

## **CHAPTER M01**

### **APPLICATION *FOR* MEDICAL ASSISTANCE**

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**CHAPTER M01**

***APPLICATION FOR MEDICAL ASSISTANCE***

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**SUBCHAPTER 10**

**GENERAL INFORMATION**

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### M01 APPLICATION *FOR* MEDICAL ASSISTANCE

#### M0110.000 GENERAL INFORMATION

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## **M0110 General Information**

### **M0110.100 Legal Base and Agency Responsibilities**

#### **A. Introduction**

Medicaid is an assistance program that pays medical service providers for medical services rendered to eligible individuals. The Medicaid eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia Medicaid must be made in written form on an official Medicaid application or in the Application/Benefit Delivery Automation Project (ADAPT) system.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the Medicaid program and be conducted in a manner which respects the personal dignity and privacy of the individual.

#### **B. Legal Base**

The Medical Assistance Program (Medicaid) is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia.

Virginia law provides that the Medicaid program be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities and for their enrollment in the Medicaid program.

#### **C. Agency Responsibilities**

##### **1. DMAS**

The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,
- the handling of appeals related to medical assistance,
- the approval of providers authorized to provide medical care and receive payments under Medicaid,

- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

**2. DSS**

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

**3. Confidentiality**

Medicaid applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

**a. Release of Client Information**

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid program, which includes but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

**b. Release of Information to Medical Providers**

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Medicaid providers by DMAS or DSS without the applicant's/enrollee's consent. Enrollee consent is not needed for the agency to provide updated *patient pay* to a Medicaid provider or to provide confirmation

*of an individual's eligibility, the dates of eligibility, and any patient pay responsibility. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources without a release of information because the provider does not need that information for medical treatment or payment.*

*Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Provider contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record without the person's release of information.*

Local agencies may release Medicaid *enrollee identification numbers* to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number *is being released* to an identifiable provider.

**c. Release to Authorized Representatives**

*Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.*

**d. Safeguarding Client Information**

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

***e.* Ownership of Records**

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

***f.* Release of Client Information with Consent**

As part of the application process for Medicaid, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in 3.a above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

***g.* Release of Client Information without Consent**

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, Immigration and Naturalization Services (INS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with INS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in these situations:

- to employees of state and local departments of social services for the purpose of program administration;
- to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
- between state/local department of social services staff and DMAS for the purpose of supervision and reporting;
- to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
- for the purpose of recovery of monies for which third parties are liable for payment of claims.

***h.* Client's Right of Access to Information**

(1) Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality.

- (2) Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.
- (3) The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:
  - All personal information about the client except as provided in §2.2-3704 and §2.2-3705,
  - The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.
- (4) Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified. When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

## **M0110.200 Definitions**

- A. Adult Relative** means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.
- B. Applicant** means an individual who has directly or through his authorized representative made written application for Medicaid at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.
- C. Application for Medical Assistance** means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. *An application for medical assistance is an application*

*for the Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.*

**D. Attorney-In-Fact  
(Named in a  
Power of Attorney  
Document)**

means a person authorized by a power of attorney document (also referred to as a "POA") to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney-in-fact to apply for Medicaid on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine that it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

**E. Authorized  
Representative**

*An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement. The authorized representative statement is valid until:*

- *the application is denied;*
- *medical assistance coverage is canceled; or*
- *the individual changes his authorized representative.*

*The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.*

EXCEPTION: Patients in DMHMRSAS facilities may have applications submitted by DMHMRSAS staff.

**F. Child**

means an individual under age 21 years.

**G. Competent  
Individual**

means an individual who has not been judged by a court to be legally incapacitated.

**H. Conservator**

means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

- I. Family Substitute Representative** means a spouse *age 18 or older* or designated relative *age 18 or older* who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.
- J. Guardian** means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.
- K. Incapacitated Individual** means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.
- L. Legal Emancipator of a Minor** means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.
- M. Medical Assistance** *means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS.*

## M0110.300 Availability of Information

### A. Information Required to be Given to the Applicant

- 1. Explanation of Medicaid Program** The agency must inform the applicant about Medicaid eligibility requirements, covered services, use of the Medicaid card, recovery (3<sup>rd</sup> party, lawsuits and estate) of funds paid, and the applicant's rights and responsibilities. This information must be given to the applicant in written form and verbally, if appropriate.

