

Presumptive Eligibility Application Process



Interview Reference

Created for

Presumptive Eligibility

Choices for Independence (HCBC-ECI)

By

DHHS, Division of Family Assistance

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8. Verification Desk Aid: Use this to determine acceptable verification.

Back Pocket: “Master” Rights and Responsibilities and Statement of Understanding to be photocopied and given to each applicant.



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF FAMILY ASSISTANCE

Nicholas A. Toumpas
Commissioner

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Director

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DATE: July 1, 2008

FROM: Terry Smith, Director DFA
Kathleen Otte, Bureau Chief BEAS

HARD COPY TO: DFA Management Team
DFA Administrative Supervisors
State Office Supervisors
Bureau of Elderly And Adult

- ACTION BY
- REPORT
- POLICY
- INFORMATION
- FAX
- SOP
- REQUEST
- E-MAIL

ELECTRONIC
VERSION TO: DFA FSS II – Servicelink
DO Supervisor

SUBJECT: Presumptive Eligibility: Choices for Independence/Home and Community Based Care Program - ECI

Implementation of RSA 151-E: 18 Presumptive Eligibility (PE)

- Aid to the Permanently and Totally Disabled;
- Aid to the Needy Blind;
- Old Age Assistance;

Applicants will be determined eligibility for Presumptive Eligibility if all the following apply:

- The applicant has not applied for PE in the past year;
- The applicant hasn't transferred any assets in the past 60 months, created a trust with in the past 60 months or purchased an annuity.

The Community Partners will complete the Form 800 application, gather all the verification for the Family Services Specialist to determine eligibility and complete the MED. The Community Partner will be performing the functions normally completed by the FSS – completing the application with the applicant and advising the application for their rights and responsibilities.

Community Partners will:

- Assist with completing the Application
- Sign Authorized Representative Form
- Conduct face-to-face interviews
- Have applicant sign necessary forms
- Collect all necessary verifications
- Send complete packet with cover memo to the appropriate Servicelink for processing

FSS will:

- Enter the application into New Heights with the received date being the application date and review verification provided by the Community Partner.
- If necessary, send the 940 packets to DDU.

Servicelink will:

- Enter the Medical Eligibility Determination (MED) into Options
- Scheduled the BEAS nurse

A formal SR and related manual pages will be released in the near future.

If you have any questions, please call 271-4254.

ANB – Aid to the Needy Blind

APTD – Aid to the Permanently and Totally Disabled

BEAS – Bureau of Elderly and Adult Services.

CFI – Choices for Independence

D.O. – District Office

DDU – Disabilities Determination Unit

DFA – Division of Family Assistance

HCBC-ECI – Home and Community Based Care for the Elderly and Chronically Ill

IRWE – Impairment Related Work Expense

MA – Medical Assistance

OAA – Old Age Assistance

SGA – Substantial Gainful Activity

SL – Servicelink

Interview Reference Guide

1. Screen the applicant to determine if he/she meets the criteria for PE.
2. Gather all necessary forms and pamphlets.
3. Complete the Authorized Representative Form with the applicant.
4. Assist the applicant in completing the Form 800, Application for Assistance.
5. Give the applicant a copy of the Rights and Responsibilities and review with the applicant using the following script:

RIGHTS AND RESPONSIBILITIES

SAY: The information you are providing to the Department of Health and Human Services is strictly confidential and cannot be shared with anyone without your written permission to do so.

SAY: The Department of Health and Human Services does not discriminate against anyone for any reason. If you feel that you have been discriminated against you can make a complaint by contacting the Controller at the address and telephone number indicated on your copy of the Rights and Responsibilities under the Nondiscrimination Notice section.

SAY: You have the right to request a fair hearing if you are not satisfied or disagree with any decisions that have been made regarding your eligibility. If you are still not satisfied and would like to request a fair hearing you need to contact the Family Services Specialist and request a Fair Hearing form or you can contact the DHHS at the address and telephone number indicated on the Rights and Responsibilities. An attorney at a Fair Hearing may represent you; the department will not pay for the cost of these legal services.

