

(MAABD) APPLICATION PROCESSING

This section provides guidance on processing applications for MAABD 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.

D-300 OVERVIEW

Accept any application form designated for medical assistance programs. When a request for medical assistance is received on a form other than MAABD application Form 2920 and additional information is needed to determine MAABD eligibility;

- contact the household to obtain the information needed to process the application for the appropriate medical category, or
- if unable to contact the applicant, mail Form 2429 requesting the additional information.

Applications **must** be accepted via:

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

Applications may be submitted online at the Division of Welfare and Supportive Services (DWSS) web page www.dwss.nv.gov. DWSS also accepts telephonic applications through their customer service 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 customer must be documented to indicate a telephonic signature was obtained.

Example: Telephonic Signature for [customer 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 customer as confirmation an application was received by DWSS.

An application must contain:

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

See below for additional instructions regarding application processing:

Incomplete Applications:

- **Unsigned Applications:**
 - An application which is not signed by the customer or A/R as an inquiry only.
 - DWSS staff must not date stamp nor register the application and must return the application to the head of household or A/R for signature.

- **No Program Selected:**
 - If the application is signed but no program is selected, DWSS staff must register and evaluate all applicable Medicaid programs for all listed household members, using prudent person judgement.
 - If any household member is over age 65 and/or lists any disability, impairment, need for additional services, or institutionalization, DWSS must evaluate for MAABD.

- **Mailing Address:**
 - If the application is new, with no open programs, and no mailing address is provided, DWSS staff must not date stamp nor register the application until the mailing address is obtained. DWSS staff must attempt to contact the household via all available phone number(s) to obtain the mailing address. If contact is not made, DWSS must hold the application.

 - For redeterminations, the address is pre-printed on the form. If the customer does not state their address has changed and there is no reason to question the mailing address on file, including for individuals who have previously used General Delivery, the mailing address on file is considered valid and the redetermination should be evaluated following normal eligibility guidelines. This includes redeterminations where the customer chooses to use other application methods instead of the NRD1 Form, as they are known to the system, and they currently have an open and ongoing case.

NOTE: It is not allowable to simply enter General Delivery for a mailing address when the information is missing on the application. A General Delivery address should only be entered when provided by the customer or A/R. Staff should make every attempt to collect the information, but if unsuccessful, hold or return the application.

Staff are instructed to use Form 2739-EG when returning an application to the household. Staff must not alter the text in the approved form.

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 (A/R);
- if the applicant is a minor or incapacitated, someone acting responsibly for the applicant;
or
- 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.

Applications for the Medicare Beneficiary program received through the Low Income Subsidy referral process do not require a signature. The applicant's signature is obtained by Social Security Administration.

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:** [customer 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:** [customer 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 them of the application, the hospital, nursing home or county agency representative and request any eligibility information to assist in processing the case.

D-305 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 DWSS web page at www.dwss.nv.gov. Applicants should be encouraged to visit the website to complete an online application for medical assistance.

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.

D-305.1 Forms Given to the Customer with Application:

1. 2179-EE Interface Consent Form
2. 6160-AF Medicaid Estate Recovery Notification of Program Operation

D-310 APPLICATION ASSISTANCE

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-315 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 Access Nevada, 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-320 WITHDRAWAL OF APPLICATION

An applicant and/or authorized representative may voluntarily withdraw an application anytime before a case decision is made.

D-325 REGISTRATION OF THE APPLICATION

All applications must be entered into the system in a timely manner. Pending applicants must be registered in the system to ensure medical providers and other agencies/states can obtain correct eligibility information.

Applications for multiple benefits 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. If the household requests to add TANF and/or SNAP during the pending process, advise the household a separate application is required.

D-325.1 Application From a Facility

If the facility employee is the authorized representative, require proof from the facility the responsible relative, if applicable, is sent a copy of the request.

