ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only: Effective Date _____ Code Number _____

Name of Agency Arkansas Department of Human Services

Department Division of County Operations

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Statutory Authority for Promulgating Rules AR Code Annotated 20-76-201 et Seq., AR Code Annotated 20-15-201 et Seq.,

Rule Title: MS 12100 - 12470, Medicaid Coverage of Alien Pregnant Women

Intended Effective Date

☐ Emergency

☐ 10 Days After Filing

☒ Other

July 1, 2004

_____

	Date
Legal Notice Published	_____
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Reviewed by Legislative Council	_____
Adopted by State Agency	_____
.....	_____

☐ Electronic Copy of Rule Provided (per Act 1648 of 2001)

☐ Electronic Copy of Rule to be e-mailed from _____ Diana Teal diana.teal@mail.state.ar.us

Contact Person Email Address

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

_____
Signature

Director, Division of County Operations

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Phone Number E-mail Address

_____
Date

12100 Medicaid Coverage for Pregnant Women 07-01-04

There are three basic coverage groups for pregnant women, PW-No Grant, PW-Medically Needy (Exceptional and Spend Down) and SOBRA PW (including Presumptive Eligibility).

PREGNANT WOMEN CATEGORIES ELIGIBILITY CHART

CATEGORY	SERVICES	POSTPARTUM	INCOME	RESOURCES
PW No Grant	Full range of Medicaid services	None if application made after birth of child. Through end of month in which 60th day postpartum falls if made while pregnant.	At or below 29% Reduced Standard of Need (Appendix T)	Not to exceed $1,000 for the unit
PW Medically Needy Exceptional	Full range of Medicaid services except Nursing Facility and Personal Care Services	None if application made after birth. Through end of month in which 60th day postpartum falls if made while pregnant.	MNIL for unit size (MS 7610)	MNRL for unit size (MS 7500)
PW Medically Needy Spend-Down	Full range of Medicaid benefits for Spend-down period except Nursing Facility and Personal Care Services	None if application made after birth. Through end of month in which 60th day postpartum falls if made while pregnant.	Above SOBRA income limit for unit size (Appendix F)	MNRL for unit size (MS 7500)
SOBRA PW	Services related to pregnancy, delivery & postpartum only	Through end of month in which the 60th day postpartum falls	200% FPL for unit size (Appendix F)	MNRL for unit size (MS 7500)
SOBRA Presumptive Eligibility (PE)	Ambulatory prenatal care only	None	200% FPL for unit size (Appendix F)	Not Applicable

12110 Medicaid for Pregnant Women - PW No Grant 07-01-04

The Pregnant Women-No Grant category was established by the Medicare and Medicaid Budget Reconciliation Amendments of 1984. This coverage was expanded by the Consolidated Omnibus Budget Reconciliation Act of 1985 to include 60 days of postpartum coverage for pregnant women who were Medicaid recipients in the month the pregnancy terminated. The Omnibus Budget Reconciliation Act of 1987 extended the postpartum coverage to the end of the month in which the 60th day postpartum occurs. In this coverage group, postpartum coverage may be authorized for a woman who has a pending Medicaid application while pregnant and is later found eligible after the birth of the child. Postpartum coverage may not be authorized if application is made after the child is born.

Medicaid coverage under the PW-No Grant group is limited to pregnant women with income at or below the 29% Reduced Standard for their unit size (Re. Appendix T). Countable resources cannot exceed $1000 for the budget unit.

Pregnant women eligible for benefits in this category are entitled to the full range of benefits under the Medical Assistance Program.

12120 Medicaid Coverage for Medically Needy Pregnant Women 07-01-04

Pregnant women may be considered for Medically Needy-EC or Spend-down if they do not meet the 29% Reduced Standard for the Pregnant Women No Grant category or the $1,000 resource limit. If a pregnant woman's income and/or resources exceed those for the PW No Grant Standards, her income and resources will be compared to the Medically Needy MNIL and MNRL to determine eligibility in PW-MN Exceptional or Spend Down. If a pregnant woman has income above the MNIL but below 200% FPL, SOBRA PW eligibility will be determined prior to determining eligibility for Spend Down.