SAY: Your case may be randomly selected for a Quality Control review. This review entails an in-depth investigation into your household's situation. The Department of Health and Human Services may contact banks, employers, companies, merchants and other appropriate sources, concerning your household and statements made to the Department.

SAY: You will be required to periodically complete a review of your circumstances. You will be sent a new application through the mail. Your Medical Assistance may be affected if you do not completely fill out the form and return it by the due date, and come in for a personal interview, if required.

All changes in your household's circumstances, such as, changes in income, hours worked, individuals moving in or out of your home, resources, etc. must be reported within 10 calendar days after the change happens.

SAY: The Department of Health and Human Services may verify information that would affect your eligibility. Your signature on the Statement of Understanding, that will be discussed later, authorizes the Department to obtain verifications needed to determine your eligibility for benefits. Your authorization to release information remains in effect until your next eligibility interview.

SAY: It is important that you provide us with correct information. If you deliberately provide false information or intentionally withhold information to become eligible or remain eligible for benefits you could be prosecuted for fraud.

6. Review the completed information on the Form 800 application and assist the applicant in gathering all necessary verifications. Acceptable forms of verifications can be found on the Verification Desk Aid. (Refer to Section 11 for verifications list.

The following verifications must be obtained, if applicable:

- Identity
- Citizenship
- Residency
- Employment Income
- Unearned Income
- Resources – 1 year of bank statements, stocks, bonds, money market, mutual funds, etc
- Life Insurance
- Deed to real property
- Deductions
- Mandatory Forms as noted on the Forms Checklist
- Any other pertinent information not specifically mentioned on the application.

7. Use the following Interview Reference Guides to review and complete the various forms and pamphlets specific to the program applied for:

APTD or OAA INTERVIEW REFERENCE

All of the following are for APTD and OAA:

GIVE: Form 771, New Hampshire Medicaid and Healthy Kids-Gold Services

SAY: This pamphlet explains the medical services that are covered or not covered by Medicaid, which services need prior approval, and service limits.

GIVE: Form 770, Reimbursement Agreement & Acknowledgement.

SAY: If you own property or obtain property while receiving assistance under the Nursing Home/Choices for Independence Program – Home and Community Based Care and:

- * you are not living on your property, or
- * your spouse, minor or disabled child(ren) are not living on your property, or
- * your sibling with an equity interest in the property is not living on your property,

the State will file a lien to get paid back for the OAA, ANB, MEAD, or APTD medical assistance (Medicaid) you received after age 55.

SAY: You are not required to sign the form, however, if you receive medical assistance and you refused to sign the form the lien will still be placed. You will receive notice from DHHS prior to a lien being recorded and you will also the right to appeal the lien placement. *When an applicant refuses to sign the form the Community Partner should write “DECLINED or REFUSED” across the applicant’s signature line, print the applicant’s name above the declination and the worker must sign and date the form.*

GIVE: Form 77s What Are Liens and Estate Claims?

SAY: This pamphlet will provide more information on liens and estate claims and provides answers to commonly asked questions about liens and estate claims.

All of the following are for APTD Only:

GIVE: Form 177b, What is APTD? *Highlight the important areas and review the form with the applicant.*

GIVE: Form 177, Non-Medical Evaluation of Disability.

SAY: This form is completed by you and must be completed in full. Do not leave anything blank. Do not answer questions with N/A, as this will not be acceptable. Make sure to include the name, address and telephone numbers of any physicians that you have seen. Be sure to sign and date this form. *(If the Authorized Representative helped complete this form be sure they sign and date it as well.)*

GIVE: Form 900, Authorization for Release of Protected Health Information Sheet *(you will need to ask the applicant how many health care providers he/she has).*

SAY: This form authorizes the Medicaid Administration Services unit to contact your medical provider(s) if they need to obtain more information about your medical condition in order to determine your eligibility. You will need to complete a form for each health care provider that you wish the Department to contact for the disability determination.

(Applicants must also sign a blank Form 900 for Social Security.)

SAY: Once all of the necessary forms have been sent to your assigned Servicelink, they will be forwarded to the Disability Determination unit. They will determine whether or not you meet the medical requirements for the APTD program.

