MA-2301 CONDUCTING A FACE-TO-FACE INTAKE INTERVIEW
REVISED 11/01/07 – CHANGE NO. 25-07

I. PRINCIPLE

During a face-to-face interview, every applicant must be provided certain written and oral information about Medicaid eligibility requirements, available Medicaid services, and his rights and responsibilities.

II. WHO MAY APPLY

The following individuals have the right to make application:

A. The individual, including a minor, who is applying on his own behalf.

B. Any representative who alleges that he is acting on an individual's behalf.

If a representative is making the application, it is preferable (though not required) that the representative has some knowledge of the individual's situation.

1. Representatives may include, but are not limited to:

   a. Relatives,

   b. Friends,

   c. Staff at medical facilities.

2. Request a written statement by the applicant/recipient from any non-relative who is applying on behalf of an individual authorizing the non-relative to act as his authorized representative. Do not refuse to take or deny the application if the statement is unavailable at application. If the statement is unavailable at application, request the statement as additional information.

3. Explain to representatives who are not financially responsible budget unit members that information regarding the application and/or ongoing case cannot be released to him without authorization. There must be a consent form authorizing the release of the information signed by the individual applying for or receiving Medicaid. Information can be released without a consent form if the representative has power of attorney or guardianship for the individual.

(II.B.)

4. Any time an application is being made by someone on the individual's behalf, the following questions should be addressed during the interview:

   a. Why is the individual not applying for himself?

   b. Does the individual have a power of attorney or legal guardian? If yes, document the power of attorney or legal guardian's name, address and phone number, if different than the representative.

   c. Is the individual able to be interviewed by the Income Maintenance Caseworker either via the telephone or a home visit? If not, why?

   d. Is the individual able to sign the "Release of Information" form himself? If not, why?

III. INFORMATION REGARDING THE MEDICAID PROGRAM

A. Medicaid Coverage Groups

Explain to the individual that the Medicaid program covers groups of people based on certain categorical requirements.

1. Medicaid for the Aged, Blind, and Disabled

   Refer to MA-2000, Non-SSI Eligibility Regulations, in the Aged, Blind, and Disabled Medicaid Manual.

   This program provides full coverage for eligible individuals who are:

   a. Age 65 or older, or

   b. Blind as defined by the Social Security Administration or a recipient of State Aid for the Blind, or

      The Social Security Administration defines blindness as a central visual acuity of 20/200 or less in the better eye, with the use of a correcting lens.

   c. Disabled as defined by the Social Security Administration.

      (1) The Social Security Administration defines disability as a physical or mental impairment, which prevents an individual from engaging in any substantial gainful activity (or for a child under 18, an impairment of comparable severity), and which has lasted or is expected to last for at least 12 months or result in death.

(III.A.c.)

(2) If the individual is not already receiving Social Security benefits based on disability, the Disability Determination Services (DDS) will determine if the individual meets the criteria for disability. Refer to MA-2525, Disability.

2. Medicare Savings Programs (MQB)

Refer to MA-2130, Qualified Medicare Beneficiaries-Q, MA-2140, Qualified Medicare Beneficiaries-B, and MA-2160, Qualifying Individuals-1, (MQB-E), in the Aged, Blind, and Disabled Medicaid Manual.

These programs provide limited coverage of services for eligible individuals who are entitled to Medicare.

3. Medicaid for the Working Disabled

Refer to MA-2150, Medicaid-Working Disabled, in the Aged, Blind, and Disabled Medicaid Manual.

This program provides limited coverage of services for qualified disabled working individuals who have lost entitlement to premium free Medicare Part A solely due to earnings as determined by the Social Security Administration.

4. Medicaid for Families and Children

Refer to MA-3230, Eligibility of Individuals Under 21, MA-3235, Caretaker Relative Eligibility, MA-3240, Pregnant Woman Coverage, MA-3250, Breast and Cervical Cancer Medicaid, and MA-3265, Medicaid Family Planning Waiver, in the Family and Children's Medicaid Manual.

These programs provide coverage to eligible children under age 21, caretaker relatives of children under age 19, pregnant women, and women enrolled, screened, and diagnosed with breast or cervical cancer including pre-cancerous conditions and early stage cancer and limited family planning coverage to women ages 19 through 55 and men ages 19 through 60.