Postpartum coverage may be authorized through the end of the month in which the 60th day postpartum falls for pregnant women who apply for Medicaid while still pregnant. This includes women who have a pending Medicaid application while pregnant and are found eligible after the birth of the child. Postpartum coverage may not be authorized in these categories if application is made after the birth of the child.

Recipients in the Medically Needy Pregnant Women categories are eligible for the full range of Medicaid benefits with the exception of nursing facility and personal care services.

12130 SOBRA Medicaid for Pregnant Women 07-01-04

The Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA) allowed states to provide medical services to indigent pregnant women, infants and children. Medicaid coverage for pregnant women could be continued through the 60th day postpartum. Arkansas elected to take this option, effective April 1, 1987. OBRA 1987 extended the postpartum coverage for this group through the end of the month in which the 60th day postpartum falls. Effective April 1, 1990,

OBRA 1989 mandated states to cover pregnant women with income up to 133% FPL. Act 1658 of

2001 of the State of Arkansas 83rd General Assembly authorized coverage for PWs with income up to 200% FPL, effective November 1, 2001.

Medicaid eligibility for the SOBRA group is limited to pregnant women with net income at or below 200% FPL for their unit size (Re. Appendix F). Countable resources for this group will be compared to the Medically Needy Resource Levels for the number of individuals in the unit.

Services to pregnant women found eligible in SOBRA will be limited to prenatal, delivery, and postpartum care, and to other conditions which may complicate pregnancy. SOBRA Presumptive Eligibility (PE) covers only ambulatory prenatal care.

12150 Eligibility Requirements for Pregnant Women 07-01-04

To qualify for Medicaid under the Pregnant Women Program, the requirements that must be met are:

1. Medical Verification of Pregnancy (MS 12150), or for application made postpartum, a birth/death certificate or medical statement that verifies a pregnancy within the 3 months prior to the date of application.

2. Residence Requirement (MS 2200).

3. Social Security Enumeration Requirement (MS 1390). NOTE: Pregnant women eligible for coverage as non-qualified aliens or qualified aliens who have not met the five-year residency requirement are not required to meet the enumeration requirement.

4. Income Requirements- Current income limits for the different PW categories are found on Appendix T (PW - No Grant), MS 7610 (Medically Needy) and Appendix F (SOBRA).

   Pregnant Women are eligible for the income disregards at MS 11400. Once the net income is determined, the income should first be compared to the Pregnant Women-No Grant income limit. If income is under the 29% Standard and the woman is otherwise eligible, the case will be certified in PW-No Grant. If over the income limit for PW-No Grant, the income will be compared to the limits for PW Medically Needy-EC. If over the income limit for Medically Needy EC, the income will be compared to the 200% limit for SOBRA. If the individual is over the income limit for SOBRA and otherwise eligible, refer to the MS 7000 section for instructions on completing a Spend-Down application.

   Once eligibility is established, there will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period. The PW will remain Medicaid eligible through the end of the postpartum period regardless of increases in income.

In the case of a minor pregnant woman, if the income of the minor PW's parents is over the income limit for ARKids coverage, the income of the minor PW's parents will be deemed to the minor PW.

In cases of alien PW's eligible for SOBRA, the income of a non-qualified alien spouse will be deemed to the PW, but his needs will not be included in the need standard. A citizen or qualified alien spouse's income must be counted in full, with his needs included in the standard. The income and needs of non-qualified alien children will be disregarded. A citizen or qualified alien child's income and needs may be included if needed.

5. Resource Requirement – PW-No Grant, $1000 or less (MS 12110); Medically Needy and SOBRA compare to MNRL (MS 7500). Resources will be determined according to instructions at MS 11300 - 11364.

6. Citizenship and Alienage Requirements - For SOBRA PE, PW-No Grant, PW-EC and PW Spend-down Categories, the rules for citizenship and alienage outlined at MS 6700 - 6769 will apply. For SOBRA PW, women who are not currently eligible as qualified aliens but who meet other eligibility factors may be eligible for coverage based on enhanced funding from SCHIP (MS 12180).

