MA-3215 PROCESSING THE APPLICATION
REISSUED 03/01/08 – CHANGE NO. 08-08

I. INTRODUCTION

After the interview has been completed or the mail-in application received and all eligibility factors have been verified, process the application. This section outlines the procedures for processing applications and all of the possible outcomes.

II. POLICY PRINCIPLES

A. There are three possible outcomes for an application: withdrawal, denial or approval. Regardless of the outcome, the applicant must be provided a written notice explaining the decision made on the application and the right to a hearing if he disagrees with the decision.

B. The application processing time standard for all Family and Children's aid program/categories is 45 calendar days.

C. Applications that include a request for both retroactive and ongoing Medicaid count as two separate applications and are tracked as two separate applications. Each part must be dispositioned.

D. In some cases, applications may be held pending for up to six months. Applications in which eligibility has been established except for receipt of U.S. citizenship/identity documentation and/or for proof of medical bills to meet the deductible when anticipated expenses are within $300.00 of meeting the deductible may be held beyond the 45-day time standard.

E. Process applications opened or reopened due to a local/state appeal reversal or remanded appeal within five workdays of receipt of the last piece of needed information.

III. PROCEDURES

A. Processing Timeframes

1. EIS calculates the 45th day based on the date of application entered into the system.

    a. The 45-day time standard begins with the day after the date the application or base document is signed.

(III.A.1.)

b. In determining the 45th day, EIS adjusts the 45th day to the next workday when the 45th day falls on a weekend or state and/or county holiday. For example, if the 45th day falls on a Sunday, EIS adjusts the Application Management Report to show that the 45th day falls on the next workday. If the 45th day falls on the Sunday prior to a state and/or county holiday, EIS adjusts the report to show that the 45th day is the first workday following the state and/or county holiday.

2. Unless two requests for the missing information have not been completed, process the application (approve, withdraw or deny) on or before the 45th day unless the application is pending for information in B.1.a. If an application is missing more than one of these items, pend the application. Indicate on the date screen the item likely to take the most time to obtain.

   a. If an application is pending proof of meeting a deductible and that is the only piece of information needed to process the application, hold the application open for up to six months if predicted medical expenses indicate that the deductible may be met.

   b. If an application is pending for citizenship and/or identity documentation and that is the only piece of information needed to process the application, hold the application open for up to six months.

   c. If the application is pending for citizenship and/or identity documentation as well as proof of meeting a deductible continue to pend the application until all items needed to process the application are received. Update the date screen in EIS. See EIS 2400, Application Processing.

3. The processing time ends the date the notice of decision is mailed or given to the individual. If the notice is automated, the processing time ends the day the system mails the notice. The automated notice is mailed the workday after the action has been keyed into and accepted by EIS.

B. Excluding Days from the Processing Time

1. Under certain circumstances, days may be excluded from the application processing time.

   a. As a general rule, days may be excluded only when the county is waiting for one item in the following list and the missing item is the only information needed to process the application. However, days may also be excluded when the county is waiting for item (9) and one of the items in (1) through (8).

(III.B. 1. a.)

(1) Medical bills to meet a deductible, or

(2) Disability determination, or

(3) Medical records needed to determine emergency dates for non-qualified aliens, or

(4) A request for additional time to supply verification extends processing time beyond the 45/90 day limit, or

(5) Receipt of the FL-2/MR-2, or

(6) Receipt of the CAP Plan of Care, or

(7) Receipt of undue hardship documentation, or

(8) Receipt of North Carolina Health Choice enrollment fee, or

(9) Receipt of U.S. citizenship and/or identity documentation.

b. The exclusion of days cannot begin any earlier than the date the individual is notified of the last pieces of information needed to process the application using the DMA-5098/DMA-5098S, Your Application for Medicaid is Pending, or the DMA-5099/DMA-5099S, Your Application for Medicaid is Pending for a Deductible, or the DMA-5113, Notice of Right To Request A Hardship Waiver or notice of date hardship waiver was mailed. See MA-2245, Undue Hardship Waiver For Transfer Of Assets.

