
RE-ENROLLMENT

MA-3420 RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

I. BACKGROUND

Federal regulations require that eligibility be evaluated periodically. This section provides re-enrollment procedures. Re-enrollments are to be completed promptly to ensure ongoing benefits are issued timely and accurately.

II. POLICY PRINCIPLES

A. Complete **the re-enrollment process according to the aid program/category prior to pull date in the last month of the certification period.**

1. Complete **the re-enrollment process** every 12 months for MIC, NCHC, MAF-D, and MAF-C. The MAF-C case cannot include a caretaker over age 18.
2. Complete **the re-enrollment process** every 6 months for MAF-N, MAF-M, HSF-N or HSF-M and MAF-C when the case includes a caretaker over 18.
3. Complete **the re-enrollment process** for newborns prior to the end of the one year automatic newborn period.
4. Complete **the re-enrollment process** for an MPW case prior to the end of the postpartum period. Follow policy in this section for an MAF-N re-enrollment.

B. Begin the re-enrollment process in time to allow a timely notice period to expire prior to the pull date in the last month of the certification period.

C. Reverify only those eligibility factors that are subject to change, such as income, household composition, resources, and the status of qualified aliens lawfully residing in the United States.

1. Verify the individual continues to reside lawfully in the United States using SAVE, Systematic Alien Verification for Entitlement Program. Follow procedures in EIS 1108, SAVE Verification Information System. The case file contains a copy of documentation provided at application and may be used.
2. DO NOT use SAVE as verification for trafficking victims. The case file contains a copy of the ORR certification letter received at application. Call the trafficking verification line at (202) 401-5510 to confirm the validity of the certification letter or eligibility letter for children if questionable.
3. If the record contains expired document and the individual is unable to present any immigration documentation evidencing his alien status, refer the applicant to the local USCIS Office to obtain documentation of his immigration status.

RE-ENROLLMENT

REISSUED 07/01/11 – CHANGE NO. 12-11

(II.)

D. Do not reverify factors that are not subject to change, such as date of birth or citizenship. Citizenship and identity documentation is required at application and does not need to be re-established at redetermination.

Review the case record(s) due for review for citizenship and identity documentation. Conduct an SOLQ social security number inquiry for each applicant or recipient at re-enrollment. If evidence is needed at redetermination, contact the recipient using the DMA-5097, DMA-5097s, Request for Information. Begin the redetermination process in case the documents are received.

There are a few exceptions when the case record may not contain citizenship documentation at redetermination.

1. North Carolina Health Choice Children

- a. The citizenship/identity documentation requirement does not apply to North Carolina Health Choice (NCHC) recipients who applied prior to January 1, 2010. NCHC recipients who applied prior to January 1, 2010 and did not provide documentation of citizenship have a C/I code 98 in EIS. At re-enrollment, citizenship does not have to be established for these individuals who continue to be NCHC eligible. Complete the redetermination and continue to use C/I code 98.

Note: If the individual terminates, at reapplication citizenship documentation is required.

- b. If a NCHC recipient who applied prior to January 1, 2010 and has a C/I code of 98 changes from NCHC to Medicaid at re-enrollment, citizenship/identity documentation must be provided. Contact the recipient using the DMA-5097, DMA-5097s, Request for Information.
 - (1) If the recipient has the documents to provide citizenship and/or identity evidence, obtain them. Make copies, document the record, and complete the re-enrollment. Return the original documents to the recipient.
 - (2) If the recipient states he does not have documentation and is making a good faith effort to obtain the needed documents, document the record. If all other eligibility requirements are met, complete the redetermination and authorize with the appropriate certification period. Retain the C/I code 98 and use Special Review Code "Z" on the DSS 8125 to follow up on the status of obtaining the documents. Use the third month of the new certification period for the date. A message will show on the Case Management Report to remind the worker citizenship and/or identity documentation is needed. (See EIS 4000, Codes Appendix.)

RE-ENROLLMENT

REISSUED 07/01/11 – CHANGE NO. 12-11

(II.D.2.)

- d. Current or former Social Security Disability Insurance (SSDI) recipient, or Medicare recipient. Use OLV to access SOLQ to prove current or former Medicare and SSDI status.
- e. Current or former lawful permanent resident (LPR). Refer to [MA-3330](#), Alien Requirements, for acceptable documentation for LPR applicants and use SAVE, Systematic Alien Verification for Entitlement Program, to verify the authenticity of the LPR document.

Print the screen with the evidentiary information and put in the Citizenship/Identity Documentation sub-folder in the recipient's permanent record.

E. Ex Parte

1. Use OLV to document citizenship and identity for current or former SSI and Medicare recipients. Use SDX to document citizenship and identity for former SSI recipients. Use SOLQ to document citizenship and identity for current or former SSDI and Medicare recipients. Continue to use C/I code 50.
2. If the individual is changing programs and an 8124 is required, a SSA data match is completed.

F. Terminate the case at the end of the certification period when the recipient has not provided required information. Allow for timely notice.

G. If you do not complete the Medicaid re-enrollment in time to send the appropriate notice and enter the information in EIS, authorize the case one month at a time until eligibility or ineligibility is established.