7. Relationship and Need Requirement (MS 12170).

8. Mandatory Assignment of Rights to Medical Support/Third Party Liability (MS 1350).

12160 Verification of Pregnancy 07-01-04

Medical documentation of the individual's pregnancy must be contained in the case record; or for applications made postpartum, a birth/death certificate or medical statement to verify pregnancy within the 3 months prior to the date of application will be required.

12161 Documentation of Pregnancy 07-01-04

The individual is responsible for providing a medical statement verifying pregnancy. Such statement must:

- Be completed on stationery which identifies the physician's/practitioner's office, clinic, etc. or be address stamped by the office or clinic.
- Be signed and dated by the patient's licensed M.D., licensed D.O., Certified Nurse Midwife, or Public Health R.N.
- State the expected term of pregnancy.

The DCO-62 can also be used as verification of pregnancy.

If the application is made postpartum, documentation of the pregnancy will be made by a

birth/death certificate or medical statement.

12170 Relationship and Need Requirement 07-01-04

To include family members in the budget unit for Pregnant Women, relationship and living with specified relative must be established. The child's "relative" must be within the degrees of relationship outlined at MS 16040 #2, and the child must be living with the relative in his/her home.

In budgeting, even though the pregnant woman is the only "eligible," the father of the unborn child, if in the home, and the unborn child will be included in the budget unit. If there are other children in the home who meet the relationship requirement, they may be included in the budget, if necessary, to raise the need standard to a level that will allow eligibility for the PW. If inclusion of
a child and the child's income and resources will result in ineligibility of the PW, that child and the child's income and resources may be excluded. However, the unborn child will always be counted in the need standard for the pregnant woman.

12180 SOBRA PW Coverage for Ineligible Aliens 07-01-04

Pregnant women who are undocumented aliens or qualified aliens who do not yet meet the five-year residency requirement may be eligible for coverage based on enhanced funding from SCHIP. The enhanced funding coverage will be available only to alien PWs who have no other insurance that covers pregnancy related services. A special indicator will be entered to track eligibility for the enhanced funds. The caseworker must select "Nonqualify Alien Preg Wom" under General Client Characteristics on the Characteristics Tab in ANSWER. As qualified aliens meeting the five-year residency requirement are eligible for Medicaid using the same criteria as for U.S. citizens, and are not eligible for the enhanced funding, the caseworker must verify alien status before authorizing coverage. As this coverage is intended to benefit unborn children who will be U.S. citizens at birth, the PW will not qualify for this coverage if she intends to leave the U.S. before the baby is born.

In some counties, DHS caseworkers will go to ADH offices to determine Medicaid eligibility for alien pregnant women on days when ADH has clinics for the pregnant women. The DHS caseworker will interview the PW or responsible individual and verify all eligibility requirements. The day the worker receives the application will be the application date. The DHS caseworker will be able to immediately key information to ANSWER, and when all verification of eligibility is received, key the approval or denial to the ANSWER system.

When a DHS caseworker is not available to take the application, the ADH worker will assist the applicant in completing form DCO-95, Application for Medical Assistance. The completed form will be sent to the local DHS office to be processed, along with any pertinent information known to the ADH worker regarding the application. If the applicant needs an interpreter, that information will also be noted.

The ADH worker will advise the applicant that DHS will be contacting her and will encourage her to respond and cooperate in providing information. The worker will emphasize that DHS will treat all information about her in a confidential manner.

The date of application will be the date the local DHS office receives the signed DCO-95 in the county office. After receipt, the application will be processed in the usual manner.

Newborns born to alien pregnant women approved under the enhanced funding from SCHIP will not be eligible for the Newborn category. However, the DCO-645 may be used to approve the newborn in the appropriate ARKids category based on the income reported at the time the mother applied. An ARKids application will not be required if a completed DCO-645 is received by the county office. The application date will be the day the DCO-645 is received in the county office.

