# (MAGI) APPLICATION PROCESSING (435.906, 435.907)

This section provides guidance on processing applications for MAGI groups.

An in-person interview is NOT required as part of the application process. **ONLY** schedule a face-to-face interview if requested by the household or authorized representative (A/R).

## D-100 OVERVIEW

Accept any application form designated for medical assistance programs. Applications **must** be accepted via:

- the internet;
- by telephone;
- mail;
- fax; or
- in person.

Applications can be submitted online the Division of Welfare and Supportive Services (DWSS) web page www.dwss.nv.gov. DWSS also accepts telephonic applications through their customer service call centers:

- Northern Nevada: 775-684-7200
- Southern Nevada: 702-486-1646
- Statewide: 877-543-7669

Paper applications completed by the customer service center over the telephone with the client must be documented to indicate a telephone signature was obtained. Example: Telephonic Signature for [client name] received on [date], by [DWSS staff name].

Once completed, signed and date-stamped, a copy of the paper application must be mailed to the client as confirmation an application was received by DWSS.

**Note:** The SSBM Telephonic Application Tool is available to customer service for use in completing paper applications. A copy of the PDF created by the tool can be printed and mailed to the client.

An application must contain:

- the applicant's name;
- address; and
- signature.

An application not signed by the client or A/R is an inquiry only and must be returned for signature. **DO NOT** date stamp unsigned applications **or** register them in the system; return them in the mail to the individual with a note for signature.

The agency must accept applications signed by:

- an adult who has a parent/dependent child (under the age of 19) relationship or tax relationship to the applicant(s);
- an authorized representative;
- if the applicant is a minor or incapacitated, someone acting responsibly for the applicant;
- an emancipated minor; or
- the spouse/domestic partner of an individual.

Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission are acceptable.

Applicants who cannot sign their name must have their mark witnessed by at least one other person. Applicants with no ability to understand what they are signing must have a competent adult family member sign for them. **Example:** [client name] by [family member name].

If there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may sign on behalf of the applicant. **Example:** [client name] by [the hospital, nursing home or county agency social service worker name]. **In this case, a public guardian referral is required.**

When applicants are unable to designate an A/R AND there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may designate themselves as an authorized representative.

The hospital, nursing home or county agency must make good faith efforts to contact family members of the applicant for information to help determine eligibility. The hospital, nursing home or county agency must provide the names and addresses of family members they contacted or tried to contact. The case manager will send Form 2534 to the relatives advising of the application, the hospital, nursing home or county agency representative and request any eligibility information to assist in processing the case.

## D-105 REQUESTS FOR AN APPLICATION

The applicant or their representative may request an application by contacting customer service, the district office or downloading an application from the Division of Welfare and Supportive Services (DWSS) web page at dwss.nv.gov. Applicants should be encouraged to visit the DWSS website to complete an online application for medical assistance. See D-125 for more information.

Form 2960, Application for Health Insurance should be provided to anyone requesting medical assistance for non-elderly, non-disabled individuals and families.

Form 2920, Application for Assistance to Aged, Blind and Disabled (MAABD) should be provided to anyone requesting medical assistance for aged, blind or disabled individuals.

Individuals applying for medical assistance under the specialized groups should apply using the specialized applications for each group.

Accept any approved medical application form, if the application requires additional information, contact the household to obtain the information needed to process the application for the appropriate medical category. If unable to contact the applicant, mail Form 2429 requesting the additional information.

## D-110 APPLICATION ASSISTANCE (435.908)

If an individual needs help completing the application or redetermination, a volunteer or staff member must help. Anyone helping complete the application form must initial the parts completed or sign the form showing they helped complete it.

## D-115 FILING THE APPLICATION

The application date is the day the district office receives an application form containing the applicant's name, address, and appropriate signature.

