or blind, a residential facility not located on the grounds of a major institution, a child care institution; and congregate care living arrangements. Persons in family care or foster care are living in their own home for Medicaid purposes. See page 416 for a discussion of the A/R living in his/her home.

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

An **approved medical institution or facility** includes the following, when operated according to Public Health Law or other applicable law:

a private proprietary or non-profit nursing home ;

the infirmary section of a home for the aged;

a public home infirmary or similar public facility for the chronically ill;

a hospital or nursing home section of a public institution operated for the care of persons with developmental disabilities;

a State hospital for the mentally disabled operated by the Department of Mental Hygiene (OMH);

a residential treatment facility for mentally disabled children certified by the Department of Mental Hygiene (OMH);

an intermediate care facility for the developmentally disabled;
and

a hospital, other than one caring primarily for the mentally disabled.

NOTE: These definitions are **NOT** to be used for the purpose of determining the district of fiscal responsibility (see OMM/ADM 97-1).

Medicaid is available to otherwise eligible persons receiving inpatient psychiatric services while residing in an institution primarily for the care of the mentally ill when: the A/R is under age 21; the A/R turns 21 during the course of his/her institutionalization, (in which case the A/R may receive assistance until s/he reaches the age of 22); the A/R is age 65 or over; or, the A/R is an FNP refugee or Cuban-Haitian entrant (in which case Medicaid may be authorized for eight months following the date of entry).

Medicaid may be provided to otherwise eligible prisoners or

individuals in the detention process or to residents of another

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

public institution during the month they enter and/or leave the institution but for only that part of the month in which they are in the community. A public institution is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. Jails, prisons, secure detention facilities and half-way houses operated by the government are types of public institutions.

Children placed in secure detention facilities may receive Medicaid (if otherwise eligible) during the month they enter or leave the facility, but only for the part of the month that they reside in the community. Children placed in Office of Family and Children Services Group Homes, Foster Homes and Contract Homes, who are otherwise Medicaid eligible, may receive full Medicaid coverage and a Common Benefit Identification Card.

This section outlines living arrangements where Medicaid may be given as follows:

Own Home;

Medical Facilities; and

Public Institutions.

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

LIVING IN OWN HOME

Description: An A/R is living in his/her own home when s/he is living alone, living with friends or relatives, living in a congregate care situation or living in foster care.

Policy: Medicaid may be given to an otherwise eligible person living in his/her own home.

References:

SSL Sect.	365 366 371 374
Dept. Reg.	360-6.6(a)
ADMs	92 ADM-15 90 ADM-18
LCMs	93 LCM-89

Interpretation: For Medicaid purposes, "home" indicates a type of residence where Medicaid may be received. The term commonly used is "community based".

An A/R may live with friends and/or legally responsible relatives and be eligible for Medicaid "in his/her own home". When an applicant is living in a communal situation, the arrangement should be investigated. When the communal arrangement represents itself as an organization, whether religious or fraternal, the status of the organization is determined. If the applicant made a commitment to the organization in return for the organization agreeing to meet his/her needs, a determination is made as to whether or not this includes medical needs. In such an agreement, resources may be held in common.

An individual is living in his/her own home when s/he is living in a congregate care situation. Some examples of congregate situations are foster care for children and adult care facilities such as family type homes for adults, shelters for adults and residences for adults. These adult care facilities provide shelter for adults who, though not requiring continual medical or nursing care, are, by reason of physical or mental disability associated with age or

other factors, unable to live independently.

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

MEDICAL FACILITIES

Description: Medical facilities are hospitals, skilled nursing facilities and intermediate care facilities which have an operating certificate issued to them by the New York State Department of Health or the Department of Mental Hygiene and have a Medicaid Provider agreement issued by the State Medicaid agency.

Policy: Medicaid may be given to an otherwise eligible person in an approved medical facility.

NOTE: This definition is NOT to be used for the purpose of determining the district of fiscal responsibility (see OMM/ADM 97-1 and page 402).

References:

SSL Sect.	365 366
	Public Health Law, Article 28
	Mental Hygiene Law, Article 31
	Mental Hygiene Law, Article 16
Dept. Reg.	360-6.6(b) - (f)
ADM	OMM/ADM 97-1
INF	88 INF-15
LCM	93 LCM-89

Interpretation: An approved medical institution or facility includes the following when operated in accordance with the provisions of the Public Health Law, Mental Hygiene Law or other applicable law:

a private proprietary, public or non-profit nursing home;

the approved infirmary section of a home for the aged;

a public home infirmary or other similar public facility for the chronically ill;

an approved hospital or nursing home section of a public institution operated for the care of persons with

developmental disabilities;

OTHER ELIGIBILITY REQUIREMENTS**MEDICAL FACILITIES**

a general or chronic disease hospital; an institution operated primarily for the care of the mentally disabled, for individuals under age 22 if the A/R turned 21 while residing in the institution or is age 65 or over or under 21; or the A/R is an FNP refugee or Cuban-Haitian entrant in which case s/he receives Medicaid (if otherwise eligible) for eight months following the date of entry; and,

an ICF for the developmentally disabled.

Medicaid may be provided to inpatients in public, voluntary or proprietary hospitals in New York State which: are in possession of a valid operating certificate issued in accordance with the provisions of Article 28 of the Public Health Law; are enrolled in the New York State Medicaid program including possession of a provider agreement, and have in effect a hospital utilization review plan.

NOTE: Medicaid may be provided in a hospital located outside New York State if the hospital: is in compliance with such legislation and requirements established by the official agency in the state in which that care is received; has a Medicaid provider agreement; and is enrolled in the New York State Medicaid program.

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

PUBLIC INSTITUTIONS

Description: A public institution is a non-medical facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Public institutions do not include a community residence serving 16 or less residents; or a child care institution serving 25 or less residents.

Policy: Medicaid cannot be provided to residents of non-medical public institutions, except when the public institution is:

a shelter for homeless adults operated by a social services district, regardless of size;

a correctional facility nursery. An infant/child residing in a correctional facility nursery while the mother is serving a prison term may receive Medicaid (see page 421);

a public emergency shelter for homeless adults. Persons residing in a public emergency shelter for homeless adults may be eligible for Medicaid when the A/R is : in receipt of or eligible for S/CC; over the age of 18 and otherwise eligible; or SSI-related. However, an SSI-related A/R may be claimed FP for only six (6) months during a nine (9) month stay within 12 consecutive months. When the six months of federal participation expires, the SSI-related A/R may be claimed FNP. Persons residing in a family shelter are not subject to such categorical restrictions; or,

a public home operated by a county. Residents of a county-operated public home may be eligible for Medicaid, without federal reimbursement.

References:

SSL Sect.	365 366
Dept. Reg.	360-3.4(a)(1) 491.1-4 500.2 500.1

OTHER ELIGIBILITY REQUIREMENTS**PUBLIC INSTITUTIONS**

ADMs	95 ADM-04
	94 ADM-20
	88 ADM-50
	86 ADM-23
	81 ADM-10
	79 ADM-87

Interpretation:

Except as listed above, Medicaid is not available to residents of non-medical public institutions.

In any month an otherwise eligible Medicaid recipient enters or leaves a public institution (in which Medicaid is not available), Medicaid may be authorized for only that portion of the month the individual is residing in the community (except as listed above).

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS
PUBLIC INSTITUTIONS**

INFANTS RESIDING WITH INCARCERATED MOTHERS

Description: Certain correctional facilities operate nurseries for infants born to inmates. Children, born to women serving prison sentences, may live in the nursery for up to eighteen (18) months. This includes a standard twelve (12) month stay plus a possible 6 month extension if there is a reasonable probability that the mother will be released within the 18 months. In the event that the mother is not released within the allotted time, the child is placed in foster care or with relatives.

Policy: Infants and children residing in correctional facilities (where their mothers are incarcerated) are not considered "inmates" of a public institution and therefore may be eligible for Medicaid.

The child is an individual under 21 and fulfills the requirements of one of the categories (see page 35). The child is budgeted as a household of one, residing in the community. After allowing appropriate disregards, the child's income is compared to the Public Assistance Standard of Need or the Medically Needy Exemption Level, whichever is greater. The PA Standard of Need is a negotiated room and board rate plus the \$45 personal needs allowance.

The district in which the mother resided at the time of her sentencing is the district of fiscal responsibility for the child.

The district of fiscal responsibility designates a person to review the application and conduct the face-to-face interview. The designated person may be a district employee or the district's Commissioner may enter into a Memorandum of Understanding (MOU) with the Superintendent of the facility, designating a correctional facility employee.

The mother of the child or the mother's representative must complete an application (see page 364) and submit it to the designated person at the correctional facility. The designated person reviews the application, conducts the face-to-face interview and forwards the application packet to the district of fiscal responsibility. The district of fiscal responsibility processes the application and determines the child's Medicaid eligibility.

The date of application is the date that a signed State-prescribed

application form, a State-approved equivalent form or process is

OTHER ELIGIBILITY REQUIREMENTS**INFANTS RESIDING WITH INCARCERATED MOTHERS**

received by the designated person. Eligibility may be established for up to three (3) months prior to the month of application (see 394). However, Medicaid can not be authorized for the period prior to the child's birth.

References:

SSL Sect.	65 366
Dept. Regs.	369.1 & .2 360-2.2
ADMs	OMM/ADM 97-1 95 ADM-04

Interpretation:

Completed applications are forwarded to the district of fiscal responsibility by the designated person at the correctional facility.

The child's eligibility is determined as if s/he resided in the community, as a household of one.

OTHER ELIGIBILITY REQUIREMENTS**IDENTITY**

Policy: All A/Rs, as a condition of eligibility for Medicaid, must be identified.

References:

SSL Sect.	366
Dept. Reg.	351.1(b)(2)(ii)(a) 351.2(a) 360-2.3
ADMs	93 ADM-29

Interpretation: It is the responsibility of the applicant to establish his / her identity. When the A/R's name changes due to marriage, divorce or legal proceedings, the local district documents the change, as appropriate.

Verification: A birth certificate is preferred as verification of identity. Other acceptable documents include, but are not limited to: baptismal certificates, immigration and naturalization papers, passports, driver's licenses, marriage certificates, military records, school vaccination records, or employer records which indicate the name of the applicant. Verification may be obtained from the applicant or collateral sources.

When the applicant is homeless, it may be difficult for him/her to establish identity. For homeless persons, the district may accept the following as proof of identity:

information from agencies or other persons who can identify the A/R; or,

any identification the applicant possesses.

Documentation: Sufficient to establish an audit trail:

- (a) type of document, any identifying numbers, date and issuing official;
- (b) for phone verification, name of person spoken to, how the person established the applicant's identity, phone number and date.

OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRRs)

Description: A legally responsible relative is a person who is legally responsible for the support and care of one or more relatives.

Policy: For Medicaid purposes, a legally responsible relative is:

a spouse of a Medicaid A/R; or

a parent of a child under the age of 21. However, the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

18 years of age or older;

under the age of 18, but **expected** to be living separately from the parental household for 30 days or more; or

participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-1.4(h) 360-4.3(f)
ADMs	OMM/ADM 97-2 89 ADM-47
GIS	91 MA/007

Interpretation: When an A/R is living with a legally responsible relative (LRR), the LRR's income and resources are generally considered available to the A/R.

When an **A/R is residing** in the community **with an LRR** and the LRR asserts that his/her income/resources are not available to the

A/R, the eligibility determination depends on whether: (a) the LRR

UPDATED: AUGUST 1999		425
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OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRR)

provides financial information; or (b) the LRR refuses to provide the requested financial information.

- (a) When the LRR provides information, but refuses to make his/her income/resources available to the A/R, eligibility for the A/R is determinable. When completing a budget, only the income/resources actually available to an A/R are counted.
- (b) When the LRR refuses to provide financial information, eligibility is generally indeterminable. However, if the A/R provides complete information concerning his/her own income and resources, including any jointly held resources, eligibility is determined based on the available information.

A dollar amount is budgeted for any non-medical needs that the LRR is meeting. For example, the LRR may be providing the A/R with food, shelter, and clothing. The value of these items would be considered income. The non-contributing LRR is not included in the household size.

If Medicaid is provided because of the failure or refusal of an LRR to make income and resources available, an implied contract is created with the non-contributing LRR. Recovery for the cost of any care provided may be pursued through legal channels.

For Singles/Childless Couples (S/CC), the income/resources of the LRR are assumed to be available to the A/R and the LRR is included in the household size, whether or not income and resources are actually being made available. In situations where the LRR refuses to provide any information, eligibility is indeterminable.

NOTE: The income/resources of parents are not considered in the eligibility determination for their pregnant daughters (of any age), regardless of where the pregnant daughter resides.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES****SPOUSE**

Description: A spouse is an A/R's legal husband or wife. (See definitions in the Glossary.) A spouse is a legally responsible relative (LRR).

Policy: The spouse of a person in need of Medicaid, if of sufficient financial ability, is responsible for that person's medical needs. (See page 342 for utilization of third party health insurance benefits.)

