G-0000 APPLICATION PROCESSING

G-100 INTRODUCTION

This section contains information on processing applications for medical assistance.

Effective October 1, 2013, in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA), a single streamlined application (BHSF Form 1-A) came into use for all Medicaid programs, with the exception of the following:

- The Breast and Cervical Cancer (BCC) program;
- Long-term care (LTC) related programs;
- Home and community-based services (HCBS) waivers;
- Program of All-Inclusive Care for the Elderly (PACE); and
- The Medicare Savings Program (MSP).

In such cases, additional contact may be required and supplemental information obtained from the applicant/enrollee.

Medicaid eligibility will be determined using the Modified Adjusted Gross Income (MAGI) Methodology for the following groups:

- Children;
- Parents and caretaker relatives;
- Pregnant women; and
- Childless adults, which includes coverage in the following programs:
  - BCC;
  - Refugee Medical Assistance (RMA);
  - Regular and Spend-Down Medically Needy;
  - Take Charge Plus (TCP); And
  - Tuberculosis Infected (TB).

See *I-1550 MAGI Determinations* for more information.

Note:
Although the term "applicant" is used in this section, this policy also applies to certified enrollees for whom a renewal of eligibility is being

completed, as well as to responsible persons acting on behalf of an applicant/enrollee.

G-200 GENERAL INFORMATION

The local office is required to:

- Provide adequate physical facilities to accommodate applicants and enrollees who come to the office, including privacy for interviews;
- Courteously and promptly greet all persons who come to, or contact, the office and refer them to the appropriate staff without unnecessary delay;
- Allow any individual the right to apply for any kind of benefit, regardless of circumstances;
- Provide an application form to anyone who requests one and offer assistance completing the application to anyone who requires or requests assistance;
- Provide, as appropriate, the applicant with the agency's website and/or direct the applicant/enrollee to the on-line application kiosk in the local office lobby;
- Make referrals to agencies and resources that are designed to meet the applicant/enrollee's needs if those needs cannot be fulfilled by the agency;
- Promptly and without undue delay (and consistent with established timelines) transfer the applicant/enrollee's electronic account via secure electronic interface to the Federally Facilitated Marketplace (FFM or Marketplace) when the applicant/enrollee:
    - Is not found eligible for Medicaid using the MAGI methodology; or
    - Is pending a decision in the non-MAGI related (formerly Aged, Blind, Disabled or Long-Term Care) categories; and
- Communicate information regarding services offered by the agency and through the Marketplace, in a clear and courteous manner. The criteria outlined below shall be used for communicating with individuals who are blind, deaf, have low literacy; or applicants/enrollees who are non-English speaking.
    - Applicant/Enrollee Who is Blind
        - Explain the various services offered through the agency and answer any questions asked by the applicant/enrollee. Read forms in their entirety and

assist with completion of forms as needed or requested.

- Applicant/Enrollee Who is Deaf
  - Secure a person proficient in sign language or communicate in writing to explain the programs, answer any questions, and assist in the application process.
- Applicant/Enrollee With Low Literacy
  - Communicate the services offered through the agency in simple terms and phrases that the applicant/enrollee may easily understand. Assist in the application process.
- Applicant/Enrollee With Language Barriers
  - Secure the assistance of an interpreter capable of speaking the applicant's language to communicate the services offered and assist in the application process by contacting Certified Language International (formerly known as the Foreign Language Line).

Eligibility staff shall expedite the application process upon receipt of the request for medical assistance for applicants with life-threatening health conditions requiring urgent medical care. In such urgent situations, the application shall be completed as quickly as possible.

Via the Customer Service Unit (CSU)
Applicants may complete the application with a CSU agent via telephone interview. A telephonic signature will be recorded and filed.

Via the Automated Online Application System (OLA)
If the applicant is using the OLA system that allows a digital signature, a handwritten signature is not required.

Via Telephone
If the applicant is speaking with a local office analyst by phone and the application is completed using the application “worker tool”, the analyst shall mail the signature page to the applicant to sign.

Note:

When applying by phone with a local office analyst, the applicant’s signature must be secured before benefits may be issued.

G-300 APPLICATION FORM

The BHSF Form 1-A shall be used for all Medicaid programs with the exception of BCC, LTC-related programs, HCBS, PACE, and MSP. A supplemental form may be necessary to gather information to determine eligibility on a basis other than MAGI.

Exception:
For children in the custody of the state, the Child Welfare Division (CWD, formerly Office of Community Services) application form is used. The BHSF Form 1-A is required to determine the Medicaid eligibility of a CWD child currently certified in Category O.

The BHSF Form 1-A shall be used to review applicants for eligibility; however, if an older version of the application is received, a determination shall be made without requiring the applicant to reapply. Any additional information needed shall be obtained prior to a decision being made.

The application form:

- Is the official agency document used to collect information necessary to determine eligibility;
- Is the applicant's formal declaration of financial and other circumstances at the time of application;
- Is the applicant's certification that all information provided is true and correct;
- Shall not be altered after the applicant has signed the form; and
- May be used in a court of law.

G-400 TIME LIMITS FOR DISPOSITION OF APPLICATIONS

Ninety (90) days are allowed for the disposition of applications in the non-MAGI-related [formerly disability (D) category] eligibility group if a disability determination by the Medical Eligibility Determination Team (MEDT) is required.

Forty-five (45) days are allowed for all other cases.