12200 Presumptive Eligibility 07-01-04

SOBRA allows for the provision of Medicaid eligibility for ambulatory prenatal care during a period of presumptive eligibility (PE). The PE period precedes the eligibility determination made by the county office, and begins on the date that a Qualified Provider determines on the basis of preliminary information that the net family income of the pregnant woman does not exceed 200% of the Federal Poverty Income Guidelines. No resource test will be imposed for presumptive eligibility. When a Qualified Provider has made this determination, the provider is required to notify the county office in the pregnant woman's county of residence within 5 working days after the date of determination**.**

Qualified aliens not meeting the five-year residency requirement and unqualified aliens will not be eligible for PE coverage. See MS 12180 for instruction on processing applications using enhanced SOBRA coverage through SCHIP for these individuals.

12210 Erroneous Payments 07-01-04

Any erroneous excess Medicaid payments made during a period of PE will not be considered an overpayment, and PE cases will not be subject to Quality Assurance review.

12220 Qualified Providers 07-01-04

Arkansas has identified the Arkansas Department of Health (ADH), Community Health Centers of Arkansas (CHC), the Area Health Education Centers (AHEC), Planned Parenthood of Arkansas and Eastern Oklahoma (PPAEO) and Boston Mountain Rural Health Center as Qualified Providers to make the determinations of PE for pregnant women.

12230 Extent of Services 07-01-04

Services to women determined presumptively eligible are limited to ambulatory prenatal care. Hospitalization is not covered.

12240 Application and Eligibility Determination Process for Presumptive Eligibility 07-01-04

The Agency will supply the Qualified Providers with Application for Assistance Forms (DCO-95s), Presumptive Eligibility Budget Sheets (DCO-62s), Checklist for Pregnant Women Forms (DCO-63s), and Notice to Pregnant Women Found Presumptively Eligible for Medicaid (DCO-63 Attachment), and with the training necessary for completion of the forms. Those pregnant women not currently Medicaid eligible will be requested by the Qualified Provider to complete an application form that will serve as the application for both the PE determination and the Agency determination of eligibility. A representative of the Qualified Provider will sign the application as the "person helping to complete the form."

In making the PE eligibility determination, after verification of the pregnancy, the Qualified Provider will compute earned income according to instructions at MS 11400. Lump sum payments will be treated as income in the month received. Income will not be verified unless it is questionable, and resources will be disregarded.

Even though the pregnant woman is the only eligible, the father of the unborn, if living in the home, and the unborn child, will be included in the budget unit. If there are other children in the home who meet the relationship requirement, they may be included in the budget unit if necessary to raise the standard to a level that will allow eligibility for the pregnant woman. If inclusion of a child and that child's income will cause the PW to be ineligible, that child and the child's income may be excluded from the budget unit.

When the total of net earned income plus unearned income is equal to or less than the FPL for the appropriate number of members in the unit (Re. Appendix F), the Qualified Provider may declare the pregnant woman PE eligible. A DCO-62 will then be completed by the Qualified Provider and the date the PE determination is made will be entered on the form. The Qualified Provider will give those women found PE eligible a DCO-63 and DCO-63 Attachment.

Only the application packets of women found presumptively eligible will be submitted to the DHS county office. The application packet must be received in the county within 5 working days after the day the PE determination was made.

The Qualified Provider will refer women with large outstanding medical bills who do not meet PE requirements to their local county offices to make Medically Needy Spend Down applications. Other women whose household composition and/or income requires complicated budgeting will also be referred to their county offices without first having a PE determination.

A PE determination may be made at any time during a pregnancy, even if there is an application pending at the county office. Only one PE period will be granted during a pregnancy.

12241 Incomplete/Incorrect Presumptive Eligibility Packets 07-01-04

If an application packet received from a Qualified Provider is incomplete, it will be returned to the

Qualified Provider with a written request to provide the missing information and provide an amended (later) date of PE determination. An application will be considered incomplete when it lacks basic information needed for registration, such as signatures or dates.

Qualified Providers have been requested to have Page 3 of the application form regarding

resources completed at the presumptive eligibility interview. However, no application will be returned if this information was not recorded on the form, as resources are not an eligibility consideration for presumptive eligibility.