ANB INTERVIEW REFERENCE

GIVE: Form 177 and Form 901, Report of Eye Examination – *Worker must complete the top section of this form before giving the form to the applicant.*

SAY: You need to complete the Release of Medical Information section of this form and your optometrist or ophthalmologist must complete the rest. This will assist the Disability Determinations Unit in determining your medical eligibility. The Disability Determinations Unit will determine whether or not you meet the medical requirements for the ANB program.

GIVE: Form 770, Reimbursement Agreement & Acknowledgement.

SAY: If you own property or obtain property while receiving assistance under the Nursing Home/Choices for Independence Program – Home and Community Based Care and:

- * you are not living on your property, or
- * your spouse, minor or disabled child(ren) are not living on your property, or
- * your sibling with an equity interest in the property is not living on your property,

the State will file a lien to get paid back for the OAA, ANB, or APTD medical assistance (Medicaid) you received after age 55.

SAY: You are not required to sign the form, however, if you receive medical assistance and you refused to sign the form the lien will still be placed. You will receive notice from DHHS prior to a lien being recorded and you will also the right to appeal the lien placement. *When an applicant refuses to sign the form the Community Partner should write “DECLINED or REFUSED” across the applicant’s signature line, print the applicant’s name above the declination and the worker must sign and date the form.*

GIVE: Form 77s What Are Liens and Estate Claims?

SAY: This pamphlet will provide more information on liens and estate claims and provides answers to commonly asked questions about liens and estate claims.

8. Review the other pamphlets:

- Programs & Services Guide.

SAY: This pamphlet provides an overview of the various programs we provide. *Turn to page 7 of this pamphlet and explain What Happens Next?*

9. Explain processing timeframes.

SAY: A decision will be made on your eligibility as quickly as possible, the clock begins when the application and the MED has been received by Servicelink:

- The Community Partner has 10 business days to provide all the verification to Servicelink, if all verification is not received the Presumptive Eligibility process stops and a face-to-face interview is required. Note: A manual NOD will be mailed to the applicant.
- The Bureau of Elderly and Adult Services has 20 business days to determine medical eligibility;
- The Family Services Specialist at Servicelink has 5 business days to process.

SAY: Once your case has been processed, you will receive a Notice of Decision in the mail telling you whether or not you are eligible, what income, resources, and deductions we used to determine your eligibility.

10. Give the applicant the Statement of Understanding to read.

- Have the applicant read each statement and initial each statement indicating understanding.
- Authorized Representative and applicant must sign and date the Statement of Understanding.

APPLICATION PROCESS COMPLETE

11. Once all verifications have been received/completed, complete the Inmate Application Cover Sheet for Medicaid, attach the following information and forward to the DFA single point of contact.

- Presumptive Eligibility Cover Sheet
- Form 800, Application
- All Verifications/Completed Forms
- MED

12. Gather all necessary forms and pamphlets.

13. Complete the Authorized Representative Form with the applicant.

14. Give the applicant a copy of the Rights and Responsibilities and review with the applicant using the following script:

RIGHTS AND RESPONSIBILITIES

SAY: The information you are providing to the Department of Health and Human Services is strictly confidential and cannot be shared with anyone without your written permission to do so.

SAY: The Department of Health and Human Services does not discriminate against anyone for any reason. If you feel that you have been discriminated against you can make a complaint by contacting the Controller at the address and telephone number indicated on your copy of the Rights and Responsibilities under the Nondiscrimination Notice section.

SAY: You have the right to request a fair hearing if you are not satisfied or disagree with any decisions that have been made regarding your eligibility. If you are still not satisfied and would like to request a fair hearing you need to contact the District Office and request a Fair Hearing form or you can contact the DHHS at the address and telephone number indicated on the Rights and Responsibilities. An attorney at a Fair Hearing may represent you; the department will not pay for the cost of these legal services.

SAY: Your case may be randomly selected for a Quality Control review. This review entails an in-depth investigation into your household's situation. The Department of Health and Human Services may contact employers, companies, merchants and other appropriate sources, concerning your household and statements made to the Department.

SAY: You will be required to periodically complete a review of your circumstances. You will be sent a new application through the mail. Your Medical Assistance may be affected if you do not completely fill out the form and return it by the due date, and come in for a personal interview, if required.