H. Deductible Cases

1. Re-enroll in deductible status
 - a. All Medically Needy cases for a consecutive 6 month certification period if all eligibility requirements continue to be met, and
 - b. The deductible
 - (1) Was met in the previous certification period or
 - (2) Is expected to be met in the next certification period. A re-enrollment must be conducted to determine if the deductible is expected to be met in the next certification period.

If a case is authorized for meeting the deductible in the previous certification and the case has a deductible in the new certification period, send the recipient a timely notice for the new deductible.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(II.H.)

2. Propose termination:
 - a. If the case is ineligible in any other aid program category, and
 - b. If the previous deductible was not met and there is no indication that the deductible can be met in the next certification period.
 - (1) If the recipient provides evidence within 10 workdays that the deductible was met or will be met within the certification period, do a complete re-enrollment of eligibility for the next certification period.
 - (2) If the recipient provides evidence after 10 workdays that the deductible was met, but before the 10th day of the following month, refer to reopen policy in MA-3215, Processing the Application.
3. Prior to termination, evaluate each individual in the case in other aid program/categories for ongoing benefits.

III. BEGINNING THE RE-ENROLLMENT PROCESS

A. MIC and NC Health Choice

1. The Case Management Report
 - a. The Case Management Report includes MIC and NCHC cases due for review three (3) months prior to the end of the certification.
 - b. This report is printed the last workday of each month.

Example: If a certification period ends December 31, the review due message is displayed on the Case Management Report that is run for October.
 - c. Two copies are mailed to each county to be received by the first week in the following month. The report is also available in NCXPTR. Refer to EIS Manual Section 1061 for accessing the Case Management Report on NCXPTR.
2. An ex parte method is used to complete the re-enrollment process for MIC and NC Health Choice for Children (MIC-J, K, S, A). See MA-3410, Terminations and Deletions, for ex parte procedures. The recipient is not required to complete a re-enrollment form. The worker identifies the cases due for review using the Case Management Report.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(III.A.2.)

- a. The automated Re-Enrollment Information Notice ([DMA-5067/DMA-5067S](#)) is generated on or about the 15th day of the 10th month of the certification period to inform the recipient that it is time to re-enroll. The DMA-5067 is a notice and does not serve as a request for information. The notice:
 - (1) informs the recipient a re-enrollment form is not necessary for evaluating continuing eligibility.
 - (2) explains the requirement of reporting changes.
 - (3) lists possible changes to report.
 - (4) explains changes must be reported by the first of the following month
 - (5) explains the recipient can report the changes in person, by phone or by mail.
 - (6) gives the recipient a means by which to report the changes. Changes can be noted on the back of the notice and mailed to the DSS.
 - (7) explains they may be lawfully punished for fraud if changes are not reported.
 - (8) informs the recipient that if eligible for Medicaid they may be eligible for assistance with transportation to medical appointments. The DMA-5067 does serve as a Medical Transportation Assistance Notice of Rights. Do not mail a DMA-5046 to MIC/NCHC recipients for ex parte reviews.
- b. Begin the ex parte process by using the Case Management Report. See MA-3410, Terminations and Deletions, for ex parte procedures which includes the definition of and examples of current income. The worker should review the case file to determine if any changes have been reported. On-line verifications (OLV) should also be conducted. Document verification on the [DMA-5075](#), Verification Checklist for MIC/NCHC Re-enrollments. The DMA-5075 is the base document for the ex parte re-enrollment. File the completed DMA-5075 in the case record.
- c. The ex parte review begins the first day of the 11th month of the current certification period. Do not react to changes in income that occur after the first day of the 11 month of the current certification period, unless the assistance unit was ineligible based on income verified in the ex parte process. Document the change in the case record for verification at the next review.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(III.A.2.c.)

- (1) To verify unearned income:
 - (a) Use the unearned income verification available in OLV (SDX, Bendex, ACTS, ESC/UI)
 - (b) If on-line matches are not available, use unearned income verification of current income found in an active agency file, including FNS, Day Care, Work First Assistance or other Medicaid case file. Do not use income shown on an EIS/FSIS profile screen as verification.
 - (c) If current unearned income information is not available in an active agency file, request the information from the source either by telephone or in writing. Telephone verification must be documented and include the date, name, title and phone number of who provided the information, what information was requested and the response.

- (2) To verify earned income:
 - (a) Use THE WORK NUMBER or other reliable internet based source of employment and wage verification to verify gross wages.
 - (b) If employer is not listed with THE WORK NUMBER, use current earned income verification found in an active agency file, including FNS, Day Care, Work First Assistance or other Medicaid case file. Do not use income shown on an EIS/FSIS profile screen as verification.
 - (c) If current earned income information is not available in an active agency file, use the most current quarter shown by ESC in OLV. Wage information in ESC is listed as quarterly. Divide the quarterly amount by 3 to get a monthly amount.
 - (d) If OLV does not provide current information, contact the employer. Document the date of the contact, who provided the information and the wages.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(III.A.2.)

- d. If unable to verify earned or unearned income by any of the above listed in b.(1) or (2) above,
- (1) Send a DMA-5097 to the recipient requesting verification.
 - (2) Allow 12 calendar days for the information to be returned.
 - (3) If the information is not provided in 12 calendar days, send a timely notice.
 - (4) Timely notice can be sent no earlier than the workday following the due date on the DMA-5097.
 - (5) Termination can not be effective any earlier than the last day of the current certification period.