The following materials must be given to the individuals specified below:

- The booklet "Virginia Social Services Benefit Programs," form # 032-01-002, contains information about the Medicaid Program and must be given to all applicants;

- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; *and*
- The "Virginia Medicaid Handbook" must be given to all recipients and must be given to others upon request.

Applicants may also be given Medicaid Fact Sheets as appropriate.

**2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)**

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

**3. Voter Registration**

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each TANF, Food Stamp, and Medicaid applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and *enrollee* the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

**a. Exceptions to Offering Voter Registration**

The only exception to offering voter registration application services is when the *individual*:

- has previously indicated that he is currently registered to vote where he lives,
- there is a completed agency certification form in the *individual's* case record indicating the same, and
- the *individual* has not moved from the address where he stated that he was registered to vote.

**b. Prohibitions**

*Local social services agencies and agency staff are prohibited from the following activities when providing voter registration application services:*

- *seeking to influence an individual's political preference;*
- *displaying any political preference or party affiliation;*

- *making any statement to the or taking any action the purpose or effect of which is to discourage the individual from applying to register to vote; or*
- *making any statement to an individual or taking any action the purpose of which is to lead the individual to believe that a decision to register or not register has any impact on the individual's eligibility for assistance or the benefit level that they may be entitled to receive.*

**c. Voter Registration Services**

*Each local social services agency must provide the following voter registration services:*

- *distribution of voter registration application forms;*
- *assistance to individuals in completing the registration application form, unless such assistance is refused, and ensuring that all spaces on the form are completed;*
- *ensuring that the certification statement on the application for benefits or statement of facts is completed; and*
- *acceptance of voter registration application forms for transmittal to the local general registrar.*
  - 1) *Each completed registration application must be submitted to the local general registrar every Friday (if Friday is a holiday, the forms must be forwarded to the local registrar on the last working day before Friday.) Completed forms are to be forwarded to the local registrar in an envelope, notated with an "A" in the upper left-hand corner and listing the number of completed registration applications included in the envelope.*
  - 2) *For split/combined agencies, all voter registration applications are to be transmitted to the general registrar in the locality where the local social services agency is located.*
  - 3) *If the individual chooses, he may take a voter registration application to be mailed to the State Board of Elections at his own cost.*

**d. Voter Registration Application**

*In Virginia, one voter registration application form will be used to serve a twofold purpose:*

- *the voter registration application will be completed by the individual with necessary assistance from local agency staff during the*

*application/review process and left at the local agency for transmittal to the local general registrar; or*

- *for individuals who do not wish to complete the voter registration during the application process, they may take a voter registration form for mail-in registration.*

***e. Individuals Required to be Offered Voter Registration Services***

*In order to be offered voter registration services, an individual must:*

- *be a member of the Medicaid family unit.*
- *be at least 18 years old by the next general election. General elections are held in all localities on the Tuesday after the first Monday in November or on the first Tuesday in May to fill offices regularly scheduled by law to be filled at those times.*

*If any question arises as to whether the individual will turn 18 before the next general election, complete the registration application and the local registrar will determine if the individual may be registered.*

- *be present in the office at the time of the application or renewal interview if an interview takes place, or when a change of address is reported in person. If a change of address is not reported in person, a registration application will be sent to the individual upon request. Any change in the Medicaid family unit composition that does not occur concurrent with an application, renewal or change of address will be handled at the next scheduled renewal.*

*Any individual accompanying the applicant/enrollee to the local agency who is not a member of the assistance unit (including payees and authorized representatives) will not be offered voter registration services by the local agency. However, a registration application is to be provided to the non-unit member upon request.*

*Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.*

***f. Voter Registration Application Sites***

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, Food Stamp, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking Medicaid applications at hospitals or local health departments and by

Medicaid staff at the state's Mental Health, Mental Retardation, and Substance Abuse facilities.

**B. Information Made Available to the Public in General**

**1. Availability of Manual**

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services, or Medicaid manuals may be ordered from:

Virginia Department of Social Services  
Division of General Services  
7 North Eighth Street,  
Richmond, Virginia 23219

**2. Medicaid Handbook and Fact Sheets**

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The "Virginia Medicaid Handbook" includes basic information about the program and provides a listing of rights and responsibilities. To supplement the "Virginia Medicaid Handbook," fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. The "Virginia Medicaid Handbook" will be given to all recipients at initial approval and to other individuals upon request. The handbook is also available on the internet at [www.dmas.state.va.us](http://www.dmas.state.va.us).