Coverage also includes the Expanded Foster Care Program (EFCP) for IAS and HSF adolescents ages 18, 19, and 20 without regard to the adolescent's assets or income levels through the month they turn age 21.

(III.)

5. North Carolina Health Choice for Children

   Refer to MA-3255, NC Health Choice, in the Family and Children's Medicaid Manual.

   This program provides health insurance for children age 6 through age 18 who are ineligible for Medicaid and have family income less than 200% of the federal poverty level. Children are evaluated for and enrolled in NC Health Choice only after they are determined ineligible for Medicaid.

B. Eligibility Requirements

Explain to the individual that, in addition to meeting the criteria for a Medicaid coverage group, he must also meet the other eligibility requirements including income and, in some cases, resource requirements. Additionally, the individual must provide and/or cooperate in obtaining proof of citizenship, identity, and state residence. The DMA-5096 is a tool for documenting the applicant's responses to basic eligibility requirements and for evaluating eligibility under all possible Medicaid coverage groups. See Figure 1.

C. Retroactive and Ongoing Medicaid

Refer to MA-2370, Retroactive Coverage.

1. Explain to the individual that Medicaid may be used to pay bills incurred in the three months prior to the month of application, if he is otherwise eligible.

   a. You must ask the individual if he has any medical bills in the retroactive months. You must also document his response.

   b. If the individual's income results in a deductible, explain the advantages and disadvantages of applying for Medicaid retroactively as opposed to ongoing. Include a detailed explanation of the reserve and residence requirements during the retroactive period.

2. Explain that ongoing coverage begins the first day of the month of application if all eligibility requirements are met. Discuss the reserve requirements, including burial exclusion, rebuttal and reduction and explain that Medicaid cannot be authorized until the reserve requirements are met.

D. Transfer of Resources

Refer to MA-2240, Transfer of Assets, MA-2241, Transition Policy for In-Home Health Services & Supplies, MA-2242, Home Equity Value & Eligibility For Institutional Services, and MA-2245, Undue Hardship Waiver For Transfer Of Assets.

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1. Interview the individual and the individual's spouse or his legal representative regarding income and resources for a period of 36 months up to 60 months to determine if a transfer (s) occurred and document the response in the case record.

2. Explain to the individual that a transfer of assets sanction may be imposed if any asset or income is transferred without receiving compensation equal to the current market value of the asset or income.

3. Explain that an individual under a transfer of assets sanction may not be eligible for assistance with nursing home cost of care, Community Alternatives Program (CAP) services, Program of All-Inclusive Care for the Elderly (PACE) services, or receive in-home health services and supplies after the individual has been sanctioned for institutionalized services.

   Review with the individual MA-2301, Figure 5, Explanation of The Effect of Transfer of Assets On Medical Assistance Eligibility. For further explanation refer to MA-2240, Transfer of Assets.

4. Explain that if the equity value of the homesite is over $500,000, and there is not a spouse, disabled, blind or minor child living in the home, the applicant/recipient is ineligible for nursing home cost of care, or CAP waiver programs, or Program of All-Inclusive Care for the Elderly (PACE). The individual may still be eligible for PLA. Refer to MA-2242, Home Equity Value & Eligibility For Institutional Services.

5. Explain that if an annuity is purchased or changed on or after November 1, 2007, by the a/r or by the a/r's spouse, or by their legal representative the State of North Carolina Medicaid Program must be named as a remainder beneficiary.

6. Excluding Program of All-Inclusive Care for the Elderly (PACE), that an individual under a transfer of assets sanction may be eligible for other Medicaid covered services. PACE applicants/recipients are only eligible for the MQB program/category. Refer to MA-2275, Program of All-Inclusive Care for the Elderly (PACE).

7. Always document the applicant's responses regarding transfer of assets in the case file.

E. Deductible

Refer to MA-2360, Medicaid Deductible.

1. Based on the client's statement of income, compute an estimated deductible, if applicable, for both the retroactive and ongoing periods.