Allow 20 calendar days from the mailing date for the applicant/authorized representative to provide the necessary information unless the customer/authorized representative has agreed in writing to a shorter time allowance. When the due date falls on a weekend or holiday, the due date will be extended until the close of the next working day.

If the customer/authorized representative does not provide the requested information within the time period given, send a denial notice.

Should the authorized representative/family member experience non-cooperation with a third-party, they must notify the office in writing and request assistance in obtaining the information prior to the 20-day deadline. Proof a request was made to the third-party is required.

Should additional information be required during the case processing period, allow 10 days to provide the additional information. Additional information is defined as information needed after the initial request or as a result of receiving information from the initial request.

D-330 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 (<i>Division of Child and Family Services</i>)
SPECIALIZED GROUPS	Breast and Cervical Cancer; Aged Out of Foster Care; Children in the Custody of a 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.

D-335 TIME FRAMES

- process MAABD eligibility no later than 45 days from the application date, and
- no later than 90 days from the application date for individuals applying for MAABD on the basis of disability,
- within 10 working days form the date the case manager receives the SSI determination, unless extenuating circumstances exist.

D-340 PRE-ELIGIBILITY VERIFICATION

When processing a new application, if the customer’s statement indicates ineligibility, deny the application based on customer statement and notify the household.

Verify all pre-eligibility factors prior to approval. Use electronic verification sources when available.

D-340.1 Non-Financial Verification

- **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 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 customer statement for residency. If a discrepancy is discovered, contact the household or a collateral contact to clarify circumstances and document the information.

- See C-100 for residency verification information.
- **Aged, Blind and Disability –**
 - **Aged** – Age is verified via NUMIDENT. Follow C-200 if a NUMIDENT discrepancy exists. If no data source is available accept customer statement for age.
 - **Blind/Disability** - Customers less than 65 years of age must be blind or disabled. DWSS uses the same blindness/disability criteria as SSA.

When SSA determines a customer is not blind or disabled, deny Medicaid for all months requested, whether or not the SSA determination covers each month of the Medicaid requested period, unless it is apparent SSA's decision is based on a disability different from that of the Medicaid period.

When SSA determines a customer is disabled, use the SSA disability onset/start date as proof of blindness/disability for any months covered by the onset date.

If the SSI disability onset date is greater than the SSA application date, deny all months prior to the onset date including months not covered by SSA determination.

If the SSI disability onset date is the same as the SSA application date and Medicaid is requested for months prior to the SSI application date request a disability determination by sending a Disability/Incapacity Determination Request Form (3304) to the Division of Health Care Financing and Policy (DHCFP) district office.

HIWA Applicants - Prior SSI recipients and/or current or prior Social Security Disability Insurance recipients, whose benefits ended for a reason other than loss of disability, do not need a new disability determination unless SSA's decision was based on a disability different from what is presented to the Division. If the disability is different or their SSI or RSDI benefits ended for loss of disability, a new disability decision is needed. If a person has never received SSI or RSDI benefits, they must provide a determination or other verification of their disability.

Example: Medicaid application date 10/20/2009 with prior medical request for three months. Customer applied for SSI on 10/30/2009. SSI is approved with an onset date of 11/10/2009. 10/2009 and all prior medical months would be denied for no disability and no 3004 would be requested.

Example: Medicaid application date 3/20/2010 with prior medical request. Customer applied for SSI 04/10/2010 and is approved with an onset date of 4/01/2010. Approve 4/2010 ongoing and send a 3004 to DHCFP district office for 3/2010 and prior medical months requested.

D-340.2 Division of Health Care Finance and Policy (DHCFP) Disability Determination

Submit a completed Form NMO-3010, completed Form 2325 (Incapacity/Disability Determination Questionnaire), and the release page of the Application for Assistance, directly to DHCFP Central Office at 1100 E. Williams Street, Suite 101, Carson City, NV 89701 requesting a disability decision for the months assistance is requested. Form NMO-3010 must include dates of service and provider information.