**C. Inquiries**

**1. General Inquiries**

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, the "Virginia Medicaid Handbook," or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at [www.dss.state.va.us](http://www.dss.state.va.us) and the Virginia Department of Medical Assistance Services website at [www.dmas.state.va.us](http://www.dmas.state.va.us) for additional information.
- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" *should not* be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.
- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional Medicaid consultants, and central office Medicaid employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for Medicaid.

All Medicaid staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state Medicaid staff.

## 2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional Medicaid consultant. Do not refer questions from attorneys (or legal questions in general) to the Regional Assistant Attorney General. These attorneys are responsible for providing legal advice to the regional Medicaid consultant and are not authorized to give legal advice to the public.

## M0110.400 Retention of Case Information

### A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. Records of active cases must be maintained for as long as the client receives benefits, while closed records must be maintained for a minimum of three years from the date of closure.

### B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,

- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid. Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications.

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the Medicaid program is being administered.

**CHAPTER M01**  
***APPLICATION FOR MEDICAL ASSISTANCE***

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**SUBCHAPTER 20**

***MEDICAL ASSISTANCE APPLICATION***

M0120 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
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**M0120.000 Medical Assistance Application****M0120.100 Right to Apply**

An individual cannot be refused the right to complete an application for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

**M0120.200 Who Can Sign the Application****A. Patients in DMHMRSAS Facilities**

Patients of any age in the *Department of Mental Health, Mental Retardation and Substance Abuse Services* (DMHMRSAS) facilities may have applications submitted and signed by DMHMRSAS staff. The DMHMRSAS facilities are listed in subchapter [M1550](#).

**B. Applicants Age 18 or Older**

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. If the applicant cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature: \_\_\_\_\_

**1. Authorized Representative**

*An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement. The authorized representative statement is valid until:*

- *the application is denied;*
- *medical assistance coverage is canceled; or*
- *the individual changes his authorized representative.*

*The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.*

*EXCEPTION: Patients in the DMHMRSAS facilities may have applications submitted by DMHMRSAS staff.*

**2. Family  
Substitute  
Representative**

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is *age 18 years or older and is* willing to take responsibility for the applicant's Medicaid business will be the applicant's "family substitute" representative. The family substitute representative will be, in this preferred order, the applicant's:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

**3. No Family  
Substitute  
Representative**

If the applicant is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, the applicant's inability to sign the application must be verified. Verification is by a written statement from the applicant's doctor that says that the applicant is not able to sign the Medicaid application because of the applicant's diagnosis or condition. Follow these procedures:

- a. Determine if anyone has begun the process to have a guardian or conservator appointed for the applicant.
- b. If action has been initiated to obtain a guardian for the applicant, meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-003, to the applicant to extend the pending application.

Once the guardian/conservator has been appointed, request verification of the appointment and that the application be signed by the guardian or conservator. Retain a copy of the application and mail the original application to the guardian/conservator. Allow 10 days for the signed application and guardian/conservator papers to be returned. If the application form and guardian/conservator papers are not returned to the agency by the specified date, deny the application because it is invalid.

- c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

Continue to pend the application until the APS investigation is completed. If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the applicant, or the applicant must sign a statement designating an authorized representative. Give the applicant 10 working days to return the signed application to the agency.

- d. If the application form is not signed by the applicant or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

**4. Procedure for  
Who Can Sign  
the Application**

When preparing to determine the Medicaid eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for Medicaid for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for Medicaid on his behalf?

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for Medicaid on his behalf.

Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY MEDICAID because of an invalid application.

NO: Does the applicant have at least one of the following *who is age 18 or older*:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny Medicaid.

**C. Applicants Under  
Age 18**

**1. Child Applicant**

A child under age 18 years is not legally able to sign his own Medicaid application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals *who is age 18 or older* must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

**a. No Guardian or Legal Custody**

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

**b. Action Is Initiated To Appoint Guardian/Award Custody**

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

**c. Action Not Initiated – Refer to Child Welfare Services**

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

**2. Minor Parent Applying for His Child**

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

**3. Foster Care Child****a. IV-E**

*The Title IV-E Foster Care & Medicaid Application/Redetermination form #032-03-636 is used for the IV-E Foster Care eligibility determination. A separate Medicaid application is not required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.*

**b. Non-IV-E**

*The Title IV-E Foster Care & Medicaid Application/Redetermination form #032-03-636 is also used for the **non-IV-E** Foster Care eligibility determination. The Medicaid application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, a Medicaid application form (*Application for Benefits or Health Insurance for Children and Pregnant Women form*) must be filed and the parent or legal guardian must sign the Medicaid application.*