Applications received by the agency outside of normal business hours, through electronic sources such as Access Nevada or the Supported State-Based Marketplace (SSBM) or local office drop boxes, are considered received and date stamped the next business day. This is the first day these applications are available to the agency for processing.

## D-120 WITHDRAWAL OF APPLICATION

An individual may voluntarily withdraw an application any time before a case decision is made.

## D-125 REGISTRATION OF THE APPLICATION

All paper applications for medical assistance, received via fax, mail, drop-box and in-person are documented and date stamped by DWSS. These applications will be electronically scanned and registered timely with DWSS for an eligibility determination.

Applications for multiple programs submitted online through Access Nevada will produce a PDF document for medical, SNAP and/or TANF. These PDF documents are application summaries only and may not be re-printed and used as a new paper application.

## D-130 DUPLICATE ASSISTANCE SCREENING

All household members requesting or applying for initial or continued assistance must be screened by social security number and name to avoid duplicating assistance.

Assistance can only be provided from one Nevada Medicaid/Children's Health Insurance Program (CHIP) program at a time. Nevada Medicaid/CHIP Programs include:

| | |
|---|---|
| FMC | Dependent Child, Parent/Caretaker Relative, Pregnant Women, Childless Adult; Transitional Medical, Post Medical, Omnibus Budget Reconciliation Act (OBRA) |
| NCU | Nevada Check Up |
| CWS | Child Welfare Services *(Division of Child and Family Services)* |
| SPECIALIZED GROUPS | Breast and Cervical Cancer, Aged Out of Foster Care, Child in Custody of Public Agency |
| MAABD | Medical Assistance to the Aged, Blind & Disabled |

When moving an individual to another household, do not post downgrades to eligibility after cut-off for the next month, Medicaid Management Information System (MMIS) cannot recognize this action and the eligibility will not be terminated.

**Note:** A system notification is sent to Healthcare.gov when an individual is enrolled in Medicaid. Healthcare.gov will notify the individual of disenrollment in Advanced Premium Tax Credits (APTC) received through Healthcare.gov.

## D-135 TIME FRAMES (435.912)

Process MAGI based eligibility determinations no later than the 45th day from the application date.

## D-140 PRE-ELIGIBILITY VERIFICATION

If client statement indicates ineligibility deny the application based on client statement and notify the household. There is no need to verify the information.

### D-140.1 Non-Financial

- **Citizenship** – Citizenship or immigrant status *must* be verified prior to approval. Citizenship is verified electronically through the federal hub or using current case information. Refer to MAM C-400 for citizenship verification requirements including additional procedures on case approvals using the "Reasonable Opportunity" policy when electronic information is unavailable to the agency.
- **Social Security Number** – Verified via NUMIDENT. When a discrepancy exists follow procedures outlined in C-200 for SSN discrepancies.
- **Residency** – Accept client statement for residency. When a discrepancy exists in the current case file, contact the household or a collateral contact to clarify circumstances and document the information. See C-100 for residency verification requirements.

- **Age/DOB –** Verified via NUMIDENT. Follow C-200 if a NUMIDENT discrepancy exists. If no data source is available accept client statement for age.

- **Household Composition** – Accept client statement for verification of household composition.

- **Pregnancy** – Accept client statement for pregnancy. When the client does not provide an expected due date (EDC) on the application, contact the client to obtain the EDC. If unable to obtain an EDC via phone, case managers should update the PREG screen and the unborn's MEMB screen with a due date eight months out from the date of application and process the case.

  Medicaid Assistance Applications received from the Supported State-Based Marketplace (SSBM) will not have an EDC on the PDF as the SSBM does not ask this question. DWSS systems require an EDC entered to process correct eligibility for pregnant women. A default date of 12/31/9999 will be entered and must be updated by the case manager during processing.

  **Note:** Currently the system does not create an AMPS task when the EDC has passed, however case managers should still receive an alert in NOMADS. When subsequent applications are received, the case manager should review and verify the PREG screen and unborn's MEMB screen are accurate and update if necessary.