2. Explain the deductible to the individual. Include the following information.

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a. Medical bills equal to or exceeding the deductible amount must be incurred before Medicaid can be authorized.

b. The individual is responsible for the deductible amount.

c. Explain to the individual whose expenses and what expenses can be used to meet the Medicaid deductible. You must ask the individual the following questions and document his response in the record:

(1) What regular medical expenses does the budget unit have on a monthly basis? (current expenses)

(2) Does anyone in the budget unit have any unpaid medical expenses for which he is still responsible? (old bills)

(3) Does anyone in the budget unit anticipate any new medical expenses, such as a scheduled hospital stay? (anticipated expenses)

3. If, based on the individual's statement, it appears that he is or will be within $300.00 of meeting the deductible, explain to the individual that, if all other factors of eligibility have been met, his application may be held for up to six months. See MA-2304, Processing the Application, for procedures.

F. MAD Applications Requiring a Disability Determination

Refer to MA-2525, Disability.

1. Explain to the individual that Disability Determination Services (DDS) will determine if his medical condition meets the definition of disability.

2. Advise the individual that DDS may contact him by phone or letter for additional information or to schedule a consultative examination.

a. If he fails to provide the information or keep the appointment, his application will be denied.

b. If he has questions or needs transportation, he may contact the IMC for assistance.

3. Explain to the individual that pregnancy alone is not considered a disabling condition and the pregnant woman will also be evaluated under the M-PW and M-AF programs.

4. If a Medicaid application has been denied for the individual in the last 60 days because DDS determined that his medical condition did not meet the definition of disability, explain the following:

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a. He may appeal the denial with the Social Security Administration or the State, or make a new application, or both.

b. The advantage of requesting an appeal of the denial is that the date of the original application is protected. This is particularly important if the individual had a retroactive need at the time of the original application.

c. Document the individual's decision in the record.

d. If the individual requests an appeal, follow policy in MA-2420, Notice and Hearings.

G. Choice of Programs

1. Explain the program options, including the advantages and disadvantages, for each program for which each individual is potentially eligible. If an individual is potentially eligible in two different programs, explain that he may apply for both.

2. An individual may choose to apply for MAABD and MQB or either MAABD or MQB. Unless the individual specifically chooses to apply for MAABD or MQB, always take and process the application for both.

3. Some examples of situations when eligibility may exist in more than one aid program/category are:

   a. A pregnant woman may be eligible as M-AF, M-PW or, depending on her age, as M-IC.

   b. A disabled parent with children under age 19 may be eligible as M-AD or M-AF, including Family Planning Waiver.

   c. A disabled individual under age 21 may be eligible as M-AD, M-AF, or M-IC.

   For example, Renee is a 19-year-old who was living with her parents. She was in an accident two weeks ago and has a severe head injury. She has been hospitalized since the accident and the full extent of her injuries is still unknown.

   Renee may qualify under Medicaid for the Disabled (M-AD), if her injury is severe enough to meet disability requirements, or Family and Children's Medicaid, as an individual under 21. The IMC must explain the program requirements for each program and the advantages and disadvantages of the programs so the parents can decide which program to apply for or if

they should file two separate applications. The issues to be explained include:

(III.G.3 c.)

(1) Parental Financial Responsibility

(a) Under the M-AF program, the income and resources of the parents must be used to determine her eligibility unless the doctor states she will be out of the home for more than twelve months.
Explain the Medicaid deductible and how it can be met. Also explain the resource limits and that if resources exceed the limit, the individual is ineligible until the resources are reduced.

(b) Under the M-AD program, the income and resources of the parents do not apply to a child age 18 or older.

(2) Disability

To receive under the M-AD category, DDS must determine if Renee's medical condition is severe enough to meet the disability criteria. Disability is not a requirement to receive under the M-AF program.

Based on the information provided, Renee's parents may choose to apply for M-AF, M-AD, or ask that Renee be evaluated for both. Renee may be approved with an M-AF deductible while her disability is being determined under M-AD. If her condition meets the criteria for disability, M-AD can then be approved back to the date of the application, if otherwise eligible.

H. Certification Periods

Refer to MA-2350, Certification and Authorization.