B. Beginning the MAF or MPW Mail-in Re-enrollment

1. MAF or MPW re-enrollment may be completed by mail, by face-to-face or telephone interview. Mail-in re-enrollment is recommended. (See III.C. below for instructions on the face-to-face or telephone interview.)
2. Case Management Report
 - a. MAF
 - (1) An MAF review due message is displayed on the Case Management Report three months prior to the last month of the certification period.

Example: If a certification period ends December 31, the review due message is displayed on the Case Management Report that is run for **October**.
 - (2) The appointment letter (DSS-8189) and mailing labels generated by EIS are mailed to each county.
 - b. MPW

If the “B” special review code and the month the baby is due are entered correctly in EIS, the message “Baby Due” appears on the Case Management Report in the month the baby is due. This indicates that a re-enrollment for the pregnant woman must be completed prior to the end of her pregnant woman coverage.

RE-ENROLLMENT**REISSUED 07/01/11 – CHANGE NO. 12-11**

(III B.)

3. Identify MAF & MPW cases due for re-enrollment.
4. Prepare a re-enrollment packet. Include:
 - a. The DMA-5063 or the DMA-5063R and the DMA-5063I, and
 - b. The DMA-5065 - Reserve supplement for MAF applications, and
 - c. The DMA-5046 – Medical Assistance Transportation Notice of Rights,
 - d. A pre-addressed return envelope. Write or stamp “MAF Re-enrollment” and the IMC's name on the envelope.
 - e. The DMA-5021, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Health Check fact sheet.
5. Mail the re-enrollment packet the first week in the month before the last month of the current certification period. Set up an internal control to flag the record on the “return by” date written on the cover letter (DMA-5063I).
 - a. Do not include the timely notice with the re-enrollment packet.
 - b. Do not propose termination until the family has failed to return the form.

C. Scheduling the MAF/MPW Face-to-Face or the Telephone Interview

A face-to-face or telephone interview may be completed if the recipient needs assistance to complete the re-enrollment process. The face-to-face interview may be an individual interview at the county dss, a group interview at the county dss, or an announced home visit. Home visits are at the discretion of the county.

1. Begin the re-enrollment in time to meet timely notice requirements prior to expiration of the certification period.
2. Refer to the Case Management Report to determine when a review is due. Identify cases that are due for review.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(III C.)

3. Appointments:

a. Face-to-Face Interviews

- (1) Send the appointment letter (DSS-8189) that is generated by EIS three months prior to the end of the certification period. Retain a copy of the letter in the case record. For MPW re-enrollments the county must create a similar appointment letter.

Option: The IMC may mail the re-enrollment forms along with the appointment letter so that the recipient can complete the forms prior to the interview.

- (2) Do not include a timely notice with the appointment letter.

b. Telephone Interviews

- (1) Contact the recipient to schedule the telephone interview. Explain to the recipient the telephone interview process. Document the appointment date and time in the case file.
- (2) Contact the recipient on the date and time of the interview.
- (3) If the recipient does not keep the appointment, send a timely notice of proposed termination requesting he contact you to conduct the telephone interview.
- (4) After the interview is completed, send the recipient the re-enrollment forms to sign. Send the DMA-5076, PMH handout if appropriate. Allow 12 calendar days for the return of the forms. If the forms are not returned by the deadline, send a timely notice to terminate.

IV. TRACKING MAF/MPW MAIL-IN RE-ENROLLMENT FORMS**A. Getting Packets to Appropriate IMC**

Train mailroom staff to recognize returned re-enrollment forms so the forms can be date-stamped and forwarded to the appropriate unit for processing. Do not register the re-enrollment form on the mail-in log as an application unless coverage is requested for a person who is not a recipient.

(IV.)

B. MAF/MPW Re-Enrollment Mail-Ins Not Returned by the Deadline

If the MAF/MPW Mail-in, including the DMA-5065, Reserve Supplement, is not returned by the deadline, send a timely notice to terminate at the end of the certification period for failure to complete the re-enrollment process.

1. If the form is returned incomplete or unsigned, return the form to the client with a manual timely notice.
2. If information requested on the form is not submitted with the form, refer to V.B.2. below for steps to follow.
3. If additional information is needed to determine eligibility, send the recipient a request for information. Allow 12 calendar days for the return of the information. If the information is not returned, send a timely notice to terminate.

C. Forms Not Received by the Recipient

Follow these procedures when the mail-in re-enrollment form is not received by the deadline and the recipient responds to the timely notice that he did not receive the review packet.

1. If the recipient reports that the re-enrollment form was not received or has been misplaced, the county must set procedures to assure that the re-enrollment is completed. Suggested procedures:
 - a. MAF/MPW Re-enrollment

Send the recipient another re-enrollment packet. Include a new "return by" date and flag the case for the new date.
 - b. When mailing the re-enrollment form, enclose a self-addressed envelope so that the form is returned to the appropriate IMC and is not listed on the mail-in log for applications. Write "Re-enrollment" and the IMC's name on the envelope and the form.
 - c. Include a timely notice with the re-enrollment form proposing termination if the re-enrollment form is not returned by the end of the 10 workday period.
 - d. Note in the case record that a second form was mailed to the recipient to complete the re-enrollment process.
 - e. If the recipient wishes to come into the county dss for an interview, use the DMA-5063 as the re-enrollment form.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(IV.C.)

