



Maryland Children's Health Program Manual

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About the Manual

Information provided in this manual applies to the Medicaid expansion component of the Maryland Children's Health Program (MCHP).

Information about MCHP Premium, the separate child health program component of MCHP, is contained in the MCHP Premium Manual.

This manual was prepared and is updated periodically by the Maryland Children's Health Program Division, Maryland Department of Health, 201 West Preston Street, Baltimore, Maryland 21201. Questions about the Manual should be directed to the Division at the address above or by calling 410-767-1463.

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Introduction and Program Overview

BACKGROUND

As part of the Balanced Budget Act of 1997 Congress passed Title XXI of the Social Security Act, the State Child Health Insurance Program (SCHIP). Title XXI permits states to provide health care coverage to certain targeted low-income children and their families.

The legislation included a significant incentive to states to provide health care to the targeted population; the Federal government matches 65 percent of states' expenditures under the new program. Each state wishing to take advantage of this federal legislation must have an approved State Plan describing its SCHIP Program. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, reviews and approves the State Plan.

Title XXI allows states two basic programmatic options for SCHIP: states may either establish a separate child health (which may charge a premium or other fees and may purchase insurance for eligible persons) or expand their existing Title XIX programs. States may also develop plans that utilize a combination of these approaches. There is substantial latitude given to states under this law, including charging premiums for coverage, and simplifying the eligibility process.

Maryland chose the expansion of its existing Title XIX program option, effective July 1, 1998. This expanded coverage was enabled by State law, the Maryland's Children and Families First Health Care Act of 1998. The regulation which implements this coverage is COMAR 10.09.11. The Maryland Department of Health (MDH) is responsible for administering MCHP. In accordance with the rules of the Affordable Care Act (ACA) in effective January 1, 2014; the application for the program is contained within the web-based Maryland Health Connection application. Local Health Departments (LHDs) and Local Departments of Social Services (LDSSs) are responsible for assisting consumers with completing the on-line application to determine MCHP eligibility. The regional Connector Entity and the MHC Consolidated Call Center have staff that can provide assistance as well.

ELIGIBILITY CRITERIA

There are both technical and financial eligibility criteria for MCHP. Technical factors include Maryland residency and citizenship or qualifying immigration status. Financial eligibility requires that family income be within allowable income standards for the size of the family. Income standards are based on Federal Poverty Level (FPL) and change annually.

To be eligible, children must be under age 19 and have family income at or below 200 percent FPL for free coverage in MCHP (under age 19 and family income at or below 300 percent FPL for MCHP Premium). To be eligible as a pregnant woman, the woman of any age must be pregnant or in the first or second post-partum month and have family income at or below 250 percent FPL.

Assets will not be considered in determining eligibility.

There are other technical criteria for eligibility, depending on the specific coverage group in which

eligibility is being tested. For example, in the MCHP P13 and P14 coverage groups and in MCHP Premium, children may not have Employer-Sponsored Insurance. There is no longer a 6-month lock-out for having voluntarily dropped insurance.

IMMIGRATION STATUS AND MEDICAID ELIGIBILITY

This document and the accompanying table provide a brief overview of the rules governing Medicaid eligibility for a variety of non-U.S. citizens.

Immigrant children and pregnant women, who are eligible except for not meeting the 5-year bar, may be considered for MCHP and MCHP Premium. Other non-pregnant adult immigrants may be eligible for Medical Assistance coverage for emergency services only.

Qualified Aliens and the 5-Year Bar

In most cases, a non-U.S. citizen must be a “qualified” alien and meet the other eligibility criteria (e.g., income) in order to receive Medicaid coverage. Most qualified aliens must be lawfully present for 5 years (“the 5-year bar”) before they can be found eligible for Medicaid. For purposes of meeting the 5-year bar, immigrants cannot count any time when they were undocumented or otherwise not in a “qualified” status. Qualified aliens who do not meet the 5-year bar are only eligible for emergency medical services. A limited number of groups of qualified aliens are exempt from the 5-year bar, primarily for humanitarian reasons. For example, refugees and asylees are not subject to the 5-year bar. Certain other groups of immigrants specified below and in the Immigration Status and Medicaid Eligibility Table are exempt from the 5-year bar.

Non-Qualified Aliens

Most non-qualified aliens are only eligible for emergency medical services until their status changes to make them qualified aliens and they meet the 5-year bar.

Exceptions for Coverage of Lawfully Residing Pregnant Women and Children

Lawfully residing pregnant women and children, both qualified and non-qualified aliens, are eligible for Medicaid and are not subject to the 5-year bar under CHIPRA § 214. Note that the definition of “lawfully residing” is different from the definition of a “qualified alien” and includes additional groups of non-citizens.

Undocumented Immigrants

Individuals who are not legally in the United States are not eligible for Medicaid. Individuals who do not meet the immigration requirements for Medicaid, but who meet all other eligibility requirements, are eligible for emergency medical services, including labor and delivery services for pregnant women.

IMMIGRATION STATUS AND MEDICAID ELIGIBILITY*

<p>Qualified Aliens Subject to 5-Year Bar</p>	<p>Lawfully Residing Non-Qualified Aliens (Eligible for EMS only except as noted in 5-Year Bar Exemptions.)</p>	<p>Immigrants Exempt from 5-Year Bar (Eligible for Medicaid)</p>
<ul style="list-style-type: none"> • Lawful Permanent Resident (LPR/Green Card holder) who <ol style="list-style-type: none"> 1.) entered the U.S. before August 22, 1996; or 2.) has been in qualified status for 5 years or more • Alien paroled into the U.S. for at least 1 year • Conditional Entrant granted before 1980 • Battered Spouse, Child, or Parent • Alien granted Withholding of Deportation or Withholding of Removal under 243(h) or 241(b)(3) of INA (unsafe to return to country) 	<ul style="list-style-type: none"> • Non-citizen with valid nonimmigrant status, such as individuals with student or work visas • Paroled into the U.S. for less than 1 year pursuant to § 212(d)(5) of INA, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings • Granted temporary resident status pursuant to § 210 or 245A of the INA • Alien under Temporary Protected Status (TPS) and pending applicant for TPS who has been granted employment authorization • Granted employment authorization under 8 CFR 2741.12(c)(9), (10), (16), (18), (20), (22), or (24) • Family Unity beneficiary • Under Deferred Enforced Departure by presidential decision • Granted Deferred Action status • Granted an administrative stay of removal under 8 CFR § 241 • Individual with approved visa petition and pending application for adjustment of status • Individual with pending application for asylum under 8 U.S.C. § 1158 or withholding of removal under 8 U.S.C. § 1231 or Convention against Torture who has been granted employment authorization or who is under age 14 • Child with pending application for Special Immigrant Juvenile Status • Individual lawfully present in American Samoa under its immigration laws 	<ul style="list-style-type: none"> • A lawfully residing child under age 21 (both qualified and non-qualified aliens) • A lawfully residing pregnant woman (both qualified and non-qualified aliens) • Asylee • Refugee • Cuban/Haitian entrant • Amerasians who were born to U.S. citizen armed services members in Southeast Asia during the Vietnam War • Victim of trafficking (and his/her spouse, child, sibling or parent) • Individual with Iraqi or Afghan special immigrant status • Veteran, active duty military and their spouses, un-remarried surviving spouses or children • Individual receiving foster care • Member of a federally recognized Indian tribe or American Indian born in Canada

*NOTE: Under the ACA, lawfully present individuals can purchase QHP coverage and may be eligible for APTC/CSR. Undocumented individuals who are not legally in the United States are only eligible for emergency medical services; these cases must be processed in CARES.

ELIGIBILITY PROCESS

Effective January 1, 2014, Maryland initiated a state-wide HUB for an insurance marketplace. Medicaid and MCHP participate in this web-based service. The application is available on the Maryland Health Connection website (www.marylandhealthconnection.gov). It is a web-based, real-time eligibility determination. Consumers must establish an account, complete applications, report a change, and complete renewals online.

MCHP consumers attest to information entered into the application. Verification is obtained through electronic information available through federal and state databases. If we are unable to obtain electronic verification, a verification check list (VCL) is generated for consumers to upload verification documents to the system. If the LHD staff assists the consumer, and VCLs are necessary, the eligibility will be pending until the verifications are provided up to a maximum of 30 days.

For renewals, notification is sent to the consumer's account. If we are able to update verifications electronically, the consumer only needs to attest that there are no changes, and eligibility is automatically renewed. If changes are reported during renewal, the consumer must update the renewal application themselves. Renewals are required every 12 months.

Persons who apply for the Program are still bound by all rules and penalties pertaining to perjury and fraud.

BENEFITS & HEALTHCHOICE ENROLLMENT

Persons who qualify under the Maryland Children's Health Program, including pregnant women, will receive a red and white Maryland Medical Care Program identification card and will be enrolled in HealthChoice. Immigrants who qualify for coverage for emergency services are not enrolled in HealthChoice and benefits are paid on a fee for service basis.

The coverage groups for Health Choice enrollment are:

Pregnant Women up to 185% FPL (P02)

Federally matched medical coverage is provided to women whose income is at or below 185% FPL. This coverage continues for a two-month post-partum period.

Pregnant Women 185% - 250% FPL (P11)

Federally matched medical coverage is provided to pregnant women whose income is greater than 185% FPL, but does not exceed 250% FPL. Except for the higher income level, eligibility and coverage in this group is identical to P02; this group is distinguished only because the Program receives an enhanced federal match for the children born to these higher income mothers.

Children under one year old (P06)

Federally matched medical coverage is provided to children who are under one year old and whose income is at or below 185% FPL. This coverage group includes former P03 and P12 newborns, with no income test.

Children between one and six years old (P07)

Federally matched medical coverage is provided to children who are one year old or older but younger than six, if their income is at or below 133% FPL.

Children between six and nineteen years old (P07)

Federally matched medical coverage is provided to children who are six years old or older but younger than nineteen, if their income is at or below 100% FPL.