1. Explain to the individual that eligibility is determined for a limited time, which is called the certification period.

2. Explain that the program in which the individual is found eligible determines the length of the certification period.

(III.)

I. Long Term Care Placement (LTC)/Community Alternatives Programs (CAP)/Program of All-Inclusive Care for the Elderly (PACE)

An application may be taken for an individual who plans to enter or is in a nursing facility, an intermediate care facility for the mentally retarded (ICF-MR), a medical institution for medical, surgical or inpatient psychiatric care or a Psychiatric Residential Treatment Facility when the stay is expected to exceed 30 days or ends with a direct move into a nursing or ICF-MR facility, or who is in need of home and community based services under a CAP waiver program or the PACE program.

When long-term care, CAP or PACE assistance is requested, the IMC must explain the following:

1. The concept of long term care and PACE budgeting and the patient monthly liability (pml), or the concept of private living budgeting and the CAP monthly deductible. See MA-2270, Long Term Care Budgeting, and MA-2280, Community Alternatives Programs Medicaid Eligibility, MA-2275, Program of All-Inclusive Care for the Elderly (PACE).

2. The protection of assets and/or income for a spouse or dependent family member. See MA-2270, Long Term Care Budgeting, MA-2275, Program of All-Inclusive Care for the Elderly (PACE), and MA-2231, Community Spouse Resource Protection.

3. The need for a Prior Approval/Continued Care Review form (FL-2/MR-2), if required by policy. Include in the explanation that the Pre-Admission Screen and Annual Resident Review (PASARR) must be completed prior to approval of the FL2/MR2. Note: PASARR is not applicable for PACE applicants/recipients. Also explain that if there is a change in the required level of care, a new FL2/MR2 is required. See MA-2270, Long Term Care Budgeting and MA-2275, Program of All-Inclusive Care for the Elderly (PACE).

   a. Inform the LTC and PACE applicant that if an FL-2/MR-2 is required, the individual must be placed within 30 days of the date of the telephone or stamped approval of the recommended level of care.

   b. Inform the CAP applicant that an annual assessment (Plan of Care) is required to determine the continued need for CAP services.

4. The importance of notifying the DSS of any changes in the living arrangement or level of care.

5. Explain Estate Recovery rules. See DMA Administrative Letter No. 23-96 and Addenda and DMA Administrative Letter 09-05.

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6. Explain transfer of asset regulations. Refer to MA-2240, Transfer of Assets, MA-2241, Transition Policy for In-Home Health Services & Supplies, MA-2242, Home Equity Value & Eligibility For Institutional Services, and MA-2245, Undue Hardship Waiver For Transfer Of Assets.

J. Pre-Need Applications

There are only two types of pre-need applications under the Aged, Blind, and Disabled Medicaid program. An application for ongoing assistance may be taken for an individual who:

1. Is not a resident of North Carolina if the individual expects to meet the state residence requirements within the 45/90 day application processing period, or

2. Has not reached age 65 if the individual expects to meet the age requirements for the MAA program within the 45-day application processing period.

   a. Explain to the applicant or his representative that the state residence and/or age requirement must be met by the 45th/90th day. If the requirement(s) is not met by the 45th/90th day, the application will be denied.

   b. Refer to MA-2220, State Residence, and MA-2350, Certification and Authorization, for procedures.

K. Medicaid Identification Card

Refer to MA-2380, Medicaid Identification Card.

Explain to the applicant or his representative the Medicaid identification card and how to use it. Explain to the PACE applicant that a Medicaid card is not issued. Refer to MA-2275, Program of All-Inclusive Care for the Elderly (PACE).

IV. RIGHTS AND RESPONSIBILITIES

Each individual or his representative must be informed, in writing or orally, of his rights and responsibilities. Document how the information was furnished. A representative has the same rights and responsibilities as the individual.

A. Rights

Review with and explain to the individual the rights listed on the base document and the DMA-5094/DMA-5094S, Notice of Your Right to Apply for Benefits, and the DSS-8227/DSS-8227S, Immigrant Access Notice. In addition, explain the following:

1. The 45/90-day application processing standard.

(IV.A.)