- **Caretaker Relative** – Accept client statement for verification of relationship.

- **Domestic Partnership** – Accept client statement for verification of relationship.

### D-140.2 Financial

Verify current monthly income using available electronic data sources. When an open TANF/SNAP case exists, always use that data source as a primary verification. If new income is reported on the application, follow TANF/SNAP verification rules.

If no data source is available, request verification of current monthly income from the applicant/household. The request should include the 30 day period beginning with the day prior to the date of application and extending back 30 calendar days.

**Note:** When a 30 day best estimate does not provide a clear presentation of the household's income, a 60 day best estimate should be evaluated.

## D-145 POST ELIGIBILITY VERIFICATION

If all factors of eligibility (Financial & Non-Financial) required during the Pre-Eligibility process are verified, the case managers must complete case processing and determine Medicaid eligibility.

When there is additional information reported on the application but not required for a Medicaid determination, send Form 2429 after posting the case and allow the applicant 10 days to provide the requested information. Post Eligibility Verifications can include:

- **Third Party Liability –** when the application indicates insurance coverage is available at no cost to the client send Form 2429 requesting the client to enroll.
- **Available Benefits –** when information on the application indicates the individual may be eligible for benefits such as RSDI, SSI, Unemployment Insurance Benefits (UIB), send Form 2429 requesting the individual to pursue benefits.
- **Tribal Enrollment** – when information on the application indicates a child eligible for Nevada Check Up is a member of an American Indian tribe, send 2429 requesting verification of American Indian descent.

## D-150 VERIFICATION SOURCES

Electronic verifications **must** be used when available **and** prior to sending Form 2429 requesting any paper documentation.

When an open TANF/SNAP case exists, always use that data source as a primary verification. If new income is reported on the application, follow TANF/SNAP verification rules.

Electronic data sources include but are not limited to:

- TANF and SNAP open case file verification
- SOLQ – Income, citizenship, residency if questionable
- UIB – Unearned income
- FHUB – Citizenship information received from the federal hub
- SAVE – Immigration status
- Work Number – Earned income
- ANSRS – Employment income and vital statistics
- BENDEX/SDX – Social Security income

Other data sources include but are not limited to:

- Collateral contact – document name, number and information received.

**Examples:**

Client reports earned income. Work income can be viewed in Work Number when client has an open SNAP case with a 30 day history from 3 months prior. Use the Work Number verification.

Client reports earned income. The only data source available is ANSRS. If the quarterly income from three months ago is the same employer and the income amount is reasonably compatible with the client statement of income, then use the ANSRS data as verification.

## D-150.1 Reasonable Compatibility (435.952)

When processing a new application, if the information received from a data source is relatively consistent and does not vary significantly from the client stated information, it is considered reasonably compatible. Income verification obtained through a data source is reasonably compatible with information provided by the individual when both are either above or both are below the applicable income standard.

When there is a discrepancy between the client statement of income and the data source, certain households are allowed an additional opportunity to provide verification of income. Follow the reasonable compatibility rules to determine when to allow the household an opportunity to provide additional verifications.

a. The data source indicates income is under the income limit; **and**
The client attested income is under the income limit;

- Consider the income verified.

b. The data source indicates income is over the income limit; **and**
The client attested income is under the income limit; **and**
The data source is over the income limit for the assistance unit size by less than $225;

- Contact the client to obtain a reasonable explanation and verification of income discrepancy.

If unable to provide verification showing their income is below the income limit, deny the application using the data source as verification.

c. The data source indicates income is over the income limits; **and**
The client attested income is under the income limit; **and**
The data source is over the income limit for the assistance unit size by greater than $225;

- Deny the application based on the data source verification.

d. There is no data source available; **and**
The client attested income is below the income limit.

- Request the individual/household to verify income prior to enrollment.