NOTE: If the applicant has not been enumerated, the Qualified Provider will enter "No SSN" in the appropriate blank on the application.

Before registration of the application, the caseworker will also check the net income shown on the DCO-62 to verify that it does not exceed the income level for the appropriate number of members in the unit. If the net income shown does exceed the limit, the county will register the application in SOBRA PW but will not register the application in PE. The DCO-62 only will be returned to the Qualified Provider for review, correction, and an amended PE determination date, before a PE application will be entered into the system and approved.

12242 PE Packets Not Received Within Five Working Days 07-01-04

SOBRA requires a Qualified Provider to notify the Agency within 5 working days after the day a PE determination has been made. Any packets received on the 6th day or later after the PE determination was made will be returned to the Qualified Provider for an amended (later) PE determination and PE determination date.

When a packet must be returned for an amended PE date, the application will be registered in SOBRA PW, but not in PE. The original application form will be retained by the county. A copy of the application form and the original DCO-62 will be returned to the Qualified Provider.

12243 Entry of PE Applications in System 07-01-04

The application will be registered on the date the signed application form is received by the county office from the Qualified Provider. The caseworker will complete the application data on the form and enter into the system. Only the PE application will be registered.

12250 Presumptive Eligibility Period 07-01-04

Presumptive eligibility begins on the date that a Qualified Provider determines that the net family income of a pregnant woman does not exceed the appropriate level of the Federal Poverty Income Guidelines. Presumptive eligibility ends with the date a final eligibility determination is made by the Agency on the SOBRA PW application.

12260 Approval of Presumptive Eligibility 07-01-04

If both the DCO-62 and the application form have been completed and signed as required, and if

the application packet was received in the county office within 5 working days after the date of PE determination, the information will be keyed to the system. Every effort will be made to key PE approvals within 5 working days from receipt of completed PE packets.

The unit size will include the pregnant woman, the unborn child, the father of the unborn child if he resides in the home, and other children in the home who meet the relationship requirement, if the applicant chooses to include them in the budget unit.

The Medicaid Begin Date will be the same as the PE determination date. Retroactive eligibility prior to the PE determination date cannot be authorized for PE pregnant women.

If the PE-PW has not been enumerated, a pseudo SSN will be obtained. The enumeration procedures at MS 1390 will be followed prior to certification in SOBRA PW.

When a PW PE application is received, it will be registered and approved, but the on-going SOBRA PW application will not be registered until it is ready to be approved. When the PE application is registered and approved, the caseworker will create a task on the To Do List as a reminder to complete the full coverage SOBRA PW application. When the caseworker is ready to approve the PW application, the PE case will be closed. The caseworker will reuse the PE Budget Unit to register and approve the on-going PW application.

The caseworker will notify the pregnant woman by system notice of the approval of PE and of the effective date of eligibility. She will be advised on the notice that her PE eligibility will end on the date that final eligibility determination has been made on the SOBRA PW application.

If the PE case is denied for any reason, the Qualified Provider must be notified of the denial by copy of the EMS-700 or by memorandum.

12280 Duplicate Applications 07-01-04

If a SOBRA PW application is already pending in the county office when an application is received from the Qualified Provider, the PE application will be registered and approved as usual. The SOBRA PW application will not be placed on the To Do List. The original SOBRA PW application will be processed.

If a PW-PE application is received and a category other than SOBRA PW is already pending, the PE application will be registered and approved as usual. The SOBRA PW application will be placed on the To Do List. If the original pending application is approved, the SOBRA PW will be cancelled from the To Do List. If the original application is denied, the SOBRA PW will be processed, and if eligible, the caseworker will close the PE and register and approve the on-going PW application, reusing the PE Budget Unit.

12300 Application Process for Agency PW Determinations 07-01-04

The county offices will not make PE determinations, but will follow routine application

procedures when an application is first made in the county office, at UAMS (RE. MS 7101.2) or at ACH (Re. MS 7101.1). If the applicant is incompetent or incapacitated, a guardian, relative or other responsible representative may apply on her behalf. A personal interview will be conducted at the county office or other place convenient to the applicant if she is incapable of coming to the office. A personal interview is not required for those pregnant women who have previously been found presumptively eligible unless the caseworker deems it necessary to clear all points of eligibility.