References:

SSL Sect.	101 366(3)(a)
Dept. Reg.	360-1.4(h) 360-4.3(f) 360-4.10 360-7.11(b)(ii)
ADMs	OMM/ADM 97-2 91 ADM-37 91 ADM-31 90 ADM-29 89 ADM-47 82 ADM-20 82 ADM-6

Interpretation: Spouses Living Together

When an A/R is **living with** his/her spouse, the spouse's income and resources are generally considered available to the A/R (see pages 443 and 388 for budgeting methodologies and availability).

When the spouse asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the spouse provides financial information; or (b) the spouse refuses to provide the requested financial information. In both instances, at a minimum, a notation is entered into the case record. (See page 424 for general treatment of legally responsible relatives.)

OTHER ELIGIBILITY REQUIREMENTS

SPOUSE

Spouses Living Apart in the Community

When an A/R is residing in the community **apart** from his/her spouse who is also residing in the community, the spouse may be requested to contribute toward the cost of medical care provided to the A/R. The amount of the requested contribution depends on the spouse's financial ability to support and the category of the A/R.

To determine the amount of the requested contribution from a spouse residing in the community, but not in the A/R's household:

when there is a child in the household under the age of 21, the case is referred to the Child Support Enforcement Unit (IV-D);

when the A/R is S/CC, local district Public Assistance procedures determine the contribution; or

when the A/R is SSI-related, the spouse is requested to contribute twenty-five percent (25%) of his/her otherwise available income which exceeds the minimum monthly maintenance needs allowance (MMMNA), plus any family member allowance(s) (see page 238).

The local district requests the LRR **other than a community spouse** to contribute any excess resources to the support of the Medicaid A/R. Only the income/resources actually received from a spouse not residing in the A/R's household are counted when determining eligibility.

When the spouse asserts that his/her income/resources are not available to the A/R, at a minimum, a notation is entered into the case record.

Institutionalized Spouse with a Community Spouse

When an A/R is an **institutionalized spouse** and his/her spouse is a community spouse, spousal budgeting rules determine the

OTHER ELIGIBILITY REQUIREMENTS**SPOUSE**

treatment of the couple's income and resources. See page 225 for the full explanation of the assessment and budgeting of income/resources.

If Medicaid is provided, in the instance of failure or refusal, an implied contract is created with the non-contributing spouse. Recovery of the cost of any care provided may be pursued through legal channels.

Both Spouses Institutionalized

When both spouses are institutionalized they are treated as two separate households, whether or not they share a room.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES**

PARENTS AND CHILDREN

Description: A child is a person under the age of 21. Generally, parents are legally responsible for their children under the age of 21.

Policy: A parent of a child under the age of 21 is legally and financially responsible for his/her child. However, the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

18 years of age or older;

under the age of 18 but **expected** to be living separately from the parental household for 30 days or more; or

participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-1.4(h) 360-4.3(f)
ADMs	OMM/ADM 97-2 82 ADM-6
LCM	95 LCM-106
GIS	91MA007

Interpretation: Generally, parents, including adoptive and step-parents (see page 440), are financially and legally responsible for their children under the age of 21. However, the income/resources of the parent or step-parent are not considered in the eligibility determination if the child is pregnant. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who meets one of the criteria specified

above.

OTHER ELIGIBILITY REQUIREMENTS

PARENTS AND CHILDREN

The income/resources of parents are counted in the determination of eligibility for certified blind/disabled child(ren) under the age of 18, unless the child is living or expected to be living separate and apart from the parent(s) for 30 days or more. Even though the child returns to the household in less than 30 days, if s/he was expected to be absent for 30 days, the income/resources of his/her parents are not considered in the eligibility determination for the child during the entire 30 days s/he was expected to be absent.

The income/resources of parents are considered in the eligibility determination for their certified blind/disabled child(ren). If the child is participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

The income/resources of parents are not considered in the eligibility determination for their pregnant daughters (of any age), regardless of where the child resides.

When the child's parent is absent from the household, a referral is made to the Child Support Enforcement Unit (IV-D). IV-D will pursue the absent parent for support.

Only the income/resources actually received (from his/her absent parent) by an A/R are counted when determining eligibility.

See page 424 for the general treatment of legally responsible relatives.

See page 388 for treatment of a non-cooperative parent residing with the A/R.

See page 440 when the child has a step-parent.

When To Verify:

When there is a certified blind/disabled or pregnant child in the household.

OTHER ELIGIBILITY REQUIREMENTS**PARENTS AND CHILDREN****Documentation:**

- (a) Certificate of blindness/disability.
- (b) Proof of absence or expected absence of a certified blind/disabled child, such as a doctor's statement.
- (c) Statement from a medical provider that the minor is pregnant.
- (d) Participation in a home and community-based waiver program where parental income/resources are not considered in the determination of eligibility.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES
PARENTS AND CHILDREN**

ABSENT PARENTS

- Description:** Absent parents are legally responsible for their children under the age of 21.
- Policy:** Generally, the income/resources of parents are considered in the eligibility determination of children under the age of 21. The income/resources of the parents of a pregnant minor are not considered in the determination of eligibility regardless of where the pregnant minor resides.
- References:**
- | | |
|------------|--|
| SSL Sect. | 101
366 |
| Dept. Reg. | 360-1.4(h)
360-4.3(f)
360-7.11(b)(iii) |
| ADMs | OMM/ADM 97-2
89 ADM-47 |
- Interpretation:** The income/resources actually contributed by an absent parent are considered in the determination of eligibility. A referral is made to the Child Support Enforcement Unit (IV-D) to determine the amount of any contribution, medical support, paternity and any appropriate recovery.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES
PARENTS AND CHILDREN**

EMANCIPATED MINOR

Description: For Medicaid purposes, an emancipated minor is a person who: is age 16 or over; has completed his/her compulsory education; is living separate and apart from his/her family; and not in receipt of or in need of foster care.

Policy: Medicaid may be authorized for an emancipated minor who is otherwise eligible.

References: Dept. Reg. 349.5

Interpretation: When a child leaves his/her family household to live on his/her own, the child, if otherwise eligible, may receive Medicaid on his/her own behalf. This child must fulfill the requirements of an emancipated minor by being age 16 or over, having completed compulsory education, living away from home and not in need of foster care.

The parents of an emancipated minor are legally responsible relatives for him/her. The parental liability for support should be established (see page 434) by an appropriate referral to the Child Support Enforcement Unit (IV-D).

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

Description: Title IV Section D (IV-D) of the Social Security Act was established to: secure and enforce child support and medical support from absent parents; establish paternity when necessary; and to provide a parent locator service. For more detailed information regarding IV-D refer to the Public Assistance Source Book, Section VIII-T.

Policy: Generally, a Medicaid household including a child under the age of 21, whose parent is absent from the home, must as a condition of eligibility meet the requirements to secure medical support and establish paternity, unless good cause not to cooperate exists. Not all IV-D requirements apply to the Medicaid program; pursuit of cash support is not a requirement for Medicaid A/Rs.

In addition to the good cause exception, the following other IV-D exceptions apply for Medicaid A/Rs:

Individuals who apply at outstation locations. The procedures that have been in place since outstationing was implemented will continue.

All pregnant women, through their pregnancy and the 60 day post partum extension period, regardless of whether:

They apply at the local district office, a qualified presumptive eligibility provider or a otherwise qualified outstation location;

They are applying for their children or themselves only; or

The long or short application is used;

TMA recipients. After the TMA extension ends and the A/Rs present for a recertification interview the A/Rs are given the opportunity to comply with any IV-D requirement before Medicaid is discontinued.

NOTE: IV-D referrals are not required when a pregnant woman is applying, whether or not she is applying for other children in addition to herself. Any IV-D referral of a pregnant woman is not completed until 60 days after the end of her pregnancy, unless specifically requested by the pregnant woman.

OTHER ELIGIBILITY REQUIREMENTS

IV-D REQUIREMENTS

References:	SSL Sect.	111 366.3 366.4(h) 367-a.2(b)
	Dept. Reg.	369.2(b) 360-4.3(f) 360-7.11 441.2
	ADMs	99 ADM-5 92 ADM-40 89 ADM-47 89 ADM-23
	INFs	90 INF-45

Interpretation: The eligible parent or other caretaker/relative of a child under the age of 21 whose parent is absent from the home must meet the following IV-D requirements, for medical support only:

Cooperate in good faith with the State and the local social services district to establish the paternity of a child born out of wedlock, to locate any absent parent or putative father and to establish, modify and enforce support orders.

The term “cooperation” includes providing information for the worker to complete the DSS-2860 form and, if required, appearing at the local Child Support Enforcement Unit (CSEU) to be interviewed. A Medicaid applicant who is not pregnant or in the 60 day postpartum period or otherwise exempt must assist in completing the DSS-2860, appear at the CSEU, as necessary, and cooperate with the CSEU unless good cause exists.

A Medicaid recipient’s continued cooperation with the CSEU is prerequisite to his or her ongoing eligibility to receive Medicaid. An A/R’s Medicaid eligibility is not delayed or denied, however, if the A/R is complying but, through no fault of the client, the IV-D process has not been completed.

OTHER ELIGIBILITY REQUIREMENTS**IV-D REQUIREMENTS**

The local district:

- (1) informs Medicaid A/Rs of the benefits of cooperating with the child support enforcement process;
- (2) provides all client books at application and recertification, including Client Information Book I (DSS-4148A), which addresses clients' rights and responsibilities regarding child support;
- (3) advises all Medicaid-Only A/Rs that, as a condition of initial and ongoing eligibility, they will be required to cooperate in:
 - (a) obtaining third party health insurance (TPHI) and medical payments for themselves and any other individuals for whom the Medicaid-Only A/R can legally assign rights;
 - (b) establishing paternity of a child born out of wedlock for whom the Medicaid-Only A/R can legally assign rights; and
 - (c) obtaining medical support for their children.

NOTE: Pregnant women should not be referred to the SCEU until after the 60-day post partum period. To the extent possible, prior to such referral, local districts continue to pursue the availability of TPHI. If a pregnant minor does not want her parents contacted, however, TPHI is not pursued. All other Medicaid-Only A/R's must cooperate in establishing paternity and securing TPHI and, in the case of an absent parent, securing medical support and child support.

An A/Rs failure, without good cause, to cooperate renders such person ineligible for Medicaid. Their children under age 21, however, are authorized to receive Medicaid if they are otherwise eligible;

OTHER ELIGIBILITY REQUIREMENTS**IV-D REQUIREMENTS**

- (4) gives and explains the DSS-4279: "Notice of Responsibilities and Rights for Support" to each A/R who is referred to the CSEU;
- (5) Medicaid worker or an appropriate designee determines whether an A/R who claims to have good cause for refusing to cooperate actually does have good cause.
- (6) refers to the CSEU cases which include a non-pregnant child under age 21 whose paternity has not been established or whose parent(s) are absent from the home. Complete the DSS-2860 form and inform A/Rs who are required to appear in the CSEU that they must bring the completed DSS-2860 to their CSEU interview. Applicants are referred to the CSEU prior to their eligibility determination or, if practicable, prior to their eligibility interview;
- (7) at next recertification, notifies CSEU of each Medicaid-Only recipient who meets the CSEU referral criteria and who currently does not have a court order for child support including medical support. Case-specific DSS-2859 forms or case listings may be used for these notifications. The CSEU will commence proceedings to obtain medical and cash support for these cases;
- (8) obtains necessary documentation from A/Rs;
- (9) when notified by CSEU that an A/R who is not pregnant has failed to cooperate, denies the applicant or discontinues the recipient's Medicaid coverage, until compliance, using appropriate notices and procedures. The A/R's children are not denied or discontinued from Medicaid for this reason;
- (10) takes appropriate action in Medicaid cases reported in the IV-D/Medicaid Interface Report and in DSS-2859 referrals from the CSEU. The weekly IV-D/IV-A Interface Report provides information to Medicaid workers about status changes in child support cases, including location of absent parents, paternity establishment, support order actions and third party health insurance coverage;

OTHER ELIGIBILITY REQUIREMENTS**IV-D REQUIREMENTS**

- (11) responds to CSEU requests for Medicaid eligibility and payment information;
- (12) at recertification and other client contacts, asks recipients for new and changed information about absent parents, forwards information to the CSEU via the DSS-2859 form; and
- (13) budgets child support income in a Medicaid-Only case with the \$50 disregard as Unearned Income.

The local district informs the A/R that s/he has a right to claim good cause as an exception to the cooperation requirement. The A/R may refuse to meet any or all of the IV-D requirements when s/he has good cause to do so. The following circumstances are considered good cause:

- (1) when cooperation may be against the best interests of the child. Cooperation in establishing paternity or seeking support is deemed to be against the best interest of the child only if the A/R's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

physical harm to the child for whom support is sought;

emotional harm to the child for whom support is sought;

physical harm to the parent or caretaker relative with whom the child is living;

emotional harm to the parent or caretaker relative with whom the child is living;

- (2) the child for whom support is sought was conceived as a result of incest or forcible rape;
- (3) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

the A/R is currently being assisted by an authorized agency (LDSS or a voluntary agency) to resolve the issue of whether to parent the child or place him/her for adoption,

OTHER ELIGIBILITY REQUIREMENTS**IV-D REQUIREMENTS**

- (4) and discussions have not gone on for more than three months.