2. He must cooperate in providing information needed to establish eligibility and, if a U.S. citizen, information to prove U.S. citizenship and identity.

3. He will be notified of any information he is to provide.

   a. He is to receive a written notice, DMA-5097/DMA-5097S, Request for Information, on the day of the application listing any information he is to provide.

   b. Another DMA-5097/DMA-5097S, Request for Information, must be sent if additional information is needed, as soon as the need becomes known.

   c. He will receive a second DMA-5097/DMA-5097S, Request for Information, if information he was to provide is not received.

   d. He may request help from the agency in getting the needed information.

4. His application may be held up to six months for proof that he can meet a Medicaid deductible or for disability to be determined provided he meets all other eligibility factors.

5. He may request help for retroactive coverage up to three calendar months prior to the month of application.

6. He does not have to have a permanent address. The only requirement is that he intends to stay in North Carolina.

   Please Note: Refer to MA-2220, State Residence, for state residency verification instructions for individuals, including the homeless, who do not have a permanent address.

   If the individual does not have a permanent address you must:

   a. Request any information from him on the date of application using the DMA-5097/DMA-5097S Request for Information.

   b. Ask the individual if he has an address where he can get mail. If he does, inform him to check his mailing address for requests for additional information, notices and his Medicaid identification card.

      If he does not:

      (1) Inform him that he must return or contact the agency to see if any additional information is needed. Negotiate a date for the contact but allow at least 12 days from the first request. Document the date on the DMA-5097/DMA-5097S Request for Information.

(2) If the application is approved, inform the individual that he must come to the agency to obtain his Medicaid identification card and any other notices.

7. He may apply for a deceased individual.

8. He has the right to appeal the decisions of the agency.

B. Responsibilities

Review with and explain to the individual the responsibilities listed on the base document, the DMA-5094/DMA-5094S, Notice of Your Right to Apply for Benefits, and the DSS-8227/DSS-8227S, Immigrant Access Notice. In addition, explain the following:

1. He must cooperate in providing information needed to establish eligibility.

2. Members of the assistance unit must apply for all benefits to which they might be entitled, such as Social Security and VA benefits. This does not apply to budget unit members.

3. Members of the assistance unit must provide a social security number or apply for a number. This does not apply to budget unit members. Refer to MA-2450, Enumeration Procedures.

V. TAKING THE APPLICATION

After discussing the individual's situation and describing his options, the individual will need to decide whether he wants to continue with the application process or stop.

A. Inquiries and Withdrawals

1. Inquiry

If the individual decides at any time prior to signing the application or the base document used to determine eligibility that he does not want to apply for assistance, complete an inquiry. Always explain to the individual his right to apply on that day and if he decides not to apply that he may apply at any time. Document that this explanation was given.

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The following must be included with each inquiry:

a. The DMA-5094/DMA-5094S, Notice of Right to Apply for Benefits, and

b. A completed DMA-5095/DMA-5095S, Medicaid/Work First Notice of Inquiry, which includes the following information:

(1) The date.

(2) The individual's name and, if applicable, the representative's name, address and telephone number.

(3) The specific reasons why the individual decided not to apply for assistance.

(a) Include all facts relevant to the individual's situation that support the decision not to apply (for example, age, income, medical bills, etc.).

If the individual decides to wait and apply for retroactive assistance because of the ongoing deductible amount, explain the timeframes for requesting retroactive assistance and the residence and resource requirements during the retroactive period. Clearly document the record that this explanation was given.

(b) If the individual refuses to give a reason for not making the application, document the refusal to explain.

(4) Document on the DMA-5095/DMA-5095S Medicaid/Work First Notice of Inquiry, any other programs that were discussed or to which the individual was referred.

c. Give the original DMA-5095/DMA-5095S Medicaid/Work First Notice of Inquiry, to the individual. Keep a copy for the agency file.

2. The individual may decide after signing the application or the base document that he does not want to continue the process. In this case, the application must be withdrawn. See MA-2305, Processing the Application, for instructions for completing the withdrawal.

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B. Date of Application

The date of the application is the date the application form or base document is signed. This rule applies regardless of where the interview takes place (in the county DSS, at an outstation, or in a county DSS outside of the individual's county of residence). See MA-2302, Receiving Mail-in Applications, regarding the date of application for mail-in applications.