2. Re-enrollment packets with DMA-5063 or DMA-5063R returned as undeliverable.
 - a. If the re-enrollment packet is returned to the agency as undeliverable, make all reasonable attempts to locate a current address. Refer to MA-3410, Terminations/Deletions, for definition of a current address.
 - b. If an address is located in NC, mail the packet to the correct address with a new “return by” date and flag the case for the new date.
 - c. If an address is not found, document the case record listing all attempts to locate an address. Terminate the case for unable to locate after sending timely notice.
3. **Terminate MAF/HSF/MPW cases for failure to return the re-enrollment form at the end of the certification period after timely notice has been given. If the notice period has not expired by pull date, authorize the case for an additional month**

D. Recipient's Request

1. Recipient does not want a mail-in re-enrollment

If the recipient prefers to complete the re-enrollment process with a face-to-face or telephone interview, schedule an appointment according to instructions in III.C.

2. Recipient requests Medicaid termination
 - a. The request must be in writing and specifically request Medicaid termination. Send the recipient an adequate notice to terminate at the end of the certification period.
 - b. If the request is not in writing, send a timely notice.
 - c. Ensure that the recipient understood that he or the children may still be eligible for Medicaid and chose not to continue. Document the record.

V. EVALUATE MAF/MPW RE-ENROLLMENT FORMS UPON RECEIPT**A. Definition of a Complete Form**

To complete the re-enrollment process, the DMA-5063 or the DMA-5063R must be completed for **MAF/MPW** cases and received in the county dss. A “complete” form is one that contains the following:

1. A signature, and
2. Requests **continuing** coverage for at least one **individual** who is in the existing case being reviewed.

B. Steps to Take When Information is Missing From the Form

1. If the form is returned incomplete or unsigned, return the form to the client with a manual timely notice.
2. If information requested on the re-enrollment form is not submitted with the form:
 - a. Search agency records to determine if the agency has current information. Refer to MA-3300 Income, for a definition of what constitutes current verification.
 - b. Document findings in the county case record.
 - c. If the agency records do not contain the income verifications, send the recipient a timely notice to terminate the case.

VI. RECEIPT OF CORRECT MAF/MPW MAIL-IN FORMS**A. After receipt of the Re-enrollment Form**

1. Mail the recipient the DMA-5046, Medical Transportation Assistance-Notice of Rights, once the re-enrollment form is received. For re-enrollments conducted in the office, complete the DMA-5046 during the interview.
 - a. Document the date and whether the DMA-5046 was sent or given to the recipient.
 - b. Review the DMA- 5046, if returned. If the recipient indicates he wishes to request assistance with transportation, assist by following procedures in MA-3550, Medicaid Transportation. File the DMA-5046 in the record.
 - c. Do not mail a DMA-5046 to MIC/NCHC recipients at re-enrollment.

RE-ENROLLMENT**REVISED 07/01/11 – CHANGE NO. 12-11**

(VI.A.)

2. If the DMA-5063 or DMA-5063R is returned and the caretaker responds “yes” to both questions in one of the boxes for questions 1 -5 on page 4, the child has special health care needs. Enter the appropriate code in EIS.
 - a. If the DMA-5063 or DMA-5063R is returned and both questions in one of the boxes for questions 1 – 5 on page 4 are checked “yes” and there is no name listed, call the client to get the name of the child. If you are unable to reach the client by phone, mail the DMA-5063 or DMA-5063R to him asking him to write the name of the child and to return the form as soon as possible.
 - b. Do not attempt to contact the client if only one question is answered “yes” on questions 1 – 5 on page 4 and the other is blank or if the parent did not sign the DMA-5063 or DMA-5063R.

B. Compare The Form to The Last Form in Record

Review the DMA-5063 or the DMA-5063R and compare information on the form to the last re-enrollment or application to determine if there are any changes that may need follow-up.

C. Request for Coverage For a Caretaker or an Additional Child

If the re-enrollment forms, DMA-5063 or DMA-5063R, request coverage for a caretaker or a child not **currently receiving Medicaid**, treat as an application.

1. Enter an unsigned DSS-8124 to register an application.
2. The date of application is the date the DMA-5063 or DMA-5063R is received in the agency and is complete. Always date stamp the date the application or other information necessary for processing the application is received in the agency. If an application is received for a case that is pending county reassignment, follow instructions in [MA-3340](#), County Residence, to complete the re-enrollment. Process the application after the re-enrollment is complete.
3. Application processing requirements found in [MA-3200](#), Initial Contact, and [MA- 3217](#), Evaluate County/ DSS Performance, apply to the application. This includes an evaluation in all Medicaid aid program/categories, including MPW or MAABD.
4. If the information included on the application indicates that the individual(s) should apply for Aged, Blind and Disabled Medicaid program:
 - a. Within one workday of receipt of the application, send the DMA-5063 or DMA-5063R, Health Check/NC Health Choice for Children Application, to the appropriate Medicaid unit within the agency.
 - b. Document on the log that the application was sent to another unit.

RE-ENROLLMENT**REVISED 07/01/11 – CHANGE NO. 12-11**

(VI. C. 4.)