(1) The DMA-5098/DMA-5098S can be mailed or given to the applicant on the day all points of eligibility are met except for receipt of the following:

(a) Disability determination, or

(b) Medical records to determine emergency days for non-qualified aliens, and/or

(c) U.S. citizenship and/or identity documentation.

Before days can be excluded for (a) and (b), third party verification must be requested from Disability Determination Services (DDS) or the medical provider. For (c) request documentation from the applicant first.

(III.B.1.b.(1)(c))

Exclude days when documentation requests are sent to a third party source such as Vital Records. The DMA-5098/DMA-5098S can be mailed or given to the applicant on the same day the third party documentation is requested or it can be sent later.

(2) The DMA-5098/DMA-5098S or if applicable, the DMA-5099/DMA-5099S can be mailed or given to the applicant at the end of the first 12-day request for information period when all points of eligibility are met except for receipt of the following information:

(a) FL-2/MR2, or

(b) CAP Plan of Care, or

(c) Medical bills to meet a deductible, or

(d) Undue hardship documentation, and/or

(e) U.S. citizenship and/or identity documentation.

Before days can be excluded, the applicant or third party must be given at least 12 full days to provide the missing information. Request the missing information from the applicant using the DMA-5097/DMA-5097S or from the third party using the appropriate verification form.

(3) The DMA-5098/DMA-5098S, Your Application for Medicaid is Pending, or DMA-5099/DMA-5099S, Your Application For Medicaid is Pending A Deductible, can be mailed or given to the applicant on the same date that the applicant or third party requests additional time to provide information and the county has met all requirements for requesting the information in MA-3210, Verification Requirements For Applications, section III.D.

When the IMC has only made one request for the information and the applicant or third party asks for additional time late in the processing period the exclusion of time does not apply.

When the second 12 days has not yet run, but the applicant or third party asks for additional time, wait until the second 12 day period has run before sending the DMA-5098/DMA-5098S or DMA-5099/DMA-5099S.

(III.B.1.b. (3))

When the IMC learns of additional information needed after the initial request (s) for information have been made, the 12/12 requirement must be met. In such a case, the applicant may request additional time even if the request comes after the 45/90 day period has run.

(4) The DMA-5098/DMA-5098S or DMA-5099/DMA-5099S can be mailed or given to the applicant on the same day of the second or subsequent request for the missing information, provided the 12-day requirement has been met, or it can be sent later.

The exclusion of days cannot begin any earlier than the 13th day after the missing information was first requested.

c. If an application is filed for both retroactive and ongoing coverage, exclusion is permitted for each part of the application.

d. When the DMA-5098/DMA-5098S or DMA-5099/DMA-5099S is mailed or given to the individual notifying him of the last piece of information needed to process the application, the days can be excluded from the application processing time. The exclusion of days begins on the date the DMA-5098/DMA-5098S or DMA-5099/DMA-5099S is given or mailed to the client following the procedures above.

e. Key the date screen in EIS. See EIS-2400.

(1) The begin date on the date screen is the date the DMA-5098/DMA-5098S or DMA-5099/DMA-5099S is mailed or given to the client.

(2) The end date for excluding days is the date that the Disability Determination Section (DDS) releases the case on the Disability Determination (DD) screen.

For non-qualified alien emergency dates, the exclusion of days ends on the date the medical records are received. Days cannot be excluded while waiting for DMA to determine emergency dates.

The end date for excluding days in NCHC cases is the day the fee is received or the 13th calendar day, whichever occurs first.

(3) The begin and end dates count in the application processing time.

(III.B.)

2. Change in Situation

a. If a change in situation, which affects eligibility, becomes known after the exclusion of days begins, request the new or additional information following procedures in MA-3210, Verification Requirements For Applications.

