
CONDUCTING A FACE-TO-FACE INTAKE INTERVIEW

MA-3205 CONDUCTING A FACE-TO-FACE INTAKE INTERVIEW

REVISED 10/01/11 – CHANGE NO. 17-11

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.

See [MA-3207](#), Receiving Mail-in Applications, for rules regarding mail-in applications.

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 never provided. 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. See [DMA-5018 Designation of Authorized Representative](#), for a suggested form.

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(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. Is the individual able to be interviewed by the Income Maintenance Caseworker either via the telephone or a home visit? If not, why?
 - c. Does the individual have a power of attorney, legal guardian or other authorized representative? If yes, follow instructions in [MA-3430](#), Notice and Hearings Process, III. If no, see 3. above.
 - d. Is the individual able to sign the [DMA-5018 Designation of Authorized Representative](#), or similar authorization 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, including Health Coverage for Workers with Disabilities (HCWD).

Refer to [MA-2000](#), Non-SSI Eligibility Regulations, and [MA-2180](#), Health Coverage for Workers with Disabilities 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 or a limitation in the field of vision of the better eye that meets specific criteria.

- 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. (Substantial gainful activity is not a consideration for HCWD.)

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- (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, in the Aged, Blind and Disabled Medicaid Manual. If an HCWD a/r has had his disability terminated within the last 12 months, a new disability determination may not be necessary. See [MA-2180](#), Health Coverage for Workers with Disabilities

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 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

- a. 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, in the Family and Children's Medicaid Manual.

These programs provide full 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.

- b. Refer to [MA-3265](#), Family Planning Waiver Medicaid.

This program provides Medicaid for family planning services in order to assist in the reduction of the number of unplanned pregnancies. Women and men over the age of 19 with income up to 185% of the federal poverty level may qualify.

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- c. 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.
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 eligible children age 6 through age 18 who are ineligible for Medicaid and have family incomes equal to or 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, except for NC Health Choice, 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.

C. Retroactive and Ongoing Medicaid

Refer to [MA-3220](#), 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 designation, rebuttal and reduction, and explain that Medicaid cannot be authorized until the reserve requirements are met.

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D. Transfer of Resources

Refer to [MA-2240](#), Transfer of Assets, [MA-2242](#), Home Equity Value & Eligibility For Institutional Services, and [MA-2245](#), Undue Hardship Waiver For Transfer of Assets, in the Aged, Blind, And Disabled Medicaid Manual.

Give the individual the [DMA-5057/DMA-5057S](#), Explanation of The Effect of Transfer of Asset (s) On Medical Assistance Eligibility.

E. Deductible

Refer to [MA-3315](#), 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.
 - 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-3215](#), Processing the Application, for procedures.

F. 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.

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(III.F.)

2. Explain that a child age 6 through age 18 cannot be enrolled in NC Health Choice until ineligibility for Medicaid has been established. The individual cannot choose to receive NC Health Choice instead of Medicaid.
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-PW, M-AF 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 (including HCWD), M-AF, or M-IC.

For example, Leah 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.

Leah 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:

- (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 limit, 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.

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(2) Disability

To receive under the M-AD category, DDS must determine if Leah'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, Leah's parents may choose to apply for M-AF, M-AD, or may ask that Leah be evaluated for both. Leah 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.

G. Certification Periods

Refer to [MA-3425](#), 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.

H. Long Term Care Placement (LTC)/Community Alternatives Programs (CAP)

An application may be taken for an individual under age 21 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 treatment has or is expected to exceed 12 months or who is in need of home and community based services under a CAP waiver program.

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

1. The concept of long term care 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 in the Aged, Blind, and Disabled Medicaid Manual.
2. Parental financial responsibility. See [MA-3305](#), M-AF, M-IC, H-SF Budgeting, and, [MA-3325](#), Long Term Care Budgeting.

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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 by the fiscal contractor or approved entity. Also explain that if there is a change in the required level of care, a new FL2/MR2 is required. See [MA-3325](#), Long Term Care Budgeting or [MA-2270](#), Long Term Care Budgeting, in the Aged, Blind, And Disabled Medicaid Manual.
 - a. Inform the LTC 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. Explain Estate Recovery rules. See DMA Administrative Letter No. 23-96 and Addenda and DMA Administrative Letter 09-05.
5. Explain transfer of resource regulations. Refer to [MA-2240](#), Transfer of Assets, [MA-2242](#), Home Equity Value & Eligibility For Institutional Services, and [MA-2245](#) Undue Hardship Waiver For Transfer Of Assets, in the Aged, Blind, And Disabled Medicaid Manual.

I. Pre-Need Applications

There is only one type of pre-need application under the Family and Children's Medicaid program. An application for ongoing assistance may be taken for an individual who is not a resident of North Carolina if the individual expects to meet the state residence requirements within the 45-day application processing period.

1. Explain to the applicant or his representative that the state residence requirements must be met by the 45th day. If the requirement is not met by the 45th day, the application will be denied.
2. Refer to [MA-3335](#), State Residence, and [MA-3425](#), Certification and Authorization, for procedures.

J. Medicaid Identification Card

Refer to [MA-3505](#), Medicaid Identification Card.

Explain to the applicant or his representative the Medicaid identification card and how to use it.

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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, 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-day application processing standard.
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 his 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-3335](#), State Residence, for state residency verification instructions for individuals, including the homeless, who do not have a permanent address.

- a. Request any information from him on the date of application using the [DMA-5097/DMA-5097S](#), Request for Information.

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- 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 and, if a U. S. citizen, information to prove U.S. citizenship and identity. NC Health Choice also requires proof of U.S. citizenship and identity. See MA-3332, U.S. Citizenship Requirements.
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 when applying for emergency Medicaid for aliens. Refer to [MA-3355](#), Enumeration Procedures.