- c. The date of the Aged, Blind and Disabled Medicaid application is the date that the complete DMA-5063 or DMA-5063 was received in the agency.
 - d. Do not require the individual to sign another application.
 - e. Use the DMA-5063, DMA-5063R, or DMA-5000 to process the application for the adult or child or both in the most appropriate Medicaid category.
5. Enter the application on the DMA-5066, Log for NC Health Choice/Medicaid Mail-In Applications as specified in MA-3207, Receiving Mail-In Applications.

VII. CONDUCTING THE MAF/MPW FACE-TO-FACE OR THE TELEPHONE INTERVIEW**A. Failure to Come to Appointment**

If the recipient fails to keep the appointment, terminate the case at the end of the certification period after timely notice has been given. If notice has not expired, authorize the case for an additional month.

B. Procedures

1. At the interview, complete forms DMA-5063 and DMA-5065.
2. Review the forms with the recipient. Compare the forms with the forms on file. If there are questions about the information provided, ask the recipient to clarify the information and/or provide documentation.
3. Signing Forms
 - a. Face-to face interview – While in the interview, ask the recipient to sign all forms that require his signature.
 - b. Telephone interviews - Mail the recipient forms he must sign to complete the re-enrollment process. **This does not apply to MIC or NCHC cases. (See III.A. above)**
4. Inform the recipient/representative that he will be notified of any changes to be made in his medical assistance following the re-enrollment.
5. Instruct homeless recipients with no permanent address to come to the agency to pick up their **annual Medicaid** ID card and necessary notices.
6. Review items C. through F. below with the recipient.

(VII.)

C. Responsibility to Cooperate With The County DSS

Inform the recipient/representative that he is responsible for cooperating with the county dss in providing information necessary for determining continuing eligibility. Explain that he is responsible for the following:

1. Providing the necessary information within a reasonable period of time to determine eligibility. For example, he must inform the county of any b. u. member's employment and provide wage stubs or names of collateral sources to verify this information.
2. Providing information on bills incurred for medical expenses when he has a deductible and explain the consequences of an unmet deductible.
3. Reporting within 10 calendar days to the county dss any change in situation such as an increase or decrease in income, change in address, employment, people living in the household, inheritances, and other sums of money. Explain that failure to report a change in situation may lead to the recipient having to repay assistance received in error, or being tried for fraud by the courts and receiving whatever penalty is imposed as a result of that trial. Explain to the recipient/representative the meaning of "fraud."

D. Inform The Recipient of His Rights

Inform the recipient of his rights and responsibilities. Emphasize the following points:

1. Information given to the agency is confidential.
2. He has the right to request termination from the Medicaid program at any time.
3. He may continue to be certified for Medicaid if found eligible, based on the rules in MA-3425, Certification and Authorization. Explain the concept of deductible or patient monthly liability, if applicable.
4. He has the right to reapply at any time if found ineligible or his case is terminated.

REISSUED 07/01/11 – CHANGE NO. 12-11

(VII.D.)

5. He has the right, following a local appeal, to appeal within the appropriate time limit to the Division of Social Services (Refer to MA-3430, Notice and Hearings Process.) if:
 - a. Medicaid is terminated,
 - b. He disagrees with having a deductible or the patient monthly liability,
 - c. He believes the amount of his deductible or patient monthly liability is incorrect,
 - d. He believes the county dss is delaying action in investigating his request for a review of his circumstances.
6. Explain the protection against discrimination on the grounds of race, creed or national origin by Title VI of the Civil Rights Act of 1964.

E. Explain Transfer of Resources

Inform the recipient that if he transfers any real property, personal property or liquid resources out of his name without receiving compensation equal to the current market value for the transferred resource, the transfer may result in a period of ineligibility. If the a/r needs assistance, now or in the future, with nursing home cost of care under **any Medicaid** program, CAP, or assistance with in-home health services and supplies under the MAABD programs, a sanction may be imposed. Refer to MA-2240, Transfer of Assets, in the Aged, Blind, and Disabled Medicaid Manual.

Document the recipient responses regarding transfer of resources in the case file.

F. Inform the Recipient of Other Services

1. Family Planning Services

Explain Family Planning Services to payees of individuals of childbearing age (including minors, both male and female, who can be considered to be sexually active) who desire such services. See MA-3205, Conducting a Face-to-Face Intake Interview, for details.

2. Health Check Program

Remind each recipient of the benefits of the Health Check Program. See MA-3205, Conducting a Face-to-Face Intake Interview, for details.

REISSUED 07/01/11 – CHANGE NO. 12-11

(VII.F.)

3. Explain the Food and Nutrition Services

Inform the recipient of the Food and Nutrition Services (FNS) offered by the department and the procedures for applying for food stamps.

- a. If he wishes to apply, initiate the required action.
- b. If he receives food stamps, the Medicaid staff must provide information requested by the Food and Nutrition Services (FNS) staff, e.g., deductible information, copy of the DMA-5036, Record of Medical Expenses Applied to the Deductible, etc.

4. Explain The Women, Infants, and Children (WIC) Program

- a. Explain the availability of benefits through WIC.

This program provides a nutritional supplement to pregnant women during pregnancy and up to six months after delivery, and breastfeeding women up to one year after the baby is born, and

- b. Make a referral to the WIC Program when services are desired.
 - (1) If services are desired, the IMC must make a referral to the WIC Program at the local WIC agency.
 - (2) Provide the recipient a WIC Brochure, titled "A Healthy Start."