(1) If the change results in an increased or decreased deductible amount, notify the applicant of the new deductible amount using the DMA-5099/DMA-5099S, Your Application For Medicaid Is Pending A Deductible.

(2) If the change results in eligibility, approve the application.

(3) If the change results in eligibility for the time prior to the change and ineligibility after the change, approve the application as open/shut. Refer to D.3.

(4) If the information results in ineligibility, deny the application.

b. On the date that eligibility or ineligibility is established, the days can no longer be excluded. Enter this date in the end date field on the date screen.

C. Calculating the Six-month Pending Period

Calculate the six-month pending period by counting forward to the sixth calendar month following the month of application. The six-month pending period ends on the same calendar day as the date of application. If the six-month pending period ends on a weekend or holiday, dispose of the application the next workday.

EXAMPLES	
Application Date	Six-month pending period ends
April 10	October 10
May 1	November 1
March 31	September 30

D. Application Outcomes

1. Withdrawal

The individual may decide after signing the application (either the DSS-8124 or the DMA-5063) that he does not want to continue the process. In this case, the application is withdrawn. The IMC must follow the procedures below:

a. Discuss with the individual the reason for the withdrawal and the facts supporting that decision.

(III.D.1.)

b. Discuss with the individual the alternatives to withdrawal. Some alternatives include but are not limited to:

(1) Completing an open-shut application for a period of time when eligibility was established, or

(2) Transferring or reopening the application to an allowable Medicaid program protecting the original date of application, or

(3) Reapplying for retroactive coverage to reduce the deductible and allow for eligibility.

c. Carefully document the reason for the withdrawal including the facts that support the decision, the alternatives to the withdrawal that were offered and the individual's response. It is suggested that a worksheet be used for documentation.

d. Use the DSS-8109, Your Application For Benefits Is Being Denied or Withdrawn, to notify the individual of the action and provide hearing rights. See Figure 1. Refer to MA-3430, Notice and Hearings Process, for instructions on completing the manual DSS-8109. The DSS-8109 is also automated.

e. If the individual requests the withdrawal by mail or by leaving a message:

(1) Make one attempt to contact the individual by phone to discuss the request and the alternatives.

(2) Document the attempt to contact the individual and, if successful, document the discussion and results.

(3) If the IMC cannot make contact with the individual, withdraw the application.

2. Denial

Prior to denying an application, evaluate eligibility under other aid program/categories for each assistance unit member. If an assistance unit member is eligible under another aid program/category, open an application for that program with the original date of application and process under that aid program/category.

a. Deny the application anytime:

(1) Ineligibility for Medicaid under all aid program/categories is established.

(III.D.2.a.)

(2) It is determined that the individual cannot meet his Medicaid deductible. Refer to MA-3315, Medicaid Deductible.

(a) If, based on the individual's statement of old, current and anticipated expenses, it appears that he is not or will not be within $300.00 of meeting the ongoing deductible, deny the application.

(b) If, based on the individual's statement and/or third party verification of old and actual expenses during the retroactive certification period, it is determined that he has not met the retroactive deductible, deny the application. Ensure that **all** of the budget unit's old and retroactive medical expenses have been evaluated.

(3) It is determined that the individual has excess resources and the individual states verbally or in writing that he does not intend to reduce his resources within the 45-day application processing time, accept his statement. Document the record and deny the application.

Do not deny the application prior to the 45th day if the individual states he does intend to reduce his resources or says nothing. Request verification of reduced resources following procedures in MA-3210 and hold the application until the 45th day for proof that resources have been reduced. See 2.c. below.

(4) The individual cannot be located.

(a) Use this reason for denial only when it is impossible to contact the individual by letter or telephone or mail has been returned by the post office.

(b) If the whereabouts of any of the children included on the application are known, continue to process the application for the children only.

(c) Since it is possible to record incorrect information during the interview, check possible sources of information such as the telephone directory, city-county directory or postal service.