C. Completing and Signing the Base Document

1. Complete one base document for each applicant. If a married couple who live together in the same household apply for M-AABD or M-QB, use one base document.

2. Complete the base document as thoroughly as possible during the interview.

3. Have the individual or his representative sign the base document to verify:

   a. He answered truthfully to the best of his knowledge, and

   b. He understands his rights and responsibilities as an applicant/recipient, and

   c. He authorizes the investigation of his eligibility for assistance by the county department of social services, the State Division of Medical Assistance and the United States Department of Health and Human Services.

D. Entering the Application into the Eligibility Information System (EIS)

Key the application into EIS within three workdays of it being signed.

VI. EXPLAINING THE AVAILABLE SERVICES

When an individual applies at the county department of social services for an adult Medicaid aid program/category, give the applicant a copy of the handbook, "A Consumer's Guide to North Carolina Medicaid Health Insurance Programs for the Aged, Blind, and Disabled" and/or "A Consumer's Guide to Medicare Savings Programs Within North Carolina Medicaid." Also give the applicant a copy of the DMA-5021, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Health Check fact sheet (Figure 4) until the handbook provided includes the updated EPSDT information.

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Explain to the applicant that the handbook and fact sheet are to be kept as a reference guide that lists the services covered by Medicaid, how to use the Medicaid card and other helpful information.
Explain services available through Medicaid, in the agency or in other agencies.

A. Community Care of North Carolina/Carolina Access (CCNC/CA)

Refer to MA-2425, Community Care of North Carolina/Carolina Access (CCNC/CA), to determine if the assistance unit members are required to participate and to explain the service.

Community Care of North Carolina/Carolina ACCESS(CCNC/CA), provides the Medicaid recipient with a medical home and Primary Care Provider (PCP) who manages care for continuity and ensures services are provided that are medically necessary.

B. Covered Services

Refer to MA-2905, Medicaid Covered Services.

Explain the Health Check program and Family Planning Services.

1. Health Check pays for health care for children under age 21, who are authorized for Medicaid in any aid program/category except M-QB and those who receive emergency Medicaid only.

    a. Review the services available and how to obtain them. (See Figure 4) Explain that transportation to medical appointments and assistance in locating a provider are also available.

    b. Explain that letters will be sent to their home reminding them of services available through the Health Check program and of upcoming scheduled appointments.

    c. If the county has a Health Check Coordinator, give the individual his or her name and phone number. Explain that the Health Check Coordinator can answer questions, help with locating a provider and help with scheduling appointments.

2. Explain Family Planning Services

    Family planning services are available to any family member (either male or female) of childbearing age, including minors. Services may include counseling, education, birth control and medical examinations.

    a. Explain the limitations on abortions and sterilizations.

(VI. B.2.)

b. Explain that the individual's decision regarding family planning does not have an effect on Medicaid eligibility.

c. If services are requested, refer to the appropriate individual or agency in your county.

3. Medical Transportation

Refer to MA-2910, Medicaid Transportation, for specific information concerning medical transportation.

a. Inform the individual that if he does not have or cannot arrange medical transportation on his own, he is entitled to help from the DSS in arranging and/or paying for medical transportation when he is authorized for Medicaid. It does not apply to individuals authorized for M-QB or NC Health Choice.

b. Explain to the individual that the DSS will not provide transportation to a provider of the individual's choice (except for CA providers) when a local provider is available.

c. Give the individual the DMA-5056, Medical Transportation Assistance Notice of Rights, along with the contact information for the person or unit in the agency that handles transportation requests. Explain his right to request assistance with medical transportation. File a copy of the DMA-5056, Medical Transportation Assistance Notice of Rights, in the case record.

4. Other Covered Services

For information about other covered services, including Adult Health Screenings, refer the individual to the handbook "A Consumer's Guide to North Carolina Medicaid Health Insurance Programs for the Aged, Blind, and Disabled."

C. Food and Nutrition Services

Ask the individual if the family receives Food and Nutrition Services.