If an A/R refuses to meet the IV-D requirements and s/he cannot show good cause, s/he is denied Medicaid.

Documentation:

An A/R who claims good cause must provide corroborative evidence within 20 days from the day the claim was made. A district may extend this 20 day period when the A/R has difficulty obtaining evidence.

Statement from a medical provider that the A/R is pregnant.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES
PARENTS AND CHILDREN**

STEP-PARENTS

Description: A step-parent is the spouse of an A/R's parent, including an adoptive parent. For Medicaid purposes step-parents are legally responsible for their step-children under the age of 21.

Policy: A step-parent of a child under the age of 21 is legally and financially responsible for his/her child. However, the income and resources of a step-parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

18 years of age or older;

under the age of 18 but **expected** to be living separately from the parental household for 30 days or more; or

participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-4.3(f) 360-7.11
ADMs	91 ADM-8 82 ADM-6 75 ADM-21

Interpretation: Generally, step-parents are responsible for their step-children under the age of 21. However, the income/resources of step-parents are not considered in the determination of eligibility when the child is pregnant; age 18 or over and certified blind/disabled or participating in a home and community-based waiver program.

The income/resources of step-parents are not considered in the determination of eligibility for their certified blind/disabled step-

child age 18 or older, regardless of where the child resides. The

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES
PARENTS AND CHILDREN**

STEP-PARENTS

income/resources of step-parents are considered in the determination of eligibility for their certified blind/disabled step-child under the age of 18, unless the child is living or expected to be living separate and apart from the step-parent for 30 days or more. Even though the child returns to the household in less than 30, days, if s/he was expected to be absent for 30 days his/her step-parent's income/resources are not considered in the eligibility determination for the child during the entire 30 days s/he was expected to be absent.

The income/resources of a step-parent are not considered in the eligibility determination of a child participating in a home and community-based waiver program pursuant to Section 1115 of the Social Security Act.

Although step-parents are financially responsible for their step-children under Social Services Law, a local district may not presume that the step-parent's income/resources are available to the child. The step-parent must actually be contributing to the support of the child for the step-parent's income/resources to be considered when determining eligibility for the child. If a step-parent refuses to support the child for whom s/he is responsible, care is provided to the child, if s/he is otherwise eligible. The district may take action to recover the cost of care from the legally responsible step-parent.

When a step-parent is divorced from the child's parent, there is no longer an obligation on his/her part to support the step-child. In case of abandonment or desertion on the part of the step-parent, the obligation to support the child still exists under Social Services Law.

When To Verify: When the A/R indicates there is a step-parent in the household.

When there is a certified blind/disabled child in the household.

Documentation: (a) Marriage certificate, birth certificate.

(b) Certificate of blindness/disability.

(d) Proof of absence or expected absence of a certified

blind/disabled child, such as a doctor's statement.

UPDATED: AUGUST 1999		442
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**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES
PARENTS AND CHILDREN**

STEP-PARENTS

- (d) Statement from a medical provider that the minor is pregnant.
- (e) Participating in a home and community-based waiver program under Section 1115 of the Social Security Act wherein the income/resources of the parent or step-parent are not considered in the determination of eligibility of the child.

OTHER ELIGIBILITY REQUIREMENTS**HOUSEHOLD COMPOSITION**

Description: Household composition is defined as the individuals included in the Medicaid household. Certain individuals are required to be included in the Medicaid household whether or not they are applying for Medicaid (i.e., LRRs living in the household). The household composition varies depending on the category of the individuals for whom eligibility is being determined.

Policy: Medicaid may be given to an otherwise eligible individual, household, or a portion of the applying household. A Medicaid household's size determines which income and resource levels are used in the determination of eligibility.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 82 ADM-6

Interpretation: This section discusses the following household compositions:

Low Income Families (LIF) household size

ADC-related household size

Family Size (Pregnant Women and Children)

SSI-related household size

Singles/Childless Couples (S/CC) household size

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION****LOW INCOME FAMILIES (LIF)**

- Description:** For applicants in the Low Income Families (LIF) category, a household consists of all persons living together whether or not they are applying for Medicaid. This includes parents of any children, minor children and siblings residing in the household. However, if they are ineligible as a unit, determine eligibility according to the lines of legal responsibility.
- Policy:** Medicaid may be given to an otherwise eligible individual, household, or a portion of the applying household.
- References:**
- | | |
|------------|--------------------------|
| SSL Sect. | 365
366 |
| Dept. Reg. | 360-4.2 |
| ADMs | OMM/ADM 97-2
82 ADM-6 |
- Interpretation:** A LIF household consists of those persons living together in a single dwelling. A single individual under 21 living separate and apart from his/her parents comprises a one person household.
- There are two (2) exceptions:
- (1) the income/resources of PA and SSI cash recipients are not considered; and
 - (2) the income/resources of parents are not considered in determining the income/resources available to a pregnant woman under 21 years of age.
- A single individual under 21 living separate and apart from his/her parents comprises a one-person household.
- Disposition:** Families with children under 21 residing in the household, persons under age 21 living alone, and pregnant women may all be eligible under LIF. This group includes families without a deprivation factor as well as families with a deprivation.

OTHER ELIGIBILITY REQUIREMENTS
LOW INCOME FAMILIES (LIF)

Disposition: The household size of a pregnant woman is increased by one to account for the additional needs associated with pregnancy.

The non-applying or ineligible parents of a pregnant minor are not included in the pregnant minor's household size.

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**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION**

ADC-RELATED HOUSEHOLD

Description: *For applicants in the ADC-related category, the household may include the applicant, legally responsible relatives and all applying and non-applying children/siblings under the age of 21 residing together in the household. The household may also include a caretaker relative as defined by ADC. If the household is ineligible as a unit, eligibility is determined according to lines of legal responsibility.*

Although parents are legally responsible for their children and stepchildren, the income and resources of the parent or step-parent are not considered in the determination of eligibility for a pregnant minor or a certified disabled or certified blind child who meets the criteria specified on page 26.

Family Assistance/Safety Net and SSI recipients are invisible when determining eligibility.

Policy: Medicaid may be authorized for an entire household or the portion of a household that is eligible.

References:

SSL Sect.	365
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 91 ADM-27 91 ADM-8 82 ADM-6
GIS	00 MA/021 00 MA/007

Interpretation: *When determining eligibility, initially include all applying and non-applying siblings under the age of 21 residing together in the household. In the event that a sibling has income and/or resources which renders the applicant(s) ineligible, the applicant has the right to exclude any applying or non-applying child(ren) with income and/or resources from the household count. This option must be explained to the applicant.*

The choice of who is applying and who is counted in the

household size is the A/R's.

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**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION**

**HOUSEHOLD SIZE FOR POVERTY LEVEL PROGRAMS
(PREGNANT WOMEN, AND CHILDREN)**

Description: *Household size for pregnant women and children under the age of 19, the family may include the applicant, legally responsible relatives and all applying and non-applying children/siblings under the age of 21 residing together in the household. The household may also include a caretaker relative as defined by ADC. If the household is ineligible as a unit, eligibility is determined according to lines of legal responsibility.*

Although parents are legally responsible for their children and stepchildren, the income and resources of the parent or step-parent are not considered in the determination of eligibility for a pregnant minor or a certified disabled or certified blind child who meets the criteria specified on page 26.

Family Assistance/Safety Net and SSI recipients are invisible when determining eligibility.

Note: *Because household composition policy now applies across program lines, the term “family size” is no longer used.*

Policy: Medicaid may be authorized for an otherwise eligible individual, household, or a portion of the applying household.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 90 ADM-9
INF	90 INF-45
LCM	95 LCM-106
GIS	00 MA/021 00 MA/007

Interpretation: The income of the parents, stepparents who acknowledge support

of stepchildren, applying siblings (including stepsiblings and half-

UPDATED: JUNE 2000		448
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**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD SIZE FOR POVERTY LEVEL PROGRAMS**

(PREGNANT WOMEN, AND CHILDREN)

siblings) residing in the household is counted when determining the eligibility of children under the age of 19. There are two (2) exceptions:

(1) the income/resources of PA and SSI cash recipients are not considered; and,

(2) the income/resources of parents are not considered in determining the income/resources available to pregnant woman under 21 years of age.

When determining eligibility, initially include all applying and non-applying siblings under the age of 21 residing together in the household. In the event that a sibling has income and/or resources which renders the applicant(s) ineligible, the applicant has the right to exclude any applying or non-applying child(ren) with income and/or resources from the household count. This option must be explained to the applicant.

The choice of who is applying and who is counted in the household size is the A/R's.

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION**

SSI-RELATED

- Description:** For adults (age 18 or over) who are aged, certified blind or certified disabled, a Medicaid household is the aged, blind or disabled person and his/her spouse who lives with him/her if the spouse is: (1) also aged, certified blind or certified disabled; or (2) has remaining income after allocations which is equal to or greater than the difference between the medically needy income level for one, and the medically needy income level for two.
- For other aged, certified blind or certified disabled adults who live with their spouses, a Medicaid household consists of one person for income purposes, but consists of two persons for resource purposes.
- For all other aged, certified disabled or certified blind A/Rs, a Medicaid household consists of one person.
- Policy:** Medicaid may be given to an otherwise eligible individual, household or a portion of the applying household.
- References:**
- | | |
|------------|---------------------------------------|
| SSL Sect. | 365
366 |
| Dept. Reg. | 360-4.2 |
| ADMs | OMM/ADM 97-2
91 ADM-27
82 ADM-6 |
- Interpretation:** A person who is SSI-related (at least age 65, certified disabled or certified blind) is only a household of two when residing with a spouse who:
- is also SSI-related; or
 - has remaining income after allocations (see page 186) which is equal to or greater than the difference between the medically needy income level for one, and the medically needy income level for two.

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION****SINGLES/CHILDLESS COUPLES (S/CC)**

Description: An S/CC household is comprised of an individual or married couple who are (1) at least age 21 but not yet 65; (2) not certified blind or disabled; (3) not pregnant; and (4) not caretaker relatives of children under age 21.

Policy: Medicaid may be given to an otherwise eligible individual; household; or a portion of the applying household.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2

Interpretation: The S/CC household includes the individual and his/her spouse residing with him/her.

The income and resources of one are considered available to the other, whether or not both are applying.

OTHER ELIGIBILITY REQUIREMENTS

CITIZENSHIP AND ALIEN STATUS

Policy:

Medicaid is provided to otherwise eligible residents of the United States who are citizens, nationals, or qualified aliens. Medicaid coverage is limited to coverage for the treatment of emergency medical conditions for otherwise eligible aliens who are not qualified or who do not meet certain other conditions.

Citizens, nationals and qualified alien applicants for Medicaid, must provide appropriate documentation of their citizenship or immigration status. Such individuals must also sign a declaration, under penalty of perjury, that they are citizens, nationals or qualified aliens and must provide, or apply for, a Social Security Number.

NOTE: Special provision is made for aliens who are not qualified, but who, on August 4, 1997, were residing in certain residential facilities or were diagnosed with AIDS (as defined by the Centers For Disease Control) and receiving Medicaid based on a determination that they were “permanently residing in the United States under color of law” (PRUCOL). Such aliens will continue to receive full Medicaid benefits if they are otherwise eligible.

NOTE: Citizenship and alien status are not considered when determining Medicaid eligibility for a pregnant woman. A pregnant woman does not need to document her citizenship/alien status until the month following the month in which the 60 day postpartum period ends.

References:

- SSL Sect. 122
131-k
- Dept. Reg. 349.3
351.1
351.2
360-3.2(f)
- ADMs 97 ADM-23
88 ADM-22
88 ADM-4
82 ADM-24
- GIS 98 MA/21
97 TA/DC022

OTHER ELIGIBILITY REQUIREMENTS**CITIZENSHIP AND ALIEN STATUS**

This section deals with the following groups:

Citizens;

Native Americans;

Qualified Aliens;

Battered Aliens;

Veteran and Active Duty Exceptions;

PRUCOL Aliens;

Undocumented/Illegal Aliens; and

Aliens Admitted on a Temporary Basis.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS****CITIZENS**

Description: A citizen is a person born in the United States or who has been naturalized.

Policy: Medicaid may be given to citizens of the United States who are residents of New York State and who are otherwise eligible.

References:

SSL Sect.	122 131-k
Dept. Reg.	349.3 360-3.2(f)

Interpretation: Natural born citizens and individuals who acquire citizenship through naturalization and who are residents of the State of New York may receive Medicaid, if otherwise eligible. For purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island shall also be regarded as United States citizens for purposes of Medicaid.

All persons who were born in the United States are, with rare exception, United States citizens. United States citizenship can also be acquired by naturalization or acquired by persons who are born in another country and whose parents are citizens of the United States. Lengthy residence in this country or marriage to a citizen do not by themselves bestow citizenship.