- Examinations will only be required when deemed necessary by DHCFP.
Katie Beckett and WIN Waivers needing a DHCFP determination are to be routed to the appropriate DHCFP district office rather than central office.
- DHCFP will notify the case manager of disability decision on Form NMO-3010.

D-340.3 Pending SSI Determinations

When a pending SSI application is approved by SSA, an eligibility decision must be made within 10 working days from the date the case manager receives the SSI determination, unless extenuating circumstances exist.

When a pending SSI application is denied by SSA, deny the pending Medicaid application. If the applicant requests reinstatement of a denied Medicaid application, request proof of filing a timely reconsideration with Social Security, if provided return the Medicaid application to pending status. The timely reconsideration must be for the same Social Security application that the original Medicaid application was based on and not a new claim.

Do not request verification of citizenship during the pending SSI period. If the applicant is approved for SSI, they will meet the citizenship documentation requirements.

If the applicant moves out of state while pending SSI:

- terminate ongoing eligibility months for no residency; and
- leave previous months pending the SSI determination; and
- when SSI decision is received, approve any verified Nevada SSI months.

If the applicant becomes eligible in another Medicaid category while pending SSI:

- terminate the SSI pending months for duplicate assistance; and
- leave any months not covered by another category pending in the system until the SSI determination is made; and
- Do not approve SSI eligibility for months the applicant was eligible under another Medicaid category. Terminate the other Medicaid eligibility and begin the SSI eligibility in the next available month.

D-340.4 Financial Verification

D-340.4.1 Income

Verify the income of the applicant and their spouse if the applicant is married and residing with their spouse or when the couple is separated due to institutionalization.

Electronic verifications must be used when available and prior to sending Form 2429 requesting any paper documentation. Request paper documentation only when no electronic data sources are available.

D-340.4.2 Resources

Verify all countable resources of the applicant and their spouse if the applicant is married and residing with their spouse or when the couple is separated due to institutionalization.

Institutional and Home-Based Waiver (HBW) Spousal Resource Assessment – Resources of an institutionalized individual or HBW applicant and their spouse must be verified regardless of living circumstances. Individuals are considered married until divorced for the purposes of the spousal resource assessment. **SSI Recipients** - All resources will be evaluated by the Social Security Administration.

- If an SSI recipient has an inpatient stay in a medical facility, see Transfer of Assets policy in MAM F-400.
- When countable resources exceed the limit for an SSI recipient, notify the Social Security Administration of the assets using Form 3911.

D-340.5 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 customer send Form 2429 requesting the customer 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.

Refer all questionable circumstances to I&R.

D-340.6 Verification Sources

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

Electronic data sources include but are not limited to:

- SOLQ - Income, Citizenship, residency if questionable
- UIB – Unearned income
- FHUB/US Citizen – Citizenship information received from the federal hub
- SAVE – Immigration status
- FHUB/Current Income – Earned income
- BENDEX/SDX – Social Security benefits

Other data sources include but are not limited to:

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

D-345 PENDING INFORMATION - INTAKE CASES

Give the applicant the Insufficient Information Form 2429-EE, detailing what verifications are needed, allowing the household at least 20 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 or postmarked within the time period given, deny the application.

If additional information is required during the case processing period, allow 10 days to provide the additional information. Additional information is defined as information needed after the initial request, or as a result of receiving information from the initial request.

D-345.1 Future Actions

If the case manager has information about anticipated changes in circumstances that may affect his or her eligibility, 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.

D-350 DISPOSITION OF APPLICATION

Individually determine eligibility for each month using the policy in effect for each month. When processing applications, authorize assistance for each eligible month, customers may be determined eligible for some months and ineligible for others.

D-350.1 Certification Period

Medical assistance is approved for 12 months for all MAABD based eligibility determinations. Individuals receiving Medical assistance must report changes by the fifth of the month following the month of the change.

