SPECIALIZED GROUPS - APPLICATION PROCESSING

This section provides guidance on processing applications for Specialized Medical Groups such as Aged-Out of Foster Care, Breast and Cervical, CCPA and Title IV-E Rite of Passage Foster Children.

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.

D-200 OVERVIEW

Each specialized medical group has their own application and process for determining eligibility.

D-200.1 Income

All income of the applicant is excluded in determining eligibility in the specialized groups.

D-200.2 Resources

All resources of the applicant are excluded in determining eligibility in the specialized groups.

D-205 AGED OUT OF FOSTER CARE

Effective July 1, 2005, young adults who have “aged out” of foster care may receive Medicaid as an “Independent Foster Care Adolescent”. This includes children who were in the custody/in foster care through the Division of Child and Family services (DCFS), DCFS-Youth Parole, Clark County DFS, Washoe County DSS, tribal social service agencies, or in foster care in another state.

Young adults, who age out of foster care in Nevada, will be given the opportunity to apply through their state or county DCFS worker when they are exiting foster care. If they choose not to apply at that time, but later decide they need assistance, they can apply at any time prior to their 26th birthday.

a. **Division of Child and Family Services (DCFS)**

DCFS will submit a one-page application, along with verification the individual has aged out of foster care; at the same time they terminate their case.

.

b. **Division of Welfare and Supportive Services (DWSS)**

Individuals who fail to apply at the time they age out of foster care, can apply through DWSS using the DCFS one-page application or a regular Medicaid application.

Upon receipt of the application, the case manager must verify:

- current age;
- citizenship; and
- aged out of foster care at age 18.

Individuals who age out of foster care at age 18 in Nevada will have a specific code entered in NOMADS from the UNITY system to identify them. Use this as verification of aging out.

D-205.1 Aged Out of Foster Care in Another State

Young adults who age out of foster care in another state may apply for benefits in Nevada. These individuals need to provide proof they aged out of foster care at age 18 and meet all other eligibility requirements. **Note:** These individuals are eligible through their 21st birthday.

Proof can be in the form of a letter from the family services agency in the other state notifying the individual they are no longer eligible for their program, or through collateral contact.

D-205.2 Reporting Requirements

Recipients are required to report the following changes:

- address
- moving to another state
- pregnancy
- birth of newborn
- third party insurance

D-205.3 Denial/Termination

Medicaid is terminated allowing for adverse when:

- the recipient reaches age 21(for those children not on Nevada Medicaid at 18);or
- the recipient reaches age 26; or
- moves to another state; or
- is placed/lives in an ineligible facility (jail/detention)

Note: Closure of an Aged Out of Foster Care case is done at the individual member level. The AO Closure reason codes are located on the individual's MEMB screen.

D-210 BREAST/CERVICAL CANCER MEDICAID

Public Law 106-354 authorizes Medicaid to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program for further diagnosis or are in need of treatment. The Women's Health Connection under Access to Healthcare Network, is Nevada's Breast and Cervical Cancer Early Detection Program. Breast/Cervical Cancer Medicaid begins July 1, 2002.

Case managers with the Women's Health Connection identify and refer uninsured women under age 65 who have been screened through them. A referral Form 2591-EM is submitted to DWSS for approval.

Note: Referrals and redetermination applications will be processed at the Elko District Office.

D-210.1 Verification

Citizenship must be verified for all MCB applicants. Follow the policy outlined in manual section C-400 for obtaining verifications electronically.

D-210.2 Presumptive Eligibility

Eligibility begins the date on which the contracted provider determines the individual meets the eligibility requirements.

Once approved, the DWSS case manager sends an application for medical assistance. If the individual does not return the application for assistance by the last day of the month following the month during which presumptive eligibility was determined, medical assistance may be terminated.

D-210.3 Eligibility Requirements

Individuals who apply for Breast and Cervical Cancer Medicaid must meet the following requirements:

- Must be a Nevada resident;
- Must be under age 65;
- Must be uninsured or underinsured;
- Not eligible under any other Medicaid eligibility group;
- Must have been screened for breast or cervical cancer by the "Disease Control and Prevention (CDC)". In Nevada Women's Health Connection is the CDC licensed provider; and
- Found to need treatment for either breast or cervical cancer.

A woman is considered to be underinsured when she;

- Is in a period of exclusion (such as a preexisting condition exclusion or an HMO affiliation period);
- Is not actually covered for treatment of breast or cervical cancer; or
- Has contract health care coverage through Indian Health Services or Tribal Clinics.

A woman is considered to have been screened if she has received a screening mammogram, clinical breast exam, or Pap test; or she has received diagnosis of breast or cervical cancer or of a pre-cancerous condition of the breast or cervix as the result of the screening under the CDC program.

A women is considered to need treatment if, in the opinion of the individual's treating health professional, the diagnostic evaluation following the clinical screening indicates the woman is in need of treatment services. Services include diagnostic services necessary to determine the extent and proper course of treatment, as well as treatment itself.