**4. Adoption Assistance & Special Medical Needs Children****a. IV-E**

*A separate Medicaid application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical*

*Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the Medicaid application form.*

**b. Non-IV-E**

**Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.**

1) Placed by a Virginia agency

*A Medicaid application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency.*

2) Placed by another state

*Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the Medicaid application form and a separate Medicaid application is not required when:*

- *the other state is an ICAMA member state, and*
- *the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non- Title IV-E Adoption Assistance children.*

*All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in [M0120](#), Appendix 3.*

***A Medicaid application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate.***

**D. Deceased Applicant**

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

- the deceased received a Medicaid-covered service on or before the date of death, and
- the date of service was within a month covered by the Medicaid application.

If the above conditions were met, an application may be made by any of the following:

- his guardian or conservator,

- attorney-in-fact,
- executor or administrator of his estate,
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

**E. Unsigned Application**

An application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

**F. Invalid Signature**

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See [M0120, Appendix 1](#) for a sample letter.

## M0120.300 Medical Assistance Application Forms

**A. General Principle – Application Required**

A signed application is required for all initial requests for medical assistance, except for:

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born to a Medicaid-eligible mother.

**1. Exception for Certain Newborns**

**EXCEPTION:** A child born to a mother who was Medicaid eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for Medicaid to age 1 year.

*If the child was born to a mother who was covered by Medicaid outside Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative or an application must be filed for the child's eligibility to be determined in another covered group.*

**2. ADAPT Request for Assistance**

The Request for Assistance – ADAPT, form #032-03-875 available at: <http://localagency.dss.virginia.gov/divisions/bp/files/fs/forms/general/032-03-0875-08-eng.pdf> may be used to establish and preserve the application date for 30 calendar days, but a signed application must be submitted within 30 calendar days in order for eligibility to be determined.

**B. Application Forms**

Medical assistance must be requested on a form prescribed (published) by the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS).

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination for those specific covered groups.

The following forms have been prescribed as application forms for Medicaid and FAMIS:

- 1. Application For Benefits**

Application for Benefits, form #032-03-824, also referred to as the Combined Application, may be used by any applicant (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Eligibility for all medical assistance programs, *except Plan First and BCCPTA*, can be determined with this application form.
- 2. Application/Redetermination For SSI Recipients**

The Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is used for SSI recipients. If the applicant is not eligible for Medicaid in the SSI recipients covered group, his eligibility in other Medicaid covered groups, for FAMIS and for SLH can be determined using this application form.
- 3. Medicaid Application/Redetermination For Medically Indigent Pregnant Women**

The Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is acceptable if submitted for pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.
- 4. Health Insurance For Children and Pregnant Women**

The Health Insurance for Children and Pregnant Women, form FAMIS-1 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is an application form for children and/or pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.

- 1. BCCPTA Medicaid Application**

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).
- 2. ADAPT Statement of Facts**

A signed ADAPT Statement of Facts (SOF) is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for Plan First and BCCPTA. The SOF cannot be used as a Plan First or BCCPTA application. If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the additional information. The pages must be signed by the applicant and attached to the SOF.
- 3. Title IV-E Foster Care & Medicaid Application/Redetermination**

The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://spark.dss.virginia.gov/divisions/dfs/fc/files/forms/032-03-0636-02-eng.doc>) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.
- 4. Application for Adult Medical Assistance**

The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. The paper form is available online at: [www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi](http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi). *The online application is available at:* <https://jupiter.dss.state.va.us/VDAMedicaid>.

5. **BCCPTA Medicaid Application** The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).
6. **ADAPT Statement of Facts** A signed ADAPT Statement of Facts (SOF) is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for Plan First and BCCPTA. The SOF cannot be used as a Plan First or BCCPTA application. If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the additional information. The pages must be signed by the applicant and attached to the SOF.
7. **Title IV-E Foster Care & Medicaid Application/Redetermination** The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.
- For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.
- For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.
8. **Application for Adult Medical Assistance** The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. *The paper form* is available online at: [www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi](http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi).

- 9. Auxiliary Grant (AG)** An application for AG is also an application for Medicaid. A separate Medicaid application is not required.
- 10. Plan First Application Form** The Plan First Application is for men and women who wish to apply for Medicaid coverage of family planning services only. Individuals who wish to apply for family planning services must complete and sign the Plan First Application. The Plan First Application form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.
- 11. SLH Application Form** The following form has been prescribed as the application form for SLH:
- Application for Benefits, form #032-03-824, also referred to as the Combined Application.