Documentation: The following are examples of items which constitute primary documentation of U.S. citizenship:

- Birth certificate;
- Religious document such as a baptismal record, recorded within 3 months of age showing that the ceremony took place in the U.S.;
- United States passport;
- Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);
- Certification of Birth (Form FS-545);
- Certification of Report of Birth (DS-1350)
- U.S. Citizen I.D. Card (Form I-197 or I-179);
- Naturalization Certificate (Form N-550 or N-570);

OTHER ELIGIBILITY REQUIREMENTS**CITIZENS**

Certificate of Citizenship (Form N-560 or N-561);
Information from a primary source Federal agency (e.g., SSA)
verifying the United States as the place of birth.

When primary documentation is not available, secondary documentation must be obtained. At least two secondary documents are needed to establish United States citizenship.

The following are examples of items which constitute secondary documentation of U.S. citizenship:

Letter of No Record To indicate an attempt was made to find a birth certificate a letter issued by the State where the individual was born stating the name, date of birth, years searched for a record and that there is no birth certificate on file for the person;

AND,

One other document showing place of birth in the U.S. such as:

Census record*

Certificate of circumcision*

Early school record*

Family Bible record *

Doctor's record of post-natal care*

A notarized affidavit from a blood relative familiar with the circumstances of the birth, i.e., a parent, aunt, uncle, sibling

A delayed birth certificate filed more than one year after birth listing the documentation used to create it. It must be signed by the attending physician or midwife or list an affidavit by the parent(s) or show early public records.

*Any of this documentation **must** be a record showing the date and place of birth and created within the first five years of life.

NOTE: Possession of a Social Security Number card, or receipt of Retirement Survivors Disability Insurance (RSDI) or Medicare does not, by itself, document citizenship or qualified alien status.

CITIZENSHIP AND ALIEN STATUS**NATIVE AMERICANS**

Policy: Native Americans born in the United States are citizens of the United States.

A non-citizen member of a federally-recognized tribe or a Native American who is at least fifty percent American Indian blood and who was born in Canada, is exempt from any limitations on Medicaid eligibility.

A Native American born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if s/he is of at least one-half American Indian blood. As such, s/he is a qualified alien. This does not include a non-citizen spouse or child of such Native American or a non-citizen whose membership in an Indian tribe or family is created by adoption unless such person is at least fifty percent Indian blood.

References:

SSL Sect.	122 131-k
Dept. Reg.	349.3 360-3.2(f)

Documentation: The following items can be used to verify Native American or federally-recognized tribal membership:

American Indian born in Canada:

- birth or baptismal certificate issued on a reservation
- tribal records
- letter from the Canadian Department of Indian Affairs
- school records

Non-citizen member of federally-recognized tribe:

- membership card or other tribal document
- confirmed by contact with tribal government

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

QUALIFIED ALIENS

Description: For purposes of Medicaid eligibility, a non-citizen must be a qualified alien in order to receive Medicaid.

Policy: The term *qualified alien* means an alien:

who has been lawfully admitted to the U.S. for permanent residence under the Immigration and Nationality Act (INA);

who has been granted asylum under Section 208 of the INA;

who has been admitted to the U.S. as a refugee under Section 207 of the INA (including Amerasian immigrants admitted under the provisions of Public Law 100-202);

who has been paroled into the U.S. under Section 212 (d)(5) of the INA for a period of at least one year;

whose deportation has been withheld under Section 243 (h) or 241 (b)(3) of the INA;

who is a Cuban and Haitian entrant [as defined in Section 501(e) of the Refugee Education Assistance Act of 1980];

who has been granted conditional entry pursuant to Section 203(a)(7) of the INA; OR

who has been determined by the local social services district to be in need of Medicaid as a result of being battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent(s) family residing in the same household as the alien.

Medicaid is provided to otherwise eligible qualified aliens who meet certain conditions. Otherwise eligible qualified aliens who do not meet these conditions and individuals, who are not qualified aliens, may receive Medicaid coverage for the treatment of emergency medical conditions only.

NOTE: A woman with a medically verified pregnancy is not required to document citizenship or alien status for the duration of her pregnancy through the last day of the month in which the 60 day postpartum period ends.

OTHER ELIGIBILITY REQUIREMENTS

QUALIFIED ALIENS

References:	Public Law	P.L. 100-202
	SSL Sect.	122 131-k
	Dept. Reg.	349.3 351.1 351.2 360-3.2(f)
	ADMs	97 ADM-23 92 ADM-10 88 ADM-47 88 ADM-22 82 ADM-24
	GIS	98 MA/21 97 TA/DC022

Interpretation: Medicaid eligibility is based on whether the alien is a qualified alien or a non-qualified alien, and the date on which the alien entered the U.S.

- A) Medicaid coverage may be given to qualified aliens if they are otherwise eligible and entered the U.S. prior to August 22, 1996. These qualified aliens are eligible for all care and services under the Medicaid program.
- B) The following qualified aliens who entered the U.S. on or after August 22, 1996 may receive all care and services available under the Medicaid program provided they are determined to be otherwise eligible:

refugees under Section 207 of the INA (including Amerasian immigrants admitted under the provisions of Public Law 100-202);

aliens who have been granted asylum under section 208 of the INA;

aliens for whom deportation has been withheld under section 243(h) or 241 (b)(3) of the INA;

OTHER ELIGIBILITY REQUIREMENTS

QUALIFIED ALIENS

aliens who are Cuban and Haitian entrants [as defined in Section 501(e) of the Refugee Education Assistance Act of 1980]; or,

qualified aliens lawfully residing in the State who are on active duty in the armed forces or who have received an honorable discharge from the armed forces and their spouses and unmarried dependent children, who are also qualified aliens.

- C) Qualified aliens who enter the U.S. on or after August 22, 1996 and who are not listed in B) above are **NOT** eligible to receive medical care or services under the Medicaid program beginning on the date the alien enters the U.S. and continuing for a period ending five years after the date status as a qualified alien is granted, unless the alien is otherwise eligible and the care and services are necessary for the treatment of an emergency medical condition.

An individual who is currently a qualified alien and can demonstrate to the satisfaction of the local district that s/he has continuously resided in the U.S. since before August 22, 1996, can be found eligible for Medicaid without regard to the length of time the individual has had qualified alien status.

An alien applicant who does not meet the criteria outlined in this section is a non-qualified alien and will be denied Medicaid. Medicaid is provided to otherwise eligible non-qualified aliens, who were residing in certain residential settings or who were diagnosed with AIDS and receiving Medicaid on August 4, 1997, based on a determination that they were PRUCOL. (See page 465 for further information on the treatment of PRUCOL aliens)

Documentation: The following INS Forms:

Lawful Permanent Residents

INS Form I-551

INS Form I-551 stamp in a foreign passport or I-94

(NOTE: Aliens with INS Forms I-151, AR-3 or AR-3a are referred to INS for a replacement card)

OTHER ELIGIBILITY REQUIREMENTS**QUALIFIED ALIENS****Refugees**

INS Form I-94 showing entry under Section 207 of the INA and date of entry
INS Form I-688B Annotated "274a.12(a)(3)"
INS Form I-766 Annotated "A-3"
INS Form I-571 (does not document date of entry)
INS Form I-551 coded RE6, RE7, RE8, or RE9

Asylees

INS Form I-94 stamped to show grant of asylum under Section 208 of the INA
Grant letter from Asylum Office of INS
INS Form I-688B Annotated "274a.12(a)(5)"
INS Form I-766 Annotated "A-5"

Amerasian Immigrants

INS Form I-94 stamped "Admitted" with the codes AM1, AM2 or AM3
INS Form I-551 coded AM6, AM7, or AM8

Persons with Deportation Withheld

Order of Immigration Judge showing deportation withheld under Section 243(h) or 241(b)(3) of the INA and the date granted.
INS Form I-688B Annotated "274a.12(a)(10)"
INS Form I-766 Annotated "A-10"

Cuban and Haitian Entrants

INS Form I-94 showing granting of parole as a "Cuban/Haitian Entrant" under Section 212(d)(5) of the INA
INS Form I-551 stamp in a foreign passport or I-94 with the code CU6 or CU7
INS Form I-551 coded CU6, CU7, or CH6

OTHER ELIGIBILITY REQUIREMENTS**QUALIFIED ALIENS****Battered Aliens**

Petition approved or pending with INS for status under INA:
Section 204(a)(1)(A)(i), (ii), (iii), or (iv)
Section 204(a)(1)(B)(i), (ii), or (iii)
Section 244 (a)(3)

Parolees

INS Form I-94 showing granting of parole under Section 212(d)(5) of the INA and the date showing parole status for at least one year

Conditional Entrants

INS Form I-94 stamped to show admission under Section 203(a)(7), refugee conditional entry form
INS Form I-688B Annotated "274a.12(a)(3)"
INS Form I-766 Annotated "A-3"

Persons on Active Duty in the U.S. Armed Forces

Original or notarized copy of current orders showing the alien is on full time duty in the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard
Military ID card - DD Form 2 (active)

Veterans of the U.S. Armed Forces

Original or notarized copy of the Veteran's Discharge Papers DD-214, With Character of Service "Honorable"

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS
QUALIFIED ALIENS**

BATTERED ALIENS

Description: An alien who, or whose child or parent, has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parents' family residing in the same household as the alien can be considered a qualified alien when it is determined that there is a substantial connection between the battery or cruelty and the need for benefits.

Policy: Battered aliens are considered qualified aliens. The Medicaid benefits available to such aliens depends upon the date of entry into the U.S. (see page 456).

References:

SSL Sect.	122 131-k
Dept. Reg.	349.3 351.1 351.2 360-3.2(f)
ADMs	97 ADM-23 92 ADM-10 88 ADM-47 88 ADM-22 82 ADM-24

Interpretation: In order to be a qualified alien based on battery or extreme cruelty, the alien must not currently be residing in the same household as the individual responsible for the battery or extreme cruelty and must have a petition approved by or pending with the INS that sets forth a prima facie case for one of the following statuses:

status as a spouse or child of a United States citizen under Sections 204(a)(1)(A)(i), (ii), (iii), or (iv) of the INA;

classification to immigrant status as a spouse or child of a lawful permanent resident alien under Sections 204(a)(1)(B)(i), (ii), (iii), or (iv) of the INA; or

suspension of deportation and adjustment to lawful permanent resident status under Section 244 (a)(3) of the

OTHER ELIGIBILITY REQUIREMENTS**BATTERED ALIENS**

A substantial connection between the battery or extreme cruelty suffered by the alien (or the alien's child or parent) and the need for Medicaid benefits exists under the following circumstances:

the benefits are needed to enable the alien and/or the alien's child to become self-sufficient following separation from the abuser;

the benefits are needed because work absence or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto cause the alien to lose his or her job or require the alien to leave his or her job for safety reasons;

the benefits are needed because the alien or his or her child requires medical attention or mental health counseling, or has become disabled as a result of the battery or cruelty;

the benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser;

the benefits are needed to provide medical care during an unwanted pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with the alien or his or her child, and to care for resulting children; or

medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

Documentation:

Petition approved or pending with INS for status under INA:

Section 204(a)(1)(A)(i), (ii), (iii), or (iv)

Section 204(a)(1)(B)(i), (ii), or (iii)

Section 244 (a)(3)

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS
QUALIFIED ALIENS**

**U.S. ARMED FORCES
ACTIVE DUTY AND VETERANS**

Description: Qualified aliens who are on active military duty or who are veterans are exempt from the five year ban for aliens entering the United States on or after August 22, 1996.

Policy: Medicaid may be authorized for a qualified alien who is on active duty or who is a veteran of the U.S. Armed Forces, providing that s/he is otherwise eligible.

References: Balanced Budget Act of 1997

SSL Sect . 122

Dept. Reg. 349.3
351.1
351.2
360-3.2(f)

Interpretation: **Active Military Duty** - The exemption from the five year ban for aliens entering the United States on or after August 22, 1996, applies to qualified aliens who are on active duty in the United States Armed Forces. The alien must be on full-time duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard. Active duty for training and full-time National Guard duty are not included in this exemption.

This exemption is also provided to the alien's qualified alien spouse and unmarried dependent children who are qualified aliens.

Veterans - The exemption from the five year ban for aliens entering the United States on or after August 22, 1996, also applies to qualified aliens who are veterans of the United States Armed Forces. The veteran's discharge must have been characterized as honorable, and not on account of his or her alien status. This exemption is also provided to the veteran's qualified alien spouse, including his or her un-remarried surviving spouse if the veteran is deceased, and any unmarried dependent children of the veteran who are qualified aliens.

NOTE: The Balanced Budget Act of 1997 provided that Hmong

and other Highland Lao veterans who fought on behalf of the

OTHER ELIGIBILITY REQUIREMENTS**U.S. ARMED FORCES**
ACTIVE DUTY AND VETERANS

Armed Forces of the United States during the Vietnam conflict and have been lawfully admitted to the United States for permanent residence are to be considered veterans for the purpose of this provision.

Documentation:**Persons on Active Duty in the U.S. Armed Forces:**

Original or notarized copy of current orders showing the alien is on full time duty in the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard; Military ID card - DD Form 2 (active)

Veterans of the U.S. Armed Forces:

Original or notarized copy of the Veteran's Discharge Papers DD-214, With Character of Service "Honorable"

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

PRUCOL ALIENS

Description: The term "permanently residing in the United States under color of law" (PRUCOL) is used to describe certain aliens known to the INS on or before August 4, 1997, who had not been lawfully admitted for permanent residence.