The Agency has the responsibility to follow up on any request and to make arrangements for completion of the application. Assistance cannot be authorized until the application is approved.

Applications must be completed and signed under penalty of perjury. The application form advises the applicant of her rights and responsibilities in giving the agency accurate information for determination of eligibility. The application may be introduced as court evidence in fraud cases.

The applicant will be relied upon as the primary source of information. However, when the applicant is unable to provide essential information, the caseworker will assist in obtaining the necessary verification.

If necessary, the caseworker will use Form DHS-81, Consent for Release of Information, to secure essential information from a collateral source. The form must be signed by the applicant, indicating the applicant's permission to release information to the Agency.

If the applicant received assistance in another county, the case information will be requested from that county.

The caseworker will document the interview covering each task completed and also record essential social and financial information in the narrative and/or on the appropriate forms.

12310 Period of Eligibility 07-01-04

An individual found eligible may receive PW Medicaid coverage only during the period of pregnancy and through the end of the month in which the 60th day postpartum falls. Postpartum coverage will be provided to women who are Medicaid certified at the time of delivery and to women who have a Medicaid application pending at the time of birth and are later found eligible for PW coverage. An individual who applies for Pregnant Woman – No Grant or PW-MN Medicaid after termination of a pregnancy may be given benefits to the end of the birth month, if eligible, but may not be given postpartum coverage. A PW who applies postpartum and is found SOBRA eligible in the month of delivery will be given the full postpartum coverage.

In determining eligibility for the PW, the caseworker must inquire if the PW had any medical bills of her own, paid or unpaid, in the 3 months prior to the date of application, and if so, determine retroactive eligibility for the retroactive period. There must have been medical bills incurred to give retroactive coverage. The medical bills must be verified, and must be for the PW. Medical

bills for other family members will not qualify the PW for retroactive PW coverage. If retroactive coverage is not given, the record should be clearly documented to show that coverage was considered and why it was not given.

If a PW applicant is not income eligible in the month of application or the month in which the 45th day falls, but is income and otherwise eligible in one of the retroactive months, and can verify

medical bills in that month, the application will be approved beginning in the earliest month of retroactive eligibility. Eligibility will then continue through the end of the month in which the 60th day postpartum falls, if the applicant is eligible for the postpartum coverage, with disregard of any income changes which occurred after the beginning month of eligibility.

There will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period, even if the applicant is not eligible in the month of application or in the month when the 45th day of the application falls.

12320 Completion of Application Forms 07-01-04

During the initial application interview, the caseworker will complete the DCO-662, and if necessary, assist the applicant in completing the application form. Whenever possible, the applicant should complete and make any changes or additions to the application form. PUB-182 will be reviewed and given to the applicant.

If the client requests Family Planning Services or WIC, the caseworker will complete form DHS-3300.

The applicant and all those to be included in the assistance unit who do not have Social Security numbers must complete an SS-5 and DCO-12 at the county office to obtain SSNs from the Social Security Administration (Re. MS 1390). Undocumented aliens are excluded from the enumeration requirement.

At the conclusion of the interview, the applicant will be given a DCO-002 or DCO-191 with the checked items needed for the eligibility determination. At least 10 days will be given for return of the items needed, or longer if the applicant requests.

12330 Entry of Application to the System 07-01-04

The application must be registered by the end of the next working day after receipt unless there is a PE application already pending. If there is a PE application pending, the PW application will be registered after the PE application is processed and the case closed. The registration date will be the date the signed application form is received in the county office. The caseworker will complete the application data on the first page of the application and enter the information into the system. Applications for Medicaid coverage of Pregnant Women will be entered in PW-No Grant, PW Medically Needy or SOBRA Pregnant Women.

12340 Denial of Application at Intake 07-01-04

When the information presented by the applicant or her representative during the first interview establishes that the applicant is ineligible, the application will be denied immediately and no further action will be necessary.