For an LTC/HCBS applicant who is awaiting placement in a facility, allow the application to remain pending up to forty-five (45) days. If the applicant has not entered the facility by the 45th day, reject the LTC application and consider eligibility in other programs such as Medically Needy Program

(MNP), MSP, and/or Medicaid Purchase Plan (MPP).

G-500 RESERVED

G-510 RESERVED

G-600 WHO MAY APPLY FOR ASSISTANCE

Anyone may apply for medical assistance. The following individuals may apply for assistance on behalf of someone else:

- The applicant/ tax filer;
- A tax filer for a dependent claimed on their federal income tax return;
- A parent or legal guardian of a child;

  Note:
  A minor may apply for assistance without the consent of the parent or legal guardian with whom they reside.

- A curator or other legal representative of an adult;
- A spouse or other responsible person acting on behalf of the applicant;
- The appropriate Office of Juvenile Justice (OJJ) worker for a child in the custody of the state;
- An authorized representative;
- Any other person who is acting for the applicant; or
- Other authorized agencies.

  Note:
  If there is another non-related adult included on the application, only the signature of the applicant is required.

A LTC facility or HCBS provider may assist with application for an individual, as necessary, although it is not recommended that provider personnel sign as the applicant's representative. Provider personnel who assume such responsibility for the applicant must adhere to the requirements established in the "Delegation of Rights" section of the *Standards for Payment For Nursing Facilities* manual.

Assistance for Homeless Families

Do not deny assistance solely because the assistance unit does not reside at a fixed address or in a permanent dwelling. For this requirement, a home is defined as the family setting maintained by the relative with whom the child lives as evidenced by the fact that the relative assumes responsibility for the day-to-day care of the child.

Assist the homeless family to establish a mailing address that will ensure receipt of their medical eligibility card (MEC). This could be the agency office, a local non-profit agency, or local post office where the recipient can pick up the MEC.

Note:
Homeless applicants must meet the residency requirement.

G-700 APPLICATION DATE

The application date is the date the signed application is received by any Louisiana Medicaid office, by the Federally Facilitated Marketplace (FFM), by an application assistor, or by a certified Medicaid application center (AC). This applies to applications taken by telephone, received in-person, by mail, by fax or electronically.

Using a Renewal Form as an Application

A renewal form may be used as an application. If the renewal form is received and ninety (90) calendar days have not elapsed since benefits were terminated, the form may be used for renewal purposes and a decision of continued eligibility may be made. If the enrollee is found eligible upon receipt of the renewal form, their certification is reopened with a start date the beginning of the month following termination.

If the enrollee provides the requested verification after benefits have terminated, but before the ninety (90) calendar days have elapsed, the case should be reopened and the eligibility determination made using the previously submitted renewal form and the information provided.

If the form is received after ninety (90) calendar days have elapsed, it shall be treated as a new application and the application date is the date the renewal form is received. Contact the enrollee to ensure eligibility factors (particularly income and household composition) are met if information is unclear on the renewal form or if there is a discrepancy in system data.

Request for Application

The request for application may be made by:

- An applicant/tax filer;
- A tax filer for a dependent(s) claimed on their federal income tax return;
- A minor, who chooses to apply without the consent of the parent or legal guardian with whom they reside;
- Family;
- Authorized representative;
- Other representative; or
- Long-term care or HCBS facility.

Representatives may be authorized to:

- Sign an application on the applicant's behalf;
- Complete and submit a renewal form; or
- Receive copies of the applicant's/enrollee's notices and other communications from the agency.

Medicaid is responsible for processing all application requests and making arrangements for completion of the application.

G-800 ACCEPTING APPLICATIONS

The agency must accept an application, and any documentation required to establish eligibility, from the following individuals:

- The FFM applicant/tax filer;
- An adult, in the applicant's household or family, who is the authorized representative;
- A minor, who chooses to apply without the consent of the parent or legal guardian with whom they reside.
- Someone acting responsibly for the applicant, if the applicant is incapacitated.

An application will be accepted:

- Via the Internet;

- By telephone;
- By mail;
- In-person;
- Via the FFM;
- From a certified application center; or
- Through other commonly available electronic means.

Identification (ID) Proofing

By Telephone

Telephone applicants must provide answers to personal computer-generated questions. Applicants are matched to LaMEDS to determine if identity has been previously verified. If not, ID proofing is performed electronically through the identity verification service used by the FFM, currently Experian. At the conclusion of the telephone application process, the application is recorded and the telephonic signature is uploaded.

By Mail

Applications received by mail do not require electronic ID proofing of the applicant. Accept the application form as an official application if it contains the applicant's name and address and is properly signed. A renewal form may be used as an application form at any time. Do not require the applicant to complete a new application form. Refer to *G-1700 Reusing the Application Form*. Contact shall be made to obtain any missing information.

In-person (Electronic Application)

In-person applicants that wish to have their application completed electronically must provide answers to personal computer-generated questions. Applicants are matched to LaMEDS to determine if identity has been previously verified. If not, ID proofing is performed electronically through the identity verification service used by the FFM, currently Experian.

In-person (Paper Application)

Electronic ID proofing is not required for in-person applicants who wish to complete a paper application. The applicant must sign the paper application unless physically or mentally incompetent or incapable even with an authorized representative. The applicant

shall not have the right to remove him or herself from the eligibility process by the act of approving an authorized representative.

