CHAPTER 3-001 - APPLICATION PROCESS

3-001.01 Interview: Households must have an interview at initial application and at least once every 12 months following initial application. An interview may be held with a relative or another individual acting on the client's behalf.

Exception: An interview shall not be required for a determination of eligibility using MAGI-based income.

3-001.02 Client Rights: The client has the right to:

1. Apply. Anyone who wishes to request and/or apply for medical assistance must be given the opportunity to do so. No one may be denied the right to apply for medical assistance;
2. Reasonably prompt action on his/her application for medical assistance;
3. Adequate notice of any action affecting his/her application or assistance case;
4. Appeal to the Director for a hearing on any action or inaction with regard to an application, the amount of the assistance payment, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the action or inaction;
5. Have his/her information treated confidentially. (Additional rules apply for disclosure of information regarding a fugitive felon);
6. Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, or political belief;
7. Have the program requirements and benefits fully explained;
8. Have information available in written translations, oral interpretation, and taglines to individuals with disabilities and limited English proficient;
9. Be assisted in the application process by the person of his/her choice;
10. Referral to other agencies;
11. Have eligibility explained and how changes affect eligibility;
12. Have eligibility and items that require verification explained;
13. Give written consent for the needed verifications;
14. Have income that may be currently or potentially available such as RSDI, SSI, Veteran's Assistance benefits (VA), etc. explored;
15. Have information given about the social and other financial services available through the agency, such as social services and Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and family planning;
16. Be informed of his/her rights and responsibilities;
17. Be informed that he/she must show his/her medical card to all providers and must inform the Department of any health insurance plan, any individual, or any group that may be liable for the client's medical expenses;
18. Have the assignment of third party medical payments explained and refund any payments received directly;
19. Be informed of the requirement to participate in the Nebraska Health Connection, if applicable;
20. Have necessary reports and information forms completed by the Department.

3-001.03 Client Responsibilities: Each applicant or client is required to:

1. Provide complete and accurate information. State and federal law provides penalties of a fine, imprisonment, or both for persons found guilty of obtaining assistance or services

for which they are not eligible by making false statements or failing to report promptly any changes in their circumstances;

2. Report a change in circumstances no later than ten days following the change. This may include information regarding:

    a. Change or receipt of a resource including cash on hand, stocks, bonds, money in a checking or savings account, or a motor vehicle;
    Note: Changes in resources does not apply to groups whose eligibility is determined using MAGI-based methodology.
    b. Changes in unit composition, such as the addition, loss of or temporary absence of a unit member;
    c. Changes in residence;
    d. Living arrangement;
    e. Disability status;
    f. New employment;
    g. Termination of employment; and
    h. Changes in the amount of monthly income, including:
        (1) All changes in unearned income; and
        (2) Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time.

For reporting purposes, 30 hours is full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change.

Good Cause must be verified for failing to report a change within ten days. Unconfirmed statements do not constitute good cause.

3. Present his/her medical card to providers;
4. Inform the medical provider and the Department of any health insurance plan, any individual, or any group that may be liable for his/her medical expenses;
5. Cooperate in obtaining any third party medical payments;
6. Enroll in a health plan and maintain enrollment if:
    i. One is available to the client;
    j. The client is able to enroll on his/her own behalf; and
    k. The Department has determined that enrollment in the plan is cost effective.

7. Reimburse to the Department or pay to the provider any third party medical payments received directly for services which are payable by Medicaid;
8. Pay any unauthorized medical expenses;
9. Pay any required medical copayment;
10. Meet the requirements of the Nebraska Health Connection, if applicable; and
11. Cooperate with state and federal quality control.

<u>3-001.04 Department Continuing Responsibilities</u>:

1. Provide timely or adequate notice of any action affecting the client's assistance case;
2. Treat the client's information confidentially;
3. Uphold the client's civil rights; and
4. Inform the client when his/her case is closed that s/he has the right to reapply.

3-001.05 Application Submittal: An application for assistance may be made in person, by letter, telephone, fax, phone, or electronic submission and may be made by the applicant, his/her guardian or conservator, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant.

3-001.06 Application: An application is considered valid the date it is received by the Department and contains:

1. Name;
2. Address; and
3. Proper signature, as defined by the appropriate program.

An application may be signed by an individual for himself/herself or by the applicant's guardian, conservator, or an individual acting under a duly executed power of attorney. The client's relative or another individual acting on the client's behalf may sign the application. An application may be taken on behalf of a deceased person (including a miscarriage or a stillborn). If there is no one to represent the deceased person, the administrator of the estate may sign the application.