Policy: Medicaid is provided to otherwise eligible non-qualified aliens, who were residing in certain residential facilities or who were diagnosed with AIDS and receiving Medicaid on August 4, 1997, based on a determination that they were PRUCOL.

Section 122 of the SSL provides an exception for PRUCOL aliens who, on August 4, 1997, were residing in certain residential settings and receiving Medicaid. Such individuals will continue to be provided Medicaid, to the extent they are otherwise eligible. The settings included in this exception are:

residential health care facilities licensed by the NYS Department of Health;

residential facilities licensed, operated or funded by the NYS Office of Mental Health (OMH), including: psychiatric centers; residential treatment facilities; family care; community residences; teaching family homes; family based treatment; and residential care centers for adults; and

residential facilities licensed, operated or funded by the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD), including: developmental centers and small residential units; intermediate care facilities for the developmentally disabled; family care; community residences; individual residential alternatives; and OMRDD certified schools for the mentally retarded.

References:

SSL Sect.	122 131-k
Dept. Reg.	360-3.2(f)(1)
ADMs	88 ADM-4
GIS	98 MA/021 97 MA/019

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS****PRUCOL ALIENS****Interpretation:**

In New York State prior to August 4, 1997, the term "permanently residing under color of law" (PRUCOL) was used to describe individuals known to the INS who were neither citizens nor aliens lawfully admitted for permanent residence, i.e., aliens who entered the United States: (1) lawfully in a status other than lawful permanent residence (e.g., refugees); or (2) unlawfully.

PRUCOL aliens were aliens who were residing in the United States with the knowledge and permission of the INS, and whose departure from the United States the INS did not contemplate enforcing. An alien was considered as one whose departure the INS did not contemplate enforcing if:

- (a) it was the policy or practice of the INS not to enforce the departure of aliens in a particular category; or
- (b) based on all the facts and circumstances in the particular case, it appeared that the INS was otherwise permitting the alien to reside in the United States indefinitely.

NOTE: There are no new PRUCOL aliens after August 4, 1997.

Verification:

The following outlines the criteria used to determine PRUCOL status for Medicaid eligibility purposes on or before August 4, 1997 and is being provided for historical reference only:

- a. Aliens admitted to the United States pursuant to Section 203(a)(7) of the Immigration and Nationality Act (INA).
 - (1) Aliens in this category were admitted as conditional entrants.
 - (2) This section of the INA was made obsolete by the Refugee Act of 1980 (Public Law (P.L.) 96-212) and replaced by Section 207 of the INA, effective April 1, 1980 (see item j.).
 - (3) Aliens in this category will have an INS Form I-94 bearing the stamped legend "REFUGEE-CONDITIONAL ENTRY" and a citation of the

section of the INA.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

PRUCOL ALIENS

- b. Aliens paroled into the United States including Cuban/Haitian entrants pursuant to section 212(d)(5) of the INA.
- (1) Aliens in this category are admitted to the United States for similar reasons as a refugee, i.e., a humanitarian reason. However, this category, unlike refugee status, does not grant legal residence status.
 - (2) Parole status allows the alien temporary status until an INS determination of his/her admissibility has been made, at which time another status may be granted.
 - (3) Aliens in this category will have a Form I-94 either indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA, or stamped "Cuban/Haitian Entrant (Status Pending) Reviewable January 15, 1981", "Employment authorized until January 15, 1981." Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.
- c. Aliens residing in the United States pursuant to an Order of Supervision.
- (1) Aliens in this category have been found deportable; however, certain factors exist which make it unlikely that the INS would be able to remove the alien. Such factors include age, physical condition, humanitarian concerns, and the availability of a country to accept the deportee.
 - (2) Aliens in this category are required to report to the INS periodically; if the factors preventing deportation are eliminated, the INS will initiate action to remove the alien.
 - (3) Aliens in this category will have an INS Form I-220

B.

(MRG)

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

PRUCOL ALIENS

- d. Deportable aliens residing in the United States pursuant to an indefinite stay of deportation.
 - (1) Aliens in this category have been found to be deportable, but the INS may defer deportation indefinitely due to humanitarian reasons.
 - (2) Aliens in this category will have a letter and/or a Form I-94 showing that the alien has been granted an indefinite stay of deportation.
- e. Aliens residing in the United States pursuant to an indefinite voluntary departure. Aliens in this category will have a letter and/or a Form I-94 indicating that the alien has been granted voluntary departure for an indefinite time period.
- f. Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure and whose departure the INS does not contemplate enforcing.

NOTE: For INS purposes, an immediate relative is: husband, wife, father, mother, or child (unmarried and under 21).

- (1) Aliens in this category are the immediate relatives of American citizens and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa.
- (2) If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.
- (3) Aliens in this category may have a Form I-94 and/or an I-210 letter. These documents, or others, indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, the INS expects the alien's visa to be available within this time. If it is not, extensions

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS****PRUCOL ALIENS**

- g. Aliens who have filed applications for adjustment of status pursuant to Section 245 of the INA that the INS has accepted as "properly filed" or has granted and whose departure the INS does not contemplate enforcing.
 - (1) Aliens in this category have filed for lawful permanent resident status.
 - (2) Aliens in this category may have Form I-94 or Form I-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant."
- h. Aliens granted stays of deportation by court order, statute or regulation, or by individual determination of the INS pursuant to Section 243 of the INA whose departure the INS does not contemplate enforcing.
 - (1) Aliens in this category have been found to be deportable, but the INS may defer deportation for a specific period of time due to humanitarian reasons.
 - (2) Aliens in this category will have a letter or a copy of the court order and/or a Form I-94.
- i. Aliens granted asylum (political, religious, etc.) pursuant to Section 208 of the INA.
 - (1) Asylum was generally granted to aliens who would be otherwise deported; however, effective with the Refugee Act of 1980, asylum may be granted to an alien if it is determined that the alien is a refugee.
 - (2) Such asylum may be terminated if the Attorney General determines that the alien is no longer a refugee due to a change in the circumstances in the alien's country.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

PRUCOL ALIENS

- (3) Aliens granted asylum will have a Form I-94 and a letter.
- j. Aliens admitted as refugees pursuant to Section 207 of the INA or Section 203(a)(7) of the INA.
 - (1) Aliens who meet the definition of a refugee as provided by the Refugee Act of 1980, will be admitted as such effective April 1, 1980.
 - (2) These aliens will have a Form I-94 identifying them as refugees under Section 207 of the INA.
- k. Aliens granted voluntary departure pursuant to Section 242(b) of the INA whose departure the INS does not contemplate enforcing.
 - (1) Aliens in this category are awaiting a visa.
 - (2) Such aliens are provided Forms I-94 and/or I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.
- l. Aliens granted deferred action status pursuant to INS operating instructions. Aliens in this category will have a Form I-210 or a letter indicating that the alien's departure has been deferred.
- m. Aliens who entered and have continuously resided in the United States since before January 1, 1972. Aliens in this category are presumed by the INS to meet certain criteria for lawful permanent residence. The local district eligibility worker obtains any documentary proof establishing entry and continuous residence. The A/R is advised to contact INS to establish a record of lawful admission for permanent residence.
- n. Aliens granted suspension of deportation pursuant to Section 244 of the INA whose departure the INS does not contemplate enforcing.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

PRUCOL ALIENS

- (1) Aliens in this category have been found deportable, have met a period of continuous residence and have filed an application for the INS to suspend deportation, which has been granted.
 - (2) Aliens in this category will have a letter/order from an immigration judge and a Form I-94 showing suspension of deportation granted. After lawful permanent residence is granted, the alien will have a Form I-551.
- o. Aliens whose deportation has been withheld pursuant to Section 243(h) of the INA.
- (1) Aliens in this category are in deportation proceedings, but deportation has been withheld because of conditions similar to those leading to a granting of refugee status, i.e., fear of persecution.
 - (2) Aliens in this category will have an I-94 and an order or letter from an immigration judge showing that deportation has been withheld.
- p. Any other aliens living in the U.S. with the knowledge and permission of the INS and whose departure that agency does not contemplate enforcing.
- (1) Aliens in this category may be in a status not listed above, but based on a determination by the INS, local districts may find them to be PRUCOL.
 - (2) Such aliens may have any of the documentation listed above or other INS forms or letters which indicate that the aliens meet PRUCOL.
 - (3) Examples include, but are not limited to: permanent non-immigrants, pursuant to P.L. 99-239, and aliens granted extended voluntary departure for a specified time due to conditions in their home countries.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS****PRUCOL ALIENS**

When a Medicaid A/R presents a document which indicates that the INS is allowing the individual to remain in the United States indefinitely, or an INS document with an expiration date one year from the date of issuance, districts may conclude, in the absence of evidence to the contrary, that the INS does not contemplate enforcing the departure of the individual. When a Medicaid A/R presents an expired INS document or an INS document with an expiration date of less than one year from the date of issuance, local districts should not conclude that the INS does not contemplate enforcing the departure of the individual, unless there is evidence to the contrary. In the case of aliens who may be PRUCOL under categories f, g, h, k, n, or p, in addition to the documents required by these categories, the districts verify with the INS or obtain documents from the alien sufficient to show that the INS does not contemplate enforcing departure.

NOTE: There are national and locally developed letters which are used in lieu of or in conjunction with other INS forms to identify various alien statuses. It will be necessary to verify the status of the alien if the letter is the only document provided. If there is any question, contact the local INS office for assistance.

If the alien has filed an INS application for a change of status (other than where specifically mentioned here), the filing of the application, in itself, is not sufficient basis for a finding of PRUCOL. Likewise, any document which raises a question of whether the INS contemplates enforcing departure is not sufficient basis for a finding of PRUCOL. The primary responsibility for documenting alien status lies with the A/R. However, the local district may verify the alien's status with the INS. Contact with the INS shall be initiated only with the permission of the alien.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS****UNDOCUMENTED/ILLEGAL ALIENS**

Description: An alien is here illegally or is undocumented if s/he entered the United States in a manner or in a place so as to avoid inspection, or was admitted on a temporary basis and the period of authorized stay has expired.

Policy: Medicaid shall be provided for the care and services necessary for the treatment of emergency medical conditions to otherwise eligible illegal or undocumented aliens.

References:

SSL Sect.	122 131-k
Dept. Reg.	360-3.2(f)(2)
ADMs	92 ADM-10 88 ADM-47 88 ADM-22 88 ADM-4 81 ADM-1

Interpretation: If otherwise eligible, an A/R cannot be denied Medicaid coverage for treatment of an emergency medical condition because of his/her alien status.

The term emergency medical condition is defined as: "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient's health in serious jeopardy;
- (b) serious impairment to bodily functions; or
- (c) serious dysfunction of any bodily organ or part.

Care and services related to an organ transplant procedure are not included in this definition.

Medicaid is available for emergency services provided to an otherwise eligible alien from the time that the individual is first given treatment for an emergency medical condition until such

time

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS****UNDOCUMENTED/ILLEGAL ALIENS**

as the medical condition requiring emergency care is no longer an emergency. If an eligible individual receives treatment for an emergency medical condition and continues to receive care after the emergency ceases, Medicaid coverage for such care is not available.

Thus, certain types of care provided to chronically ill persons are beyond the intent of the federal and implementing state law and are not considered "emergency services". Such care includes alternate level of care in a hospital, nursing facility services, home care (including private duty nursing) and personal care.

NOTE: A woman with a medically verified pregnancy is not required to document citizenship or alien status for the duration of her pregnancy, through the last day of the month in which the 60 day postpartum period ends.

Verification:

The decision as to whether or not the medical treatment is for an emergency medical condition must, in all cases, be made by a physician. The form DSS 3955 "Certification of Treatment of Emergency Medical Condition," must be completed by the attending physician. The certification form is maintained by the local district in the applicant's case record. The local district notifies the provider of the acceptance/denial of the application, and furnishes the provider with the individual's CIN when appropriate.

**ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND ALIEN STATUS**

ALIENS ADMITTED ON A TEMPORARY BASIS

Policy: Aliens admitted on a temporary basis are non-qualified aliens and, if otherwise eligible, are limited to Medicaid coverage for the care and services necessary for the treatment of emergency medical conditions.

References:

SSL	122 366(1)(b)
Dept. Reg.	360-3.2(f)
ADMs	92 ADM 10 88 ADM-47 88 ADM-22 88 ADM-4

Interpretation: Certain aliens may be lawfully admitted to the United States temporarily for a specific purpose and for a specified period of time. Students, visitors, tourists, some workers and diplomats are admitted but restricted due to the temporary nature of their admission status. Thus, although these individuals may be residing in the United States with the knowledge and permission of the INS, they are not qualified aliens (see page 456).

Otherwise eligible aliens who are admitted on a temporary basis and who require immediate medical care which is not otherwise available may receive Medicaid coverage for the treatment of emergency medical conditions only. Such aliens may receive this coverage, provided that they have not entered the State for the purpose of obtaining medical care.