Children up to 185% FPL (P13)

Children whose income exceeds the standards for P07 may qualify for federally matched medical coverage if their income does not exceed 185% of the FPL, and they are not covered by employer-sponsored insurance.

P14 (Title XXI – Children Under 19 Years Old, with Income Greater than 185% but less than 200% FPL)

An enhanced federal match under the Maryland Children's Health Program provides medical coverage to children under the age of 19 whose income is greater than 185% but at or below 200% of the FPL, and they are not covered by employer-sponsored insurance.

OTHER COVERAGE GROUPS

There are some benefits available to women and children who do not qualify under the groups above. They are as follows:

Family Planning Program (P10)

The Family Planning Program is a limited benefit program that provides certain family planning services, such as birth control and physical exams, to eligible women under age 51, who lost their Medicaid coverage after they were covered for a pregnancy. The Family Planning Program does not cover enough services to be a health insurance plan.

Family Planning services include:

- Advice about birth control methods;
- Physical exams, including pelvic and breast exams;
- Screenings, such as pap smears and for sexually transmitted infections, when done as part of the family planning visit;
- Birth control pills and devices, such as IUDs;

- Emergency contraception; and
- Permanent sterilization (must be age 21 or over).

Undocumented and Ineligible Immigrants (XO2)

Persons who are illegal immigrants, or who are legal but do not meet the definition of a qualified alien, may receive federally matched medical coverage for emergency medical services. Labor and delivery are considered emergency services. To be eligible in this coverage group a person must meet all technical and financial criteria for the MCHP program, or any other federally matched coverage, except citizenship/immigrant status and Social Security number.

MCHP Premium

Children eligible for the MCHP Premium Program, have family income above 200% FPL but at or below 300% FPL. These children have a family-level contribution amount assessed monthly for participation in MCHP Premium. Children are certified for MCHP Premium only if they fail to qualify for coverage groups P06, P07, P13 or P14 because household income exceeds 200% FPL.

MCHP Premium recipients have an additional eligibility requirement that the recipient may not be covered by employer-sponsored health insurance. Medical care services for MCHP Premium coverage group recipients are provided through HealthChoice, Maryland Managed Care Program. This group receives a HealthChoice card from the MCO they select and a red and white Medical Assistance card for certain services not covered by the MCO.

D02 (HealthChoice) 200% - 250% FPL

Federally matched medical coverage is provided to uninsured children under the age of 19 whose income is greater than 200% FPL but at or below 250% of FPL.

D04 (HealthChoice) 250% - 300% FPL

Federally matched medical coverage is provided to uninsured children under the age of 19 whose income is greater than 250% FPL but at or below 300% of FPL. Because the family income is higher than the D02 group, the monthly contribution amount the family must pay is higher.

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MCHP MONTHLY & ANNUAL INCOME GUIDELINES

(Based on stated % of Federal Poverty Level for the PW/MCHP track)

Effective March 1, 2017

Family Size	P02 189%	P06 199%	P07 (ages 1 - 6) 143%	P07 (ages 6 -19) 138%	P11 264%	P13 189%	P14 211%
1	N/A	\$24,000 \$2,000	\$17,246 \$1,438	\$16,643 \$1,387	N/A	\$22,794 1,890	\$25,447 \$2,121
2	\$30,694 \$2,558	\$32,318 \$2,694	\$23,224 \$1,936	\$22,412 \$1,868	\$42,874 \$3,573	\$30,694 \$2,558	\$34,267 \$2,856
3	\$38,594 \$3,217	\$40,636 \$3,387	\$29,201 \$2,434	\$28,180 \$2,349	\$53,909 \$4,493	\$38,594 \$3,217	\$43,087 \$3,591
4	\$46,494 \$3,874	\$48,954 \$4,080	\$35,178 \$2,932	\$33,948 \$2,829	\$64,944 \$5,412	\$46,494 \$3,875	\$51,906 \$4,326
5	\$54,395 \$4,532	\$57,273 \$4,773	\$41,156 \$3,430	\$39,717 \$3,310	\$75,980 \$6,332	\$54,395 \$4,533	\$60,726 \$5,061
6	\$62,295 \$5,191	\$65,591 \$5,466	\$47,133 \$3,928	\$45,485 \$3,791	\$87,015 \$7,252	\$62,295 \$5,192	\$69,546 \$5,796
7	\$70,194 \$5,850	\$73,909 \$6,160	\$53,111 \$4,426	\$51,254 \$4,272	\$98,050 \$8,171	\$70,194 \$5,850	\$78,366 \$6,531
8	\$78,095 \$6,508	\$82,227 \$6,853	\$59,088 \$4,924	\$57,022 \$4,752	\$109,085 \$9,091	\$78,095 \$6,508	\$87,186 \$7,266

**Note: For every family member over "8", add as indicated:

P02 & P13 ADD \$659 per person for monthly/\$7,901 for annual.

P06 ADD \$694 per person for monthly/\$8,319 for annual.

P07 (ages 1-6) ADD \$498 per person for monthly/\$5,971 for annual.

P07 (ages 6-19) ADD \$481 per person for monthly/\$5,769 for annual.

P11 ADD \$920 per person for monthly/\$11,036 for annual.

P14 ADD \$735 per person for monthly/\$8,820 for annual.

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Program Regulations

COMAR 10.09.11

Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 11 Maryland Children's Health Program

Authority: Health-General Article, §§2-104(b), 15-101(f), 15-103, 15-105, and 15-301 et seq., Annotated Code of Maryland, Ch. 202, Acts of 2003

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**COMAR 10.09.11.01
PURPOSE AND SCOPE**

A. This chapter governs the determination of eligibility for the Maryland Children's Health Program with an income standard based on the modified adjusted gross income methodology specified in the Affordable Care Act of 2010, effective January 1, 2014.

B. Eligibility for the Maryland Children's Health Program may be established for children younger than 19 years old whose family income is equal to or less than 200 percent of the federal poverty level.

**COMAR 10.09.11.02
DEFINITIONS**

A In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub.L.111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub.L.111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub.L.112-56).

(2) Applicant.

(a) "Applicant" means an individual whose application for the Maryland Children's Health Program has been submitted to the local health department or the local department of social services but has not received final action.

(b) "Applicant" includes an individual whose application is submitted through a representative.

(3) "Application" means the filing of a written, telephonic, or electronic signed application for health coverage in an Insurance Affordability Program to the Department or its designee.

(4) "Application date" means the date on which a written, telephonic, or electronic signed application is received by the Department or its designee.

(5) "Authorized Representative" has the meaning stated in COMAR 10.01.04.12.

(6) "Child" means an individual younger than 21 years old.

(7) "Child recipient" means a child younger than 19 years old who is certified as eligible for the Program.

(8) "Children's Health Insurance Program" means the program for uninsured targeted low-income children established under Title XXI of the Social Security Act.

(9) "Department" means the Maryland Department of Health.

(10) "Designee" means any entity designated to act on behalf of the Department such as:

(a) Baltimore City or a county social services department under the supervision of the Department of Human Services;

(b) Baltimore City Health Department and its subgrantees, or a county health department; and

(c) The Maryland Health Benefit Exchange

(11) "Determination" means a decision regarding an applicant's eligibility for the Maryland Children's Health Program.

(12) "Eligibility worker" means an employee of the local health department, or the local department of social services, responsible for determining the eligibility of applicants and recipients.

(13) Emergency Medical Condition.

(a) "Emergency medical condition" means a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(b) "Emergency medical condition" includes labor and delivery.

(c) "Emergency medical condition" does not include services related to an organ transplant procedure.

(14) "Family members" means those individuals living with the applicant whose income is counted, or would be counted if there were any, as household income under Regulation .07B of this chapter.

(15) "Federal poverty level" means the nonfarm income official poverty level as defined by the Office of Management and Budget and revised annually in accordance with §673(2) of the Omnibus Budget Reconciliation Act of 1981.

(16) "Inpatient services" means services received by a recipient while in a medical institution, birthing center, or clinic for which Medical Assistance is provided.

(17) "Institution for mental diseases" means an institution which falls within the jurisdiction of Health-General Article, §19-307(a)(1), Annotated Code of Maryland, and is licensed under COMAR 10.07.04.

(18) "Insurance Affordability Program" means a program that is one of the following:

(a) The Maryland State Medicaid program;

(b) The Maryland Children's Health Insurance Program (CHIP), including the program known as Maryland Children's Health Program (MCHP) Premium;

(c) An optional state basic health program established under §1331 of the Affordable Care Act;

(d) A program that makes available to qualified individuals coverage in a qualified health plan through the Maryland Health Benefit Exchange with advance payments of the premium tax credit established under §36B of the Internal Revenue Code; or

(e) A program that makes available coverage in a qualified health plan through the Maryland Health Benefit Exchange with cost-sharing reductions established under §1402 of the Affordable Care Act.

(19) "Living together" means sharing a common household.

