OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND *RENEWAL*

RENEWAL

Description:

A recertification/**renewal** for Medicaid is a determination to continue or discontinue Medicaid based upon the eligibility of the recipient.

All active Medicaid cases, including those receiving both Medicaid and ***Temporary*** Assistance, are recertified periodically. The recipient must submit a written ***renewal*** (recertification) to continue Medicaid. The re-authorization period may not exceed one year, **except for Family Planning Benefit Program (FPBP) cases, which are continued for 24 months. A *system reauthorization for FPBP cases will extend the twelve-month authorization for another twelve-month period.***

Policy:

Each month, the district/State produces reports of cases due for renewal, generally at least 60 days prior to the date coverage expires. Based on the district's entry of the appropriate code in the Client Notices System (CNS), a renewal package is produced and mailed to the recipient, or districts may opt to have the State automatically generate the renewal package through a one time entry in the AFA field on WMS. This process is described in a WMS/CNS Coordinator Letter dated November 1, 2004.

The renewal package advises the recipient that coverage is expiring and explains the need for the recipient to provide current information and documentation to the local district. The deadline for returning the renewal form and the return address are included. It is the responsibility of the recipient to return the renewal form and the required documentation to the local district by the deadline provided.

NOTE: The renewal form for community cases, except for FPBP cases, contains pre-printed information from the Medicaid Budget Logic (MBL) and the Welfare Management System (WMS). It provides space for the recipient to amend the pre-printed information and provide new information, when appropriate.

OTHER ELIGIBILITY REQUIREMENTS

RENEWAL

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	***04 OMM/ADM-6*** ***03 OMM/ADM-2***
GIS	***04 MA/021***

Interpretation:

The period covered by a recertification may vary by category and circumstances but may not extend beyond one year **except for FPBP cases. Eligibility for the FPBP is continued for twenty-four months unless the district is advised of relevant changes**. Most recipients are certified for one year; however, when a recipient is unemployed or receives variable or seasonal income, s/he may require more frequent recertification.

Verification/ Documentation:

The recipient is not required to document and verify items that remain constant, such as age and identity. The information printed on the renewal form such as income and expenses must be documented, as well as anything the recipient indicates has changed, such as a person moving into the household or the loss of a job.

Medicaid recipients who are not seeking coverage of long-term care services are not required to document resources (see page 303.4).

All SSI cash recipients who enter a nursing facility ***and*** 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

OTHER ELIGIBILITY REQUIREMENTS

RENEWAL

is reviewed to determine the amount, if any, of their net available monthly income (NAMI) to be contributed toward the cost of care.

(THIS PAGE WAS INTENTIONALLY LEFT BLANK)