All changes in your household's circumstances, such as, changes in income, hours worked, individuals moving in or out of your home, etc. must be reported within 10 calendar days after the change happens.

SAY: The Department of Health and Human Services may verify information that would affect your eligibility. Your signature on the Statement of Understanding, that will be discussed later, authorizes the Department to obtain verifications needed to determine your eligibility for benefits. Your authorization to release information remains in effect until your next eligibility interview.

SAY: It is important that you provide us with correct information. If you deliberately provide false information or intentionally withhold information to become eligible or remain eligible for benefits you could be prosecuted for fraud.

HCBC-ECI/CFI PE Medicaid Eligibility

Check the program the individual is applying for:

APTD OAA ANB

Obtain verification where indicated by an *.

1. **GENERAL INFORMATION:**

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status:	
*Identification Verification:	
*Citizenship Verification:	
*Resident of NH:	

2. ***RESOURCES:**

Does the individual have any other types of resources such as a trust or an annuity? If yes, stop and refer to Servicelink for a scheduled face-to-face interview.
Does the individual have other Resources such as real property, checking and saving, mutual funds, money market accounts? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:

<input type="checkbox"/> Checking <input type="checkbox"/> Saving <input type="checkbox"/> Mutual Funds, IRA, 401K, Roth, stocks, or savings bonds <input type="checkbox"/> Life Insurance – Face value _____ Cash value _____ <input type="checkbox"/> Prepaid Irrevocable Burial Fund <input type="checkbox"/> Burial Plot
<input type="checkbox"/> Real property Address:

3. ***INCOME:**

Will the individual have any other source of income such as regular contributions from family or church? If yes, how much and when does it begin? Yes No
Please list:

4. **LIVING ARRANGEMENT:**

What type of living arrangement will the individual reside in? For example – the individual lives alone, with family, in subsidized housing, in a residential care facility or nursing home.

5. ***DEDUCTIONS:**

Does the individual make court ordered support payments for child support or alimony?
 Yes No
Please list:

6. ***DISABILITY QUESTIONS:**

Is the individual unable to work, seek work or participate in an Education/Training activity due to a physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the individual blind, disabled or over age 65 with work related expenses? (I.e., Disability Insurance, Federal Withholding Taxes, Mandatory Retirement/Union Dues, Special Clothing, Transportation Costs, Other) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> One Time <input type="checkbox"/> Ongoing Begin/End Dates:
Will the individual incur Impairment Related Expenses? (I.e., Attendant Care, Medical Devices, Installation or Maintenance of Home, Medical Services, Prosthesis, Transportation Costs, Work Related Assistant/Equipment, Other) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> One Time <input type="checkbox"/> Ongoing Begin/End Dates:

7. ***MISCELLANEOUS:**

Does the individual have a pending lawsuit or waiting for a settlement? <input type="checkbox"/> Yes <input type="checkbox"/> No

Additional comments to the FSS at the Servicelink Office:

APTD/OAA/ANB/MEAD FORMS AND PAMPHLETS CHECKLIST

FORMS/PAMPHLETS YOU MUST GIVE FOR ALL APTD, OAA, ANB, MEAD APPLICANTS:

- Form 771, New Hampshire Medicaid and Healthy Kids-Gold pamphlet
- Form 800A, DFA Programs & Services
- New Hampshire Administrative Appeals, Pamphlet
- Form 789, Resource Information Sheet
- Form 11, Authorization to Release
- Form 778, Authorized Representative Declaration

APTD Only Additional Forms:

- Form 177, Non-Medical Evaluation of Disability – This form is a self-declaration form completed by client. You can include prison employment for work history.
- Form 177B, What is APTD - This form gives an overview of what the APTD program is.
- Form 900, Authorization to Release Information –a form must be completed for each health care provider listed on the Form 177. The only information that can be completed by the worker on the Form 900 is the name and address. All other information **MUST** be completed by the client or authorized representative. Additionally, if any information on the form does not apply to the client, **DO NOT WRITE N/A**. The client should write, “does not apply.” If the client refuses to indicate information on the Form, indicate on the Form 940, Comments section that the client refused to fully complete the form or that the client indicated that none of the statements applies to him/her. Applicants must also sign a blank 900 for Social Security. Can do one 900 if applicant has several Dr.’s in one clinic – enter the name of the clinic. Don’t use dates, remember to initial and sign.
- Medical documentation to substantiate disability.