D-210.4 Do Not Apply the Following Eligibility Requirements

- SNAP Joint Processing
- Household Determination
- Resources and Income
- Applicant Job Search/Employment Services/NEON
- Assistance Unit Needs Budgeting
- Transitional Medicaid
- Third Party Liability
- Medicaid Managed Care Health Plans (MCHP)
- Financial Management
- Cooperation with Child Support Enforcement

D-210.5 Termination

A woman's Medicaid eligibility ends when her course of treatment is completed or she no longer meets the criteria for this eligibility category. A woman eligible in this category is eligible for all Medicaid services.

D-215 CHILDREN FOR WHOM A PUBLIC AGENCY HAS ASSUMED FINANCIAL RESPONSIBILITY

Medicaid is available for some children for whom financial responsibility is assumed in whole or in part by a public agency.

Public agencies include county, state and Native American social service agencies.

The Division of Child and Family Services (DCFS) is a qualifying public agency only if:

- the agency is assuming partial or full financial responsibility for the child; **and**
- the child is placed at Desert Willow; **and**
- DCFS DOES NOT have custody of the child.

D-215.1 Application

To apply for Medicaid, the responsible agency must:

- Complete and return Form 2447-EM, Medicaid Application for Children in the Custody of a Public Agency; **and**

- Provide the information required for an eligibility determination.

The DWSS case manager **must** make an eligibility determination within 3 working days from receiving the completed application AND the information required to process the case, unless unusual circumstances exist.

The public agency **must** be mailed notification of the eligibility decision on the date the determination is made. If unusual circumstances prevent the application from being processed within this time frame, the reason for the delay must be documented in the case record.

Medical benefits are approved when eligibility criteria are met. Notify the applying agency of the approval with the Notice of Decision, Form 2447-EM (page 3).

D-215.2 Verifications

By signing the application, public agencies (except DCFS) are attesting to having full or partial financial responsibility of the child for whom they are making application. If the agency is requesting prior medical assistance under this category, the agency must have had supervision of the child for a portion of the month for which assistance is being requested.

- Children in the custody of DCFS ARE NOT eligible for this category of assistance. Children for whom DCFS is NOT taking custody, but for whom DCFS is assuming partial or full financial responsibility, may be eligible if the child meets all other eligibility criteria.

- The public agency is required to provide legal documentation showing physical or legal supervision or wardship, copies of Agreements for Substitute Care Placement, reports to the court, or other pertinent documents showing changes in legal or physical supervision status as the documents become available.

- When documents are not available at the time of application, **do not** delay Medicaid assistance for the child. The agency's statement on the application will be accepted until formal documentation is available. Request documentation in writing, and allow thirty (30) days for the agency to respond. If the agency indicates the documents will not be available by the due date, document the reason for the delay and when the documents are expected. (i.e., when is the court date scheduled? How long after the court date do you expect to receive the court order?)

- **Age/School** - Verify school attendance and expected date of graduation for every child who is age 18.

- **Financial Responsibility** -To qualify for Medicaid under this category, a public agency must have assumed full or partial financial responsibility for the child. The agency's statement on the application is acceptable verification.

- **Citizenship** – Follow citizenship rules in C-100.

- **SSN** – Follow SSN rules in C-100.

- **Third Party Liability** – Follow TPL rules in C-100.

- **Living Arrangement (placement)**-To qualify for Medicaid under this category, a child must reside in:

    a. A group family foster home (this may include the home of a relative in or out of state, other than the child's parent); or
    b. A private institution (including hospitals, residential treatment centers); or
    c. A detention facility or public institution such as Kids Kottage or Child Haven (only when temporarily placed pending other arrangements appropriate for their needs). At the time of application, the facility must indicate the anticipated date and long-term placement of the child.

The child must not be considered an inmate of a training school, forestry camp or other facility for the detention of delinquent children.

If the child's stay has exceeded thirty (30) days, the child is not considered temporarily placed, unless the public agency provides evidence of reasonable efforts to place the child.

The agency's statement on the application is acceptable verification of placement.

D-215.3 Denial/Termination

Assistance is denied or terminated when:

- eligibility criteria is not met; and/or
- information essential for determining eligibility was requested in writing is not provided by the required date.
- the agency fails to provide the child's current status as requested on the monthly report

Notify the applying agency of the denial/termination and the reason with the Notice of Decision, Form 2447-EM (page 3)

Thirteen (13) days adverse action notice is required; unless the responsible agency reports the child is no longer under their supervision or the child has been moved to an ineligible placement.

If the child may be eligible for medical assistance under a different category of Medicaid or Nevada Check Up, inform the agency of the child's potential eligibility and attach the appropriate application to the Notice of Decision.

D-215.4 Reporting Requirements

Public agencies are required to report the status of children receiving Medicaid or for whom a Medicaid application has been submitted to the Division by the 10th of each month.