**Example:** 138% FPL for a household of 3 is $2,247

- Application indicates monthly income of $2,200 month for a household of 3.
- ANSR reports quarterly wages of $7,228/3= $2409.33 month. (No other more current data source is available)

The data source verification is over the income limit by less than $225. $2247-2409.33= $162.33 therefore the client is given a reasonable opportunity.

Contact the household to obtain reasonable explanation and verification of income.

## D-150.2 MAGI Discrepancy with Supported State-Based Marketplace Applications (§435.603(h)(3)(i))

Applications for Medicaid received through the Supported State-Based Marketplace (SSBM), are sent to the state when the applicant's stated annual income is determined to be below 100 percent of the Federal Poverty Level (FPL). This type of income is attested income provided by the applicant to the SSBM and may or may not be verified. The information is populated on the application as verified income and the SSBM will attempt to match this information with approved electronic data sources via the SSBM datalink with the Federal HUB. However, the application does not reflect whether or not the attested information was verified.

If an individual is determined to be ineligible for Medicaid due to current monthly income budgeting **and** the application for the individual was received from the SSBM stating that the income is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with the annual income budgeting method (See MAM E-135).

Income used by the SSBM must be reasonably compatible to the current MAGI monthly income as verified by DWSS. If a discrepancy between the SSBM'S stated annual income and the current of MAGI monthly income are not reasonably compatible or the difference explainable, additional verification of the stated annual income will be needed before an eligibility determination can be made.

**Example:** It is reported on the SSBM application that the client expects to make $22,000 this year. MAGI budgeting shows excess income of $2,500/mo or $30,000 annually. The $8,000 discrepancy between the SSBM and MAGI must be verified. The client will need to provide additional verification to explain the difference in income.

Verifications may include (not all inclusive)

1-Copy of seasonal work contract
2-Migrant farmer contract
3-Statement from Employer

## D-155 PENDING INFORMATION

Give the applicant the Insufficient Information Form 2429-EE, detailing what verifications are needed, allowing the household at least 10 days to provide requested verifications. *When the due date falls on a weekend or holiday, the due date is the next*

*working day.* File the suspense copy of Form 2429-EE with the current application, reflecting the verification request due date**.**

If information is not provided within the time period given, deny the application or terminate assistance allowing adverse action. Do not deny individuals if the pending information is not used in that individual's eligibility determination.

**Example:** Household consists of grandma, adult child and grandchild. Grandma claims all members on her taxes. Household fails to provide grandmother's income verifications. The grandchild would not be denied because the grandmother's income is not used in her eligibility determination.

If information is provided prior to the denial/termination action being taken, process the case using the verifications.

**Note:** When proof of pregnancy ending/birth of child is requested but not provided, and no information is available through collateral contact or approved electronic data source, the ongoing eligibility of the pregnant woman must be re-evaluated for all other Medicaid coverage groups (without the unborn member) prior to termination. The unborn member record(s) and pregnancy information should be updated to reflect the unborn as no longer present in the household (see MAM D-520).

### D-155.1 Future Actions

If the case manager has information about anticipated changes in circumstances that may affect ongoing eligibility of a case, they must re-evaluate eligibility at the appropriate time based on such changes. Create a future action for the date of the anticipated change to affect the change timely.

**Example:** Critical age changes, birth of a child(ren), seasonal employment.

## D-160 CERTIFICATION PERIOD

Medical assistance is approved ongoing from the first month of eligibility. Individuals remain eligible for Medicaid until information is received indicating they no longer meet eligibility criteria. A redetermination of eligibility must be completed at least every 12 months.

### D-160.1 Nevada Check Up

Nevada Check Up is approved effective the month following the month of approval. If processed after cut-off the effective date is the second month after the month of approval.

Approve Nevada Check Up for 12 months from the enrollment date. Child(ren) are entitled to 12 months continuous eligibility, as long as quarterly premiums are paid and as long as the child(ren) are not Medicaid eligible.