5. Explain Lifeline/Link-Up Assistance Program

Lifeline provides a monthly discount on an eligible recipient's local telephone bill. If the recipient does not have a telephone, Link-Up provides a 50% discount, up to \$30, on the cost of connecting local telephone service.

To be eligible for Life Line/Link Up the individual must: Receive Medicaid under MAF, MPW, MAABD, MQB-Q, MQB-B or MQB-E and receive telephone service listed in his name from one of the telephone companies listed on the DMA-5058, Participating Telephone Service Providers.

The caseworker must provide applicants/recipients information on Lifeline/Link-Up and provide households with the address of their participating telephone service provider (see DMA-5058). Instruct households to complete the DSS-8168-I and mail it to their telephone service provider if they meet the eligibility requirements for Lifeline/Link-Up. Refer to [MA-3205](#), VI. F, Conducting A Face-To-Face Interview for Life Line/Link Up.

REISSUED 07/01/11 – CHANGE NO. 12-11

(VII.F.)

6. Other Available Services

- a. Explain that other services are available within the department and make a referral for any services requested.
- b. Explain the use of the Medicaid Identification (MID) card.
 - (1) Explain that a gray Medicaid Identification (MID) card is issued yearly, and that a new card is issued only when there is a change in the PCP, a legal name change, or when the card is lost, destroyed, or stolen.
 - (2) Make sure he understands that the MID is not proof of Medicaid eligibility. See MA-3505, Medicaid Identification Card.
 - (3) Remind him of his responsibility in using the ID card only for eligible members and that he must take the card with him, along with other ID for adults and any other insurance cards including Medicare, when requesting services.
 - (4) Tell him he must sign the card, and that if he becomes ineligible for Medicaid he should not throw away the card. He may become eligible again and need the card.
- c. Provide recipients with the appropriate Medicaid handbook if a request is made. The handbooks are provided to families at the time of application and there is no requirement to provide them again at re-enrollment.
- d. Explain the benefits of choosing a Pregnancy Medical Home (PMH) and, give a copy of the DMA-5076, PMH handout. Refer to MA-3205, VI. B., Conducting A Face-To-Face Interview for PMH.

7. Inquiries of Issuance of Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires that group plans and health insurance issuers which offer group coverage furnish certificates of creditable coverage when an individual ceases to be covered by the plan. The certificate issuance is automated and issued by the fiscal agent when a recipient is terminated. Certificates can be provided up to 24 months after termination. If a recipient inquires about a Certificate of Creditable coverage, refer him to the fiscal agent.

REISSUED 07/01/11 – CHANGE NO. 12-11

(VII.F.)

8. National Voter Registration Act (NVRA)

The purpose of the NVRA is to make available more opportunities for people to vote. Voter registration forms are to be available to recipients during their visits for their re-enrollments.

- a. If a recipient asks for assistance in completing voter registration forms, assist the recipient.
- b. Inform recipients that the Board of Elections processes applications to register to vote and questions concerning voter registration must be directed to the local Board of Elections.

VIII. DETERMINING ELIGIBILITY**A. Processing Requirements**

1. Determine eligibility based on the requirements for the aid program/category you are evaluating.
2. Review the form and compare information to the last re-enrollment or application to determine if there are any changes that may need follow-up.
3. Verify eligibility factors that are subject to change, such as income, household composition or resources.
 - a. Request only information from the recipient when it is necessary to determine ongoing eligibility.
 - b. If information is current or is already available to the agency, do not request it from the recipient. Refer to MA-3300, Income, for what constitutes current and available.
4. If verification of income, countable resources or other information is questionable, contact the casehead by telephone or in writing.
 - a. If the request is in writing, use the DMA-5097, or DMA-5097S
 - b. If a telephone request is made, advise the recipient what information is needed and that he may request assistance in obtaining the necessary information. Document the record to show the date of the telephone contact, the specific information requested and that the recipient was offered assistance.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(VIII.A.4.)

- c. Set a deadline for the recipient to return the information that is 12 calendar days from the date of the request. Explain to the recipient that he is responsible for providing necessary information by the deadline.

B. Requested Information is Not Received

1. Make every attempt to process the re-enrollment no later than “pull” in the last month of the certification period.
2. If **requested** verification is not received by the deadline, send a timely notice proposing termination for failure to provide necessary information. Terminate the case at the end of the certification period provided timely notice has been given and timely notice period has expired by pull date in the last month of the current certification period.
3. If notice has not expired for MAF, MPW, MIC-N and **NC Health Choice** cases, authorize the case for an additional month. Follow instructions in EIS-3051 Redetermining Eligibility for Medicaid Only Programs, to issue benefits

C. Evaluate for Medicaid In All Categories or NC Health Choice Prior to Termination

1. If the recipient no longer meets the eligibility criteria under the original aid/program category, evaluate eligibility in all other aid program/categories.
 - a. Transitional Medicaid (MAF-C). Refer to MA- 3405, Twelve Month Transitional Medicaid.

If a pregnant woman would have been eligible for MAF-C when she became employed or otherwise had an increase in earned income that results in her now being ineligible for Medicaid, evaluate for Twelve Months Transitional Medicaid.
 - b. Four Month Transitional (AAF payment type 4). Refer to MA-3400, Four Months Transitional Medicaid.
 - c. If the recipient is moving from MIC to NCHC, do not key an 8124 until the fee is paid or the insurance is terminated. Refer to MA-3255, NC Health Choice.