- (20) "Local health department (LHD)" means the Baltimore City Health Department and its subgrantees, or a county health department.
- (21) "MAGI" means modified adjusted gross income, as calculated for purposes of determining eligibility for insurance affordability programs under the Affordable Care Act.
- (22) "MAGI Exempt Coverage Group" means coverage groups such as Aged, Blind, Disabled; Categorically Needy; and Medically Needy as defined under COMAR 10.09.24.02, whose eligibility is not determined by MAGI.
- (23) "Maryland Children's Health Program (Program)" means the program established in Health-General Article, §15-301 et seq., Annotated Code of Maryland, to provide comprehensive medical care and other health care services to certain children.
- (24) "Maryland Health Benefit Exchange" means the unit of State government that determines initial and continuing eligibility for the MAGI based insurance affordability programs, including, by delegation, certain eligibility in the program.
- (25) "Maryland Medicaid Managed Care Program" means the Health Choice Program authorized by:
- (a) Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland; and
 - (b) A waiver issued by the federal government under §1115 of the Social Security Act.
- (26) "Medical Assistance (Medicaid)" means the program administered by the State under Title XIX of the Social Security Act which provides comprehensive medical and other health-related care for eligible individuals.
- (27) "Period under consideration" means the specific months which are assessed in order to determine eligibility.
- (28) Public Institution.
- (a) "Public institution" includes an:
 - (i) Institution that is the responsibility of a government unit or over which a government unit exercises administrative control; or
 - (ii) An establishment that furnishes, in single or multiple facilities, food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.
 - (b) "Public institution" does not mean a medical institution, a skilled nursing facility, or a publicly operated community residence that serves not more than 16 residents.
- (29) "Qualified alien" means an individual who:
- (a) Has been fully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);

- (b) Has been granted asylum in the United States as a refugee under §208 of the INA;
- (c) Has been admitted into the United States as a refugee under §207 of the INA;
- (d) Has been paroled into the United States under §212(d)(5) of the INA for a period of at least 1 year;
- (e) Has had deportation withheld under §243(h) of the INA;
- (f) Has been granted conditional entry into the United States under §203(a)(7) of the INA which was in effect before April 1, 1980;
- (g) Is a documented or undocumented immigrant who has been battered or subjected to extreme cruelty by the individual's U.S. citizen or lawful permanent resident spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the alien, if:
 - (i) The spouse or parent consented to, or acquiesced in, the battery or cruelty;
 - (ii) The immigrant has filed a Violence Against Women Act (VAWA) immigration case or a family-based visa petition with Immigration and Naturalization Service (INS); and
 - (iii) In the opinion of the agency providing benefits, there is a substantial connection between the battery or cruelty and the need for the benefits to be provided;
- (h) Is a victim of a severe form of trafficking who has been subjected to:
 - (i) Sex trafficking if the act is induced by force, fraud, or coercion, or the individual induced to perform the act is younger than 18 years old; or
 - (ii) Involuntary servitude;
- (i) Is a member of a federally recognized Indian tribe, as defined in 25 U.S.C. §450b(e); or
- (j) Is an American Indian born in Canada to whom §289 of the INA applies.

(30) "Recipient" means an individual who is certified as eligible for the Maryland Children's Health Program.

(31) "Redetermination" means a determination regarding the continuing eligibility of a recipient.

(32) "Spouse" means an individual who has been determined to be the husband or wife of another person under State law and for the purpose of determining eligibility for Social Security benefits.

(33) "Title XIX" means the title of the Social Security Act, 42 U.S.C. §1396 et seq., which governs establishment of a medical assistance program for low income individuals.

(34) "Title XXI" means the title of the Social Security Act through which funding is provided, in part, for the Maryland Children's Health Program.

**COMAR 10.09.11.03
COVERAGE GROUPS**

Eligibility may be established for the Maryland Children's Health Program for children younger than 19 years old whose household income is equal to or less than 200 percent of the federal poverty level.

**COMAR 10.09.11.04
APPLICATION**

A. The Department or its designee shall determine eligibility for children.

B. The Department or its designee shall give oral, written, or electronic information about the Maryland Children's Health Program such as:

- (1) Requirements for eligibility;
- (2) Available services;
- (3) An individual's rights and responsibilities;
- (4) Information in plain English, supported by translation services; and
- (5) Information accessible to disabled individuals requesting an application.

C. An individual requesting health coverage from an Insurance Affordability Program shall be given an opportunity to apply.

D. The Department or its designee shall make the application available to the individual without delay, by telephone, mail, in-person, internet, other available electronic means, and in a manner accessible to disabled individuals requesting an application.

E. A resident temporarily absent from the State but intending to return may apply for health coverage from an Insurance Affordability Program by telephone, mail, in-person, internet, and other available electronic means to the Department or its designee in any jurisdiction. The individual shall:

- (1) Demonstrate continued residency in the State; and
- (2) Meet all nonfinancial and financial requirements in order to be determined eligible.

F. Application Filing and Signature Requirements.

(1) An individual who wishes to apply for health coverage under an Insurance Affordability Program shall submit a written, telephonic, or electronic application signed under penalty of perjury to the Department through its designee in any jurisdiction. An applicant is responsible for completing the application but may be assisted in the completion by an individual of the applicant's choice.

(2) For the purpose of establishing eligibility of a child applicant who is neither pregnant or postpartum, a parent or stepparent living with the child shall complete and sign the written, telephonic, or electronic application. If the child does not live with a parent, an authorized representative who is 21 years old or older shall complete and sign the application.

G. The date of application shall be the date on which a written, telephonic, or electronic, signed application is received by the Department or its designee. The application may be mailed or submitted electronically to the Department or its designee.

H. An individual who has filed a written, telephonic, or electronic application may voluntarily withdraw that application but the application remains the property of the Department or its designee and the withdrawal does not affect the periods under consideration specified under §I of this regulation.

I. Period Under Consideration. The Department or its designee shall establish a current period under consideration based on the date of application established under §G of this regulation. For a child, the period under consideration is the 12-month period beginning with the month of application.

J. Processing Applications — Time Limitations.

(1) When a written, telephonic or electronic application is filed, a decision shall be made promptly but not later than:

(a) 10 days from the date of application when filed at the local health department; or

(b) 30 days from the date of application when filed at the Department or its designee, but not the local health department.

(2) The time standards specified in §J(1) of this regulation cover the period from the date of application to the date the Department or its designee sends a written or electronic notice of its decision to the applicant.

(3) The Department or its designee shall inform the applicant by written or electronic notice of the missing information needed to determine eligibility, and the applicable time limit of 10 or 30 days.

(4) When an applicant fails to complete the application or to provide the required information needed to determine eligibility within the 10 or 30 day limit provided under §J(1) of this regulation, the applicant shall be determined ineligible.

(5) If an applicant is determined ineligible for the current period under consideration due to a nonfinancial factor, the application shall be disposed of and the application date may not be retained. If the applicant reapplies, a new period under consideration shall be established based on the date the new application is filed.

K. Required Information. All information needed to determine eligibility for the Maryland Children's Health Program shall be reported. When there is evidence of inconsistency with attested information given by the applicant and reported by the state and federal databases, the applicant shall be required to offer an explanation and appropriate verification to reconcile the inconsistency.

COMAR 10.09.11.05
APPLICATION: ADDITIONAL REQUIREMENTS

A. Social Security Number.

- (1) As a condition of eligibility, an applicant shall furnish to the Department or its designee a Social Security number for the applicant. If the applicant cannot furnish a Social Security number, the applicant shall apply for a number. Assistance may not be denied, delayed, or discontinued pending the issuance or verification of the number if the applicant complies with this subsection.
- (2) Eligibility may not be established until the applicant:
 - (a) Furnishes a Social Security number; or
 - (b) Requests the assignment of the number through the Social Security Administration.
- (3) Failure to provide the required Social Security number shall result in ineligibility for the applicant.
- (4) If an applicant lacks the resources to meet the requirements of this regulation, the Department or its designee services shall assist the applicant in obtaining the necessary documents, and any costs incurred shall be paid for out of administrative funds.
- (5) If the application indicates that a Social Security number was issued previously, the Department or its designee shall request validation of the number by the Social Security Administration.
- (6) Individuals described under COMAR 10.09.24.05D(4)(b) who are applying for limited benefits to treat an emergency medical condition are not subject to the requirements in §A(1)—(4) of this regulation.

B. Third-Party Liability.

- (1) A recipient shall notify the Department or its designee within 10 working days when medical treatment has been provided as a result of a motor vehicle accident or other occurrence in which a third party might be liable for the recipient's medical expenses.
- (2) A recipient shall cooperate with the Department or its designee in completing a form designated by the Department to report all pertinent information and in collecting available health insurance benefits and other third-party payments.
- (3) In accident situations, a recipient shall notify the Department or its designee of the:
 - (a) Time, date, and location of the accident;
 - (b) Name and address of the attorney;
 - (c) Names and addresses of all parties and witnesses to the accident; and
 - (d) Police report number if an investigation is made.

C. The Department or its designee shall:

- (1) Maintain a written or electronic record including documentation of any required elements of eligibility; and
- (2) Restrict disclosure of information concerning a recipient to purposes directly connected with the administration of the Medical Assistance Program, including:
 - (a) Establishing eligibility;
 - (b) Determining the extent of coverage under Medical Assistance;
 - (c) Providing services for recipients; and
 - (d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Medical Assistance Program.

D. An applicant or recipient shall give consent to verify information needed to establish eligibility to the Department or its designee, by submitting a written, telephonic or electronic application.

COMAR 10.09.11.06
NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. **Citizenship.** In order to be eligible for full benefits under the Maryland Children's Health Program, an individual shall meet the federal requirements for Medical Assistance eligibility as a citizen or qualified alien, as specified at COMAR 10.09.24.05.
- B. **Residency.** In order to be eligible for benefits under this chapter, an individual shall be a resident of Maryland, in accordance with the requirements at COMAR 10.09.24.05-3.
- C. **Age.** In order to be eligible for benefits under this chapter, a child shall be younger than 19 years old.
- D. **Inmate of a Public Institution.** In order to receive benefits under this chapter, an individual may not be an inmate of a public institution, as specified at COMAR 10.09.24.05-5B.
- E. **Institution for Mental Diseases.** In order to be eligible for benefits under this chapter, an individual between 21 and 64 years old or a child applying under Title XXI of the Social Security Act may not be a patient in an institution for mental diseases, unless such individuals are eligible in accordance with COMAR 10.09.24.05-5C.
- F. **No Private Health Insurance.** In order to be eligible for benefits under Title XXI of the Social Security Act, an individual whose income is equal to 133 percent but less than 200 percent of the Federal Poverty Level, may not be covered by an employer-sponsored health benefit plan.
- G. **An alien who fails to meet the requirements under §A of this regulation, but meets all other nonfinancial and financial factors of eligibility under this chapter, may be determined eligible for coverage under COMAR 10.09.24.05-2.**
- H. **Documentation of Citizenship and Identity.**
- (1) An applicant may not be determined eligible for Maryland Children's Health Program until the requirements of this regulation are met.
 - (2) An applicant or recipient shall be required as a condition of eligibility to provide documentary evidence of identity as well as citizenship or nationality, to the Department's satisfaction, based on federal requirements, if the individual is:
 - (a) Declared to be a citizen or national of the United States; and
 - (b) Being determined for:
 - (i) Initial eligibility based on an application filed on or after September 1, 2006; or
 - (ii) Continuing eligibility based on a redetermination with an end date on or after September 30, 2006.
 - (3) An applicant may be determined eligible for Maryland Children's Health Program for a period of 90 days to provide requested documents. When an applicant fails to provide documentation of citizenship within the 90 day period, the applicant shall be determined ineligible.