- An enrollee's 12 months' continuous eligibility may be terminated if during the course of a case review or audit process, it is determined the family provided

erroneous information or errors were made in the original determination or redetermination process, resulting in an incorrect eligibility determination.

When a household has members eligible under Nevada Check Up and Medicaid the 12 month certification period is effective the month of approval.

### D-160.2 Newborns (AKA OBRA)

OBRA eligibility is approved for 12 months from the child's date of birth. These children are entitled to 12 months continuous eligibility, as long as they remain a Nevada resident (see MAM B-120.1).

When approving OBRA coverage, the case manager needs to manually change the redetermination (RD) date to the month the child turns age one.

### D-160.3 Transitional Medicaid

Transitional Medicaid eligibility is approved for 12 months continuous eligibility, as long as they continue to meet eligibility criteria as indicated in MAM B-130.

When approving Transitional Medicaid coverage, the case manager needs to manually change the redetermination (RD) date to 12 months from the date the case rolls to Transitional Medicaid.

## D-165 NEVADA CHECK UP PREMIUMS

Families with children enrolled in Nevada Check Up are charged a quarterly premium based on the family's monthly taxable income. Premiums are charged per family, not per child.

NCU premium payments must be paid using a check or money order. Clients should be advised to include their UPI number on the payment.

- Cash payments are not accepted
- Payments are not accepted online or over the phone

All NCU premium payments should be sent to:

Nevada Check Up Program
PO Box 847346
Los Angeles, CA 90084-7346

Households with children who are Native American and Alaskan Natives are not charged a monthly premium. Children of American Indian descent are exempt from the premium. Verification of American Indian descent must be provided in order to waive the premium. The child's tribal affiliation should be entered on the MEMB screen.

Premiums are calculated by the system and transmitted for collection. Disenrollment will occur if a household is 60 days or two full months past due. Case workers will be notified with a task in the system when non-payment has occurred. See D-500 Changes for processing non-payment.

## D-170 CASE DOCUMENTATION (435.913)

The case manager must include in each applicant's case record facts to support the decision on the application. Documentation must be clear and concise. Provide enough information so anyone reviewing the case can determine the reason, logic and accuracy of the case manager's decisions and actions.

### D-170.1 Case Records (NRS 239.080, NRS 230.125)

The agency must maintain case files in accordance with the state's record retention schedule.

Records must be maintained for 37 months after the case closure date.

## D-175 PRIOR MEDICAL COVERAGE

Prior medical coverage is available for up to three months prior to the application month if the individual requesting the coverage meets all eligibility requirements for that month. See A-115 Prior Medical.

## D-180 REINSTATEMENTS

Reinstatements are allowed for the following reasons:

- The household provided verification within 10 days from date of denial.
- The household provides verifications prior to the termination action being taken.
- The client provides RD form and all verifications within 90 days from termination of RD. (See Redeterminations)

Reinstatements for other reasons are made at the discretion of the social services manager (SSM) or supervisor.

## D-185 "PRUDENT PERSON" PRINCIPLE

The policies included in the **manual** are rules for determining eligibility. It is impossible to foresee and give examples for all situations; therefore, case managers are encouraged to use reason and apply good judgment in making eligibility decisions when rare and unusual situations are encountered. Reasonable decisions made by staff based on the best information available using good judgment, program knowledge, experience, and expertise in a particular situation is referred to as the prudent person principle.

Document the rationale used to make a decision and any applicable **manual** references and policy interpretations. Follow local office procedures for obtaining an interpretation from Eligibility and Payments (E&P) Program Specialists in Central Office, or submit Form 6018, Policy and Procedure Inquiry requesting clarification or directives, to the Chief of E&P, when it is impossible or inadvisable to follow the prudent person principle because of a lack of information or program knowledge.

**Note**: All questionable circumstances should be referred to Investigations and Recovery (I&R) using Investigative and Recovery Information System (IRIS).