APTD, OAA, and ANB Additional Forms

- Form 770, Reimbursement Agreement & Acknowledgement (APTD, OAA, MEAD, ANB)
- Form 77s, What Are Liens and Estate Claims? (APTD, OAA, MEAD, ANB)
- Form 940, Cover Memo for Medical Eligibility Determination (use for APTD and ANB only).

ANB Only

- Form 901, Report of Eye Examination

APTD/OAA/ANB/MEAD FORMS AND PAMPHLETS CHECKLIST (continued)

FORMS/PAMPHLETS YOU MAY USE

- Form 65, Client Statement – This form should be completed by the client and signed as indicated for all of the following situations: Shelter Statement, Fraud Statement; Voluntarily Withdrawing an Application; Voluntarily Terminating Assistance; Loss of Employment; or Other.
- Form 756, Employment Form
- Form 776, Termination of Employment Form
- Form 779, Retroactive Medical Assistance Request Form – Use this form when an individual has unpaid medical expenses in the 90 days prior to the date of application. Request proof of income and resources for each 30-day period requested. *Refer to the retroactive medical assistance interview reference.*

Verification Checklist
Long Term Care – Medicaid Application
Nursing Home and Choices for Independence

Please call the local District Office or Servicelink to schedule an interview.

In order to serve you better, **please provide COPIES** of the following documents at the interview. If you experience any problems obtaining the documents, you will be given 10 additional days after the interview to provide any missing verifications.

Effective 2/8/06 the Federal and State Laws were reviewed to allow for a look back period of 60 months.

If you are married and have a spouse in the community, please talk to your Family Services Specialist as you have a right to a **Resource Assessment** that could protect some of your assets for your spouse in the community after you have been hospitalized and it is anticipated that you will require Long Term Care Assistance for 30 consecutive days or longer.

IMPORTANT: Please note that the resource limit for Medicaid is \$2,500. You will need to provide documentation with bank/financial statements verifying that your total resources are \$2,500 or less at the interview. You will be responsible for any bill at the nursing home until the date you can verify that your total resources fell below \$2,500.

Citizenship Status & Age - Examples include one of the following: birth certificate, naturalization papers, US passport, baptismal certificate issued within 3 months of age, voter registration card, alien registration card, marriage license

Identity (Not needed if applicant receives Medicare.)

Marital Status – Examples included one of the following: marriage certificate, death certificate, divorce decree or legal separation papers

Social Security # and/or Claim Number if different and Veterans Claim Number

Medical Insurance – include all health insurance cards (front and back) & proof of premium

Authorized Representative, General Power of Attorney, or Guardianship

Residence – Address(s) of where you resided prior to entering the institution and with whom, along with dates. The list should identify type-subsidized housing, private rental, shared rental and or own property

Burial Contract (Irrevocable) and **Burial Plot**

All gross monthly income showing deductions - Examples include Social Security, Supplemental Security Income, Veterans payments, alimony, annuities (complete contract), disability payments, rental income, other pensions or retirement income. Copy of the award letter showing gross payment.

All resources/assets since February 8, 2006. Examples include: checking account statement(s), savings account(s), stocks, IRA, 401K, bonds, mutual funds, CD, Christmas Club, trusts, etc. **Provide copies of checks & verification of deposits & withdrawals over \$500. (FOR ANY OPEN OR CLOSED ACCOUNTS)**

Current patient account balance at nursing home.

Life Insurance –policy and the face value and current cash value from the life insurance company

Long Term Care Insurance policy – complete policy

Trust: Proof of what assets were used to establish the trust and what assets are in the trust today. Along with a copy of the trust document.

Annuity Contract

Real property – home, land, joint with others include deed and tax bill – real property includes a life estate in another person's property.

Transfers – if either the individual or their spouse has transferred, sold or given away property OR assets in the last 60 months, provide supporting documentation of the transfer, sale or gift(s).