D-355 MEDICAID, SPECIAL LOW-INCOME MEDICARE BENEFICIARY (SLMB) & QUALIFIED INDIVIDUALS (QI)

Medicaid assistance begins with the first day of the month for which a customer is determined eligible. There is no partial month eligibility.

Example: Customer applies November 11 and is approved effective November and ongoing. Medicaid eligibility coverage begins November 1st and ongoing.

If all information needed to determine Qualified Medicare Beneficiary (QMB)/SLMB eligibility is received, approve the case as a QMB/SLMB only case and future action the case for determining eligibility under the other category. If the customer is later determined eligible under the other category, the Medicaid is approved with the first month of eligibility.

If the customer states in writing they do not want the Medicaid coverage and only want the QMB/SLMB coverage, the worker will convert the case to a QMB/SLMB only case (a new application is not needed unless an RD is due).

When the customer is determined ineligible for another category for any reason, the customer may be eligible for QMB/SLMB only coverage as long as all the requirements are met and all the necessary information for QMB/SLMB coverage has been obtained. The QMB/SLMB only coverage CANNOT be denied because the customer did not meet a requirement or did not cooperate in providing verifications specifically needed for another medical category.

D-355.1 Medicaid, Qualified Medicare Beneficiary (QMB)

Coverage begins with the first of the month following the month an eligibility decision is made.

Examples:

QMB Only:

Customer applies November 11th. The eligibility decision is made in December. QMB coverage begins effective January 1st and ongoing.

QMB and Medicaid (Dual Eligible):

Applicant applies 12/3 as a state institutional case and is currently enrolled in Medicare Part A. The customer cooperates and is determined eligible as a state institutional case. Because this customer has Medicare Part A, the case manager must also determine whether the customer is eligible for QMB coverage. If the customer's income and resources meet QMB criteria, they will qualify for both Medicaid and QMB coverage.

QMB and SSI:

Applicant applies 12/3 and has \$250 SSA disability income. The customer has not applied for SSI, but is probably eligible. The customer meets all the other requirements of a QMB.

Request the customer apply for SSI and give the normal time limit for applying. However, once the worker is able to determine the customer is eligible for QMB coverage (all verifications needed are in), the case would be approved as a QMB only case. Future action the case for the SSI information. If the customer failed to cooperate in applying for SSI, or was determined ineligible, the case would remain open as a QMB only case as long as he continued to meet the criteria. If the customer were approved for SSI, the case would be converted to an SSI case effective with the month of SSI eligibility (this could include prior med).

QMB and <30 day hospital stay:

Applicant applies and is approved for QMB coverage. Sometime after approval, the customer enters the hospital for 7 days. The case would continue as QMB and NO PATIENT LIABILITY would be determined, UNLESS the customer qualified as a state institutional case (if income is less than SSI payment level, the customer does not have to be in 30 consecutive days).

If the case qualifies as a state institutional case, the case would be converted and customer would receive full Medicaid coverage and QMB coverage. When the customer is released from the institution, the case would be converted back to a QMB only case, allowing adverse action, as long as all requirements were still met.

D-360 CASE DOCUMENTATION

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-360.1 Case Records (NRS 239.080, NRS 239.125)

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.

The MAABD case file should include:

- The original application **must** be retained in the current case file **and** not purged.
- A signed copy of the Medicaid Estate Recovery notice.
- A copy of the original spousal resource assessment.

D-365 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. Eligibility is determined on a month-by-month basis for each individual requesting coverage.

Follow eligibility budgeting rules for the appropriate medical category to determine financial eligibility for each month coverage is requested.

Exceptions:

- QMB categories are not eligible for prior medical coverage. Eligibility for these groups is effective in a future month.
- Prior Medical under the Health Insurance for Work Advancement (HIWA) program CANNOT exist prior to July 1, 2004.

D-365.1 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-365.2 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 including citizenship.

Prior Medicaid coverage may be provided even if:

- the household is not currently eligible for Medicaid; or
- the person who received the medical care or services is deceased.