(d) If there is a forwarding address, do not deny the application because the applicant has moved.

(e) Do not deny the application because the applicant does not have a permanent address.

(III.D.2.a.(4))

(f) Clearly document all attempts to locate the individual prior to denial.

(5) The applicant refuses to assign his own rights or those of any other individual for whom he can legally make an assignment or he refuses to cooperate in identifying and providing TPR information. Refer to MA-3510, Third Party Recovery.

b. Deny the application the next workday following the second scheduled appointment for an intake interview when the individual failed to complete the interview and two appointments were scheduled with at least 12 calendar days between the appointments.

The IMC may schedule appointments more frequently than 12 days apart, but if the applicant fails to keep all of them, the application cannot be denied unless there are at least 12 days between the first appointment and one of the subsequent appointments.

c. Deny the application on the 45th day when:

(1) The individual or third party fails to provide information needed to determine eligibility. This information includes medical records needed to determine emergency dates for non-qualified aliens, DMA determination of emergency dates, FL-2/MR-2 or CAP Plan of Care, even if days are being excluded from the processing time,

And

(2) The information was requested following procedures in MA-3210, Verification Requirements For Applications. There must be at least two requests for the information with at least 12 calendar days between the requests and 12 calendar days must have passed since the second request.

(a) Excess Resources

1) If the individual with excess resources states verbally or in writing that he does intend to reduce his resources, explain to him that the resources must be reduced by the 45th day **and** he must provide verification that the resources have been reduced within the application processing time.

(III.D.2. d.(2)(a))

2) If the individual has not provided verification of the reduced resources on the 45th day and the 12-12 rule has been met, deny the application.

3) If the individual has not provided verification of the reduced resources on the 45th day and the 12-12 rule has not been met, hold the application pending until the end of the second 12-day period or until ineligibility is verified.

For example, an applicant is notified of excess resources on the 40th day. The individual is notified of the reserve reduction options and allowed 12 calendar days to reduce, rebut or designate assets for burial. At the end of the 12-day period, a second notice is sent to the individual.

If excess resources can be reduced by rebuttal or burial designation, hold the application pending until the end of the second 12-day period for verification of rebuttal evidence or burial designation.

If the excess resources cannot be reduced by rebuttal or burial designation and resources are not reduced by the 45th day, the case is ineligible. Deny the application once ineligibility is verified.

(b) Emergency Medical Dates

1) If the case is pending a decision from DMA regarding emergency dates, contact DMA on the 45th day to see if the decision has been made.

2) If DMA has not made a decision and the 12-12 rule has been met, deny the application.

3) If a favorable decision of emergency dates is received from DMA after the application is denied, reopen the application as an administrative application using the original date of application.

(c) Never deny on the 45th day if the 12-12 rule has not been met **and** ineligibility has not been established.

(III.D.2.d.(2)(c))

1) If 12 days have not passed since the second request for information and ineligibility has not been established, hold the application pending for the full 12 days, even if it pends beyond the 45th day.

2) If the verification is provided by the end of the second 12-day period and all other points of eligibility are met, authorize assistance.

3) If the application is pending for a reason cited in III.B.1. and for other information that the individual or third party must provide, deny the application on the 45th day, provided the 12-12 rule has been met.

For example, an individual in an MAF application has a deductible that based on his statement might be met during the certification period. However, the individual has not returned required verification of resources. Deny the application on the 45th day.

d. Deny the application at the end of six months when the:

(1) Application pended for proof of meeting a deductible and the individual has failed to provide proof that the deductible was met, or

(2) Application pended for a disability determination and the decision has not been rendered, or

(3) Application pended for proof of citizenship and/or identity and the information has not been received.

3. Approval

a. Approve assistance anytime all factors of eligibility have been verified and eligibility is established.

b. Open/shut approvals

(1) If at any time during the application process, the individual is determined ineligible for Medicaid under the program for which he applied, evaluate whether the individual is eligible under any program for any portion of the time covered by the application.