3-001.07 Assistance with Application or Renewal: An individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient shall be provided with assistance by the Medicaid agency.

Note: The Medicaid agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.

3-001.08 Application with a Designated Provider: Any individual may apply for medical assistance with a designated outreach provider or who has contracted with the Department to accept Medicaid applications at their location.

3-001.9 Alterations: The application, when completed and signed by the client or his/her representative, constitutes his/her own statement in regard to eligibility. Information may be added to an application up to the date of approval or completed renewal.

3-001.10 Prompt Action on Applications: Reasonable promptness must be taken on all applications for assistance. A determination of eligibility must be made on an application within 45 days from the date of the application for all applicants with the exception of applicants who are applying under the disability category which allows for 60 days. Notice of Action must be sent every 45 days from the date of application for a pending application for all applicants with the exception of applicants who are applying under the disabled category who receive a notice every 60 days.

3-001.11 Withdrawals: The applicant may voluntarily withdraw an application verbally or in writing. A Notice of Action must be sent to the applicant.

3-001.12 New Application: A new application is required after ninety days of ineligibility.

3-001.13 Authorization for Investigation: Release of Information may be obtained from the client when it appears that information given is incorrect or inconsistent, when the client is unable to furnish the necessary information, or for sample quality control verification.

3-001.14 Renewals

3-001.14A Renewal of Eligibility: A redetermination of eligibility for medical assistance must be completed every 12 months.

Renewal shall be completed on the basis of information available to the agency without requiring information from the individual. Information will only be required from the individual when not available through other sources (See 477-000-002).

Note: A prepopulated renewal form shall be required every 12 months for non-MAGI based renewals.

If information is not available to complete a renewal, a prepopulated renewal form shall be sent. The completed renewal form and necessary verifications shall be returned within 30 days of the date the renewal form was sent.

If the renewal form and necessary information is submitted within 90 days after termination, a new application shall not be required.

Note: For Medically needy category the client is ineligible if there is no medical need. The client shall be informed in writing that they may reapply if there is a medical need at a later date.

3-001.14B Renewal for SSI Recipients: An application is not required at the time of renewal for clients who are receiving SSI.

1. If SSI is discontinued and;
    a. The last application was completed more than 12 months from the last month of eligibility for SSI, a complete renewal of eligibility must be done within the next 30 days, including completion of an application.
    b. If it has been less than 12 months since completion of the last application, a review of all eligibility requirements that are necessary for continued assistance must be completed.

Exception: A renewal is not required for periodic non-pay for income due to an extra pay period.
Note: Clients who are determined eligible for Medicaid by SSI under the provisions of 1619(b) are not required to complete an application at renewal. Resources do not need to be verified.

3-001.14C Income Review for AABD/MA Clients: A review of income eligibility must be completed every 12 months for AABD/MA. An income review is not required for SSI recipients. Income must be reviewed for clients who are placed in 1619(b) status by SSI.

3-001.14D Disability Review for AABD/MA Clients: A review of disability for AABD/MA cases must be completed as required by the State Review Team.

3-001.15 Continuous Eligibility

3-001.15A Continuous Eligibility for Pregnant Women: Once a pregnant woman is determined Medicaid eligible, she remains continuously eligible through the 60-day postpartum period.

Note: Continuous eligibility does not apply to pregnant women covered during a period of presumptive eligibility.

3-001.15B Continued Eligibility for a Newborn: If Medicaid pays for the birth, eligibility continues through the month the child turns age one. For 599 CHIP, see 477 NAC 18-004.07

3-001.15C Six Months' Continuous Eligibility for Children: Children from birth through age 18 are eligible for six months of continuous Medicaid from the date of initial eligibility. Months of retroactive eligibility do not count in the six months of continuous eligibility unless there is no prospective eligibility. For 599 CHIP, see 477 NAC 18-004.07.

3-001.15D Exceptions to Continuous Eligibility:

1. The child turns 19 within the 6 months;
2. The recipient moves out of state;
3. It is determined that the original eligibility was based on erroneous or incomplete information;
4. The recipient dies; or
5. The recipient enters an ineligible living arrangement.

3-001.15E Review After Six Months' Continuous Eligibility for Children: Once a household has received six months' continuous eligibility, a desk review is completed and any information known to the agency shall be acted on.