Verification: Aliens admitted on a temporary basis will have the following types of documentation:

INS Form I-94, Arrival-Departure Record (Some PRUCOL aliens also receive Form I-94, see page 465.);
INS Form I-185, Canadian Border Crossing Card;
INS Form I-186, Mexican Border Crossing Card;
INS Form SW-434, Mexican Border Visitor's Permit; or
INS Form I-95A, Crewman's Landing Permit.

OTHER ELIGIBILITY REQUIREMENTS**RECOVERIES**

Description: Recovery is the repayment or taking back of funds expended for Medicaid.

Policy: A recovery may be made:

from the estate of a permanently institutionalized individual of any age;

from the estate of an individual who was 55 years of age or older when s/he received Medicaid;

from a personal injury award or settlement;

based upon a court judgment, for Medicaid incorrectly paid;

from a legally responsible relative who fails or refuses to make his/her income and resources available to the Medicaid recipient (see page 388); or

from the sale of real property of a permanently institutionalized individual (see page 336) when a lien had been placed against the real property of such person pursuant to SSL 369(2)(a)(ii).

A recipient may elect to voluntarily reimburse a district for Medicaid correctly or incorrectly paid.

References: SSL Sect. 366(3)(a)
369

Dept. Reg. 360-7.11

ADMs 92 ADM-53

Interpretation: Medicaid paid on behalf of a recipient age 55 or older or a permanently institutionalized individual of any age is recoverable from the recipient's estate. Medicaid can only be recovered if there is no surviving spouse, and/or child of any age who is certified blind or certified disabled, and/or any surviving child under age 21.

If a recipient who is not permanently institutionalized (non PI) was 65 years of age prior to October 1, 1993, a claim may be made

against the estate for the amount of Medicaid paid from the date the recipient became 65 until his/her death. If such recipient was

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

less than 65, but more than 55 years of age as of October 1, 1993 then a claim may be made against the estate for the amount of Medicaid paid from the date the recipient became 55 years old or October 1, 1993, whichever is later.

The local social services district is a preferred creditor of the estate. After all debts (including Medicaid) of the estate are satisfied, the remainder goes to the beneficiary or beneficiaries designated by will or by law, if no will exists. The estate includes excess revocable burial funds or payments for burial space items that are not used.

Medicaid which has been paid for an ineligible recipient is incorrectly paid and may be recovered. This may be done by:

requesting voluntary repayment from the recipient for any incorrect payment.

going to court to obtain a judgment that the payment was incorrectly made.

The amount of Medicaid incorrectly paid is calculated from the first day the recipient became ineligible for Medicaid (including any Medicaid paid during the notice period, and pending a fair hearing decision). Medicaid paid prior to the day the recipient became ineligible is Medicaid correctly paid.

When Medicaid has been incorrectly paid because the recipient had excess income and/or resources that were not considered in the eligibility determination, the amount of Medicaid incorrectly paid is limited to the amount of the recipient's excess income/resources liability. The overpayment is restricted to the amount of the spenddown liability. In any event recovery cannot exceed the amount that Medicaid paid.

When Medicaid is provided to a person with a legally responsible relative (LRR) who refuses or fails to make his/her income available to the A/R, an implied contract is created with the non-contributing LRR. The LRR may be responsible for Medicaid paid. Recovery for Medicaid paid may be pursued through court action. The LRR can be offered the opportunity to voluntarily reimburse the district before a court action is initiated. By clearly explaining the district's procedures, a court action may be

avoided.

OTHER ELIGIBILITY REQUIREMENTS**RECOVERIES**

The cost effectiveness of pursuing recoveries for Medicaid paid is determined. Cost effectiveness is based on a variety of factors, including but not limited to: the administrative cost of a court action; the amount of overpayment; the availability of income or assets from which to recover; and previous experience with the court.

See page 479 for a discussion of recovery from the real property of an institutionalized individual. An institutionalized individual is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, who is not reasonably expected to be discharged from the medical institution to return home.

NOTE: A recovery cannot be made for Medicaid correctly paid on behalf of a Medicaid recipient with a long term care insurance policy certified under the New York State Partnership for Long Term Care in accordance with SSL 367-f.

The sections that follow discuss these forms of recoveries:

Liens; and

Voluntary repayments.

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES

LIENS

Description:

A lien is a legally filed claim against property as security for the payment of a debt.

An institutionalized individual is an A/R who: is an inpatient in a medical facility, intermediate care facility for the mentally retarded or other medical facility; and is not reasonably expected to be discharged to the community. The A/R has the right to rebut the expectation that s/he will not be discharged and return home, with adequate medical evidence. When an A/R is in chronic care status, s/he is considered an institutionalized individual.

NOTE: An institutionalized individual may express intent to return home (regardless of any medical evidence to the contrary). The homestead remains exempt.

Policy:

A lien may be placed against a recipient's:

exempt real property if the individual is permanently institutionalized. **NOTE:** No lien may be placed against an A/R's homestead if any of the following individuals reside in the home: the spouse of the recipient, a child under 21 years of age, a child of any age who is certified blind or disabled, or a sibling of the A/R who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the A/R's admission to a medical institution;

personal injury claim or suit for Medicaid expenditures related to the injury;

estate, if the deceased recipient was 55 years of age or older when he or she received Medicaid; and,

estate, if the deceased recipient was any age and was permanently institutionalized;

NOTE: A lien may be imposed on a mobile home only if the mobile home is on land owned by the institutionalized individual, and the mobile home has been permanently affixed to the land (e.g., a basement, foundation, or other immovable structure ties the mobile home to the land).

OTHER ELIGIBILITY REQUIREMENTS**LIENS**

NOTE: When Medicaid is correctly paid or to be paid pursuant to a long term care insurance policy under the Partnership for Long-Term Care Program, a lien cannot be placed against an institutionalized individual's real property.

References:	SSL Sect.	104
		106
		366.3(a)
		369
	Dept. Reg.	360-7.11
	ADMs	92 ADM-53

Interpretation: When a recipient is anticipating a court award, settlement, or claim that resulted from a personal injury, a lien is placed against it. Such awards, settlements or claims may result from, but are not limited to insurance payments and law suits. A lien may not be imposed against Workers' Compensation, Social Security, SSI or other such benefits. The lien is for the cost of medical care provided to treat the personal injury for which the payment is intended.

Incorrectly paid Medicaid is any Medicaid furnished to a recipient at a time when s/he was ineligible. Only by instituting a court action can a district place a lien on a recipient's real property to recover Medicaid incorrectly paid.

The institutionalized individual is given an opportunity to transfer his/her homestead to a specified relative, before a lien is imposed. (See page 353 for a list of who an A/R may transfer his/her homestead to without penalty.) Generally, the transfer is made within 90 days of the eligibility determination. A longer period may be allowed if necessitated by delays beyond the institutionalized individual's control.

If an institutionalized individual is discharged and returns to the community, any liens against his/her real property are removed. If the individual wants to continue Medicaid coverage, his/her eligibility is determined based on his/her new circumstances.

OTHER ELIGIBILITY REQUIREMENTS**VOLUNTARY REPAYMENTS**

Disposition: A voluntary repayment is a payment made by a recipient, without coercion, to the local district for Medicaid correctly or incorrectly paid.

Policy: A client may elect to reimburse a local social services district for Medicaid correctly or incorrectly paid. Reimbursement for Medicaid correctly paid is always voluntary. The record clearly documents that the decision to reimburse the district was totally voluntary and that the client fully understood that s/he had no obligation to provide reimbursement. A recipient who receives a lump sum payment, placing him/her over the resource limit, may choose to reimburse the district for previously paid medical bills and continue his/her eligibility uninterrupted.

See page 476 for recovery and voluntary reimbursement or repayment of assistance incorrectly paid.

References: Dept. Reg. 360-7.11

Documentation: A statement from the A/R or his/her representative that the repayment was voluntary. The statement should include the amount of the repayment and when appropriate, the services or time period covered by the repayment.

When the repayment is for assistance correctly paid, the statement clearly indicates that the decision to reimburse was totally voluntary and that the A/R understands s/he is under no obligation to reimburse the district.

OTHER ELIGIBILITY REQUIREMENTS

STATE AND FEDERAL CHARGES

Description:

Generally the cost of any care provided through federally reimbursable (FP) Medicaid is shared by the federal, State and local government at a rate of 50/25/25. Under certain circumstances, the federal and/or State government assumes responsibility for a greater share or the full cost of care provided by the Medicaid program. For example: the federal government is responsible for approximately 50%, the State for about 40% and the local government around 10% of the cost of care provided to recipients of certain long term care services.

Federal charge refers to care fully reimbursed by the federal government; there is no local or State share. State charge refers to care reimbursed by both the federal and State governments or by the State alone. There is no local share in the cost of care provided to a recipient entitled to State or federal charge status.

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time limited waiver was granted pursuant to Section 1115 of the Social Security Act.

Policy:

The cost of Medicaid may be borne completely by the State government, or it may be shared with the federal and local governments. The cost of care for a specified time period for refugees and Cuban-Haitian entrants is totally reimbursable by the federal government. The cost of care is fully reimbursed by the State and/or federal government for: Native Americans and their families residing on reservations; and individuals who have been patients in an Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD) facility for five or more continuous years under Chapter 621 of the Law of 1974.

NOTE: The New York State Veteran's Home at Oxford is a State-operated facility for New York State veterans and their dependents. The State and federal government are financially responsible for veterans and their dependents who are patients at the Oxford Home. Local districts are administratively responsible for determining MA eligibility and processing the eligibility for these A/Rs.

New York State also operates other nursing facilities for veterans. These facilities include the New York City Veteran's Home at St.

Albans, the New York State Veteran's Home at Batavia and

OTHER ELIGIBILITY REQUIREMENTS

STATE AND FEDERAL CHARGES

the Long Island Veteran’s Home. Local districts share in the administrative and fiscal responsibility for residents of these facilities.

NOTE: To assure proper claiming special coding is available through WMS.

References:

- SSL Sect. 2.19
62.4(c)
153
365
- ADMs 97 ADM-2
OMM/ADM 97-1
96 ADM-7
82 ADM-24
81 ADM-47
- INF 89 INF-43
88 INF-67
- LCM 95 LCM-92

Interpretation:

This section discusses: A/Rs for whom local districts retain only the administrative responsibility of providing Medicaid, but no fiscal responsibility; and A/Rs for whom local districts have no responsibility (eligibility is determined by the State). It is organized as follows:

- Native Americans and their families living on a reservation;
- Refugees and Cuban-Haitian entrants;
- Human Services Overburden;
- OMH/OMR Chapter 621 eligibles.
- Office of Mental Health (OMH);
- Office of Mental Retardation/Developmental Disabilities.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES****NATIVE AMERICANS AND THEIR FAMILIES LIVING ON A RESERVATION**

- Policy:** There is no local participation in the cost of Medicaid provided to Native Americans and their families living on reservations in New York State. When such a person is eligible (see page 455), the cost of his/her care is shared by the State and federal government.
- References:** SSL Sect. 2.19(b)
368-a(1)(c)
- Interpretation:** Although there is no local share in the cost of Medicaid provided to Native Americans and their families living on reservations, local districts remain administratively responsible for processing the cases of such persons. For Native Americans **not** living on reservations and receiving Medicaid, the local share of the cost of care is the usual percentage (see page 482).
- Disposition:** Local districts determine Medicaid eligibility for Native Americans and their families living on reservations using the appropriate category. The cost of care for such persons is fully reimbursed by the State or by the State and federal government.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES****REFUGEES AND CUBAN-HAITIAN ENTRANTS**

Description: Refugees, including Amerasians, and Cuban-Haitian entrants are aliens who receive special consideration under the **Refugee Assistance Program** (see 96 ADM-7 for more detailed description).

Policy: The cost of care of a refugee or Cuban-Haitian entrant who is categorically S/CC is totally reimbursed by the federal government for the first eight months following the month of entry. During this period, such A/Rs, have their eligibility for Medicaid determined using the medically needy treatment of income and resources. After this period of time, such A/Rs must meet the income/resources requirements for S/CC in order to be eligible for Medicaid.

References:

Dept. Reg.	349.3
ADMs	96 ADM-7 82 ADM-24

Interpretation:

- (1) For refugees and Cuban-Haitian entrants who are S/CC A/Rs, a categorical waiver is available for the first 8 months after entering the country or registering with INS. After this period of time, such A/Rs must meet the S/CC income/resources levels in order to be eligible for Medicaid. The cost of care for the first 8 months is fully reimbursed under the Refugee Assistance Program; however, local social service districts maintain administrative responsibility for such A/Rs.
- (2) During the eight (8) month period, if the refugee or Cuban-Haitian entrant receives increased earnings from employment, the increased earnings do not impact his/her continued Medicaid eligibility.

The Medicaid authorization is continued for the refugee or entrant through the end of the eight month period. This is required for refugees/entrants receiving Medicaid and Public Assistance or Medicaid only.

Verification: For refugees, Amerasians, and Cuban-Haitian entrants applying for Medicaid:

- (1) the date of entry or registration is determined.

(2) documentation of refugee/entrant status is obtained.

UPDATED: AUGUST 1999

486

OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES

HUMAN SERVICES OVERBURDEN

Policy: The State will reimburse 100% of the local share for Medicaid expenses paid on behalf of an overburden-qualifying mentally disabled person.