(III. D.3.b.)

(2) If at any time the individual is authorized for SSI Medicaid, continue to determine eligibility for any period of time, retroactive and ongoing, that is covered by the application. Refer to MA-3120, SSI Medicaid.

(3) If at any time the individual requests to withdraw his application, explore with him the possibility of his eligibility for any period of time during his certification period. If he wishes to be evaluated for eligibility for any period of time covered by his date of application, do not withdraw the application.

(4) When an individual is found eligible for a portion of a certification period, authorize assistance open/shut for the period of time the individual was eligible.

When a medically needy applicant requests ongoing Medicaid, the six-month deductible must be met prior to authorization regardless of the number of months in the ongoing certification period unless there is a change in income or the individual dies.

(a) **Example #1** A medically needy non-qualified alien has a medical emergency during the month of application. Emergency medical dates are approved by DMA. The individual must meet the ongoing six-month deductible before the emergency medical dates can be authorized.

In this situation, the IMC should fully explain to the individual the option of applying for retroactive assistance including the reserve and residence requirements.

(b) **Example #2** A medically needy individual requests withdrawal of his application because he has moved to another state to live with his son. The individual reports that he moved to the other state upon discharge from the hospital.

The individual also reports that he has enough medical bills to meet the original six-month deductible. The certification period is January through June. Medical bills indicate that the six-month deductible was met on March 9th. The individual moved to the other state on March 16th.

Approve the application open/shut for March 9th through March 31st. Do not re-compute the deductible. The ongoing six-month deductible must be met even if the certification period is three months.

IV. REOPENED DENIALS, WITHDRAWALS, APPROVALS OR INQUIRIES

Any time it is determined that an individual was discouraged, that an application was improperly or incorrectly denied or withdrawn, or that a state or local appeal decision reverses the denial of an application or the termination of a case, the county must take action to reopen the application or case. Additionally, some terminated cases may be reopened administratively when certain criteria are met. This section outlines the procedures to follow to reopen applications or cases.

A. Discouragement

1. Discouragement can occur with or without a signed application and can be discovered in several ways including a report by the applicant or potential applicant, through a second party review, or by the application monitor.

2. When discouragement is alleged, review the case record. If the case documentation shows that retroactive benefits, coverage for minor children and/or dual eligibility were offered and declined or that the client was afforded the opportunity to apply but declined, no discouragement occurred and no further action is required.

3. When the agency learns from any source that an individual has been discouraged and the allegation cannot be refuted based on record documentation, follow the procedures in IV.B. to reopen the application.

B. Reopening Denials, Withdrawals, and Approvals

A reopened application refers to an application that was originally denied or withdrawn but the denial or withdrawal is incorrect, improper or reversed. It can also refer to an application or inquiry when there is evidence of discouragement. The agency must re-assess the denial, withdrawal or inquiry and protect the original date of application for processing time.

1. An application must be reopened within 5 days as a result of any of the following:

   a. Local or state appeal reversal, or

   b. Remanded appeal by the local or state hearings officer, or

   c. Improper denial or withdrawal found by the county, monitors, or Medicaid Program Representatives, or

(IV.B.1.)

d. Misapplication of policy (incorrect denial), or

e. Discouragement.

2. Follow these procedures when reopening an application due to local/state appeal reversals, improper denials or withdrawals, remanded appeals, incorrect denials, or discouragement with a signed application.

a. A signed application is not required.

b. Key the DSS-8124 screen:

(1) Local/State Appeal Reversals or Remanded Appeals

Key the DSS-8124 within 5 workdays of the date the Notice of Decision is final. The date of application is the reopen or current date.

(2) Improper Denials/Withdrawals or Discouragement

Key the DSS-8124 on the date the agency learns of the improper denial/withdrawal or discouragement. The date of application is the date the agency learns of the improper action or discouragement.