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

D-365.3 Prior Medical Income Computation

Use actual income and expenses when determining eligibility for prior medical coverage. Determine the assistance unit's countable income. Compare the countable income to the income limit for each month that eligibility is being determined.

D-370 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 customer 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-375 "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 Investigations and Recovery (I&R) using the appropriate I&R referral process.

D-380 KATIE BECKETT

Applications must first be evaluated for all other MAGI coverage groups. If determined ineligible for any MAGI programs, follow the process below for evaluation of the Katie Beckett program.

Send Form NMO-3010 to DHCFP district office requesting a Katie Beckett determination and, if necessary, a disability determination. If DHCFP disability determination is needed, DWSS must obtain form 2325-Incapacity/Disability Questionnaire, completed by parent(s) of applicant prior to submission of 3010 to DHCFP.

Do not delay sending the DHCFP disability request while waiting for an SSI decision. The DHCFP decision can be pursued at same time as SSI for Katie Beckett. If the child previously received SSI and was denied for income, use the SSA disability determination. At the same time form NMO-3010 and if applicable form 2325-Incapacity/Disability Questionnaire is sent to DHCFP for level of care and/or disability determination, request required verification if needed.

Verifications:

- Citizenship - Only verify citizenship of the applicant
- Social Security Administration (SSA) verification that Supplemental Security Income (SSI) has been applied for "applicant"
- Income – "Applicant" parent's tax return for the prior year or if no tax return available; all earned and unearned income received for the parent(s) of applicant for the past 3 months
- Form 2451 – Authorization for Release of Information for applicant
- Form 2325 – Incapacity/Disability Questionnaire for applicant (if applicable)
- Form 2525 – Designation of Authorized Representative (if applicable)
- Add DHCFP as secondary Designated Authorized Representative

Note: Katie Beckett eligibility decision must wait until DWSS receives the level of care determination from DHCFP on form 3010 and if applicable, disability determination.

When DWSS receives verification that applicant meets the level of care requirement, DWSS staff will complete the following steps:

1. Determine financial and non-financial eligibility for Katie Beckett program.
2. Complete section #5 on 3010-Home and Community Based Services Waiver Eligibility Status Form.
3. Send completed 3010-Home and Community Based Services Waiver Eligibility Status Form back to DHCFP.
4. If applicant determined eligible for Katie Beckett, DWSS will calculate monthly parent premium.

Calculating Monthly Parental Premiums

Based on the applicant parent(s) federal income tax return or gross monthly income, use form NMO 7011B-Payment Agreement Guide, (Katie Beckett Premium Matrix), to determine family monthly premium amount. DWSS will use this matrix to complete form NMO-7011 Income Review/Premium Payment Agreement. DWSS will send completed NMO-7011 Income Review/Premium Payment Agreement to parent of applicant to sign and agree to monthly premium payment determination. Parent will be allowed a 10-calendar day timeframe to return NMO-7011 Income Review/Premium Payment Agreement. Once DWSS receives signed NMO-7011 Income Review/Premium Payment Agreement from parent of applicant, DWSS will email completed NMO-7011 form to DHCFP at dhcfpkatiebeckett@dhcfp.nv.gov.

If parent of applicant does not return completed NMO-7011 Income Review/Premium Payment Agreement, DWSS Institutional case worker will email DHCFP at dhcfpkatiebeckett@dchcfp.nv.gov, advising that no signed NMO-7011 Income Review/Premium Payment Agreement form was received. If no signed NMO-7011 Income Review/Premium Payment Agreement form is received back from a parent of applicant DHCFP will assess the maximum monthly premium of \$250.00

***Note:** DO NOT terminate a case for not receiving a signed NMO-7011 Income Review/Premium Payment Agreement back from the applicant's parent.