Consider the paper application form properly signed if it contains:

- The signature of the applicant/tax filer or the signature of a responsible person or authorized representative if the applicant was unable to sign;
- The signature of the minor unmarried mother (MUM) and the MUM's parent or legal guardian if residing with the MUM; or
- The signature of at least one of the parent(s) of the child who resides in the home.

Note:
The signature of a minor who chooses to apply, without the consent of the parent or legal guardian with whom they reside, is acceptable. Document the circumstances in the Enterprise Document Management System (EDMS).

The application should be completed and signed by the applicant/tax filer. If the applicant is unable to complete and/or sign the application, document the case record with the reason and allow the following persons to act:

For an adult:

- A spouse or responsible person;
- A curator or other legal representative; or
- Any other person who is acting for the applicant.

Note:
If the applicant has a legal curator, the curator shall complete and sign the application form.

For a child:

- A parent;
- A qualified relative; or
- A legal guardian, including a custodial agency (e.g., OJJ).

Note:
If the child resides with both parents, the signature of one parent is acceptable. If the minor chooses to

apply without the consent of the parent or legal guardian with whom they reside, the signature of the minor is acceptable. Document the circumstances in the EDMS.

If the application is for a child in state custody, for example, with the OJJ, the application must be completed by:

- The relative if the child has been placed with a relative; or
- A representative of the custodial agency, if the child is in any other placement situation.

Exception:
Any responsible person with whom a child resides may act on behalf of a CHAMP or LaCHIP child.

For LTC applicants only:

- An employee of the LTC facility may give information for completion of the form if there is no responsible person, legal guardian, or curator.
- If the applicant is unable to complete the application form and there is no one to act on his behalf, the agency representative shall sign the application as the person helping to complete the form. Refer to *G-810, Applicant Unable To Participate In The Eligibility Determination Process*.

For a deceased applicant:

- Refer to G-810 *Applicant Unable To Participate In The Eligibility Determination Process* and G-1500 *Death Of Applicant Before Certification*.

Note:
It is not recommended that facility personnel, including administrators, assume responsibility as the authorized representatives for applicants. See G-600 *Who May Apply For Assistance* for requirements.

G-810 APPLICANT UNABLE TO PARTICIPATE IN THE ELIGIBILITY DETERMINATION PROCESS

If the applicant is physically or mentally unable to complete the application form, or is deceased and has no one to act on their behalf, complete the form with information received from:

- The applicant, parent, spouse, curator, or legal guardian (a person legally responsible for the care and management of the person or property of an individual considered by law to be incompetent to manage his own affairs); or
- The responsible person (a person trusted or depended upon to assist in the care and management of the person or property of an individual, who has not been declared incompetent to manage his/her own affairs);

  Note:
  If the responsible person refuses or fails to cooperate, assist the applicant in designating another responsible person.

- From a different friend or relative;
- From any other person with information about the applicant's situation who is designated to act as an authorized representative; or
- By the agency representative's verification and documentation.

  Note:
  If the applicant is unable to participate in the eligibility process, or when the LTC responsible person fails to keep appointments or provide requested information, it becomes the agency representative's responsibility to assist the applicant in completing the application process. When the applicant is unable to participate, obtain and document supervisory approval when assuming this responsibility.

G-900 APPLICATION INTERVIEWS

G-910 GENERAL INFORMATION

Interviews are official and confidential discussions of household circumstances. Whenever an interview is conducted, the agency representative must:

- Inform applicants of their rights and responsibilities;

- Provide information about program policies and procedures;
- Review information on the application form;
- Evaluate all available information, including the existing case record; and
- Explore and resolve any unclear or incomplete information.

In-person interviews shall not be required as part of the application process in determining eligibility.

Appropriate referrals should be made to other agencies based on the needs of the applicant, including referral to the FFM should the applicant not be eligible for Medicaid/LaCHIP.

G-911.2 SOURCES OF VERIFICATION

Self-attestation may be accepted for the following eligibility factors, unless contradictory information is discovered during routine systems checks for other eligibility factors. Refer to *S-0000 Verification And Documentation.*

- Income;
- Residency;
- Age;
- Household Composition;
- Pregnancy;
- Caretaker Relative;
- Medicare;
- Application for other Benefits; or
- Third party liability (TPL).

Note:
Requiring paper documentation from the applicant/enrollee would be of last resort.

Self-attestation may not be accepted for the following eligibility factors that are cleared through the data services Hub and, as a backup, through electronic data sources used by the agency:

- Social Security Number (SSN);
- Citizenship;

- Immigration status; or
- Income from self-employment.

Note:
A reasonable opportunity period must be given to the applicant/enrollee in an effort to obtain satisfactory evidence of citizenship and identity before taking action affecting the individual's eligibility. This period follows the 45/90 day time frame limits, which begin from the date of the request for information.

Verification of citizenship is not required unless the SSA data match is not successful. In that event, the analyst shall allow the applicant/enrollee a reasonable opportunity period of ninety (90) days to secure acceptable documentation of citizenship. The ninety (90) day period begins with the date of the request for information. See *I-352 Reasonable Opportunity to Present Satisfactory Documentary Proof of Citizenship*.

Verify any questionable information that affects eligibility. Sources may include Louisiana Workforce Commission system clearances, LAMI, SOLQ, collateral contacts, copies of paid or unpaid medical bills, contacts with former employers or absent parents, or any other source that can verify the applicant/enrollee's situation.

Request any verification from the applicant/enrollee that can reasonably be provided. Give the applicant/enrollee written notice of the specific verifications required and the date the information is due. Allow at least ten (10) calendar days for an applicant/enrollee to provide the requested verifications.