REISSUED 07/01/11 – CHANGE NO. 12-11

(VIII.C.)

2. Other possible programs
 - a. MAA if the record verifies an assistance unit member is 65 years or older, or
 - b. MAD if the record verifies an assistance unit member receives Social Security disability or there is a DMA-4037 in the record verifying that the assistance unit member has been determined disabled. If the DMA-4037 is in the case record but there is a subsequent denial of disability, evaluate the caretaker for all other aid program categories.
 - c. MPW when the question, Is anyone in the home pregnant, is checked yes. If the pregnancy verification was not submitted, contact the recipient to request verification of pregnancy to evaluate for MPW. Allow 12 calendar days to provide the verification of pregnancy. If the a/r requests more time to get the verification, allow an additional 12 calendar days.
 - d. MAF for women who qualify for Breast and Cervical Cancer Medicaid (BCCM). Refer to MA-3250, Breast and Cervical Cancer Medicaid.
 - e. MAF-M when the income exceeds the categorically needy income limits. Refer to II.F. for policy on certifying a case in deductible status.

IX. DISPOSITIONS**A. Enrollment Fees**

If an enrollment fee is due for NC Health Choice because income is greater than 150% of the poverty level, do not re-enroll the case unless the fee is paid.

1. Once eligibility has been determined and it has been determined that the family must pay an enrollment fee, send a written notice instructing the recipient to pay the fee within 12 calendar days of the date of the notice.
2. If the fee is paid, re-enroll for ongoing NC Health Choice eligibility.
3. If the fee is not paid within 12 calendar days, do not update the certification period. Send a timely notice proposing termination.
4. If the recipient is moving from MIC to NCHC, do not approve for NCHC until the fee is paid.
5. If the fee is paid and the case terminated because the 12th calendar day falls after "pull night" refer to reopen procedures in XIII. below. If NCHC is frozen, then follow policy in MA-3255, NC Health Choice.

RE-ENROLLMENT**REISSUED 07/01/11 – CHANGE NO. 12-11**

(IX.A.)

6. If a MIC child is being added to a NCHC case at the NCHC review, do not charge an enrollment fee for the child being added. Do not charge a \$100.00 fee until the next NCHC review after the child has been on the case for a year. See MA-3255, NC Health Choice, for policy on changes in household composition.

B. All Eligible/Some Eligible

1. Re-enrollment of all children in the same aid program/category (MIC-N remains MIC-N and/or NCHC (MIC J, K, S, A) remains NCHC):

Follow instructions in the EIS Manual to update eligibility on the DSS-8125 screen for MIC (N) or NC Health Choice (MIC - J, K, S, A). The certification period is 12 months.

2. Children are eligible for MIC (N) who were previously authorized for NC Health Choice (MIC - J, K, S, A).

Follow instructions in the EIS Manual to update eligibility on the DSS-8125 screen. The certification period is 12 months.

3. Approving NC Health Choice (MIC - J, K, S, A) for children previously MIC (N):
 - a. Complete a reapplication to change the MIC classification and approve NC Health Choice.
 - b. If NCHC is frozen, follow policy regarding the freeze in MA-3255, NC Health Choice.
4. Some children are eligible for MIC/MAF and others for NC Health Choice:
 - a. Delete the Medicaid eligible children from the case. Enter an administrative application to open a new MIC case.
 - b. The children eligible for NC Health Choice remain in the original case.

RE-ENROLLMENT

REISSUED 07/01/11 – CHANGE NO. 12-11

(IX.B.)

5. Some children are eligible for NC Health Choice Code L and others Codes J, K, S, A:
 - a. Delete the children eligible for NC Health Choice Codes J, K, S, and A.
 - b. Enter an administrative application to open a new case for the children with Codes J, K, S, and A.
 - c. The children eligible for NC Health Choice Code L remain in the original case. Ensure the appropriate code is entered into EIS to transfer the NCHC case to an L classification.
6. Process the re-enrollment and update the certification period in EIS by "pull night" of the 12th month of the certification period.
7. If eligibility is established for everyone in the assistance unit, authorize assistance in EIS no later than "pull" in the last month of the certification period. The length of the new certification period is based on the category.

Example There is a 12 month certification period for MIC or Health Choice, and 6 month certification period for MAF-M or MAD. For MPW, the certification period goes through the post partum period.
8. If any one in the assistance unit is ineligible for ongoing Medicaid in any category including MPW, MAABD or NC Health Choice, send a timely notice to terminate Medicaid.

C. Process by Pull or Extend

Process the re-enrollment to authorize ongoing Medicaid or send timely notice to terminate no later than "pull" in the last month of the certification period. If the review is not completed by this time, authorize the case for an additional month in order to complete the re-enrollment and allow for timely notice requirements.

1. Do not authorize cases for an additional month if the case is in deductible status at the end of the certification period.
2. If the re-enrollment is completed after extending the certification period for a month and the case remains eligible, use the one month certification period as the first month of the new certification period.

(IX)

D. Termination or Beginning Deductible

If the result of the re-enrollment is ineligibility or changing from authorized to deductible status, send a timely notice. The timely notice should end prior to the “pull” in the last month of the certification period.

1. MIC-N/MAF/HSF

Terminate the case or certify in deductible status if timely notice has expired by “pull” in the last month of the current certification period. If notice period has not expired, authorize the case for an additional month.