Change in Income and/or Household Size Reported:

Verify reported change in income and/or household size. DWSS will complete form NMO-7013 Income Review/Payment Agreement Amendment. DWSS will use form NMO-7011B Payment Agreement Guide, (Katie Beckett Premium Matrix), to determine family's monthly premium amount. DWSS will request a signature by parent of applicant on form NMO-7013 Income Review/Payment Agreement Amendment and allow 10 calendar days to return. Once completed NMO-7013 Income Review/Payment Agreement Amendment is received, DWSS will email form to DHCFP at dhcfpkatiebeckett@dchcfp.nv.gov.

Note: If no signed NMO-7013 Income Review/Payment Agreement Amendment form is returned, Katie Beckett monthly premium will remain unchanged, and the DWSS Institutional will take NO NEGATIVE action on case.

Households with children who are American Indian (AI)/Alaska Native (AN) are not charged a monthly premium. Child of American Indian/Alaska Native descent are exempt from the premium. Verification of American Indian/Alaska Native descent must be provided to waive the premium. The child's tribal affiliation should be entered on the Member BAP.

Disenrollment will occur if a household is 60 days or two full months past due. DHCFP will notify DWSS of households who are 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-380.1 Division of Health Care Finance and Policy (DHCFP) Determination

DHCFP Central Office processes disability determinations and DHCFP district offices complete level of care assessments.

After all other eligibility requirements are met, the DHCFP Central Office will determine disability, level of care, medical costs, and if home care is appropriate. DHCFP determinations are made per the Medicaid Operations Manual. The case manager or, if appropriate, the Title XIX Social Worker will send Form NMO-3010 to DHCFP.

DHCFP will notify the district office of the review board's decision of disability and/or final eligibility under 1902(e)(3) on Form NMO-3010.

DHCFP will send Katie Beckett Premium invoices/notices to families with detailed information on how to make premium payments. Families with children enrolled in Katie Beckett option are charged a monthly premium based on the family's monthly taxable income and household size. Premiums are charged per family, not per child. Payment arrangements may be made monthly, annually, or anything in-between with DHCFP.

Katie Beckett premium payments must be paid using a check or money order. Customers should be advised to include their Medicaid number on the payment.

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

All Katie Beckett premium payments should be sent to DHCFP at:

Katie Beckett
745 W. Moana Ln. Ste 200
Reno, NV 89509

Late payments paid in-person will be accepted at the following locations:

Carson City
1000 E William St. Ste. 118
Carson City, NV 89701
(775) 684-3660

Elko
1010 Ruby Vista Dr. Ste. 103
Elko, NV 89801
(775) 753-1191

Las Vegas
1210 S. Valley View Blvd. Ste 104
Las Vegas, NV 89102
(702) 668-4200

D-385 PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN

Parents are financially responsible for their children's medical expenses paid by Medicaid. Financially able parents will be assessed a monthly payment amount to reimburse the DHCFP for incurred medical costs.

This section applies to disabled children under age 19 eligible for Medicaid in categories in which there is no deeming of parental income/resources in determining eligibility for public assistance programs. These categories include, without limitation:

- State Institutional Category (including SSI recipients residing in medical facilities);
- Physically Disabled Waiver Program;
- Nevada Division of Public and Behavioral Health (DPBH) Waiver Program (including SSI recipients residing in intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) facilities); and
- SSI recipient, age 0-19, residing in appropriate settings as determined by Medicaid.

Under no circumstances will the policy in this section affect the child's Medicaid eligibility.

D-385.1 Definitions

- Parent – natural/adoptive parents and stepparents.
- Income – all earned and unearned income to include but not limited to the sources described in D-300 Types of earned and unearned without regard to any exclusions.

D-385.2 Calculating Monthly Parental Reimbursements

Based on the parent(s) gross monthly income and considering court ordered child support/alimony, home care credit, medical expenses, and health insurance covering the disabled child, the amount of monthly reimbursement is determined as:

1. Family Size

Determine family size, choosing one of the following methods, whichever is greater (most benefits the parent(s) in allowing the family deduction):

- Count the disabled child(ren), his/her blood-related siblings, and natural/adoptive parent(s) living in the home; or
- Allow the total number of exemptions claimed on last year's federal income tax form 1040 or 1040A.