## M0120.400 Place of Application

### A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of *locality* residence is not required. Medicaid applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

*Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence.*

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for Medicaid application/ enrollment purposes.

### B. Foster Care, Adoption Assistance, Department of Juvenile Justice

#### 1. Foster Care

Responsibility for taking applications and maintaining the case belongs as follows:

##### a. Title IV-E Foster Care

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody.

Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

##### b. State/Local Foster Care

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for Medicaid and are not eligible for Medicaid in Virginia (see [M0230](#)).

**2. Adoption Assistance**

Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.

**3. Virginia Department of Juvenile Justice/Court (Corrections Children)**

Children in the custody of the Virginia Department of Juvenile Justice or who are the responsibility of a court (corrections children) apply at the local agency where the child is residing.

**C. Institutionalized Individual (Not Incarcerated)**

When an individual of any age is a resident or patient in a medical or residential institution, except DMHMRSAS facilities and the Virginia Veteran's Care Center, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

**Exception:** If the applicant is applying for or receives Food Stamps, responsibility for processing the Medicaid application and determining Medicaid eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

**D. Individuals in DMHMRSAS Facilities**

**1. Patient in a DMHMRSAS Facility**

If an individual is a patient in a state DMHMRSAS institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining eligibility rests with the state department of social services' eligibility technicians located in DMHMRSAS facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in DMHMRSAS facilities is located in Subchapter [M1550](#).

If an individual is a patient in a State DMHMRSAS Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

**2. Patient  
Pending  
Discharge  
(Pre-release  
Planning)**

**a. General Policy**

For DMHMRSAS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DMHMRSAS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate *local* department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

**b. Pending Discharge to a Facility**

If a patient who was not Medicaid eligible in the DMHMRSAS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

**c. Pending Discharge to the Community**

If a patient who was not Medicaid eligible in the DMHMRSAS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

**d. Eligibility Determination and Enrollment**

*The local agency determines the patient's Medicaid eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is discharged from the DMHMRSAS institution.*

*When the individual is discharged, the DMHMRSAS discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.*

**E. Individuals In  
Virginia Veteran's  
Care Center**

Medicaid applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

**F. Incarcerated  
Individuals Pre-  
release Planning**

Inmates of state correctional facilities may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the inmate was living prior to incarceration. Applications are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated individual is found eligible, he is **not** enrolled in the Medicaid program until after he has been released from the correctional facility.

Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

***a. Department of Corrections Procedures***

The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.
- The correctional facility staff will request a pre-admission screening for nursing home *or community-based* care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

***b. Eligibility Determination and Enrollment***

*The local department of social services determines the patient's Medicaid eligibility BEFORE actual release, based on the type of living arrangement to which the applicant will be released. If the applicant is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is released from the Department of Corrections facility.*

*The Corrections facility's pre-release planner or the individual may call the local agency worker on the release date. The worker can then enroll the eligible applicant in the MMIS and provide the enrollee number.*

## M0120.500 Receipt of Application

### A. General Principle

An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

### B. Qualified Individuals (QI)

Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. A QI must submit a new Medicaid application on or after January 1 of each year in order to receive continued coverage. Applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see [M0320.208](#)).

### C. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf. The application may be received by mail, fax, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency's business hours, the date of the application is the next business day.

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

## M0120.600 When An Application Is Required

### A. New Application Required

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter [M1520](#) for renewal policy and procedures.

**B. Application NOT  
Required**

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

Commonwealth of Virginia  
Department of Social Services

NOTICE REGARDING MEDICAID APPLICATION REQUIREMENTS

A Medicaid application has been filed on the behalf of \_\_\_\_\_ (name of applicant). However, the application is not valid and cannot be processed because the application must be signed by one of the following persons:

- the parent of a person under age 18,
- the adult who is the legal guardian or has legal custody of a person under age 18,
- any adult related by blood or marriage with whom a person under age 18 lives,
- the person for whom Medicaid is requested if the person is over age 18 or an emancipated minor,
- the authorized representative for the person who is requesting assistance, who may be
  - any person to whom he/she has legally given power of attorney, or
  - any person who he/she has designated by a signed written statement to apply on his/her behalf for Medicaid or public benefits, or
- the guardian, conservator, or committee of a person over age 18 who has been judged legally incapacitated by a court of law.