2. NC Health Choice

If the recipient has not previously been given timely notice, send a timely notice that the case is ineligible for ongoing benefits. If the recipient will be certified for Medicaid with a deductible, include this information on the notice.

X. NEWBORN PROTECTION

When re-enrolling a formerly pregnant woman at the end of her post partum period, evaluate her child(ren) for automatic newborn protection. Refer to [MA-3230](#), Eligibility of Individuals Under 21.

XI. CHILD SUPPORT

For MAF/MIC (N)/MIC 1, follow procedures in [MA-3365](#), Child Support.

For NCHC (MIC J, K, S, A), follow procedures in [MA-3255](#), NC Health Choice.

XII. COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS (CCNC/CA)

CCNC/CA are managed health care programs for Medicaid **and NCHC** recipients. The county dss must either enroll recipients in CCNC/CA or exempt recipients at application, redetermination or any time a recipient contacts the agency to request a change in CCNC/CA enrollment status. For those recipients who are not enrolled, follow the procedures below. Refer to [MA-3435](#) CCNC/CA policy.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(XII.)

A. Face-to-Face and Telephone Re-enrollments

1. The county DSS must enroll recipients in CCNC/CA or exempt recipients as defined in this policy. The county DSS must enroll all recipients who are mandatory in CCNC/CA at application, redetermination, or any time a recipient contacts the agency to request a change in CCNC/CA enrollment status. The DMA-9017, CCNC/CA: The Benefits of Being a Member-NCHC, must be explained to all recipients who are mandatory and optional at application, redetermination, or anytime a recipient contacts the agency to request a change in CCNC/CA enrollment status. **Enrollment must be offered. Do not automatically exempt a recipient in an optional group.** Refer to MA-3435, CCNC/CA, VII. B. and C. to determine who is Mandatory, Optional, or Ineligible.
2. Provide each recipient with a list of CCNC/CA primary care providers (PCP). Do not include the PCP's provider number on this list.
3. Make every effort to help the recipient choose a doctor for each person during the interview based on the provider availability, restrictions, and medical needs.
4. If the recipient cannot choose or refuses to choose a PCP (and is not otherwise exempt), choose a PCP for each recipient based on his enrollment history, location of residence, and type of care. In addition, verify the provider availability and restrictions. Refer to MA-3435, CCNC/CA VII. A.
5. Complete the Carolina ACCESS Enrollment Form for Recipients of Medicaid and Health Choice, (DMA- 9006) for all Medicaid and North Carolina Health Choice (NCHC) recipients and file in the case record. If exempt, complete the form with the appropriate exemption code and file in the case record.
6. Educate the recipient using the CCNC/CA Member Handbook.

B. MAF/ MPW Mail-in or MIC/NCHC Ex parte Re-enrollments

1. Review the case for CCNC/CA enrollment.
2. If enrolled, mail the CCNC/CA Recipient Handbook including the PCP name and phone number to the recipient.
3. If not enrolled, see MA-3435, CCNC/CA for procedures.

REVISED 07/01/11 – CHANGE NO. 12-11

(XII.)

C. Questions Regarding CCNC/CA

For questions regarding CCNC/CA, contact your Medicaid Program Representative.

XIII. REOPENS**A. A case which terminates for not cooperating with the re-enrollment process may be reopened if certain criteria listed below are met: This includes information requested during the MIC/NCHC ex parte process.**

1. The case meets criteria in MA-3215, Processing the Application.
2. The re-enrollment form and all information necessary to approve eligibility is received by the 10th of the month following termination.
 - a. If the NC Health Choice client received notification of the enrollment fee, it must be paid by the 10th of the month.
 - b. If an enrollment fee is due, it must be paid by the 10th of the month following termination. If it has not been paid, do not reopen the case. If the client is not notified that a fee is due until the 10th day, give the client 12 calendar days to pay the fee.
3. Reopen the case in EIS as an administrative application. Enter “Y” in the ADMIN field on the DSS-8124 screen. The date of application is the first day of the month following termination.

B. Do not reopen the case if a completed re-enrollment form is required and the completed form is received after the 10th of the month.

1. Treat the signed re-enrollment form as an application. Do not require the recipient to complete and sign a DMA-5063.
2. Enter a reapplication in EIS. All application processing standards apply. The application counts in the report card.
3. The date of application is the date the re-enrollment form is received and is complete.
4. If income can't be verified through other current agency records, request verification of income.
5. Verify other eligibility factors as necessary. Use current agency records.

RE-ENROLLMENT

REVISED 07/01/11 – CHANGE NO. 12-11

(XIII.B.)

6. If an enrollment fee is due for NC Health Choice, allow the recipient 12 calendar days to pay the fee before denying the application. Refer to MA-3255, NC Health Choice.

C. Do not use the re-enrollment form as an application if a re-enrollment form is required and was previously received, but information needed to process the re-enrollment is not received until after the 10th of the month. Require the recipient to complete a DMA-5063 to start the application process over.

1. Call or write the recipient and explain that he or she must reapply for benefits.
2. Send the recipient a DMA-5063 and return the enrollment fee if applicable.
3. When the completed DMA-5063 is received, follow application processing procedures in MA-3255, NC Health Choice, or MA-3215, Processing the Application.