D-220 MEDICAID ELIGIBILITY FOR TITLE IV-E ELIGIBLE FOSTER CHILDREN AT RITE OF PASSAGE

Medicaid coverage may be provided for children residing at Rite of Passage facilities in Nevada and receiving Title IV-E foster care payments from another state.

If an agency fails to respond to the monthly report by the end of the month it is due, the eligibility worker will terminate the case(s).

D-220.1 Application

Rite of Passage staff must:

- complete and sign Form 2447-EM, Medicaid Application for Children in the Custody of a Public Agency; and
- provide all of the information required for an eligibility determination.

Applications will be processed in the Yerington District Office regardless of the location of the child. Applications will be processed within 3 working days of receipt of the application AND the required documentation, unless unusual circumstances exist.

The redetermination date in the system should be set to coincide with the IV-E redetermination.

If the child may be eligible for medical assistance under a different category of Medicaid or Nevada Check Up, inform the agency of the child's potential eligibility and attach the appropriate application to the Notice of Decision.

D-220.2 Verifications

Title IV-E eligibility - Staff at Rite of Passage must provide the following written verification from the custodial state (the state making placement):

- Child's name
- Child's Social Security Number
- Child's gender
- Verification of the type of IV-E assistance (adoption or foster) provided
- The amount of IV-E cash assistance the child receives each month
- Proof of any other medical insurance coverage (Third Party Liability)
- The next redetermination due date for IV-E eligibility

Citizenship – follow citizenship rules in C-100

Age – Child must be less than 18 years of age.

Living arrangement – child must be residing at Rite of Passage facility in Nevada

D-220.3 Denial/Termination

Assistance is denied when:

- One or more of the eligibility criteria is not met; and/or
- Information essential for determining eligibility is requested in writing, but not provided by the required date.
- Rite of Passage fails to provide the information needed to complete the redetermination process, and/or
- the recipient no longer meets the eligibility criteria for this category of assistance.

Notify the applying agency of the denial and the reason for the denial/termination.

Note: If the child may be eligible for medical assistance under a different category of Medicaid or Nevada Check Up, inform the agency of the child's potential eligibility and attach the appropriate application to the Notice of Decision.

D-220.4 Reporting Requirements

Rite of Passage staff must report if a child no longer resides at their facility or if the child's IV-E eligibility ceases.

D-220.5 Case Management

A Medicaid redetermination (RD) must be timed to coincide with the Title IV-E eligibility review. The custodial state must provide the IV-E RD date prior to approval, and the Medicaid RD due date should be adjusted in the system at approval to ensure the case comes up for review at the appropriate time.

Request a new application and written verification from the custodial state regarding continued IV-E eligibility from Rite of Passage staff.

Continue the case if all eligibility criteria continue to be met.

D-225 REQUEST FOR INFORMATION

For all specialized medical applications, when the application is incomplete or information required for an eligibility decision is not provided at the time of application, send a written request to the agency allowing at least 10 working days for the agency to complete the application and/or provide the information. A copy of the application and the request must be kept in the eligibility file until the information is returned.

D-230 WITHDRAWAL OF APPLICATION

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

D-235 DUPLICATE ASSISTANCE SCREENING

All household members applying for or requesting 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 program at a time. Nevada Medicaid Programs include:

FMC	Dependent Child; Parent/Caretaker Relative; Pregnant Women; Childless Adult
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

Exception: When a child(ren) moves from one household to another household, there may be overlapping months of eligibility. When moving an individual to another household, do not post downgrades to eligibility after cut-off for the next month, MMIS cannot recognize this action and the eligibility will not be terminated.

D-240 "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: Suspicious circumstances should be referred to I&R using Investigative Referral Form (2683-EE).

D-245 PRIOR MEDICAL COVERAGE

Prior medical coverage is available for up to 3 months prior to the application month if the individual requesting the coverage received medical services in the month(s) for which Medicaid is requested and met eligibility requirements for the specialized group. Proof of medical service is required for each month prior medical coverage is requested. Eligibility is determined on a month-by-month basis for each individual requesting coverage.

D-245.1 How to Apply for Prior Coverage

A request for prior medical coverage may be made on any medical assistance application and is considered a separate application because it is for months predating the initial application. Prior medical requests may be added during the pending period and during the 12 month period after approval provided the case remains open.

Therefore, approval, denial or pending of a prior medical request must always be addressed in a notice to the household.

Do not delay an ongoing eligibility decision while obtaining information to determine prior medical eligibility. In addition, if the household is only requesting prior coverage, provide an ongoing eligibility decision at the time of application.

D-245.2 Eligibility for Prior Coverage

Approve medical assistance for the person requesting coverage in the three months prior to the application month only for those months in which the individual met all eligibility requirements for the specialized group including citizenship, and provides proof medical care or services were received in the requested months.

Individuals determined eligible for a month of prior medical coverage are eligible from the first day of month, regardless of when the medical care or services were provided, or the date eligibility requirements were met.

D-245.3 Prior Medical Determinations

For Rite of Passage applicants, the custodial state **must** verify payment of IV-E foster care funds on behalf of the child for the month of requested coverage.