References: INFs 89 INF-43

Interpretation: The local share of Medicaid expenditures for qualifying mentally disabled recipients is 100% reimbursable by the State. For Human Services Overburden funding, a person defined as mentally disabled meets one of the following criteria:

- (1) resides in a Residential Treatment Facility certified by the New York State Office of Mental Health or in an Intermediate Care Facility for the Developmentally Disabled certified by the New York State Office of Mental Retardation and Developmental Disabilities;
- (2) was discharged from a New York State Office of Mental Health Psychiatric Center or New York State Office of Mental Retardation and Developmental Disabilities Developmental Center from April 1, 1971 to December 31, 1982 and has 90 or more cumulative days of inpatient treatment;
- (3) resides in a community-based facility as certified by the New York State Office of Mental Health or the New York State Office of Mental Retardation and Developmental Disabilities. This includes A/Rs who:
 - have received services in certified Community Residences (CR) or Individual Residential Alternatives (IRA);
 - are residents of schools certified by the New York State Office of Mental Retardation and Developmental Disabilities;
 - are inpatients in Terrance Cardinal Cook (Flower Hospital); or
- (4) receives a minimum of 45 visits in any calendar quarter of day or continuing day treatment programs (including Subchapter A day treatment).

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

OMH/OMR CHAPTER 621 ELIGIBLES

Description: Full State and federal reimbursement is available for the cost of care provided to A/Rs who meet the requirements for State charge funding under the provisions of Chapter 621 of the Laws of 1974. These A/Rs are frequently referred to as 621 eligibles.

621 eligibles are A/Rs who: are discharged from a psychiatric center operated by the Office of Mental Health (OMH) or a developmental center being operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD) (including stays in Family Care); and have spent five or more continuous years in these facilities.

Policy: Local districts are responsible for determining Medicaid eligibility for 621 eligibles residing within the geographic boundaries of the district regardless of other residency rules (see page 402). There is no local district financial participation in the cost of care for 621 eligibles.

NOTE: 621 eligibility is determined solely by OMH or OMR/DD and is transmitted to the local social services district by form OMH-5 or OMR-5 respectively.

References:

SSL Sect.	62 131 365
ADMs	97 ADM-1 82 ADM-72 75 ADM-28 74 ADM-134
INFs	89 INF-43
LCMs	95 LCM-92

Interpretation: 621 eligible persons have their eligibility for Medicaid determined by the local social services district in which they are found. The local district determines eligibility and processes the A/R's case, regardless of other residency issues. Full reimbursement for the cost of medical care for 621 eligibles is available from the State and federal government.

OTHER ELIGIBILITY REQUIREMENTS**OMH/OMR CHAPTER 621 ELIGIBLES**

- Verification:** 621 status is verified by contacting the appropriate Psychiatric Center or Developmental Center medical records office.
- When to Verify:** when an A/R or his/her representative indicates that s/he was a resident in an OMH or OMR/DD facility;
- when an A/R or his/her representative states that s/he is 621 eligible; or
- when an A/R is living in an OMH or OMR/DD community facility.
- Disposition:** Local social services districts are responsible to determine Medicaid eligibility for 621 eligible persons living within their district. The cost of care for these persons is fully reimbursed by the State and federal government.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES****OFFICE OF MENTAL HEALTH (OMH)**

Policy: The Office of Mental Health (OMH) is responsible for providing care to persons with mental illness, as defined in Mental Hygiene Law.

References:

ADM	97 ADM-1
INF	89 INF-43
LCMs	93 LCM-40 92 LCM-119

Interpretation: The following are living arrangements, operated or certified by OMH, with which local districts have the greatest contact:

- (1) Psychiatric Centers (PC) (Adult, Children, and Forensic) - The State Department of Health (SDOH) in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in PCs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (2) Family Care (FC) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Family Care (SOFC) facilities. Local districts are responsible for determining Medicaid eligibility for A/Rs in Voluntary Operated Family Care (VOFC) facilities. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (3) Residential Treatment Facilities for Children and Youth (RTF) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in RTFs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (4) Community Residence (CR) - Generally, the SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Community Residences (SOCR). (See 89 INF-43 for exceptions.) Local districts are responsible for determining Medicaid eligibility for A/Rs in a Voluntary Operated Community Residence (VOCR). Generally for SOCRs, Medicaid funding is shared jointly (50/50) by New York State and the federal government. For

A/Rs in VOCRs, Medicaid funding is shared (50/25/25) by the

(MRG)

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES****OFFICE OF MENTAL HEALTH (OMH)**

federal government, New York State and local districts. For all categories, except S/CC, local districts receive reimbursement of the local share through overburden (see page 486);

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time-limited waiver was granted pursuant to Section 1115 of the Social Security Act.

- (5) Residential Care Centers for Adults (RCCA) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Residential Care Centers for Adults (SORCCA). Local districts are responsible for determining Medicaid eligibility for A/Rs in Voluntary Operated Residential Care Centers for Adults (VORCCA). For A/Rs in SORCCAs, funding is shared jointly (50/50) by the federal government and New York State. For A/Rs in VORCCAs, funding is shared (50/25/25) by the federal government, New York State and local districts. Local districts receive reimbursement of the local share through overburden (see page 486 and NOTE above);
- (6) Family Based Treatment (FBT) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in FBT. Medicaid funding is shared jointly (50/50) by the federal government and New York State.
- (7) Teaching Family Homes (TFH) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in TFH. Medicaid funding is shared jointly (50/50) by the federal government and New York State.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

Policy: The Office of Mental Retardation and Developmental Disabilities (OMRDD) is charged with the responsibility of caring for persons who are mentally retarded and/or have developmental disabilities as defined in Mental Hygiene Law.

References:

ADM	97 ADM-1
INFs	92 INF-33 89 INF-43
LCMs	94 LCM-24 93 LCM-62 92 LCM-170

Interpretation: The following are living arrangements operated or certified by OMRDD, with which local districts have the greatest contact:

- (1) Developmental Centers (DC) - The State Department of Health (SDOH) in conjunction with OMRDD is responsible for determining Medicaid eligibility for A/Rs in DCs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (2) Small Residential Units (SRU) - The SDOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for A/Rs in SRUs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (3) Family Care (FC) - The SDOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for A/Rs in State or Voluntary Operated Family Care homes. For A/Rs in State and Voluntary Operated FCs, Medicaid funding is shared jointly (50/50) by the federal government and New York State.
- (4) Community Residence (CR) and Individual Residential Alternative (IRA) - The SDOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for 621 eligible individuals in State Operated Community Residences (SOCRs) and State Operated Individual Residential Alternatives (SOIRAs). Local districts are responsible for determining Medicaid eligibility for all other A/Rs in VOCRs or

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES****OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES**

administered cases and 621 eligible local district cases, Medicaid funding is shared jointly (50/50) by the government and New York State. For all categories except S/CC, non-621 eligible A/R's Medicaid funding is shared (50/25/25) with the local share reimbursable through overburden funding (see page 486).

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time-limited waiver was granted pursuant to Section 1115 of the Social Security Act.

- (5) Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) - The SDOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for 621 eligible A/Rs in State or Voluntary Operated ICF/DDs. Local districts are responsible for determining Medicaid eligibility for non-621 eligible A/Rs in State or Voluntary Operated ICF/DDs. For 621 individuals, Medicaid funding is shared jointly (50/50) by the Federal government and New York State.

For non-621 individuals, Medicaid funding is shared 50/25/25 with the local share being reimbursed through Overburden funding for all categories, except S/CC.

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

Policy: With certain exceptions, all applicants present a Social Security number (SSN) or apply for an initial or replacement Social Security card.

NOTE: An undocumented alien, applying for Medicaid coverage of care and services necessary for the treatment of an emergency medical condition, is not required to apply for or provide an SSN.

A pregnant woman is not required to apply for or provide an SSN. Districts cannot require a pregnant woman to provide an SSN until the end of the month in which the sixtieth (60th) day following the end of her pregnancy occurs (see page 42). However, some pregnant women may want to provide a SSN and may do so.

An SSN is not required for a child, born to a woman eligible for and receiving Medicaid, at the time of the child's birth for up to one year (see page 42).

References: TaxPayer Relief Act of 1997

- SSL Sect. 131-c
- Dept. Regs. 369.2(a)
370.2(c)(3)
- ADMs OMM/ADM 97-2
97 ADM-23
93 ADM-4
90 ADM-9
89 ADM-12
88 ADM-47
88 ADM-4
87 ADM-25
83 ADM-29
80 ADM-75
80 ADM-42
- INFs 90 INF-14
- GIS 00 TA/DC-008
98 TA/DC-014

Interpretation: Medicaid applicants, age 21 or over, who fail to furnish appropriate verification of their SSN, are ineligible for Medicaid.

UPDATED: JUNE 2000

494

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

See NOTE above for the two exceptions.

The Taxpayer Relief Act of 1997 requires the SSN of each parent to be on the application for an original SSN for a child under 18.

Effective June 30, 2000, all applications for original SSNs and replacement cards must be made directly to the applicant's local SSA Office. The local SSA office will issue a SSA-5028 (Receipt for Application for a Social Security Number) if the applicant requests verification that s/he has applied for an SSN.

Except for S/CC, a non-applying legally responsible relative (spouse or parent) of an A/R is not required to furnish a Social Security number. The local district may request the non-applying spouse or parent to provide an SSN, but the individual is informed that the disclosure is voluntary and how the number will be used.

For S/CC, the non-applying legally responsible relative living with an A/R is required to furnish a social security number. If the legally responsible relative does not comply, the S/CC A/R is ineligible for Medicaid. There are two exceptions: (a) when the legally responsible relative is a pregnant woman, she is not required to supply an SSN; and, (b) when the legally responsible relative is an alien, s/he may not have to provide an SSN, depending on his/her alien status.

Verification:

The Social Security card is the primary source of documentation. When the applicant does not have a Social Security card, a secondary source may be used to document his/her number. Secondary sources include, but are not limited to: SSA-5028 (Receipt for Application for a Social Security Number); Social Security award letter; SDX report; or Social Security check.

Form SSA-2853 (Message from Social Security), verification that an application was made through the Enumeration at Birth (EAB) process, or a copy of the birth certificate indicating enumeration at birth are the primary evidence that a newborn has applied for an SSN. An SSN is not required for a child born to a woman eligible for, and receiving Medicaid, at the time of the child's birth for up to one year.

OTHER ELIGIBILITY REQUIREMENTS**PRESUMPTIVE ELIGIBILITY**

Policy: Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

References:

SSL Sect.	364-i 368-a
Dept. Reg.	360-3.7 Part 531
ADM	97 ADM-10 90 ADM-9

Interpretation: A/Rs can apply for Medicaid through the presumptive eligibility process if they meet one of the following certain conditions:

a pregnant women who applies for Medicaid at a prenatal care office certified to provide presumptive eligibility (qualified provider); or

a patient in an acute care hospital awaiting discharge but needing the type of medical care provided by a Certified Home Health Agency, Long Term Home Health Care Program, nursing facility or hospice.

The sections that follow discuss these forms of presumptive eligibility:

Nursing facility, hospice or home health care services; and

Pregnant women.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

**NURSING FACILITY, HOSPICE OR
HOME HEALTH CARE SERVICES**

Policy:

Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

Presumptive eligibility for nursing facility, hospice or home health care services is available to persons meeting the following criteria:

- (1) the applicant is receiving care in an acute hospital at the time of application;
- (2) a physician certifies that the applicant no longer requires acute hospital care, but requires the type of medical care provided by a Certified Home Health Agency (CHHA), a Long Term Home Health Care Program (LTHHCP), nursing facility or hospice;
- (3) the applicant or his/her representative states that there is insufficient insurance coverage for this type of care and that the applicant would not otherwise be able to pay for that required care;
- (4) it appears that 65% of the cost of care provided by the nursing facility or hospice, would be less than the cost of continued hospital care computed at the Medicaid rate (alternate care rate); and
- (5) the applicant appears to meet all the criteria, financial and non-financial, for Medicaid. A screening checklist is used to eliminate those cases from the presumptive eligibility process which require in-depth reviews to determine eligibility.

Persons applying for presumptive eligibility for home health care services are budgeted as community cases. They are not considered to be in chronic care.

A period of presumptive eligibility begins on the date of discharge from the hospital and continues for sixty (60) days or until the standard eligibility determination is completed, whichever is earlier.

OTHER ELIGIBILITY REQUIREMENTS

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

During a period of presumptive eligibility, all Medicaid services are covered except:

- (a) hospital-based clinic services;
- (b) hospital emergency room services;
- (c) acute hospital inpatient services (except when provided as part of hospice care); and
- (d) bed hold for an individual determined presumptively eligible for Medicaid coverage of nursing facility services.