(3) Incorrect Denials

Key the DSS-8124 on the date the agency learns of the incorrect denial. The date of application is the reopen or current date.

c. Complete the date screen. Refer to the instructions in the EIS-2400.

(1) Local/State Appeal Reversals or Remanded Appeals

For appeal reversals or remanded appeals, review the case record according to the hearing decision, considering additional information and/or policy as instructed in the decision.

(a) If no additional information is needed, dispose of the application within five workdays of reopening the case.

(IV.B.2.c.(1))

(b) If additional information is needed from the individual or a third party, including medical bills to meet the deductible, follow procedures in MA-3210, Verification Requirements for Applications and MA-3215, Processing the Application.

(c) Process the application within 5 workdays of receipt of the last piece of required information.

For remanded appeal decisions, the application disposition decision may be the same as or different from the original decision.

(2) Improper Denials/Withdrawals, Incorrect Denial or Discouragement

(a) If no additional information is needed, dispose of the application.

(b) If additional information is needed from the individual or a third party, including a disability determination or medical bills to meet the deductible, follow procedures in MA-3210, Verification Requirements for Applications and MA-3215, Processing the Application.

(c) If all necessary information (except a disability determination or medical bills to meet the deductible) is not received, deny the application on the 13th calendar day after the second request for information or once the application has pended a full 45 days, whichever occurs later.

1) To determine if the application has pended the 45 days, subtract the number of days the original application pended from 45. The difference is the number of days the reopened application must pend to meet the 45-day requirement. Do not include any days the application was closed.

2) For example, an MAF application dated June 10th was improperly denied on June 25th. The original application pended a total of 15 days. On August 30th, an administrative DSS-8124 was entered to reopen the application. The reopened application must pend for at least 30 calendar days (September 29th) or until 13 calendar days after the second request for information, whichever is later.

3) If the application has not pended a total of 45 days, hold the application until the 45th day.

(d) If all necessary information (except a disability determination or medical bills to meet the deductible) is received, and the anticipated medical expenses are within $300.00 of meeting the deductible continue to pend the application for up to 6 months.

1) To determine if the application has pended 6 months, subtract the number of days the original application pended from 180. The difference is the number of days the reopened application must pend to meet the 6 month requirement. Do not include any days the application was closed.

2) For example, a MAF application dated June 10th was improperly denied on June 25th. The original application pended a total of 15 days. On August 30th, an administrative DSS-8124 was entered to reopen the application. A review of the case record indicates that anticipated medical expenses are within $300.00 of meeting the deductible and this is the only information needed to complete the application. The reopened application must pend for at least 165 days (February 11th) or until 13 calendar days after the second request for information, whichever is later.

(e) If all necessary information (except a disability determination or medical bills to meet the deductible) is received, and the anticipated medical expenses are not within $300.00 of meeting the deductible, deny the application.

C. Discouragement Without A Signed Application

Follow these procedures to reopen a case when cited for discouragement and there is no signed application.

1. Send the DMA-5097DMA-5097S Request For Information, to the individual scheduling an appointment to complete an application along with a letter explaining that it has been determined that he has been discouraged and that eligibility will be evaluated back to the date of discouragement.

(IV.C.)

2. If you can determine from the case documentation that the individual was discouraged from applying enclose the application form with the DMA-5097/DMA-5097S

   Instruct the individual that he can either keep the scheduled appointment or return the completed application form by the appointment date.

3. If the individual fails to keep the scheduled appointment or if applicable, does not return the application form, send another DMA-5097/DMA-5097S to schedule a second appointment. There must be at least 12 calendar days between the two appointments.

   a. If the individual fails to keep the second scheduled appointment or if applicable, does not return the application form by the second appointment date, no other action is needed.

   b. If the individual does file an application by the established deadline, follow procedures in IV.B.2. to key and process the reopened application.

   c. If the application form is received after the 12-12 date, the date of application is the date the completed form is received. Do not treat as a reopened case due to discouragement.