Exception:
Allow at least thirty (30) calendar days for an enrollee to provide the requested verifications needed for a renewal of eligibility based upon MAGI methodology.

G-911.3 CASE RECORD DOCUMENTATION REQUIREMENTS

Document in the case record how any questionable information was verified.

G-911.4 CASE ACTION

Do not deny benefits simply because expenses exceed income. Consider reasonable explanations. Do not deny benefits because of questionable

or inconsistent information, unless defined as refusal to cooperate. Deny benefits or close the case when the applicant/enrollee fails to provide verification or refuses to cooperate in providing verification. Refer to *G-1100 Cooperation* thru *G-1140 Failure to Cooperate* for exceptions.

G-920 INTERVIEWS

A face-to-face interview is not required. A telephone interview is allowed.

If a telephone interview is necessary, conduct the interview with:

- The applicant/tax filer;
- The curator, if the applicant is interdicted;
- The parent(s) living in the home, if the applicant is a minor;
- The applicant and her parent(s), if the applicant is a MUM or pregnant unmarried mother (PUM);

  Note:
  If a minor chooses to apply without the consent of the parent or legal guardian with whom they reside, conduct an interview. Document the circumstances in the EDMS.

- The person requesting assistance for a CHAMP child applicant; or
- The applicant's designated authorized representative.

If the applicant is unable to be interviewed by telephone and wishes to have a responsible person or authorized representative interviewed, document the reason given by the applicant and conduct the telephone interview with the responsible person/authorized representative.

Note:
If a telephone interview is necessary and the applicant/enrollee is legally competent, interview the applicant/enrollee. A curator or legal guardian is the legal representative of an individual. Interview the curator or guardian instead of the applicant.

When the applicant or parent of a minor applicant is unable to be interviewed, the following persons may be interviewed:

- A curator or other legal representative of an adult;
- A responsible person; or
- Any other person acting for the applicant that has been designated as an authorized representative.

Note:
Interview the MUM or PUM if her parent is not present. If the minor has chosen to apply without the consent of the parent or legal guardian with whom they reside, an interview with the adult is not required. Document the circumstances in the EDMS.

If a long-term care interview cannot be conducted, refer to *G-810 Applicant Unable to Participate in the Eligibility Process*.

G-930 INTERVIEW SITES

If the applicant/enrollee requests a face-to-face interview, conduct it at the local office or an application center, if possible.

If not possible, conduct the interview at a site that is adequate to preserve the privacy and confidentiality of the interview, and convenient to both the applicant and the agency representative.

Adequate sites may include a hospital or a LTC facility.

G-940 REQUIRED INTERVIEW EXPLANATIONS

During the application interview, certain explanations must be made using terms that the applicant can understand.

Explain the following:

- The applicant's responsibility to provide information that is true and correct to the best of their knowledge;
- The applicant's responsibility to cooperate in the eligibility determination process;
- The applicant's responsibility to report all changes that may affect eligibility;
- The legal penalties for withholding information or providing false information;
- That the applicant's SSN will be matched against files of the Social Security Administration (SSA);
- The agency's confidentiality policy;
- The agency's nondiscrimination and equal delivery of services policy;
- The programs available through the agency;
- The Women, Infants and Children (WIC) program to all applicants

who are pregnant women, postpartum women (until six (6) months after a pregnancy ends), breastfeeding women (until the baby's first birthday), or families with infants and children up to age five (5);

- The agency's responsibility for implementing policy in determining eligibility, including the responsibility to verify and document the eligibility decision made;
- The agency's time limits for determining the final disposition of applications;
- The agency's requirement to refer ineligible applicants/enrollees to the Federally Facilitated Marketplace;
- The applicant's right to an agency conference or a fair hearing. Refer to the Appeals chapter of the *BHSF Eligibility Administrative Procedures Manual*; and
- Assignment of rights to medical support and third party resources.

G-1000 SECURING INFORMATION TO DETERMINE ELIGIBILITY

Secure essential information for determining eligibility. Only require the applicant to provide information that cannot be obtained from other data sources and is necessary to make an eligibility determination or for purposes directly connected to the administration of the Medicaid State Plan.

The agency shall not request verification for information that has been verified and sent to the agency by the FFM.

Consider the applicant as the primary source of information. The act of designating an authorized representative does not change or diminish the applicant/enrollee's responsibility to provide complete and correct information on the application form.

The applicant/enrollee/responsible person or authorized representative is required to:

- Make an effort to obtain all information needed to determine eligibility;
- Authorize the obtaining of documents from third parties;
- Answer all eligibility related questions to the best of their knowledge; and
- Report any changes that may affect eligibility.

If the applicant cannot furnish all of the required verifications at the time of application:

- Send a request for information (RI) that contains a list of the items or actions needed with the deadline for submission specified. Allow at least ten (10) calendar days for an applicant/enrollee to provide the requested verifications.

  Exception:
  Allow at least thirty (30) calendar days for an enrollee to provide the requested verifications for a renewal of eligibility based upon MAGI methodology.

If the applicant is unable to obtain the needed information, provide assistance by:

- Review of the EDMS;
- Checking electronic data sources;
- Use of consent forms signed by the applicant to request verification directly from collateral sources; and
- Requesting assistance from other Medicaid regions and State agencies in order to secure court records and other pertinent data.