(4) If an applicant or recipient fails to meet the requirements of §H of this regulation within the time standards specified in Regulation .04J(1) of this chapter, and the time standards are not extended, the Department shall:

- (a) Deny eligibility for an applicant; or
- (b) Terminate eligibility for a recipient, in accordance with the requirements for timely notice in COMAR 10.01.04.

(5) The requirements at §H of this regulation shall be met for all Medical Assistance coverage groups except for:

- (a) Supplemental Security Income beneficiaries;
- (b) Newborns who are deemed eligible, for a period of 1 year, for Medical Assistance based on the mother's Medical Assistance eligibility for the newborn's date of birth;
- (c) Newborns deemed eligible who are born to an otherwise eligible non-qualified alien woman meeting the requirements of under COMAR 10.09.24.05-2 who has filed an application and has been determined eligible for Medical Assistance for the newborn's date of birth;
- (d) Individuals who are entitled to Medicare benefits or enrolled in any part of Medicare;
- (e) Individuals receiving SSDI disability insurance benefits under §223 of the Social Security Act, or monthly benefits under §202 of the Social Security Act, based on the individual's disability;
- (f) Children who are receiving foster care or adoption assistance under Title IV-B or Title IV-E of the Social Security Act; and
- (g) Other categories of individuals who are considered by the federal government to have previously presented satisfactory documentary evidence of identity as well as citizenship or nationality.

(6) Continuing eligibility for a recipient may not be approved at redetermination until the requirements of §H of this regulation are met.

(7) If there is documentation in an applicant's or recipient's written or electronic record or a federal or state's database that demonstrates that the individual meets the requirements of §H of this regulation, the individual shall be considered to meet the requirements of §H of this regulation, unless the:

- (a) Department has cause to question the documentation previously accepted; or
- (b) Federal government requires additional documentation.

COMAR 10.09.11.07
CONSIDERATION OF FAMILY INCOME

A. The applicant shall report the income of any family member, except for the income of a member that does not file a federal tax return and is not claimed as a federal tax dependent.

B. Determining Countable Household Income.

(1) In determining an applicant's financial eligibility for the Maryland Children's Health Program, the applicant's current household income is considered.

(2) For the child applicant who is neither pregnant nor postpartum, household income shall consist of the income of the child applicant and the following family members when living with the child applicant:

(a) The child applicant's parents; and

(b) At the option of the child applicant's parents, any of the child applicant's siblings.

(3) For the married child applicant who is neither pregnant nor postpartum, household income shall consist of the income of the married child applicant and the married child applicant's spouse.

C. When an individual has regular income the amount to be considered is that which is available or can reasonably be expected to be available for a projected period of 12 months, including the month of application.

D. Treatment of Income.

(1) Countable gross income for the Maryland Children's Health Program shall be the household income calculated according to MAGI.

(2) MAGI income limits shall be:

(a) Converted from traditional income limits to account for elimination of income disregards.

(b) Increased by 5 percentage points of the federal poverty level for the following circumstances:

(i) When an individual's income exceeds the Medicaid income standard; and

(ii) The income standard is the highest income standard under which the individual can be determined eligible.

(3) Household Composition. For purposes of determining the income standard applicable to an applicant or recipient, the following rules apply.

(a) An individual plus anyone for whom the individual claims personal exemption shall be included in the federal tax filing unit in the taxable year in which an initial determination or renewal of eligibility is being made.

(b) For an individual who does not file a federal tax return and is not claimed as a federal tax dependent in the taxable year in which an initial determination or renewal of eligibility is being

made, the household size shall consist of the individual and the following individuals:

(i) Spouse; and

(ii) Natural, adopted or step children.

(c) In the tax year in which an initial determination or renewal of eligibility is being made, the household size of a child applicant shall consist of the child and the following individuals:

(i) Natural, adopted, or step parents; and

(ii) Natural, adopted, or step siblings.

(d) In the case of a married couple living together, each spouse shall be included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return in the taxable year in which an initial determination or renewal of eligibility is being made.

(4) No resources or assets test may be applied to an applicant or recipient who is subject to a MAGI-based income test.

**COMAR 10.09.11.08
CONSIDERATION OF FAMILY INCOME: EARNED AND UNEARNED INCOME**

Repealed.

**COMAR 10.09.11.09
CONSIDERATION OF FAMILY INCOME: INCOME DISREGARDS**

Repealed.

**COMAR 10.09.11.10
DETERMINING FINANCIAL ELIGIBILITY**

An applicant is financially eligible for the Maryland Children's Health Program if, for the period under consideration, the applicant's countable household income as determined under Regulation .07 of this chapter does not exceed 200 percent of the federal poverty level for a family size equal to the size of the family for child applicants younger than 19 years old.

**COMAR 10.09.11.11
CERTIFICATION PERIODS**

A. For a newborn, certification begins on the day the child is born to an eligible woman and ends on the last day of the month of the child's 1st birthday.

B. For an eligible child, certification begins on the first day of the month of application, or up to 3 months before the month of application, if medical expenses were incurred during the earlier months, and continues until the day the child is determined ineligible.

C. A child who, on the day the child becomes 19 years old, is receiving acute inpatient services under this chapter and who, but for attaining that age, would remain eligible for Medical Assistance benefits, shall continue to receive benefits until the end of the stay for which acute inpatient services are furnished.

**COMAR 10.09.11.12
COVERED SERVICES**

A. A child certified for the Program is entitled to all health benefits through the Maryland Medicaid Managed Care Program.

B. In the case of an alien who is eligible for benefits under COMAR 10.09.24.05D(4)(b), covered services are limited to those that are necessary for the treatment of an emergency medical condition, as defined under Regulation .02B of this chapter.

COMAR 10.09.11.13
POST ELIGIBILITY REQUIREMENTS

A. Notice of Eligibility Determination. The Department or its designee shall inform an applicant of the applicant's legal rights and obligations and give the applicant written or electronic notification of the following:

(1) For eligible individuals:

- (a) The basis and effective date for eligibility;
- (b) Instructions for reporting changes that may affect the recipients eligibility; and
- (c) The right to request a hearing;

(2) For ineligible individuals:

- (a) A finding of ineligibility, the reason for the finding, and the regulation supporting the finding;
- (b) Information regarding application for MAGI Exempt coverage groups; and
- (c) The right to request a hearing.

B. Recipient Responsibility. After an individual has been determined to be eligible for MCHP and is enrolled in MCHP:

(1) The Department shall periodically redetermine the recipient's eligibility for MCHP as specified under §D; and

(2) The recipient or the recipient's representative shall, within 10 days of the occurrence, notify the Department if there is a change in the recipient's, the recipient's parent's, or the recipient's guardian's:

- (a) Income;
- (b) Employment;
- (c) Address; or
- (d) Health insurance coverage status.

(3) A recipient or the recipient's representative shall limit use of the Medical Assistance card to the individual whose name appears on the card.

(4) When written or electronic notice of cancellation is received, a recipient shall discontinue use of the Medical Assistance card on the first day of ineligibility and return the card to the Department.

(5) Failure to comply with the provisions of §B(1)—(3) of this regulation may result in:

- (a) The termination of assistance; or

(b) Referral to the Department for fraud investigation, or for criminal or civil prosecution.

(6) A recipient shall cooperate with the Department's quality control and audit review process, including verification of all information pertinent to the determination of eligibility.

(7) If the recipient refuses to cooperate, the recipient's coverage shall be terminated subject to the regulation governing timely and adequate notice under COMAR 10.01.04.

C. Unscheduled Redetermination.

(1) The Department or its designee shall:

(a) Promptly make an unscheduled redetermination of a child recipient's eligibility when changes in circumstances or relevant facts are:

(i) Reported by someone on the recipient's behalf, or

(ii) Brought to the attention of the Department or its designee from other responsible sources;

(b) Notify the recipient that redetermination is required to establish continuing eligibility; and

(c) Notify the recipient of the required information and verifications needed to determine eligibility and the time standards in acting in the redetermination process.

(2) Eligibility Decisions. Recipients who are determined:

(a) Eligible for the remainder of the certification period shall be sent notice in accordance with §A(1) of this regulation; or

(b) Ineligible because of a change in circumstances or failure to establish eligibility following a change in circumstance shall be sent notice in accordance with §A(2) of this regulation.

(3) A recipient whose eligibility has been canceled may reapply at any time after the cancellation of eligibility and a new period under consideration shall be established.

D. Scheduled Redetermination. Except for children eligible as newborns of eligible women, the Department or its designee shall make a scheduled redetermination of a child recipient's eligibility at least every 12 months.

**COMAR 10.09.11.14
HEARINGS**

The requirements relating to hearings under COMAR 10.01.04 apply to this chapter.

**COMAR 10.09.11.15
FRAUD AND ABUSE**

The requirements relating to fraud and abuse under COMAR 10.09.24.14 apply to this chapter.

**COMAR 10.09.11.16
ADJUSTMENTS AND RECOVERIES**

The requirements relating to adjustments and recoveries under COMAR 10.09.24.15, with the exception of COMAR 10.09.24.15A(1) and (2), apply to this chapter.

**COMAR 10.09.11.17
INTERPRETIVE REGULATION**

State regulations shall be interpreted in conformity with applicable federal statutes and regulations, except if the language of a specific regulation indicates an intent by the Department to provide reimbursement for covered services to Program recipients without regard to the availability of federal financial participation.