1. If the family receives, has applied for or would like to apply for Food and Nutrition Services, you must notify the Food and Nutrition Services office of the status of the Medicaid application. Use the DSS-8194, Income Maintenance Transmittal Form, to notify the Food and Nutrition Services office.

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2. If an individual does not receive Food and Nutrition Services, inform him that the program is offered and provide him with instructions for applying.

D. Women, Infants and Children Program (WIC)

WIC is a supplemental food and nutrition education program that provides supplemental foods to improve diets and reduce chances of health problems by poor nutrition. WIC foods include infant formula, milk, eggs, cheese, juice (including infant juice), cereal (including infant cereal), and dry beans and peas.

1. The program serves:

   a. Pregnant women, and
   b. Postpartum women (up to 6 months after delivery), and
   c. Women who are breastfeeding, and
   d. Children under six years of age.

2. If the individual is interested in the WIC program, make a referral to the local WIC agency.

E. Lifeline/Link-Up Assistance Program

The Lifeline Assistance Program is designed to promote universal service by helping low-income individuals afford telephone service and to receive a credit on their monthly telephone bill. You may access the Lifeline and/or Link-Up Application, forms DSS-8168I,/DSS-8168Isp by using the links in this section.

Lifeline Assistance allows adults to receive a credit each month on their telephone bill. A wireless cell phone bill can be credited if the wireless cell phone is the recipient's only phone.

The Link-Up program provides a 50% discount, up to $30.00 off the price of a telephone hook-up. It is 50% as long as the 50% doesn't exceed $30. If 50% is less than $30, the credit will be 50%. For example an installation charge of $40 would receive a $20 credit and an installation charge of $80 would receive a credit of $30. Both programs are available to adults who:

1. Receive Medicaid under MAF, MPW, MAABD, or MQB-Q, or MQB-B. MIC, HSF, IAS, and FPW recipients are not eligible for Lifeline/Link-up.

2. Have a current, participating Lifeline Link-Up Assistance Program telephone service and receive a bill listed in the adult recipient's name, for Lifeline Assistance and

3. Receive service from one of the participating telephone companies listed on the reverse side of the Lifeline and/or Link-Up Application, DSS-8168I,/DSS-8168Isp.

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The caseworker must explain the Lifeline and Link-Up Assistance Programs to the applicant. Provide a brochure, if available. If the individual meets the eligibility requirements to receive Lifeline/Link-Up Assistance and wants to apply:

a. Complete the DSS-8168I,/DSS-8168Isp Lifeline and/or Link-Up Application. Enter the household's ten digit telephone number, two digit telephone company code (located on the back of the DSS-8168I/DSS-8168Isp) and an alpha code (L for landline phone and C for wireless cell phone) in Field 22 of the DSS-8590. Have the recipient sign it. Hold the DSS-8168I/DSS-8168Isp until you dispose of the Medicaid application.

   Verification of the telephone bill is not required for the client to apply for the Lifeline Program.

b. Document the current telephone company and make sure it is listed on the reverse side of the DSS-8168I/DSS-8168Isp, Lifeline and/or Link-Up Application.

c. Once ongoing Medicaid eligibility is determined, enter the adult recipient's social security number in the appropriate block on the form. Ensure the information written on the DSS-8168I/DSS-8168Isp is correct. Send the DSS-8168I/DSS-8168Isp, Lifeline and/or Link-Up Application without delay to the recipient's appropriate telephone company.

   Upon receipt of the DSS-8168I/DSS-8168Isp, the telephone company verifies the recipient's name and telephone number and keys the information into its system. The recipient receives the credit with his next billing cycle.

d. If the application is denied or withdrawn, file the form in the case file. Do not forward to the telephone company.

4. A person requesting new telephone service, Lifeline Link/Up, will need to apply for service at a local participating Lifeline Link-Up Assistance Program telephone company. The telephone company will either mail the application form to the appropriate local agency or will give the client the application form to be taken to the appropriate local agency to be signed and for the agency to verify that the client is receiving benefits that make him eligible for Link-Up Assistance.

   If the Medicaid recipient brings the application into the agency, the assigned Medicaid caseworker for that individual must complete the form, and return it to the telephone company.