Please return the signed application and the authorized representative statement (if needed) by \_\_\_\_\_ so that the application may be processed. Thank you.  
(date)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Phone Number

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES  <p style="text-align: center;"><b>Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application</b></p>	<b>AGENCY USE ONLY</b>		
	DATE RECEIVED: _____		
	CASE NAME/NUMBER: _____		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;">LOCALITY: _____</td> <td style="padding: 5px;">WORKER</td> </tr> </table>	LOCALITY: _____	WORKER
LOCALITY: _____	WORKER		

**Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.**

**1. IDENTIFYING INFORMATION**

---

LAST NAME:	FIRST NAME:	MI:	SOCIAL SECURITY NUMBER:
ADDRESS:	CITY:	STATE:	ZIP: STATE OF RESIDENCE:
MAILING ADDRESS (If different):	CITY:	STATE:	ZIP: HOME PHONE #: DAYTIME PHONE #:

**2. ADDITIONAL INFORMATION**

---

RACE:	<input type="checkbox"/> WHITE	<input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE	MARITAL STATUS:	<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED
	<input type="checkbox"/> BLACK	<input type="checkbox"/> ASIAN/PACIFIC ISLANDER		<input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED
	<input type="checkbox"/> HISPANIC	<input type="checkbox"/> OTHER		<input type="checkbox"/> SEPARATED	

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

U. S. CITIZEN? YES  NO  IF NO, ALIEN NUMBER: \_\_\_\_\_

DO YOU RECEIVE SSI? YES  NO  ARE YOU PREGNANT? YES  NO  DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES  NO

DO YOU HAVE HEALTH INSURANCE? YES  NO  IF YES, COMPANY NAME: \_\_\_\_\_

POLICY #: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ TYPE OF COVERAGE: \_\_\_\_\_

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES  NO  IF YES, LIST MONTHS: \_\_\_\_\_

**3. BCCPTA CERTIFICATION**

---

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: \_\_\_\_\_ DIAGNOSIS DATE: \_\_\_\_\_ FACILITY/SERVICE SITE: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SIGNATURE OF BCCEDP CASE MANAGER : \_\_\_\_\_ DATE: \_\_\_\_\_

**YOUR RIGHTS AND RESPONSIBILITIES**

**By signing below, I agree to the following:**

**I have the right to:**

- ◆ Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- ◆ Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services or be notified of the reason for any delay.
- ◆ Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

**I have the responsibility to:**

- ◆ Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- ◆ Report any changes in information provided on this form within 10 days to my local department of social services.
- ◆ Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

**I further understand and agree that:**

- ◆ This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- ◆ The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- ◆ The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- ◆ Each provider of medical services may release any medical records pertaining to any services received by me.
- ◆ I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

\_\_\_\_\_  
**Signature or Mark**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness/Authorized Representative**

\_\_\_\_\_  
**Date**

**VOTER REGISTRATION**

Check one of the following:

- ( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
- ( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
- ( ) I do not want to apply to register to vote.
- ( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

*Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and  
Reciprocity*

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Alabama	Yes	Yes	Reciprocity with ICAMA member states only
Alaska	Yes	Yes	Reciprocity with all states
Arizona	Yes	Yes	Reciprocity with all states
Arkansas	Yes	Yes	Reciprocity with all states
California	Yes	Yes	Reciprocity with all states
Colorado	Yes	Yes	Reciprocity with all states
Connecticut	Yes	Yes	Reciprocity with ICAMA member states only
Delaware	Yes	Yes	Reciprocity with all states
District of Columbia	Yes	No	
Florida	Yes	Yes	Reciprocity with ICAMA member states only
Georgia	Yes	Yes	Reciprocity with all states
Hawaii	Yes	No	
Idaho	Yes	Yes	Reciprocity with all states
Illinois	Yes	No	
Indiana	Yes	Yes	Reciprocity with all states
Iowa	Yes	No	
Kansas	Yes	Yes	Reciprocity with all states
Kentucky	Yes	Yes	Reciprocity with ICAMA member states only
Louisiana	Yes	Yes	Reciprocity with all states
Maine	Yes	Yes	Reciprocity with all states
Maryland	Yes	Yes	Reciprocity with all states
Massachusetts	Yes	Yes	Reciprocity with all states
Michigan	Yes	Yes	Reciprocity with all states
Minnesota	Yes	Yes	Reciprocity with all states
Mississippi	Yes	Yes	Reciprocity with all states
Missouri	Yes	Yes	Reciprocity with all states
Montana	Yes	Yes	Reciprocity with ICAMA member states only
Nebraska	Yes	No	
Nevada	Yes	No	
New Hampshire	Yes	No	
New Jersey	Yes	Yes	Reciprocity with ICAMA member states only
New Mexico	No	No	
New York ***	Yes	No	
North Carolina	Yes	Yes	Reciprocity with ICAMA member states only
North Dakota	Yes	Yes	Reciprocity with ICAMA member states only
Ohio	Yes	Yes	Reciprocity with all states
Oklahoma	Yes	Yes	Reciprocity with all states
Oregon	Yes	Yes	Reciprocity with all states