When an application is denied at intake, the caseworker will complete both the application data and denial data on the application before entering in the system.

12350 Home Visits 07-01-04

A home visit will be made only if necessary to clear all points of eligibility.

12351 Securing Information From Collateral Source 07-01-04

Collateral information is evidence provided by written documents or by persons other than the applicant. Persons with vested interest in the applicant will not be accepted as collateral sources. The applicant will be informed that the collateral(s) will be contacted. To establish eligibility, collateral information may be obtained to verify statements of the applicant.

If necessary, the caseworker will use the DHS-81, Consent for Release of Information, to secure essential information from a collateral source. The form must be signed by the applicant, giving permission to release information to the Agency.

The caseworker will protect the rights of the applicant during collateral interviews and will give only the information necessary to enable the person interviewed to understand the need for the information requested.

When an original, photocopy, or certified copy of a document used as evidence is not a permanent part of the case record, it will be necessary for the narrative to contain definitive information as follows:

- The location of the document, e.g., where or by whom the document is kept.
- The pertinent facts contained in the document that established authenticity; the date the document was made, where registered or filed, registration or filing identification, serial number, etc.

12360 Forty-Five-Day Time Limit On Disposition of Application 07-01-04

The caseworker will have a maximum of forty-five (45) days from the date of application to dispose of the application by one of the following actions: approval, denial or withdrawal.

12361 Delayed Action on Application by County Office 07-01-04

When action on an application will be delayed because of the county office, the applicant will be notified by the county office of the reasons for the delay and of her right to an appeal.

12362 Delayed Action on Application by Applicant 07-01-04

If the applicant has been given a DCO-002 or DCO-191 requesting information to clear eligibility but fails to provide the information by the end of the specified time, the application will be denied and a DCO-700 or DCO-55, system generated notice, will be sent to advise the applicant of the denial. However, if the applicant is having difficulty providing essential information, and requests additional time, the caseworker will acknowledge the request by sending a second notice that

clearly specifies what information is needed by the end of the extended time period, and will assist the applicant in obtaining information, if possible. If the information has not been provided by the end of the extended time period, the application will be denied. The applicant will be notified of the denial by Form DCO-700 or DCO-55.

12370 Approval of Application 07-01-04

The caseworker will complete the following tasks when approving an application:

- Record all pertinent information in the case.
- Complete Form DHS-3300 for Referral for Family Planning and/or WIC if requested.
- Enter approval data to system

The client will be notified of the approval and the beginning date of eligibility via system notice.

NOTE: A PW "Minor Parent" (under age 18) will always be given a 101 suffix.

12380 Denial and Withdrawal 07-01-04

The caseworker will complete the following tasks when denying an application:

- Record pertinent information in the case narrative. Information included on forms will not be repeated. Only the factor that makes the applicant ineligible must be verified. However, verification of other factors of eligibility that have been obtained will be recorded for future reference.
- Complete Form DHS-3300 for referral for Family Planning Services and/or WIC, if requested by the client.

The client will be notified of the denial by manual or system notice.

For withdrawal of an application, obtain a signed written statement from the applicant that she wishes to withdraw her application.

12390 Transfer to Another County 07-01-04

When an applicant moves out of the county in which her application was taken, the case record must be transferred to the new county of residence.

12391 Responsibility of Transferring County 07-01-04

When an applicant moves from the county in which her application was made, the caseworker in the initial county will:

- Obtain from the applicant her new address, the county to which she has moved and any other pertinent information regarding the move.
- Forward the application, including all forms which have been completed and/or signed by the applicant and any other information which has been obtained regarding the applicant's eligibility, to the county to which the applicant has moved with an explanatory memorandum attached.
- Complete the denial data and enter into system.

12392 Responsibility of Receiving County 07-01-04

Upon receipt of a transferred application, the receiving county will:

- Enter the application on the system using the original date of application in the previous county of residence.
- Enter the date received in the upper margin of the first page of the application.
- Use the original date of application when determining eligibility.

12400 Authorization of Eligibility 07-01-04

When all factors of eligibility have been established for Pregnant Women coverage, the caseworker will complete the approval on the system.