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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.

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.

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. Include information regarding the Medicare Low Income Subsidy program, (LIS). See MA-2309, LIS Application For Medicaid, in the ABD Medicaid Manual.

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- 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-3215](#), Processing the Application, for instructions for completing the withdrawal.

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-3207](#), 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 all applicants in the same household requesting MAF, MIC or MPW.
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.

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When an individual applies at the county department of social services for a Family and Children's Medicaid aid program/category or **North Carolina Health Choice for Children (NCHC)**, give the applicant a copy of the handbook, "**North Carolina Health Care Coverage Programs for Families and Children.**" Explain to the applicant that the handbook is to be kept as a reference guide that lists the services covered by Medicaid/**NCHC**, how to use the Medicaid/**NCHC** card and other helpful information.

Explain to the individual that, if any children for whom he is applying are found eligible for NC Health Choice for Children, he will receive enrollment information through the mail from Blue Cross and Blue Shield of North Carolina. The information will include an insurance card and a member handbook.

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-3435](#), 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. Pregnancy Medical Home (PMH)

PMH provides additional obstetric care to pregnant Medicaid recipients with the goal of improving the quality of maternal care, improving birth outcomes, providing continuity of care and 24 hour provider availability to the recipient. Each recipient receives an initial screening at their first doctor's visit. If a recipient is identified as high risk, she is referred for a thorough assessment by a care manager. The recipient's level of need is determined by the care manager assigned to the PMH. Care managers closely monitor the pregnancy through regular contact with the physician and recipient to promote a healthy birth outcome.

If a pregnant Medicaid recipient's aid program category covers pregnancy, they are eligible to participate in this program. This program is NOT just for MPW. In addition, any provider who bills global, package or individual pregnancy procedures can participate in this program as long as he agrees to the program requirements. It is not just for OB providers.

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1. Caseworker Responsibilities

- a. Explain the benefits of choosing a Pregnancy Medical Home (PMH).
- b. Give a copy of the DMA-5076/DMA-5076S, PMH handout at each application and redetermination to all pregnant Medicaid applicants/recipients.
- c. Encourage all pregnant Medicaid recipients to choose a PMH.
- d. Assist all pregnant Medicaid recipients in choosing a PMH. Review with the recipients the PMHs available in their county and surrounding counties, if there are none in their county. Also, explain that the PMH is effective the first day in the following month. (See 2 below for Provider Directory information).

2. Provider Directory

A monthly report “DHREJA-PREGMED-HOME-PROVDIR,” summarizing any changes in the PMH providers is available in XPTR the first workday of each month. (Refer to [EIS 1061](#) for instructions on accessing XPTR reports).

A designated dss employee such as a Medicaid supervisor, caseworker, administrative or clerical staff is responsible for running the report and maintaining a county PMH directory that can be printed or viewed on line. The directory contains all information necessary to assist the recipient in choosing a PMH including provider specialty and location. (Refer to [EIS 1061](#) for reports.)

C. Covered Services

Refer to [MA-3540](#), 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.

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- a. Review the services available and how to obtain them. 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

2. 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.
- 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.

Note: Medicaid Family Planning Waiver is different. It is a Medicaid program that covers men ages 19 through 60 and women ages 19 through 55 solely. Refer to [MA-3265](#), Medicaid Family Planning Waiver.

3. Medical Transportation

Refer to [MA-3550](#) 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.

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- c. Give the individual the [DMA-5046](#), Medical Transportation Assistance, Notice of your 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 your Rights, in the case record.

4. Other Covered Services

For information about other covered services, including Adult Health Screenings, refer the individual to the brochure “A Consumer’s Guide to North Carolina Medicaid Health Insurance Programs for Families and Children.”

D. 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.
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.

E. 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.

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F. 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.

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. Only one Lifeline benefit is available per household. Long distance call blocking is available to Lifeline recipients at no charge upon request. If the individual receives any one of the public assistance benefits listed below he can receive Lifeline/Link-Up benefits.

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.

NOTE: MIC, HSF, IAS, and FPW recipients are ineligible for Lifeline/Link-up.

The North Carolina Utilities Commission recently approved a Self-Certification process for recipients of low income programs to use when applying for Lifeline/Link-up benefits. The application form is the DSS-8168-I, North Carolina Life Line/Link-Up Self-Certification Letter.

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.

If a household requests assistance with completing or mailing the DSS-8168-I, the assigned Medicaid caseworker for that individual must complete the form, and return it to the appropriate provider.

Recipients requesting new telephone service must apply for Lifeline/Link-Up directly with the telephone company.

Upon receipt of the Lifeline and/or Link-Up Application, DSS-8168-I, 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.

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G. 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.

H. 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 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 1-800-688-6696 or Automated Voice Response (AVR) at 1-800-723-4337.

I. Health Insurance Premium Payment (HIPP)

1. HIPP is a program in which the Division of Medical Assistance (DMA) will pay 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.

2. To be eligible for the premium payment, the recipient must be authorized for Medicaid and have private health insurance. DMA will only pay premiums on existing or known policies. DMA will 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.

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Family members that are not Medicaid recipients will not receive Medicaid payment of deductible, coinsurance or cost sharing obligations.

HIPP is not available to individuals in deductible status. DMA will no longer pay 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. If the recipient voluntarily drops the insurance coverage, Medicaid benefits may be terminated.

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 will pay 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.
 - 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:

Attn: NC HIPP
4441 Six Forks Rd, Suite 106-227
Raleigh, NC 27609

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- d. In addition to county dss referrals, DMA will provide 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 will be 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.

J. Children with Special Health Care Needs

If the [DMA-5063/DMA-5063sp](#), 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 Manual 4000.