D. Reopening Terminated Cases

1. Certain actions that require entering a DSS-8124 in EIS may be done administratively. A signed application is not required and a "Y" must be entered in the administrative field of the DSS-8124. Application processing time standards do not apply. These actions include:

   a. Moving an individual from one case to another, in the same or different aid program/categories, or

   b. Posting eligibility to a terminated case, or

   c. Reopening cases terminated in error, or

   d. Reopening a terminated case as the result of a state/county appeal reversal or remanded appeal. See MA-3430, Notice and Hearings, or

   e. Reopening Medicaid terminations. See 3.

(IV.D.)

2. Follow instructions in EIS-2012 for processing administrative actions.

3. To reopen terminated Medicaid cases follow these procedures.

   a. All of the following criteria must be met for a terminated case to be reopened. If these criteria are not met, the individual must reapply for Medicaid.

      (1) The case must have been terminated for one of the following reasons:

         (a) Failure to complete a redetermination of eligibility,

         (b) Unable to locate the recipient(s) in the case,

         (c) No eligible child in the home,

         (d) The recipient(s) in the case moved out of state,

         (e) The recipient(s) in the case became a resident of a public, non-medical institution.

      (2) The request to reopen the case must be received no later than the 10th calendar day of the month following the month of termination. The request may be made in person, by telephone call, in writing, or by receipt of information needed to complete the review.

         NOTE: If the 10th calendar day falls on a non-workday, allow the individual until the next work day to request his case be reopened.

      (3) All information needed to reopen the case must be received by the 10th calendar day of the month following the month of termination.

         This includes, but is not limited to, the re-enrollment form and any required verifications. If reopening a NC Health Choice case with a fee, always allow the individual ten calendar days to pay the fee.

         If notice of a fee was provided prior to the case terminating, the individual has until the 10th calendar day of the month following the month of termination to pay the fee.

      (4) All of the individuals included in the case when it was terminated must be included in the reopened case.

(IV. D. 3. a.)

(5) All of the individuals included in the case must continue to live in the county that had responsibility for the termination.

(6) The individuals must be eligible in the same aid program/category as the terminated case.

b. Verify that eligibility continues.

(1) If the case was terminated for failure to complete the re-enrollment, gather all the required information and follow verification requirements in MA-3420, Re-Enrollment.

(2) If the case was terminated for unable to locate, no eligible child in the home, moved out of state, or residency in a public institution, accept the client's statement as verification of current residence/living arrangement for the household.

c. Reopen the case.

(1) Enter the DSS-8124 screen. Key a "Y" in the administrative field.

(2) The date of application is the first day of the month following the effective date of the termination. Do not key the DSS-8124 screen into the system until the month following the month of termination.

(3) Enter the certification period as follows:

(a) When reopening a case that was terminated at the end of a certification period and a review is being completed, begin the certification period with the month following the effective date of the termination.

(b) When reopening a case that was terminated during the certification period, the certification begin date is the first day of the month following the month of termination. The certification end date is the end date of the certification period in the original case.

For example, a case being reopened was originally certified from January 1 through December 31. The case was terminated effective June 30. Reopen the case with a certification period of July 1 through December 31.

(IV.D.3.c.)

(c) When reopening a medically needy case with a deductible, do not re-compute the deductible if the certification period entered is less than six months unless there was a change in income.

(4) The Medicaid status must be A (authorized). If the case cannot be authorized because the deductible has not been met, hold the application pending until the end of the certification period.

Timely notice is required prior to denying the administrative application at the end of the certification period.

(5) The Medicaid effective date must be no earlier than the first day of the month following the month of termination. If eligibility is needed for an earlier period, use the DB/PML screen.

d. If, at any time during the reopening process, it is determined that the case cannot be reopened because it does not meet the criteria in IV.D.3.a., a signed application is required.

(1) The date of application is the date of the face-to-face interview or the date the base document is signed.

(2) Follow all requirements for an application.

(3) The application does count in the county's report card.