In situations involving a life-threatening health condition requiring urgent medical care, the Medicaid analyst shall expedite the application process, taking special steps to obtain any required verifications, including a field visit, if necessary. Refer to the Urgent Care section in the Applications (non-LTC) chapter, of the *BHSF Eligibility Administrative Procedures Manual,* for more information relative to the MEDT package.

G-1100 COOPERATION

The agency representative has a responsibility to decide whether an applicant is capable of participating in the eligibility process. Refer to *G-810 Applicant Unable to Participate in the Eligibility Determination Process*.

For all applicants incapable of cooperation due to a physical, mental or intellectual condition, the application shall not be rejected for failure to cooperate.

G-1110 COOPERATION BY PHYSICALLY AND MENTALLY ABLE APPLICANTS

The applicant must cooperate in the process of determining eligibility by completing an application form, being interviewed (when necessary), and providing required information. Refer to *G-1130 LTC Refusal To Cooperate.*

The agency representative shall:

- Allow adequate time for the applicant/enrollee to receive notice of the interview and make arrangements to attend;
- Inform the applicant in writing of what is required and the consequences of not cooperating;
- Allow at least ten (10) calendar days for the applicant to provide the information or advise the agency representative that the requested information cannot be secured; and
- Assist the applicant in obtaining the needed information or identify and secure alternate information.

The applicant/enrollee shall not be asked to provide information that is clearly impossible for him to secure. If the agency representative's responsibilities have been fulfilled, but the applicant fails or refuses to provide information necessary to complete the eligibility determination process, take action to deny the application or close the case using adverse action procedures.

If the applicant fails to keep the scheduled application appointment and does not contact the office by the close of business on the appointment date, deny the application the next working day. If the applicant does not provide the information by the date noted on the agreement form and does not contact the agency, deny the application the next working day. Refer to *G-1140 Failure to Cooperate*.

G-1120 COOPERATION BY LTC AND OTHER APPLICANTS UNABLE TO PARTICIPATE

For applicants unable to participate in the eligibility determination process, refer to *G-810 Applicant Unable to Participate in the Eligibility Determination Process* for alternatives. Other methods to use are visits to the applicant at home, in the hospital or in the LTC facility, and personal or telephone contact with any of the applicant's relatives, friends, the hospital, or other medical provider staff who can supply needed information.

G-1130 LTC REFUSAL TO COOPERATE

The application may be rejected only if the applicant, parent, or legal guardian:

- Is physically, mentally, or intellectually able to apply and provide information;
- Has been notified of the need to provide information;
- Has been advised of the consequences of not cooperating; and
- Has refused to do so.

Do not reject an application for refusal to cooperate if the responsible person refuses to cooperate. In this case, assist the applicant in designating another responsible person. If none can be located, refer to *G-810 Applicant Unable to Participate in the Eligibility Determination Process* or *G-1120 Cooperation By LTC And Other Applicants Unable To Participate.*

G-1140 FAILURE TO COOPERATE

It is the agency's responsibility to pursue the eligibility determination through the decision, unless the applicant/enrollee refuses to cooperate. Refer to *G-1130 LTC Refusal to Cooperate.*

Before denying eligibility for failure to cooperate, review the case record to determine the following:

- That the applicant/enrollee/responsible person is physically, mentally, or intellectually able to meet responsibilities;
- That adequate time was given to provide the information or evidence;
- That the applicant/enrollee was given enough notice to make arrangements to attend the interview (if there is any doubt, schedule another interview);
- That the request for information was clear, in writing, and dated;
- That the applicant/enrollee/responsible person was informed of the responsibility for providing and consequences of not providing information; and
- That the applicant/enrollee is not claiming good cause for failure to cooperate in pursuing a responsible third party. Refer to *I-200 Assignment of Rights*.

G-1150 SECOND CONTACT SITUATIONS

Second contacts are required in the following situations:

A patient in an acute care hospital is given ten (10) calendar days to provide requested information. If the information is not provided, a final notice is sent to the applicant with an additional ten (10) calendar days given to supply the requested information. If the information is not received, the application cannot be rejected until the 45th calendar day for MAGI categories or the 60th calendar day for Non-MAGI categories.

If the agency representative is unable to judge the applicant's capability, contact the applicant or responsible person prior to rejecting the application for:

- Failure to cooperate in supplying requested data;
- Refusal to comply with agency regulations; or
- Failure to keep an appointment without contacting to reschedule.

After the second contact, if the applicant or responsible person fails to comply with the above, reject the application the day after the date of noncompliance.

G-1200 RESERVED

G-1300 OBVIOUS INELIGIBILITY

Reject the application at any point during the eligibility determination that enough information is obtained and recorded to establish ineligibility.

- If enough information is provided on the application form or in the interview that establishes that not all eligibility factors are met, explain that the application will be rejected without any further investigation. Advise the applicant that the case is being referred to the FFM for review for enrollment in an Insurance Affordability Program (IAP).
- If the information is received after the initial interview, contact the applicant to establish that the information is correct. If correct, explain that the application will be rejected and send the appropriate notice of rejection. Advise the applicant that the case is being referred to the FFM for enrollment in an IAP.

If ineligibility is based on resources, determine whether the applicant is also income ineligible.

- If the applicant is only resource ineligible, the rejection notice shall advise the applicant to reapply when resources are reduced below the limit and/or inform the applicant of policy regarding transfer of resources. Refer to *I-1400 Need - General Information* through *I-1600 Need - Resources - General Information* for resource eligibility. Advise the applicant that their case is being referred to the FFM for review for enrollment in an IAP.
- If the applicant is also income ineligible, the rejection notice shall advise of both the income and resource ineligibility. Advise the applicant that the case is being referred to the FFM for review for enrollment in an IAP.