References:	SSL Sect.	364-i
	Dept. Reg.	360-3.7 531.1
	ADM	97 ADM-10

Interpretation: When an application is being made for presumptive eligibility, the local district:

- (1) determines that the applicant meets the above criteria;
- (2) waives the face to face interview requirement. The local district is not expected to visit or converse with the applicant or hospital staff, at this time;
- (3) makes an eligibility determination by reviewing the application package;
- (4) notifies the applicant of his/her presumptive eligibility determination within **five** working days of the receipt of the presumptive eligibility application package or by the discharge date if that date is later. The local social services district sends the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care", whichever is appropriate. The local social services district sends the notice

OTHER ELIGIBILITY REQUIREMENTS

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

if there is no authorized representative), the hospital, and the proposed provider, if presumptively eligible. In addition, the provider is advised of the client's liability toward the cost of care, if applicable.

NOTE: See 97 ADM-10 for copies of the Notices.

- (5) authorizes the applicant for up to sixty days of presumptive eligibility from the date of discharge from the hospital if the stated conditions are met; and
- (6) processess a routine, complete and fully documented eligibility determination including a face to face interview with the A/R or his/her representative.

Documentation:

The LDSS-2921, completed by the applicant or authorized representative, is submitted to the local social services district, with the physician's statement that the patient no longer requires care in an acute care hospital, but does require nursing facility, CHHA, LTHHCP, or hospice services. Included with the application package is the completed Screening Checklist (Attachment I to 97 ADM-10), the medical documentation from the hospital of the type of care and, in the case of CHHA services, the amount of care required.

Upon receipt of the application for presumptive Medicaid eligibility, the local social services district must review the application package, including the Screening Checklist, to determine if the applicant meets the basic qualifying conditions to participate in the presumptive Medicaid eligibility program.

The local social services district may ask questions to resolve conflicting information, particularly for items on the Screening Checklist. However, documentation cannot be required to determine presumptive Medicaid eligibility. Attestation of facts is sufficient to determine if an individual is presumptively eligible for assistance.

The local social services district or its agent must agree that the CHHA or LTHHCP services recommended are appropriate. The local social services district agent providing the evaluation of medical need might be a Community Alternative Systems Agency

OTHER ELIGIBILITY REQUIREMENTS

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

social services district is neither expected to or required to visit or converse with the applicant or hospital staff at this time to evaluate medical need. The evaluation is performed from the written material provided by the hospital to explain the care required.

The hospital submits medical documentation of the type of care required. The hospital may use the suggested Medical Documentation Transmittal Form (Attachment II to 97 ADM-10) to transmit this information to the local social services district. Documentation of the type of care required should be sufficiently detailed to enable a local social services district to evaluate the appropriateness of LTHHCP or CHHA services. In addition, documentation needs to be sufficiently detailed to enable the local social services district to determine cost effectiveness of CHHA services.

1. Home Care

If the applicant will be receiving the services of a CHHA, the local social services district multiplies the hourly or visit rate for each home health service by the number of hours or visits the patient requires per month. This monthly amount is then divided by 30 days to determine the average daily cost. Sixty five percent of the average daily cost is then compared to the hospital's Medicaid alternate level of care rate to determine cost effectiveness.

No cost comparison is required for persons who will receive their care through a LTHHCP, since in order to participate in the LTHHCP the cost of care in that program must be less than the cost of care in a skilled nursing facility.

2. Nursing Facility and Hospice Services

If the applicant will be receiving nursing facility services, the local social services district compares 65 percent of the average regional Medicaid nursing facility rate with the appropriate (Upstate or New York City/Metro Region) Medicaid alternate level of care rate to determine cost effectiveness.

OTHER ELIGIBILITY REQUIREMENTS**NURSING FACILITY, HOSPICE OR
HOME HEALTH CARE SERVICES**

To determine cost effectiveness of hospice services (whether provided to an individual residing in the community or to an institutionalized individual), the local social services district compares 65 percent of the average regional Medicaid nursing facility rate with the appropriate alternate level of care rate.

NOTE: Presumptive eligibility is not available for S/CC.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY****PREGNANT WOMEN**

Policy: Presumptive eligibility is a means of immediately providing Medicaid services for prenatal care pending a full Medicaid determination. A qualified provider or designee performs a preliminary assessment of a pregnant woman's income. Then, based upon guidelines established by the Department, s/he determines whether or not the woman is presumptively eligible for a limited array of medical services, based on income.

References:

PHL	2529
Dept. Reg.	360-3.7(d)
ADMs	90 ADM-9
INF	90 INF-45
LCM	95 LCM-106
GIS	97 MA/028 95 MA/034 94 MA/016 91 MA/007

Interpretation: A pregnant woman is presumed eligible for limited Medicaid coverage when a qualified provider determines that the woman's income does not exceed 185% of the federal poverty level. The information used in the presumptive eligibility determination does not have to be verified. Pregnant women have the benefit of a larger "family size" by counting other family members (parents, stepparents, siblings, step-siblings and half-siblings), whether or not they are applying. The income of such family members residing in the household is counted when determining the eligibility of pregnant women and children under the federal poverty levels, with two exceptions:

1. Public Assistance and SSI cash recipients and their income are invisible; and
2. The income/resources of parents are not considered in determining the income/resources available to a pregnant minor.

OTHER ELIGIBILITY REQUIREMENTS

PREGNANT WOMEN

The following deductions from income are allowed: \$90 from earned income (see page 144); child care from employment income (see page 162); \$50 from child support received (see page 150); and health insurance premiums (see page 163), if not already deducted from the wages. All resources are disregarded.

When the pregnant woman's family income is equal to or less than 100% of the federal poverty level, she is presumptively eligible for all ambulatory Medicaid covered services.

When the pregnant woman's family income exceeds 100% of the poverty level, but is less than 185%, she is presumptively eligible for Medicaid covered ambulatory prenatal services only (see page 115 for the federal poverty levels).

The qualified provider or designee:

- completes the screening checklist at the first visit to determine the applicant's presumptive eligibility;

- assists the pregnant woman in completing the standard application for assistance;

- advises a presumptively eligible woman of her responsibility to complete the Medicaid application process which includes the requirement of a face-to-face interview;

- forwards screening checklist and Medicaid application to the appropriate local social services district within five working days; and

- provides the pregnant woman with a copy of the checklist and notice of presumptive eligibility determination.

The Prenatal Care Assistance Providers (PCAP) and other qualified providers conduct the face to face interview for pregnant women. In addition the personal interview may be conducted by provider staff at local district authorized outreach sites. Outreach sites that are not PCAPs or qualified providers are **not** able to authorize presumptive eligibility

The local social services district will authorize Medicaid for the presumptively eligible woman. If the woman does not submit the

OTHER ELIGIBILITY REQUIREMENTS**PREGNANT WOMEN**

required documentation by the date specified on the documentation checklist, without good cause, her presumptive case may be closed after appropriate notification.

Eligibility for pregnant women is determined as follows:

- (a) If the net household income is equal to or less than 100% of the federal poverty level, Medicaid level or Public Assistance standard of need (whichever is greater), the woman and any infant under age one are fully eligible for all Medicaid services.
- (b) If the net household income is above 100% of the federal poverty level and less than 185% of the federal poverty level, the woman is eligible for Medicaid prenatal care services and any infant under age one is fully eligible for all Medicaid services. If the family income exceeds 185% of the federal poverty level, the pregnant woman is referred to the local social services district to determine eligibility for Medicaid under the "spenddown" provisions.

Disposition:

A pregnant woman may be determined presumptively eligible for Medicaid. A qualified provider completes a preliminary assessment of the woman's income and establishes her eligibility based on Department guidelines. If the woman's income is less than 100% of the federal poverty level, she is eligible for all ambulatory Medicaid services. When the income is above 100% but less than or equal to 185% of the poverty level, the pregnant woman is eligible for ambulatory prenatal care Medicaid services only. For the pregnant woman to continue her coverage past the period of presumptive eligibility, she submits the required documentation to the local social services district. Only one period of presumptive eligibility is allowed per pregnancy.

The date the pregnant woman applied for presumptive eligibility is considered her application date for full coverage, if she completes the documentation requirements after applying for presumptive eligibility.

OTHER ELIGIBILITY REQUIREMENTS**IMMEDIATE MEDICAL NEED**

Policy: An A/R with an immediate medical need is referred to a hospital and/or advised to seek medical care.

References: ADM 86 ADM-7

Interpretation: Applicants who indicate that they have a medical need are advised to seek medical care. When a local district believes that an A/R requires immediate medical care, i.e., a life-threatening situation, the A/R is referred to a hospital. Under 10 NYCRR Part 405, hospitals are obligated to provide care to the individual regardless of the source of payment. An applicant may advise his/her medical provider that s/he has applied for Medicaid and that if s/he is eligible, reimbursement may be available for care and services provided up to three months prior to the month of application.

When an applicant has an emergency medical need and does not have available liquid resources to meet this need, an application interview is scheduled on an expedited basis. Whenever possible, such interview is conducted on the same day. If the applicant cannot be interviewed due to a physical or mental condition, the interview is conducted with the applicant's authorized representative. The application is processed as quickly as possible. When primary sources of documentation are not available, secondary sources are used as appropriate.

OTHER ELIGIBILITY REQUIREMENTS**VETERANS' AFFAIRS REFERRAL**

Policy: Veterans and/or their dependents explore and utilize all available veterans' benefits. Veterans and their dependents must agree to be referred to a State or county veterans' office so that their eligibility for veterans' related benefits can be assessed.

References: Dept. Reg. 360-7.4
ADMs 93 ADM-21

Interpretation: When an A/R indicates on the application/ recertification that s/he is a veteran or may be eligible for veterans' benefits, the local district advises him/her of potential benefits available through Veterans' Affairs (VA). When the A/R states on the application/recertification that s/he is not a veteran nor eligible for veterans' benefits, the local district clarifies that the A/R has not had military experience in the Armed Forces or as a merchant seaman.

An A/R who has served in the military files for benefits at the appropriate State/local VA office. Eligibility for family members can not be denied based on the veterans' failure to file.

**Verification/
Documentation:** Referrals to the VA office may be in writing or by telephone. When made in writing, the LDSS-2640, "Request for Action/Services" may be used. When the referral is made by phone, a notation is made and kept as part of the case record.

OTHER ELIGIBILITY REQUIREMENTS**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)****Description:**

COBRA allows certain persons who lose their health insurance coverage, provided through an employer, to continue coverage by paying the entire premium himself or herself. The premium is paid at the group rate paid by the employer. Generally, COBRA continuation election must be made within 60 days of the date coverage ends or the date of notice of the coverage option from the plan administrator, whichever is later. The plan must allow no less than 45 days from the date of the initial election to pay for the premium for the period beginning the day coverage would otherwise have ended. Coverage can continue for 18 to 36 months depending on the circumstances.

To be a COBRA Continuation Beneficiary (CCB), the individual must meet the following conditions:

- 1. Be an employee, spouse, or dependent child (ren) of the employee, or a retiree and/or his/her dependents or surviving spouse.**
- 2. Have lost group health insurance coverage because of one of the following:**
 - Death of the covered employee**
 - Termination of covered employee's employment (except due to gross misconduct) or reduction in hours**
 - Divorce or legal separation of covered employee from the employee's spouse**
 - Covered employee's entitlement to Medicare**
 - Dependent child loses dependent status under the requirements of the group health plan**
 - For a covered retiree, the filing of Chapter 11 bankruptcy by the employer under certain circumstances.**

Policy:

A CCB may be eligible for Medicaid to pay the COBRA premium when they meet the following criteria:

- Coverage is available through an employer with 75 or more employees**
- The insurance is cost effective**

OTHER ELIGIBILITY REQUIREMENTS**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)**

- *The A/R's income, using SSI budgeting (see page 174) does not exceed 100% of the Federal Poverty Level (see page 115)*
- *The A/R's resources, using SSI budgeting (see page 318) do not exceed twice the SSI resource level (see page 318)*
- *The A/R meets all other non-financial requirements for Medicaid eligibility.*

When a member of the household, other than the former employee, is eligible for the COBRA Continuation Program Coverage, Medicaid may pay for family coverage. For example: A mother and her 3 children apply for coverage. The mother is receiving Unemployment benefits and her oldest child is receiving child support. The income of the mother and the second child is below 100% of the FPL. The oldest child has income above 1000% of the FPL and is not eligible for Medicaid payment of COBRA COVERAGE. However, because the youngest child is eligible for COBRA Continuation Program coverage, Medicaid will pay the premium for family coverage. If it is determined cost effective, the mother and both children will receive health insurance coverage.

Disposition:

Medicaid pays the health insurance premium only. The recipient incurs any co-payments.

Medicaid payments for premiums may be made to the insurance company, employer, or recipient. Payments are only made to the recipient to reimburse for self-payment or when the employer/insurance company refuses to accept Medicaid payments.

The decision to continue coverage is to be made within 60 days after coverage ends or date of notice of coverage option from plan administrator. Premium payment is to be made within 45 days after election is made to continue coverage. If payment is not made in a timely manner, coverage will end.

Verification:

The following information is verified:

Group health insurance plan coverage, including COBRA

coverage effective date, exclusions to enrollment, services covered and premium amounts;

UPDATED: AUGUST 2000

508

OTHER ELIGIBILITY REQUIREMENTS

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

That the A/R is CCB eligible;

The dates of the 60 day enrollment period; and

All other appropriate eligibility criteria are meet.