Although the father of the unborn child, if in the home, and children in the degrees of relationship will be included in the budget unit, Medicaid will only be authorized for the PW. A Medicaid End Date will be given based on the delivery date or expected date of delivery and eligibility for postpartum coverage.

12410 Certification Period 07-01-04

When certifying a case prior to delivery, certify the case in fixed eligibility, entering an end date of the last day of the month in which the 60th day postpartum falls. No reevaluation will be scheduled.

If certification is made after termination of a pregnancy, the case will also be certified in a fixed

period of eligibility.

When all data is accepted and entered into the system a case number is assigned. If the case contains no critical errors, the client should receive a letter with instructions for obtaining a picture I.D. for the Medicaid card within a week to 10 days.

12420 Continuing Eligibility 07-01-04

The Division of County Operations has the responsibility to provide assistance to eligible individuals and to assure that assistance is not provided to ineligible individuals.

Both the Agency and the recipient have the responsibility for insuring that information concerning the recipient's eligibility status is current and complete.

Once the application has been approved, income increases during pregnancy and the postpartum period will not affect eligibility. The PW will remain eligible through the end of the postpartum period regardless of increases in income. Changes in resources, however, may affect eligibility, as the PW must remain under the resource limit throughout the coverage period to remain eligible for Medicaid. The PW must also continue to be a resident of Arkansas throughout the coverage period.

12430 Responsibilities of the County Office 07-01-04

The county office is responsible for:

- Explaining the policies and procedures for determining eligibility.
- Explaining to the recipient the requirement of reporting material changes within 10 days (use PUB-182).
- Redetermining eligibility as soon as possible when a change is reported, and processing necessary terminations.
- Making an investigation into the recipient's continued eligibility when eligibility status is in question. The caseworker will send a 10-day notice when additional information is needed and/or when the case is to be closed.
- When a case is transferred, the caseworker will obtain a DCO-76, Collateral Statement, to verify new residence and household composition. The caseworker will make necessary changes and enter data into the system. The recipient will not be required to complete a new application or have a personal interview unless necessary to clear any points of continuing eligibility.

12440 Responsibilities of the Recipient 07-01-04

The recipient is responsible for providing complete and accurate information concerning her situation whenever a request is made by the county office.

The recipient has the additional responsibility to report any material changes in her circumstances within 10 days, including the termination of the pregnancy, so that an adjustment can be made to the end of the postpartum coverage, if necessary.

12450 Advance Notice Requirement for Termination of Assistance 07-01-04

When the county office proposes to terminate Medicaid Assistance, Form DCO-700 or a system notice must be given to or mailed to the recipient at least 10 days prior to the termination. Only a 5-day notice must be given in instances of probable fraud.

The notice must provide a statement of the planned action, the reason(s) for the intended action and the specific policy that is the basis for the action.

If a hearing is not requested during the advance notice period, the case will be closed or other action completed. If a hearing is requested during the advance notice period, the county office will forward a copy of the DCO-700, if applicable, along with the DCO-1200 to Appeals and Hearings, and delay action pending the hearing.

12460 Termination Actions Not Requiring Advance Notice 07-01-04

Assistance will be terminated without advance notice when:

- The Agency has factual information concerning the death of the recipient.
- The Agency has received a statement signed by the recipient that she no longer wishes to receive assistance or that provides information that requires termination of assistance, and the recipient has indicated that she understands the consequences of providing the information.
- The recipient has been admitted or committed as an inmate to a public institution.
- The recipient's whereabouts are unknown and Agency mail directed to her has been returned by the Post Office indicating no known address.
- It has been verified that the recipient has been accepted for assistance in a new jurisdiction.
- The recipient has been informed in writing at the time of initation of assistance that assistance will automatically terminate at the end of a specified period.

12470 Other Changes 07-01-04

Changes other than termination will not require recipient notification. When the agency becomes aware of changes such as changes of address, appropriate verification will be secured and case and member information will be updated.

All changes will be evaluated in regard to their impact on recipient eligibility before update.