Prior to rejection of any application, consider eligibility in all other Medicaid programs.

Note:
Do not advise the applicant/enrollee either to dispose of their resources, or of any specific manner of disposing of their resources.

G-1400 WITHDRAWALS

Withdrawals are initiated by the applicant/enrollee.

An applicant may voluntarily withdraw the application or request closure of their case at any point in the eligibility process.

The applicant is allowed to request withdrawal verbally or in writing. Document the case record with the reason for withdrawal/closure and send the appropriate notice.

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G-1500 DEATH OF APPLICANT BEFORE CERTIFICATION

If an applicant dies before certification and eligibility is established, certify the case. Eligibility cannot extend beyond the date of death.

An eligibility determination may be made even if the applicant dies before signing the application form. If there is no one to act for the deceased applicant, complete the application form with information received:

- From any person who has information about the applicant's situation; or
- By agency representative verification and documentation. The

agency representative shall obtain sufficient evidence to support the decision.

Note:
A medical provider shall not be allowed to sign the application form.

A disability decision is required for deceased applicants for the period of assistance requested, if the application is in the disability-related non-MAGI category (Category D) and the applicant did not receive disability benefits.

G-1600 SECURING DISABILITY DECISIONS FOR NON-MAGI (FORMERLY B AND D) CATEGORIES

Refer to *E-220 Blind (B)* and *E-240 Disabled (D)* and *I-2100 Supplemental Security Income (SSI) Eligibility Status*.

If the applicant has not already been determined disabled by SSA, submit the Medical Eligibility Determinations Team (MEDT) package with complete medical and social information.

G-1610 DISABILITY DECISIONS

Louisiana Medicaid's MEDT determines categorical eligibility for disability/blindness based on medical criteria established by the SSA under Section 1634 of the Social Security Act. An SSA Supplemental Security Income (SSI) disability decision takes precedence over any contrary state disability determination. An MEDT decision should not be requested when the individual receives SSA or SSI Disability benefits or Medicare.

An MEDT decision on disability shall not be requested if the individual is otherwise ineligible. Send the appropriate denial notice and refer the applicant's case to the FFM for review for enrollment in an IAP.

All Medicaid applications or renewals based on disability, including those for nursing facilities or waiver services programs, require submission of a complete MEDT package, unless there is an existing MEDT approval that covers the certification period. For more information, refer to the Form MS instructions.

The Medicaid analyst is expected to take special steps to obtain any required medical documentation for the package. In situations involving life-threatening health conditions requiring urgent care, expedite the

application process. Refer to the Urgent Care section in the Applications (non-LTC) chapter of the *BHSF Administrative Procedures Manual* for more information relative to the MEDT package.

G-1610.1 MEDT PACKAGE

The MEDT Package consists of:

- Form MEDT (electronic request);
- Social information on Social Information Interview, Form MS, for all adult decisions, or Form MS/C, if a child;
- Medical records obtained from providers;
- All previous MEDT decisions and supporting documentation;
- Noted applicable program type; and
- Period of coverage requested.

G-1610.2 MEDT DECISION REQUIRED

An MEDT decision is required if:

- A disability decision has not been rendered by SSA;
- SSA has rendered an unfavorable disability decision and:
    - Medical documentation is available to demonstrate the deterioration of the applicant's medical condition since the SSA denial;
    - A new medical condition can be documented;
    - The applicant is appealing the SSA determination; or
    - The applicant is employed and applying for Medicaid Purchase Plan coverage;
- Retroactive eligibility is requested; or
- The applicant has been diagnosed as, or is suspected of being, infected with tuberculosis and is not eligible in a non-MAGI category (formerly category A, B, or D).

G-1610.3 MEDT DECISION NOT REQUIRED

An MEDT decision is not required if:

- A favorable SSA decision has been rendered for disability or Medicare which covers the requested period of Medicaid eligibility;

- The applicant is otherwise ineligible; or
- The applicant has lost RSDI/SSI for a reason other than cessation of disability, and a favorable SSA disability decision has been made within the twelve (12) months prior to application.

G-1610.4 MEDT APPROVAL

If the applicant is otherwise eligible, certify the case and set the renewal date for the same month the Form MEDT is to be resubmitted, if within the allowed renewal time frame.

The MEDT decision remains in effect even if the case is closed and later recertified, unless there has been improvement in the enrollee's condition.

If there has been improvement in the enrollee's condition, submit Form MEDT prior to the due date.

A subsequent adverse disability decision made by SSA/SSI, that is not timely appealed, takes precedence over the MEDT decision.

Exception:
Submit Form MEDT for re-evaluation of the agency's disability determination if a subsequent adverse disability decision by SSA is made for an MPP enrollee.

G-1610.5 MEDT DENIAL

Reject the application or close the case upon receipt of the MEDT decision. If applicable, issue an advance notice of closure.

G-1610.6 RECONSIDERATION OF MEDT DENIAL

A request for reconsideration of the MEDT decision should be completed if:

- New medical or social information is obtained; or
- During the BHSF appeals process, additional medical documentation is available which supports the deterioration of the applicant/enrollee's condition; or
- A new medical condition can be documented.