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Pennsylvania	Yes	Yes	Reciprocity with all states
Rhode Island	Yes	Yes	Reciprocity with ICAMA member states only
South Carolina	Yes	Yes	Reciprocity with all states
South Dakota	Yes	Yes	Reciprocity with all states
Tennessee	Yes	Yes	Reciprocity with all states
Texas	Yes	Yes	Reciprocity with all states
Utah	Yes	Yes	Reciprocity with ICAMA member states only
Vermont			
Virginia	Yes	Yes	Reciprocity with ICAMA member states only
Washington	Yes	Yes	Reciprocity with all states
West Virginia	Yes	Yes	Reciprocity with all states
Wisconsin	Yes	Yes	Reciprocity with all states
Wyoming			

\* *per COBRA 1985 law, the ICAMA member state’s Medicaid program covers its own Non-IV-E (state-local) Adoption Assistance [AA] children).*

\*\* *the ICAMA member state’s Medicaid program covers Non-IV-E AA children who have adoption assistance agreements with another state and move to the state.*

\*\*\* *ICAMA Associate Member State  
 ICAMA Non-Member State (Vermont, Wyoming)*

**CHAPTER M01**  
**APPLICATION *FOR* MEDICAL ASSISTANCE**  
**SUBCHAPTER 30**

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**APPLICATION PROCESSING**

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## M01 APPLICATION *FOR* MEDICAL ASSISTANCE

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## M0130.100 Processing Time Standards

### A. General Principle

Agencies are required by the State Plan to adhere to prescribed standards for the processing of medical assistance (Medicaid and FAMIS/FAMIS MOMS) applications. The amount of time allowed to process an application is based on the covered group under which the application must be evaluated.

### B. Processing Time Standards

#### 1. 10 Day Requirement (Expedited Application)

##### a. Pregnant Women

Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application form.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the Medicaid eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) on the 10th day. The NOA must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the NOA must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

##### b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made

immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a NOA on the 10<sup>th</sup> day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-calendar-day processing time limit is reached.

**2. 45/90 Day Requirement**

Applications, including requests for retroactive coverage, must be processed within 45 *calendar* days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

*For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45<sup>th</sup> calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 E.2). Exception: allow up to the full 90 calendar days when the individual or agency is unable to obtain documentation of citizenship and/or identity within 45 calendar days of the application date (see M0220.100 D.9).*

The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of Medicaid is mailed to the applicant. The applicant must be informed of the agency's time standards.

The eligibility worker must allow at least 10 days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

**3. Processing Priority**

Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other covered services. These applications must be processed as quickly as possible.

**4. Time Standard Exceptions**

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,
- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

**C. Application for Retroactive Coverage**

Retroactive Medicaid eligibility must be determined when an applicant for Medicaid or other medical assistance reports that he, or anyone for whom he requests assistance, received a medical service within *the retroactive period* - the three months prior to application. Eligibility for SLH must be determined when the individual is not eligible for Medicaid if the applicant reports receiving a **hospital** service within the 30 days prior to the application date.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

*There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined.* Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the *entire retroactive period* – all three months prior to the application month – *even if a covered medical service was received in only one retroactive month*. The applicant must provide all verifications necessary to determine eligibility during *the retroactive period*.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which *retroactive* eligibility exists.

**M0130.200 Required Information and Verifications**

**A. Identifying Information**

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or a statement that the individual applied for the SSN, and date of birth.

- 1. Name** The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) record verification. If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.
- For purposes of the case record only, the agency may choose to set up the case in the individual's alleged name before it is changed on the Social Security card.
- 2. SSN** The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA.
- B. Required Verifications** An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information.
- The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.
- 1. Copy Verification Documents** Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies.
- It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.
- 2. Information Not Provided** If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied or the coverage cancelled due to the inability to determine eligibility.
- C. Verification of Nonfinancial Eligibility Requirements** The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:
- 1. Verification Not Required** Verification is not required for:
- Virginia state residency,
  - application for other benefits,
  - institutional status,
  - age for children under age 19,

- health insurance information (see sections F and G below), and
- dependent child information for individuals applying as parents or the caretaker-relative of a dependent child.