2. Countable Income

Determine the amount of the natural/adoptive parent(s) adjusted gross income using Federal Income Tax Form 1040, 1040A, or Form W-2. Parent(s) who are self-employed must provide copies of their last two (2) income tax returns.

Parent(s) claiming their current income is substantially different than the income reported on their tax forms must provide proof of their actual income.

If the natural/adoptive parent is married and living with an individual who is not the natural/adoptive parent of the disabled child (stepparent to the disabled child), total the natural/adoptive parent's and stepparent's gross annual income and divide it equally.

This one-half share will be considered the natural/adoptive parent's annual gross income to determine the reimbursement amount.

3. Court Ordered Child Support or Alimony

Court ordered child support obligations paid by the natural/adoptive parent will be deducted as an annual cost from the gross annual income.

When the custodial parent and non-custodial (NCP) live separate and apart, consider their income separately. Alimony paid by the (NCP) is deducted from the NCP income and counted in the ex-spouse's income when determining amount of reimbursement.

4. Annual Family Deduction

Subtract the following family deduction amount (200% of Federal Poverty Guidelines) from the adjusted annual gross income (total annual gross income less child support deduction) to arrive at the net annual gross income amount:

2024 Federal Poverty Limit			
Family Size	200% FPL Amount	Family Size	200% FPL Amount
1	\$30,120	5	\$73,160
2	\$40,880	6	\$83,920
3	\$51,640	7	\$94,680
4	\$62,400	8	\$105,440

Add \$10,760 for each additional family member.

5. Net Annual Gross Income

Multiply the net annual gross income which is:

- a. Up to \$50,000 by 10%
- b. Additional income between \$50,000 - \$60,000 by 13%
- c. Additional income between \$60,000 - \$75,000 by 16%
- d. Any additional income over \$75,000 by 19%

Add the percentage increase amounts in a, b, c and d, then divide the total by 12 to reach the Monthly Reimbursement Amount.

6. Home Care Credit

Natural/adoptive parents who care for their disabled child(ren) in their home will receive a \$300 deduction from the monthly reimbursement amount.

7. Medical Expenses

Allow medical deductions claimed on last year’s federal income tax form 1040, line 4 (Medical and Dental Expenses) of Schedule A – Itemized Deductions.

8. Health Insurance

If a parent carries private or group comprehensive health insurance which covers the disabled child, the entire amount of the monthly insurance premium is deducted from the monthly reimbursement amount.

A health insurance penalty of 5% is imposed IF the natural/adoptive parent has health insurance available and does not elect to secure coverage for the disabled child.

DO NOT apply the insurance penalty IF the health insurance coverage would cost more than 5% of their gross annual income.

9. Court Orders

If a parent alleges a court order which specifies the noncustodial parent is responsible for all medical costs, obtain a copy of the court order and forward to the local child support enforcement unit AND the Chief of Eligibility and Payments.

In this instance, DO NOT assess a monthly reimbursement until directed by the Chief of Eligibility and Payments.

10. Noncooperation

If a parent fails to provide income information, provides false or misleading statements; misrepresents, conceals or withholds facts to avoid financial responsibility, a monthly reimbursement of \$1,900 is assessed.

If a parent provides only partial information/verification, request the remaining information/verification giving 10 days. If all the information/ verification is not received by the deadline given, assess \$1,900.

If, after receiving notification of the \$1,900 obligation, the parent later provides needed verifications, determine monthly reimbursement amount and notify I&R of change in monthly obligation effective the month after the month of cooperation.

D-385.3 Redetermination of Eligibility

At each scheduled redetermination of eligibility (at least once per year), the monthly reimbursement is recalculated for the upcoming year. Adjustments to the previous year's assessment will be reported to I&R via Form 6009-AG.