G-1610.7 RESUBMIT TO MEDT

Resubmit a complete MEDT package:

- If the MEDT decision does not include the needed period of coverage, i.e., retroactive;
- For a different categorical decision requiring MEDT approval;
- At renewal;
- At renewal for an enrollee who lost RSDI/SSI for a reason other than cessation of disability;
- At renewal for a case certified or continued based on a Division of Administrative Law decision;
- If there are changes in the case which require approval by MEDT for continuance; or
- If a subsequent adverse disability decision is made by SSA/SSI for an MPP enrollee.

Exception:
Do not resubmit to MEDT if the SSA Denial code is N07, N08, N15, N16, N30, N35, N40, N41, N44, N46 or N51.

Note:
Verbal MEDT approval will not be provided.

G-1610.8 REAPPLICATION AFTER MEDT DENIAL

If the applicant reapplies within ninety (90) days from the date of a previous MEDT denial, reject the Medicaid application unless there has been a significant deterioration of the applicant's medical condition or a new medical condition is documented.

Include the applicant's statement regarding the change in his medical condition since the last MEDT denial on the Form MS or MS/C.

G-1610.9 REQUESTING AUTHORIZATION FOR MEDICAL EXAM

The analyst should first determine if medical documentation is available from a licensed physician, clinic, hospital, Disability Determination Services (DDS), Louisiana Rehabilitation Services (LRS), or other

sources. If medical documentation is not available for an MEDT decision, a request for authorization of a medical exam shall be included on the Form MEDT.

Note:
A completed Form MS is required with the submittal.

If authorization is approved, the analyst shall request a written report from the physician regarding the applicant's medical condition. In accordance with instructions, Form MR-A shall be used to authorize payment for the examination. The written report shall be included as part of the complete MEDT packet.

G-1610.10 SSA CERTIFIES APPLICANT FOR SSI

Upon receipt of documentation that SSA has certified the applicant for SSI:

- Certify for Medicaid (manually or through the State Data Exchange (SDX) process);
- Certify for LTC retroactively to the date of SSI eligibility if the applicant was a resident of an LTC facility and met all of the other eligibility factors (Refer to *H-800 Long Term Care*); and
- Make appropriate case changes, if the case was certified based on the Form MEDT approval.

G-1610.11 SSA DENIALS

If SSA has denied the applicant's/enrollee's SSI application based on disability in the last twelve (12) months and the applicant is not appealing the SSA denial, reject the application or initiate closure action if the case was certified based on the Form MEDT approval. Refer to *L-0000 Changes*.

Exception:
Submit or re-submit a MEDT packet for an MPP disability determination if the applicant/enrollee is employed.

G-1610.12 SSI APPEALS

Pending Application Disability-Related Medicaid

Request an MEDT decision if SSA has denied the application based on disability in the last twelve (12) months and the applicant provides

documentation that the SSA determination has been timely appealed. Submit or re-submit an MEDT packet for a MPP disability determination if the applicant/enrollee is employed.

Certified Disability-Related Medicaid Case

If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled under the SSI standard and the individual provides documentation that the SSA determination has been timely appealed, continue Medicaid coverage when all other eligibility factors are met until the final determination of disability has been made by SSA. Submit an on-line query or contact the local SSA office requesting notice of appeal decision.

Follow-up with SSA is required every ninety (90) days.

G-1610.13 SIGNIFICANT DETERIORATION IN MEDICAL CONDITION AFTER SSA DENIAL

If the applicant has been denied based on disability within the twelve (12) months prior to the Medicaid application, reject the Medicaid application unless:

- An SSI appeal is in process and the applicant's income is above the Federal Benefit Rate (FBR);
- A significant deterioration in medical condition can be documented;
- A new medical condition can be documented; or
- The applicant is employed and is applying for MPP coverage.

Include the applicant's statement regarding the change in medical condition since the denial on the Form MS or MS/C. Give the applicant ten (10) days to provide additional documentation verifying the change in medical condition before submitting Form MEDT.

G-1615 RESERVED

G-1620 SIMPLIFIED DISABILITY DECISIONS FOR INFANTS

Louisiana Medicaid allows a simplified determination of disability based on minimal evidence for premature or low birth weight infants and/or those infants with an allegation or diagnosis of Down syndrome, even if no other medical impairments exist.

A simplified disability decision for infants always begins on the date of

birth and extends until the child reaches the age of one (1) year (date of birth through the 12th month).

Continuing eligibility for Medicaid must be explored whenever there are changes in the child's circumstances that affect eligibility or once the simplified disability period ends. Another MEDT decision is required for an ongoing disability decision. A review of all current medical evidence must be completed.

G-1620.1 MEDT PACKAGE

MEDT will make the simplified disability decision for infants. Submit a MEDT package consisting of a current Form MEDT requesting a simplified disability decision with a birth certificate or other evidence (e.g., the hospital admission summary, physician or other medical professional's statement) that shows:

1. A weight below 1,200 grams (2 pounds, 10 ounces) at birth;
2. A gestational age (age from conception to birth) at birth as specified in the bulleted list below with the corresponding birth weight indicated:
   - If the gestational age is 37- 40 weeks and the weight at birth is less than 2,000 grams (4 pounds, 6 ounces);
   - If the gestational age is 36 weeks and the weight at birth is less than 1,875 grams (4 pounds , 2 ounces);
   - If the gestational age is 35 weeks and the weight at birth is less than 1,700 grams (3 pounds, 12 ounces);
   - If the gestational age is 34 weeks and the weight at birth is less than 1,500 grams (3 pounds, 5 ounces);
   - If the gestational age is 33 weeks and the weight at birth is at least 1,200 grams, but no more than 1,325 grams (2 pounds, 15 ounces); or
3. An allegation or diagnosis of Down syndrome.