**2. Verification Required**

The following information must be verified:

- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older;
- disability and blindness; and
- pregnancy.

See item E. below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

**D. Social Security Numbers**

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

**1. Exceptions**

- Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met, as long as the mother *is eligible for Medicaid or* would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together. A child eligible in this covered group does not need a Social Security number.
- Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

**2. SSN Not Yet Issued**

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "APP" as the individual's SSN. For example, an individual applied for an

SSN on October 13, 2006, enter "APP101306" as the individual's SSN. If entering the individual directly in MMIS, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "888" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "888101306" as the individual's SSN.

**E. Legal Presence  
(Effective January  
1, 2006)**

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based

waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.** An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

**2. Documents That Demonstrate Legal Presence**

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**3. Failure to Provide Proof of Legal Presence**

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

**4. Relationship to Other Medicaid Requirements**

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by **M0130.200 D.** does **NOT** meet the SSN requirement.

**F. Third Party Liability (TPL)**

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no

TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at [TPLUnit@dmas.virginia.gov](mailto:TPLUnit@dmas.virginia.gov), or send the information to:

DMAS Third Party Liability Section  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

**G. Health Insurance  
Payment Program  
(HIPP)**

If a member of the assistance unit is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan the HIPP Application and Medical History Questionnaire must be completed by the applicant. The Insurance Verification Form must be given to the applicant/recipient for completion by the employer (see [M0290](#)).

**H. Verification of  
Financial  
Eligibility  
Requirements**

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the State Verification Exchange System (SVES) or State Online Query-Internet system (SOLQ-I) cannot be used. If the SDX system is used to verify benefits, the case record must be documented to show why SVES or SOLQ-I was not used.

Chapters [M05](#) through [M11](#) include specific instructions for the verification of resources and income. Subchapter [M1450](#) includes instructions for verifying the transfer of assets.

## **M0130.300 Eligibility Determination Process**

**A. Evaluation of  
Eligibility  
Requirements**

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

The evaluation of eligibility requirements must be documented in writing *for cases not processed in the ADAPT system*. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

*Because ADAPT has a built-in verification log and evaluation record, a written evaluation is not used for cases processed in ADAPT.*

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter [M0210](#) contains the general principles of Medicaid Eligibility determination.

**B. Hierarchy of Covered Group**

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering *limited* coverage. Further specific instructions regarding the determination of covered group are contained in chapter [M03](#).

**C. Applicant's Choice of Covered Group**

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

**D. Application Disposition**

**1. General Principle**

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see [M0130.400](#)).

*If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.*

**2. Entitlement and Enrollment**

**a. Entitlement**

*Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section [M1510.100](#) for detailed entitlement policy and examples.*

**b. Enrollment**

Medicaid *enrollees* must be enrolled in the Medicaid Management Information System (MMIS). Effective June 16, 2003, a new MMIS system was implemented. The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the current MMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:

- The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit “0.” (e.g. AC 051).
- Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.
- The former cancel reasons are now prefaced by the digit “0” (e.g. cancel reason 007).

When enrolling an individual in the MMIS, the appropriate aid category (AC) for the applicant’s covered group must be used. Enrollment procedures

and a list of ACs are found in the MMIS Users’ Guide for DSS, that can be accessed from the DSS local agency intranet at:  
[http://localagency.dss.virginia.gov/divisions/bp/me/vammis\\_documents.cgi](http://localagency.dss.virginia.gov/divisions/bp/me/vammis_documents.cgi).

**3. Notification to Applicant**

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;
- the retroactive Medicaid coverage was approved, including the effective dates;
- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;
- there is a reason for delay in processing his application;
- a request for re-evaluation of an application in spenddown status has been completed; and
- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

**E. Notification for Retroactive Entitlement**

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

## M0130.400 Applications Denied Under Special Circumstances

### A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.

### B. Withdrawal

An applicant may withdraw his application at any time. The request *can* be verbal or written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement *or by a verbal statement* specifically indicating the wish to withdraw the retroactive coverage part of the application.

*A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.*

When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid *to the applicant*.

### C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

### D. Duplicate Applications

Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.