**COMAR 10.09.11.9999
Administrative History**

Effective date:

Regulations .01—.17 adopted as an emergency provision effective July 1, 1998 (25:15 Md. R. 1182); adopted permanently effective November 30, 1998 (25:24 Md. R. 1773)

Regulations .02—.07 and .09—.13 amended as an emergency provision effective July 1, 2001 (28:14 Md. R. 1319); amended permanently October 29, 2001 (28:21 Md. R. 1856)

Regulation .01B amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulations .01B amended as an emergency provision effective July 1, 2004 (31:16 Md. R. 1251); amended permanently effective September 27, 2004 (31:19 Md. R. 1432)

Regulation .02B amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulation .03B amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulations .03B amended as an emergency provision effective July 1, 2004 (31:16 Md. R. 1251); amended permanently effective September 27, 2004 (31:19 Md. R. 1432)

Regulation .04I amended effective June 21, 2004 (31:12 Md. R. 911)

Regulation .06 amended effective October 8, 2007 (34:20 Md. R. 1737)

Regulation .06A amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulation .06C amended effective June 21, 2004 (31:12 Md. R. 911)

Regulation .06I amended effective April 19, 2010 (37:8 Md. R. 614)

Regulation .07C amended effective April 19, 2010 (37:8 Md. R. 615)

Regulation .08A, B amended effective April 19, 2010 (37:8 Md. R. 615)

Regulation .09A amended effective June 21, 2004 (31:12 Md. R. 911); April 19, 2010 (37:8 Md. R. 615)

Regulation .10A amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulations .10A amended as an emergency provision effective July 1, 2004 (31:16 Md. R. 1251); amended permanently effective September 27, 2004 (31:19 Md. R. 1432)

Chapter revised effective January 6, 2014 (40:26 Md. R. 2162)

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Program Policies and Procedures

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Section 400: Applications

INTRODUCTION

Eligibility for persons applying for MCHP is determined by the Maryland Health Connection online application process, assisted by the LHD or the LDSS. These departments along with the Maryland Health Connection, Connector Entities, the Consolidated Call Center, are responsible for providing oral and written information about the eligibility requirements, coverage, scope and related services of MCHP and an individual's rights and responsibilities under the Program, to anyone requesting this information.

APPLICATION FILING AND SIGNATURE REQUIREMENTS

A person who wishes to apply for MCHP must submit a signed application form in the Maryland Health Connection. The LHD or LDSS can lend assistance to consumers. The LHD, LDSS, and Connector Entity can assist the consumer in completing and filing the on-line application. No face-to-face interview is required. If the consumer requests a paper application it will be provided. An applicant is responsible for completing the application but may be assisted by the person of their choice, including local department staff. An application that has no signature is not a valid application, even if it is otherwise complete, and the application must be submitted to be uploaded to the Maryland Health Connection.

For the purpose of establishing eligibility for a pregnant or postpartum woman, the applicant may sign the application form if over eighteen years of age. If the pregnant woman applicant is under age 18, the application must be signed by someone over age 21 who is acting responsibly for the minor applicant.

For the purpose of establishing eligibility for a child who is neither pregnant nor postpartum, a parent or stepparent, regardless of age, if living with the child must complete and sign the application form. When the child does not live with a parent or stepparent, an authorized representative who is at least 21 years old must complete and sign the application.

For the purpose of establishing eligibility for a married child applicant, i.e., a married person under 19 years old, who is neither pregnant nor postpartum, the applicant may complete and sign the application form if age 18 or older, if under age 18 the applicant must have someone aged 21 or older to sign regardless of whether or not they live with a parent.

APPLICATION DATE

The date of application is the date on which a written, telephonic, or electronic signed application form is received by the Maryland Health Connection. For the purpose of establishing the date of application only, a person acting on behalf of the applicant may sign the application form. Before eligibility can be established, the application must be signed by the appropriate person, as described above. The application may be mailed, submitted electronically, or hand delivered to the Maryland Health Connection, but date of application will be established by the date the on-line application is submitted or the paper application is uploaded to the electronic system.

PERIOD UNDER CONSIDERATION

The local department must establish a period under consideration based on the date of application. "Period under consideration" means the months for which income is considered for a determination of eligibility. Income received prior to the period under consideration, and income anticipated beyond the period of consideration, may not be included in the eligibility determination. For a pregnant or postpartum woman or a child, the period under consideration is the 12-month period beginning with the month of application.

An individual who has filed an application may voluntarily withdraw that application, but the application remains the property of the local department and the withdrawal does not affect the periods under consideration

PROCESSING APPLICATIONS—TIME LIMITATIONS

When a written, telephonic, or electronic application is filed at the LHD, a decision shall be made no later than 10 working days from the date of application. When a LHD hands off an application to the LDSS, connector entity, or call center, the application date is the date the application was received at the LHD.

When a written, telephonic, or electronic application is filed at the LDSS, a Connector Entity, or the Call center, a decision shall be made no later than 30 days from the date of application. Applications transferred from the LHD to the LDSS are also subject to the 30-day time standard, beginning with the date the application is submitted on the MHC.

These time standards cover the period from the date of application to the date the Department or its designee sends a written or electronic notice of its decision to the applicant.

The local department must inform the applicant of any missing information needed to determine eligibility, and must specify a date by which the information must be submitted. This date must be early enough for the local department to meet the applicable time limit of 10 or 30 days. When the applicant fails to complete the application or provide the requested information within the 30-day time limit, the applicant shall be determined ineligible.

If an applicant is determined ineligible for the current period under consideration due to a nonfinancial factor the application shall be disposed of, denied, and the application date shall not be retained. A "technical factor", for the MCHP Program, is a condition of eligibility, including citizenship, residency, age, pregnancy, inmate status and health insurance coverage. If the applicant previously denied for a technical factor reapplies, a new period under consideration is established based on the date of the new application.

REACTIVATION OF AN APPLICATION

"Reactivation" is the reopening of an application previously denied for missing information or verifications. The reactivation period applies to the earliest rejected application which is less than 6 months old. The applicant may establish eligibility at any time during the reactivation period by providing the missing required information or verifications. Eligibility will begin the first day of the month of application

REQUIRED INFORMATION AND VERIFICATION

The information needed to determine eligibility for MCHP, including the applicant's earned and unearned income, shall be accepted, without written documentation, by the local department unless the information is inconsistent with other available information. The Case Manager should compare the information provided on the application form with other information available to the Case Manager, including but not limited to, other agency records, such as Food Stamp cases, reports from other sources, and interfaces with the Federal HUB, MABS, New Hire's, SVES, etc.

If information is missing from the application form or information on the application Form is inconsistent/incompatible with other available information, the Case Manager must contact the applicant or recipient to obtain necessary information to correct the deficiency or reconcile the inconsistency. The applicant's explanation is an acceptable means of correcting the deficiency or reconciling the inconsistency. However, the Case manager may request written verification of any factor of eligibility if there is a compelling reason to doubt the veracity of the applicant's or recipient's declaratory statement. Providing written verification that resolves the inconsistency is the responsibility of the applicant or his representative.

If a parent or spouse whose income must be considered in determining eligibility does not supply their own Social Security number, they are required to supply written verification of their income since a wage screening cannot be completed without their Social Security number.

Maryland Children's Health Program

Policy Alert 04-1

Issued March, 2003

Summary:

Maryland law requires that applications and other forms which solicit information regarding ethnic origin and race allow for separate identification of race and ethnicity and for the selection of more than one racial group. State law further requires that ethnic origin shall include Hispanic and Latino as separate ethnicities, and specifies the racial groups, which must be listed on the forms. Each consumer may now select as many racial groups as s/he chooses that apply to all household members. Hispanic and Other have been removed from the Race block. Native Hawaiian/other Pacific Islander, Alaska Native and Native American Indian have been added as a racial group.

Section 500: Applications--Additional Requirements

SOCIAL SECURITY NUMBER

As a condition of eligibility, the applicant (child or pregnant woman) must furnish the Department or its designee with their Social Security number. If the applicant does not have a Social Security number they are required to apply for one. Eligibility cannot be established until the applicant furnishes a Social Security number or requests assignment of a number through the Social Security Administration. Eligibility cannot be denied, delayed, or discontinued pending the issuance or verification of the number if the applicant has requested it.

If an applicant lacks the resources to apply for a Social Security number, the Department or its designee must assist the applicant in obtaining the necessary documents. Any costs incurred by the local department shall be paid for out of administrative funds. If the application indicates that a Social Security number was issued previously, the local department shall request validation of the number through the Social Security Administration.

The local department shall request the Social Security number of the parent of a child applicant or spouse of a pregnant woman applicant for the purpose of verifying the parent's or spouse's income. However, if the parent or spouse does not provide their number, they must, as a condition of eligibility, provide written verification of their income. Eligibility may not be denied for a child or pregnant woman because a parent or spouse refuses to supply their Social Security number. Family members who are not applicants, nor persons whose income must be considered, are not required to furnish a Social Security number.

Applicants who are ineligible immigrants or Undocumented immigrants and who are applying for limited benefits for coverage of an emergency medical condition are not required to provide a Social Security number. Applicants who are U.S. citizens, but whose family members are ineligible or illegal immigrants, are not required to furnish Social Security numbers for those family members.

THIRD PARTY LIABILITY

If a recipient receives medical treatment as a result of being in a motor vehicle accident or other incident in which a third party may be liable, the recipient must report the occurrence to the local department within 10 working days. The recipient must provide the local department with all pertinent information and must cooperate in pursuing available health benefits and other third party payments.

The recipient must provide the local department with the following information when an incident has occurred:

1. Time, date and location of the accident;
2. Names and addresses of the attorneys;
3. Names and addresses of all parties and witnesses to the accident; and
4. Police report number, if an investigation is made.

This information should be submitted to the Division of Recoveries and Financial Services, Office of Operations and Eligibility, MDH, on Form DHMH 1169-Notice of Potential MA Payment Recovery.