G-1700 RE-USING THE APPLICATION FORM

An application form may be reused to open a new application only in the following situations:

- To reopen an application rejected in error; and
- To reopen a Spend-Down MNP case when there is no break in quarters of coverage.

RE-USING THE RENEWAL FORM

A renewal form may be used as an application form when the enrollee submits the form, or the requested information, within ninety (90) days of closure. Reconsider eligibility of the enrollee. The date of application will depend upon when the form or requested verification was received and whether there was a break in eligibility.

- Use the original application date if the case was closed for failure to provide verification and the enrollee submits the requested verification in the month of renewal.
- The application date is the date the verification is received by the agency if, after closure for failure to provide verification, the enrollee submits the requested verification on or prior to cut-off in the month after the month of renewal. The application date is different because at least a month elapsed between the month of closure and the month in which the verification was received.

Applications Rejected in Error

Use the previous application date as the date of application when reopening an application rejected in error, or upon reconsideration, resulting from an appeal request.

Update the application and interview the applicant, in-person or by telephone, as necessary.

Spend-Down Medically Needy Program (SD-MNP)

The BHSF Form 1-A used in making a determination for SD-MNP is valid for up to twelve (12) months from the date of application as long as there is no break in quarters of coverage. Refer to *H-1011 MNP Groups* for more information on SD-MNP.

G-1800 RESERVED

G–1900 REFERRALS TO SSI

An application for SSI is not a requirement for eligibility in any Medicaid Program.

If the applicant/enrollee applies for SSI, the parish office will be notified by SDX of SSI certification or denial.

Scenarios for general Medicaid applications: (See *Z-400 Federal Benefit Rate* for FBR amounts)

Individuals with/without spouse	Income and resources below FBR. Referral for SSI is required.
Individuals with/without spouse	Income below FBR but resources above SSI resource limit. Ineligible for SSI and Medicaid. Do not refer to SSI.
Couple	If both members of a couple are applying and their countable couple income falls below couple FBR and couple resource limit. Referral for SSI is required.

Scenarios for general Medicaid applications: (See *Z-400 Federal Benefit Rate* for FBR amounts)

LTC applicant w/o community spouse	Applicant's income and resources below FBR. Referral for SSI is required.
LTC applicant w/o community spouse	Applicant's income below individual FBR, but resources exceed individual limit. Do not refer to SSI.
LTC applicant w/community spouse	Applicant's income below individual FBR. Resources in applicant's name exceed SSI individual limit and/or countable couple resources exceed the individual resource limit. Do not refer for SSI. Explain the spousal impoverishment resource provisions and the allowance under Medicaid LTC Program for transfers to the community spouse. Referral for SSI may be appropriate at renewal.
LTC applicant w/community spouse	Applicant's income below individual FBR and countable couple resources below

	individual SSI resource limit. Referral for SSI required.
LTC Couple	If both members of a couple are applying, consider income eligibility separately as individuals. If either has income below individual FBR, refer only that member for SSI.

Scenarios for general Medicaid applications: (See *Z-400 Federal Benefit Rate* for FBR amounts)

HCBS applicant, no spouse	Income and resources below individual FBR. Referral for SSI required.
HCBS applicant, no spouse	Income below individual FBR, but resources exceed limit. Do not refer for SSI.
HCBS applicant w/spouse	Applicant's income (including deemed income from ineligible spouse) and resources fall below individual FBR. Referral for SSI required.
HCBS applicant w/spouse	Income is below FBR, but resources exceed individual limit. Do not refer for SSI. Explain the spousal impoverishment resource provision and the allowance under Medicaid LTC/HCBS programs for transfers to the community spouse.

G-2000 DECISION NOTICES

Send the eligibility decision notice to the applicant upon disposition of the application.

For limited certifications (e.g., deceased applicant, complete retroactive certifications, and SD-MNP), the notice of certification may also serve as the closure notice.

The agency must provide individuals with the choice to receive notices and information in electronic format or by regular mail.

When an applicant/enrollee is determined ineligible using the MAGI income methodology and the applicant/enrollee is not aged, blind, or disabled, a notice shall be sent advising the applicant/enrollee of the decision and advising them that their application is being referred to the Marketplace.

WIC

Send Flyer-WIC with the notice of decision for every certification which includes pregnant women, postpartum women (until six (6) months after a pregnancy ends), and families with children under age five (5).

LTC Only

Send a notice of the eligibility decision to the applicant/authorized representative and the LTC facility.

HCBS Only

Send a notice of eligibility decision to the applicant, the HCBS provider, and the DHH Office for Citizens with Developmental Disabilities (OCDD) or DHH Office of Aging and Adult Services (OAAS), as applicable.

G-2100 RETROACTIVE REIMBURSEMENT

The agency reimburses the Medicaid enrollee for part or all of any medical expenses paid by them from the effective date of eligibility through the date that they are expected to receive their MEC or the reactivation of the MEC.

Enrollees are eligible for reimbursement of medical expenses paid up to three (3) months prior to the month of application only if they request retroactive eligibility on their application and they are certified for the months requested.

Refer to the Retroactive Reimbursement chapter in the *BHSF Eligibility Administrative Procedures Manual* for more information.