(VI. E. 4.)

Upon receipt of the Lifeline and/or Link-Up Application, DSS-8168I/DSS-8168Isp, the telephone company verifies the recipient's name and telephone number and keys the information into its system. The recipient receives the credit with his next billing cycle.

F. National Voter Registration Act (NVRA)

The purpose of the NVRA is to make available more opportunities for people to vote. Ensure voter registration forms are available to individuals during their visits. If the individual asks for assistance in completing the voter registration form, provide the assistance. Inform the individual that the Board of Elections processes applications to register to vote. Questions concerning voter registration must be directed to the local Board of Elections.

G. Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires that group plans and health insurance issuers, including Medicaid, who offer group coverage furnish certificates of creditable coverage when an individual ceases to be covered by the plan. The purpose of the certificate of creditable coverage is to present evidence that the individual had prior creditable coverage that will reduce or eliminate pre-existing exclusions under subsequent health coverage. Health plans that impose pre-existing condition exclusions must reduce the length of an exclusion period by an individual's creditable coverage.

The issuance of the certificates is automated and is done by DMA's fiscal contractor s when a recipient is terminated. Certificates can be provided up to 24 months after termination. If an individual has questions about a Certificate of Creditable Coverage refer him to Electronic Data Systems (EDS) at 1-800-688-6996.

H. Health Insurance Premium Payment (HIPP)

1. HIPP is a program in which the Division of Medical Assistance (DMA) pays private health insurance premiums for Medicaid recipients when it is cost effective to do so. Cost effectiveness is established when the annual cost of the premiums, deductibles and coinsurance is less than the anticipated Medicaid expenditures.

   HIPP is most cost effective for Medicaid recipients with catastrophic illnesses such as end stage renal disease, chronic heart problems, congenital birth defects, cancer, or AIDS.

(VI.H.)

2. To be eligible for the premium payment, the recipient must be authorized for Medicaid and have private health insurance. DMA only pays premiums on existing or known policies. DMA does not find new coverage for a recipient. Premiums may be paid for a family coverage policy when the policy is cost effective and it is the only way the recipient can be covered by the policy. Family members that are not Medicaid recipients do not receive Medicaid payment of deductible, coinsurance or cost sharing obligations.

   HIPP is not available to individuals in deductible status. DMA no longer pays the health insurance premium when a recipient is placed in deductible status at redetermination or due to a change in situation.

3. When DMA determines that a group health insurance plan available to a recipient through an employer is cost effective, the recipient is required to participate in the plan as a condition of eligibility for Medicaid.

   a. If the recipient voluntarily drops the insurance coverage, Medicaid benefits may be terminated.

   b. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer. However, if it is determined that the policy is cost effective, DMA pays the cost of premiums, coinsurance and deductibles of non-group health plans if the recipient chooses to participate.

4. Referrals

   a. Give a brochure, and the DMA-2069, Health Insurance Premium Payment Application Form, to any recipient who has a qualifying catastrophic illness. Refer to Figure 3.

   b. Assist the recipient in completing the form and advise him to have the physician submit any requested medical record.

   c. Ask the recipient to return the completed form to the county dss for submission to DMA.

      Submit the completed forms to:

      HIPP Coordinator
      Third Party Recovery Section
      Division of Medical Assistance
      2508 Mail Service Center
      Raleigh, North Carolina 27699-2508

(VI.H.4.)

d. In addition to county dss referrals, DMA provides HIPP program information to recipients by placing brochures and applicable forms in local health departments, hospitals, hospices, and physicians' offices.

5. Recipients who request assistance through the HIPP program are notified in writing within 30 days of the outcome of the request. For recipients who are approved, health insurance premiums cannot be applied to the deductible or allowed as an unmet medical need effective the month DMA begins paying the premium.

I. Children with Special Health Care Needs

If the DMA-5063, Application for Health Check/Health Choice, shows a child has a special health care need, enter the appropriate special needs code in the individual data on the DSS-8125. EIS automatically inserts a Special Needs code for individuals in certain aid program/categories. The caseworker has the responsibility for keying the Special Needs code for other aid program/categories. See EIS 4000, Codes Appendix.