CASE RECORD MANAGEMENT

The Maryland Health Connection will maintain an electronic record, including electronic record and documentation of any required elements of eligibility, for every active case. When the applicant has no associated pending, preserved or active Family Investment Administration (FIA) case (Medical Assistance, Temporary Cash Assistance or Food Stamps), the case is referred to as "MCHP only". For "MCHP only" cases, the local health department will assist consumers in setting up accounts and processing the application. The Maryland Health Connection will maintain the case and perform ongoing renewals of eligibility at least once every twelve months. A "renewal" is a reevaluation of a recipient's on-going eligibility.

DISCLOSURE OF INFORMATION

The local department must restrict disclosure of information concerning a recipient to purposes directly connected with the administration of the Program, including:

1. Establishing eligibility;
2. Determining the extent of coverage under the Program;
3. Providing services for recipients;
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

An applicant or recipient shall give consent to verify information needed to establish eligibility to the Department or its designee, by submitting an application by internet or other electronic means, telephone, in person, mail, and in a manner accessible to a disabled individuals request.

Section 600: Non-Financial Eligibility Requirements

A. CITIZENSHIP – (See Section 500 of the Medical Assistance Eligibility Manual).

United States citizenship or immigrant status is a factor of technical eligibility for MA and MCHP. MCHP applicants, or representatives of child applicants, affirm by signing the application form that the pregnant woman or child applying is a U.S. citizen, lawful immigrant, or is applying for emergency services only.

Policies Effective on or after July 1, 2006

See Section 500.4 of the Maryland Medical Assistance Eligibility Manual for the policies related to verification of citizenship, immigrant status, and identity.

Undocumented or Ineligible Immigrants (XO2)

Persons who are undocumented aliens or who are legally present but are not federally eligible immigrants may receive federally matched Medical Assistance coverage for emergency medical services only. Labor and delivery are considered emergency services, but not routine prenatal or postpartum care.

To be eligible in the XO2 coverage group, a person must meet all technical and financial criteria for the appropriate Medical Assistance or MCHP community based coverage group, except the requirements related to citizenship/immigrant status and Social Security number. This group includes undocumented immigrants and ineligible legal immigrants.

- An ineligible immigrant is lawfully in the United States. The person may be admitted only for a temporary or specified time period, such as foreign students and visitors. An ineligible immigrant may also be a “qualified alien” who entered the United States on or after 8/22/96 and has not yet lived in the United States for the required 5 years as a qualified alien.
- An undocumented immigrant is any person not lawfully admitted to the United States. This also includes persons whose visas have expired.

An ineligible or undocumented immigrant may be covered for emergency medical services (as defined in COMAR 10.09.24.02), if the person has an emergency medical condition (as defined in COMAR 10.09.11.02B) and meets all requirements (except citizenship and Social Security number) to be eligible in a federal coverage category (Medical Assistance or MCHP) but for the immigrant status.

NOTE: It is important that the case manager evaluate the applicant's status as of the date the emergency medical services were rendered.

DOCUMENTATION OF EMERGENCY MEDICAL SERVICES: LABOR AND DELIVERY

The applicant must provide the local department with a copy of her discharge summary, or other written

documentation from the hospital (but not nurses' notes or a bill), which includes her name, admission and discharge date, and a description of her hospital stay.

If a discharge summary is not available, a written statement or documentation from the hospital verifying the following information is acceptable:

- date of admission
- date of delivery
- date of discharge
- confirmation of live birth
- name of mother
- name of child

The documentation does not have to be signed by the physician or another hospital representative.

The local department will determine whether the applicant meets the medical eligibility requirements based on the documentation of labor and delivery discussed above.

DOCUMENTATION OF OTHER EMERGENCY MEDICAL SERVICES

Children may be eligible for coverage of emergency medical services. Pregnant women may be eligible for coverage of events other than labor and delivery. To be eligible for coverage as an ineligible or undocumented immigrant in coverage group X02, the service received must be consistent with the emergency medical services definition.

The determination of whether the service meets the coverage requirements is made by a medical professional within the MDH Medical Care Programs by reviewing the medical report on the treatment. MDH must make this medical evaluation before eligibility is determined by the local department. Payment will not be made for services that are not directly related to the illness or injury that caused the emergency. The approval authorizes payment for only those services necessary for treatment and stabilization of the emergency medical condition. The medical report must be of sufficient detail to determine both the diagnosis and whether the treatment was of an emergency nature. Mandatory information includes:

- Complete diagnoses;
- Description of treatment; and
- Dates of treatment.

Since most emergency services are received at a hospital, a copy of the discharge summary should be submitted. Case record materials, including immigration documents, should not be submitted. Medical bills and physicians' and nurses' hand-written notes are unacceptable as documentation of emergency services.

MEDICAL ELIGIBILITY REVIEW PROCESS

The medical report for determining medical emergency for all emergency services other than labor and delivery must be referred to:

Maryland Department of Health
Office of Eligibility Services
201 West Preston Street, Room L-9
Baltimore MD 21201

Please mark envelopes "Alien Emergency Services".

The DES 401 Cover Sheet should accompany each report. The medical report will be evaluated by MDH personnel to determine if the services received were for the treatment of an emergency medical condition. The local department will be notified whether the services meet that requirement.

CERTIFICATION OF ELIGIBILITY FOR X02

If all eligibility requirements are met, certify on an OTO (one-time-only) basis the immigrant who has the incurred expense for the approved emergency service (including labor and delivery). Certify only for the month(s) in which the approved emergency service was received.

Since CARES certifies X02 for at most 2 months at a time, the LHD or LDSS must re-certify the recipient for another period(s) if medical eligibility is approved by MDH for longer than 2 months. If medical eligibility is approved as "ongoing" without an end date (e.g., end stage renal disease, AIDS, etc.), eligibility for X02 does not need to be redetermined and a new application is not required until 12 months after the month of application. The CARES narration should quote MDH's medical decision, and should specify the actual date of application, the dates for the 6-month period under consideration, and the end date for the 12-month certification period. The case manager should set a "745" alert reminder to manually initiate a redetermination at least 60 days before the 12-month period ends.

DENIAL OF ELIGIBILITY FOR X02

Denial reasons relevant to X02 for the case manager to include on the manual denial notice are:

- "The service provided was not emergency in nature" or
- "Technically ineligible (non-federal)"

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Immigration Status/ Qualified Alien Status (Q/NQ) Q = qualified alien NQ = not qualified alien	Immigrant Qualifies for a P-track MCHP Coverage Group Code			Not Eligible for P-track, but may Qualify for X-track in Coverage Group X02 if pregnant and qualified alien for emergency medical services if resident
	The applicant entered the United States before August 22, 1996.	The applicant entered the United States on or after August 22, 1996 and is:		
		Exempt from a minimum period of U.S. residence.	A qualified alien who has resided in the U.S. for at least 5 years as a qualified alien.	
Lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (INA) Status: Q	Yes		Yes	Yes
Granted asylum under § 208 of the INA Status: Q	Yes	Yes		
Admitted as a refugee under §207 of the INA Status: Q	Yes	Yes		
Paroled into the United States under §212(d)(5) of the INA for at least one year Status: Q	Yes		Yes	Yes
Has deportation withheld under §243(h) of the INA before 4/1/97 or §241(b)(3) of INA as amended Status: Q	Yes		Yes	Yes
Granted conditional entry into the United States under §203(a)(7) of the INA which was in effect before April 1, 1980 Status: Q	Yes		Yes	Yes

Immigration Status/ Qualified Alien Status (Q/NQ)	Qualifies for a P-track Coverage Group Code			Not Eligible for P-track, but may Qualify for X-track in Coverage Group X02 if pregnant and qualified alien for emergency medical services if resident
	The applicant resided in the United States before August 22, 1996.	The applicant entered the United States on or after August 22, 1996 and is:		
		Exempt from a minimum period of U.S. residence.	A qualified alien who has resided in the U.S. for at least 5 years as a qualified alien.	
Documented or undocumented immigrant who has been battered or subjected to extreme cruelty by the individual's U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household as the alien (see 10.09.11.02B for further conditions which apply) Status: Q	Yes		Yes	Yes
Victim of a severe form of trafficking (see 10.09.11.02B for further conditions which apply) Status: Q	Yes	Yes		
Member of a federally recognized Indian tribe, as defined in 25 U.S.C. §450b(e) Status: NQ	Yes	Yes		
American Indian born in Canada to whom §289 of the INA applies. Status: NQ	Yes	Yes		

Immigration Status/ Qualified Alien Status (Q/NQ)	Qualifies for a P-track Coverage Group Code			Not Eligible for P-track, but may Qualify for X-track in Coverage Group X02 if pregnant and qualified alien for emergency medical services if resident
	The applicant resided in the United States before August 22, 1996.	The applicant entered the United States on or after August 22, 1996 and is:		
		Exempt from a minimum period of U.S. residence.	A qualified alien who has resided in the U.S. for at least 5 years as a qualified alien.	
Honorably discharged veteran of the armed forces of the United States Status: Q	Yes	Yes		
Alien on active duty in the armed forces of the United States Status: Q	Yes	Yes		
Spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of an honorably discharged veteran or alien on active duty in the armed forces of the United States Status: Q	Yes	Yes		
Cuban or Haitian entrant as defined in §501 (e) of the refugee Education assistance act of 1980 Status: Q	Yes	Yes		

Immigration Status/ Qualified Alien Status (Q/NQ)	Qualifies for a P-track Coverage Group Code			Not Eligible for P-track, but may Qualify for X-track in Coverage Group X02 if pregnant and qualified alien for emergency medical services if resident
	The applicant resided in the United States before August 22, 1996.	The applicant entered the United States on or after August 22, 1996 and is:		
		Exempt from a minimum period of U.S. residence.	A qualified alien who has resided in the U.S. for at least 5 years as a qualified alien.	
Alien admitted for permanent residence as an Amerasian immigrant under Title II of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1989 Status: Q	Yes	Yes		
Legal permanent resident who first entered the country under another exempt category (see 10.09.11.06 for categories) and later converted to legal permanent resident status Status: Q	Yes		Yes	Yes
Alien admitted to the United States for a temporary or specified time period (student, visitor, etc.) Status: NQ				Yes—X02
Alien not lawfully admitted to the United States (undocumented or visa expired) Status: NQ				Yes—X02

B. RESIDENCY – (See this Section in Chapter V of the Medical Assistance Eligibility Manual.)

In order to be eligible for MA or MCHP benefits, an applicant must be a resident of Maryland. A resident is defined as voluntarily living in Maryland for a permanent or indefinite period with the intention of making Maryland their home. There is no requirement that a person reside in Maryland for any length of time prior to being considered a resident.