D-385.4 Undue Hardship

Responsible parents may apply for a "hardship waiver" if they are unable to pay their assessed monthly reimbursement amount due to:

1. a change in families monthly income (25% or more); or
2. payment of the monthly reimbursement amount would severely compromise the health, shelter or subsistence needs of their family.

Individuals seeking a hardship waiver should fully document their circumstances in writing and submit their request to the Chief of I&R in the Central Office. No adjustment of the monthly parental reimbursement amount will be made without the prior approval of the Chief of I&R.

D-385.5 Responsibilities of Eligibility Staff

The case manager:

- Requests completion of Form 2069-EM "Parent Income and Household Information" and verification of income, court-ordered child support/alimony, medical expenses and health insurance coverage at application and redetermination.

- Determines the monthly reimbursement amount based on the family size, annual income, child support/alimony, home care credit, medical expenses and medical insurance using Form 2028-EE, "Parental Reimbursement Worksheet." Notify the parents of their monthly reimbursement amount using Form 2849-EM.
- If the monthly reimbursement is greater than zero, send copies of the parent questionnaire and copy of Form 2849-EM with the recovery referral form to I&R in their service area.
- If a parent's whereabouts is unknown, the case manager will refer eligibility information to I&R for parent locate services using Form 2683-EE "Investigation Referral Form."
- If eligibility for the child terminates, the case manager will notify I&R on Form 6009-AG.

Example computation: A family of 4 has an annual gross income of \$150,000.

\$150,000	
- 1,200	Child Support
<u>\$148,800</u>	
-44,700	Family Deduction
<u>\$104,100</u>	Net Annual Gross Income

- a. \$50,000 of net annual gross income is multiplied by 10% or 15% (5% Insurance Penalty)
 - $\$50,000 \times 10\% = \$5,000$ or $15\% = \$7,500$
- b. The net annual gross income is also between \$50,000 - \$60,000, multiply \$10,000 by 13% or 18% (5% Insurance Penalty)
 - $\$10,000 \times 13\% = \$1,300$ or $18\% = \$1,800$
- c. The net annual gross income is also between \$60,000 - \$75,000, multiply \$15,000 by 16% or 21% (5% Insurance Penalty)
 - $\$15,000 \times 16\% = \$2,400$ or $21\% = \$3,150$
- d. The net annual gross income is also OVER \$75,000, multiply the amount which is over \$75,000 by 19% or 24% (5% Insurance Penalty)
 - $\$29,100 \times 19\% = \$5,529$ or $24\% = \$6,984$

Add the results of a, b, c and d, then divide by 12 for the monthly reimbursement amount.

No Insurance Penalty	Insurance Penalty 5%
\$ 5,000	\$ 7,500
1,300	1,800
2,400	3,150
<u>+ 5,529</u>	<u>+ 6,984</u>
\$14,229/12	\$19,434/12
= \$1,185.75	= \$1,619.50

From either of these two monthly reimbursement amounts, the home care credit, medical expenses and/or health insurance premium would be deducted to reach the net monthly reimbursement amount.

D-385.6 Investigations and Recovery (I&R) Staff Responsibilities

- Create a case file for each referred case.
- Send the initial notice of monthly reimbursement letter along with a copy of the worksheet, Form 2028-EE. A monthly reimbursement will be calculated for each month the disabled child is Medicaid eligible.
- Control and receive the monthly reimbursement funds.
- Send delinquent letters, file small claims court actions and make referrals to the Deputy Attorney General, as appropriate.
- Evaluate and negotiate undue hardship requests.
- On an annual basis, review the child's medical costs in comparison to paid reimbursement amounts and provide a credit against future month reimbursement amounts for any funds in excess of the child's medical costs. Medicaid-paid Provider 60 amounts are not included in the "child's medical costs" for these purposes.