A child assumes the residency of the parent with whom the child resides.

An individual entering the State for a temporary purpose is not a resident of Maryland.

An individual (and their family) is considered a Maryland resident if they enter the State as a migrant worker, with a job commitment, or seeking employment.

Residency is retained until abandoned. Temporary absence from the State, with the intention to return to the State, does not interrupt residency. A Maryland resident who is temporarily absent from the State but who intends to return may apply for assistance on-line at MHC or by mail to the LHD or LDSS in the jurisdiction where their home is located.

The applicant must demonstrate their residency in the State. A post office box does not establish residency, although it is acceptable as a mailing address if the person has otherwise demonstrated residency. A street address demonstrates residency, but is not necessary. Persons who are homeless, living in shelters or other temporary living arrangements may be considered residents even though they do not have a permanent street address. A person in any of these circumstances who states that she intends to remain in the State permanently, or for an indefinite period of time, may be considered a State resident. Verification of these statements is required only if conflicting information exists, such as receipt of benefits in another state.

A student, who is residing in Maryland and who states that she intends to remain permanently, or for an indefinite period, is a Maryland resident. A student who states that she does not intend to remain, but will return to her home in another state upon completion of the school year, is here for a limited period of time and is not considered a Maryland resident. The same policies applicable to students are applicable to a person residing in a Job Corps center.

County residency is **not** a factor of eligibility. A Maryland resident may apply in the jurisdiction where she resides at the time of application. Having an address in another Maryland jurisdiction to which she may return does not require that the application be processed in that jurisdiction.

Applicants who anticipate a change of address should be advised that the case manager must be notified promptly (within 10 days if possible) of such a change, in order to ensure that the Medical Care Program card and other important correspondence are received.

EVALUATING RESIDENCY OF UNDOCUMENTED OR INELIGIBLE IMMIGRANTS AND THEIR U.S. CITIZEN CHILDREN

NOTE: From March 2004 through June 2005, immigrants who entered the U.S. on a temporary visa failed the technical eligibility factor of Maryland residency if their entry documents indicated a temporary, specified period of stay and their scheduled departure date from the U.S. had not passed. Proof of visa classification and scheduled departure date was required. U. S. citizen children born to immigrants who failed to establish Maryland residency because of their visa classification and future departure date were denied eligibility, also.

The Office of Civil Rights of the U.S. Department of Health and Human Services has advised that it is not appropriate to deny eligibility solely on the basis of a temporary visa classification. The Office of Civil Rights also advised that immigration documents and a Social Security number may not be required from a person who is not requesting public benefits (e.g., the parents of a child applicant). The revised policy for evaluating residency for undocumented or ineligible immigrants and their U.S. citizen children is set out below.

EVALUATING RESIDENCY OF THE U.S. CITIZEN CHILD OF AN UNDOCUMENTED OR INELIGIBLE IMMIGRANT

The U.S. citizen child residing with an undocumented or ineligible immigrant parent assumes the residency of the parent with whom the child resides. If the parent establishes Maryland residency, the child is also considered a resident of Maryland. The parent's immigration documents and Social Security number may not be requested if the parent is not requesting MAM/CHP benefits.

EVALUATING RESIDENCY OF UNDOCUMENTED OR INELIGIBLE IMMIGRANTS

Undocumented or ineligible immigrants applying for coverage of emergency medical services, including labor and delivery, are subject to the same residency requirements as all other applicants.

The declaration of a Maryland address on the application form constitutes proof of Maryland residency unless the Case Manager finds that the statement is inconsistent with other available information (e.g., CARES case history or applicant's statement). In that instance, the Case Manager should require verification. Examples of acceptable documentation of residency include a rent receipt or agreement, utility bill, driver's license, school enrollment documents, and a written statement signed by a Maryland resident with whom the applicant resides.

Example A—Ineligible Immigrant

Child A is 18 years old. He has been living with a relative in Baltimore County for 2 years. He entered the United States on a Visitor's Visa and has had his departure date extended several times. His current departure date is six months in the future. Child A was taken to the hospital due to severe abdominal pains. He was admitted, diagnosed with acute appendicitis, and an emergency appendectomy was performed. Upon release from the hospital, Child A recuperated at his relative's home.

Child A's relative filed an application for coverage of the emergency medical services with the

Baltimore County Health Department. The case manager questioned Child A's immigrant status and was advised by Child A's relative that Child A intends to apply for permanent residency and obtain employment in Maryland after he recovers from his surgery. He will continue to reside with his relative in Baltimore County. Child A meets the state residency requirement and is eligible for coverage of the emergency medical services.

Example B—Ineligible Immigrant with U.S. Citizen Child

Ms. B entered the United States on a Visitor's Visa. Her departure date is two months after arrival. Ms. B was pregnant, and the baby was due two weeks after her departure date. Ms. B stays with her sister in Prince George's County. One month after her arrival, Ms. B went into labor and was taken to the local hospital where she delivered a baby girl.

After delivery, Ms. B filed an application with the Prince George's County Health Department for coverage of the labor and delivery. Ms. B told her Case Manager that she intended to return to her country of origin within one month, after her postpartum check-up. She plans to take her baby with her. Because Ms. B has declared that she does not intend to remain in Maryland. She fails the technical factor of residency and is ineligible for coverage of the labor and delivery. Her U.S. citizen child living with her also fails the factor of residency and so is ineligible based on Ms. B's stated intent that she will not remain in Maryland.

Example C—Undocumented Immigrant

Child C entered the United States on a Visitor's Visa. She stayed with family in Frederick County and failed to leave the country by her designated departure date. Her failure to leave when scheduled changed her status from ineligible immigrant to undocumented immigrant. One week after the designated departure date, Child C arrived at a hospital emergency room complaining of pain and fever. She was diagnosed with cancer and operated on to remove several tumors.

While Child C was in the hospital, her family applied for coverage of her emergency medical services. Child C's family stated that she plans to remain in Maryland indefinitely. If all other factors of eligibility are met, Child C may receive coverage of her emergency medical services.

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Sample Immigration Documents

Certificate of U.S. Citizenship (Form N-560 or N-561) is a document issued by the United States government as proof of U.S. citizenship. The alien registration number (also called USCIS number) is 8 or 9 digits long, and the citizenship certificate number is 7-12 characters long. Both can be obtained from this document. NOTE: Pre-1956 certificates do not contain an alien/USCIS number.

UNITED STATES OF AMERICA

DEPARTMENT OF HOMELAND SECURITY

U.S. CITIZENSHIP AND IMMIGRATION SERVICE

No. **AS000042**

USCIS Registration No. **A1111111**

*Personal description of holder as of date of issuance of this certificate: Sex: **MALE** Date of birth: **NOVEMBER 10, 1985**
Height: **5 feet 10 inches** Marital status: **SINGLE** Country of birth: **CHINA, PEOPLE'S REPUBLIC OF***

I certify that the description above given is true, and that the photograph affixed hereto is a likeness of me.

SAMPLE

As it appears that
JOHN JOSHUA GRAY
now residing at **WASHINGTON, DISTRICT OF COLUMBIA**
having applied to the Director of U.S. Citizenship and Immigration Services for a certificate of citizenship pursuant to Section 311 of the Immigration and Nationality Act, having presented to the satisfaction of the Director, that he/she is now a citizen of the United States of America, having a status thereof on **FEBRUARY 2, 2002**
and is now in the United States.

Now therefore, in pursuance of the authority contained in Section 311 of the Immigration and Nationality Act, this certificate of citizenship is issued this **20th** day of **OCTOBER**, **TWO THOUSAND ELEVEN**, and the seal of the Department of Homeland Security affixed pursuant to statute.

SAMPLE

U.S. Citizenship and Immigration Services

CITIZEN CERT. #

USCIS #

Certificate of Naturalization (Form N-550 or N-570) are forms the Department of Homeland Security issues for naturalization. The alien registration number (also called USCIS number) is 8 or 9 digits long, and the citizenship certificate number is 7-12 characters long. Both can be obtained from this document. NOTE: Pre-1956 certificates do not contain an alien/USCIS number.

UNITED STATES OF AMERICA

CERTIFICATE OF NATURALIZATION

No. **80000000** ← **CITIZEN CERT. #**

U.S.C.I.S. Registration No. **A999999999999999** ← **USCIS.#**

I certify that the description given is true, and that the photograph affixed hereto is a likeness of me.

New Citizen Signature Here
(Complete and true signature of holder)

Be it known that, pursuant to an application filed with the Secretary of Homeland Security

at: **USCIS FIELD OFFICE CITY NAME, STATE NAME**

The Secretary having found that:

NEW CITIZEN NAME – EPSON B-5 10DN – NEW ASC PHOTO

residing at:

Mytown, State

having complied in all respects with all of the applicable provisions of the naturalization laws of the United States, being entitled to be admitted as a citizen of the United States, and having taken the oath of allegiance at a ceremony conducted by

U.S. CITIZENSHIP AND IMMIGRATION SERVICES

at: **CEREMONY CITY, STATE** on: **JULY 99, 0000**

such person is admitted as a citizen of the United States of America.

**** TEST CERTIFICATE ****

U. S. Citizenship and Immigration Services

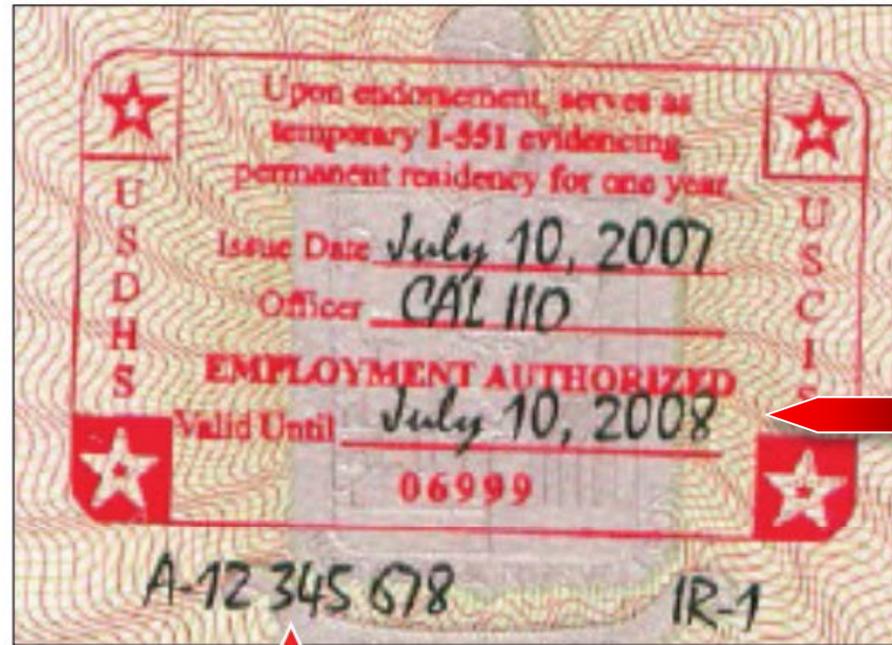
DEPARTMENT OF HOMELAND SECURITY

FORM N-550 (Rev. 08/10)

Employment Authorization Cards (or I-766s) are issued to some people who are authorized to work temporarily in the U.S. The alien registration number (also called USCIS number which is 8 or 9 digits long), the Receipt/Card Number (which is 13 digits, the first three of which are alphabetic), and the expiration date can be obtained from this document.



Temporary I-551 stamps can be used to attest to permanent resident status. A temporary I-551 stamp will have a handwritten or stamped issue date and a "valid until" date. This stamp can be found on the front of an I-94 form or in the foreign passport. The alien registration number (also called USCIS number which is 8 or 9 digits long), the Passport Number (optional, which is 6-12 characters long), the country of issuance (optional), and the expiration date of alien document (optional) can be obtained from this document.



EXPIRATION DATE

ALIEN REGISTRATION NUMBER

I-94 Arrival/Departure Records are issued to foreign travelers when they enter the U.S. The bottom portion of the I-94 should be stapled to the passport. The I-94 paper form will no longer be provided upon arrival to the U.S. at most air and sea ports of entry, except in limited circumstances. If a person doesn't have a paper version of the I-94, they can get a copy at cbp.gov/I94. The I-94 number (11 digits, or add zeros at the beginning to make 11 digits), SEVIS ID (optional, 10 digits), and the expiration date of alien document (optional) can be obtained from this document.

I-94 Arrival/Departure Records are issued to foreign travelers when they enter the U.S. The bottom portion of the I-94 should be stapled to the foreign passport.

I-94 NUMBER



Departure Number

OMB No. 1651-0111

626633123 12

I-94
Departure Record



EXPIRATION DATE



14 Family Name

SAMPLE

15 First (Given) Name

JANE

16 Birth Date (Day/Mo/Yr)

23 03 68

17 Country of Citizenship

NEW ZEALAND

See Other Side

CBP Form I-94 (10/04)

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C. PREGNANCY

In order to be eligible for MCHP benefits, a woman who is age 19 or older must be pregnant or be within the postpartum period. She must provide her expected date of delivery. If an applicant claims to be postpartum, she must provide the date of her delivery. A woman is no longer technically eligible as pregnant once her pregnancy is terminated due to an abortion or miscarriage.

D. AGE

In order to be eligible for MCHP benefits, a child must be younger than 19 years old. Age is considered to be reached as of the end of the month of birth.

E. INMATE OF A PUBLIC INSTITUTION – (See Section 500 of the Medical Assistance Eligibility Manual.)

In order to be eligible for MA or MCHP benefits, an applicant may not be an inmate of a public institution. A public institution is a facility run by a governmental agency, which provides food, shelter, and treatment or services to four or more people unrelated to the proprietor. Public institutions include local, State, and federal correctional institutions for adults and juveniles. Public institutions do not include medical institutions, skilled nursing facilities, a privately operated juvenile correction facility, or publicly operated community residences that serve no more than 16 residents.

F. INSTITUTION FOR MENTAL DISEASES – (See Section 500 of the Medical Assistance Eligibility Manual.)

In order to be eligible for MA or MCHP benefits, an institutionalized individual who is 20 years old or younger may not be an inpatient in an institution for mental diseases (IMD). IMDs include State hospitals, residential treatment centers (RTC), and private psychiatric facilities, which provide acute and chronic inpatient treatment of mental diseases.

G. HEALTH INSURANCE

In order to be eligible for MCHP benefits in the P13 and P14 coverage groups, an applicant may not be covered by an employer-sponsored health benefit plan. An applicant eligible in a P02, P06, P07, and P11 coverage group may also have coverage in an employee-sponsored health benefit plan.

Health insurance that is limited to vision and/or dental services only is not a health benefit insurance plan. However, coverage of any other outpatient or inpatient medical services does constitute a health benefit plan.

Coverage under private insurance (not employer-sponsored insurance), whether purchased by the child's parents or other parties (other family members such as grandparents or non-related individuals), does not disqualify the individual from MCHP in a P13 or P14 coverage group.

Dropping employer-sponsored insurance based on the cost of coverage, level of coverage, convenience, or complaints against providers is considered voluntary termination of health benefits. This no longer disqualifies the individual from MCHP.

**MARYLAND DEPARTMENT OF HEALTH
Maryland Children's Health Program Division
201 W. Preston St., Room SS-10
Baltimore, Maryland 21201
410-767-1463**

Maryland Children's Health Program Policy Alert 06-02

Effective December 1, 2009

COMMENTS

For children and pregnant women applying through MCHP, the declaration of a Maryland address on the application form will constitute proof of Maryland residency, unless the Case Manager finds that the statement is inconsistent with other available information. In that instance, the Case Manager may require verification such as a rent receipt, utility bill, driver's license, school enrollment document, or a written statement signed by a Maryland resident with whom the applicant resides. A Social Security number or a copy of the visa or other immigration documents may not be required for individuals who are not applying for benefits, such as a newborn's parent.

The Local Health Departments are not required or authorized to perform a general review of applications from immigrants with a temporary visa classification who were previously denied for failing to meet the eligibility factor of Maryland residency, or whose U.S. citizen children were denied because of the parent's lack of Maryland residency.

Questions:

Questions about Immigrant status and eligibility should be directed to the Maryland Children's Health Program Division at 410-767-1463.

Section 700: Consideration of Family Income

When considering financial eligibility under the Maryland Children's Health Program (MCHP), the applicant's current household income is considered. **There is no consideration of assets for any applicant or recipient who is subject to a MAGI-based income test.** When an individual has regular income the amount considered is what is available; or can reasonably be expected to be available, for a projected period of 12 months including the month of application.

Countable gross income is the household income calculated according to MAGI, and should be converted from the old traditional income limits if necessary, to account for the elimination of income disregards. When an individual's income exceeds the Medicaid income standard; and the income standard is the highest income standard under which the individual can be determined eligible, increase the MAGI income limit by 5 percentage points. This is the "wobble room" that allows applicants to qualify who are within 5% of the MAGI income limits.

Because eligibility is based primarily upon a declaratory system, the LDSS and the LHD Case Managers are expected to use the information provided on the declaratory statement to make the income eligibility determination. However, if the application is incomplete, income information is missing, or there is evidence of regular expenditures that are inconsistent with reported income, the Case Manager must contact the applicant or recipient to obtain the necessary information to correct the deficiency or reconcile the inconsistency.

The applicant's explanation is an acceptable means of correcting the deficiency or reconciling the inconsistency. However, the Case Manager may request income verifications if there is a compelling reason to doubt the applicant's or recipient's declaratory statement.

For initial eligibility determinations and redeterminations, the income of all family members must be reported by the applicant, except for the income of a member that does not file a federal tax return and is not claimed as a federal tax dependent. This is the tax filing unit of the household upon which MAGI is based. For those individuals who do not file taxes and are not claimed as a dependent, the household consists of the spouse and natural, adopted or step-children. The household size of a child applicant consists of the child and natural, adopted, or step parents and natural, adopted, or step siblings. When a married couple lives together each spouse is included in the household of the other spouse, regardless of whether they expect to file a joint tax return.

In determining financial eligibility under MCHP for the pregnant or postpartum applicant, the non-excludable income of the spouse, if those persons are living with the applicant.

The child applicant and parents' income must be counted for an unmarried child applicant who is neither pregnant nor postpartum, if the parents and child applicant are living together. At the option of the parents, any income received by the child applicant's siblings who are under the age of 21 years old and living with the child applicant, may be considered in determining the child applicant's eligibility.

If the child applicant is married, regardless of whether or not he or she lives with parents, his or her income and the income of his or her spouse are counted in making the eligibility determination.

JOINT CUSTODY OF CHILDREN

In cases of separated or divorced parents, custody may be awarded to either or both parents. When both parents are awarded custody, the courts refer to this arrangement as "joint custody". This generally means that each parent has equal responsibility for the care and support of the child(ren) and that the child(ren) will live with either parent at intervals.

For situations of joint custody, the parent who files the MCHP application for the child, if the child lives with that parent at least part of the time, will be referred to as Parent No. 1. The other parent will be referred to as Parent No. 2. If both parents file a MCHP application including the child, neither parent voluntarily withdraws the application, and both assistance units would be eligible, the application with the earliest date of application is approved and the other application is denied as duplicative.

To determine financial eligibility for the child, count:

- Income of Parent No. 1
- Income of the child, if any
- Income of other family members living with the applicant, whose income must be counted

DO NOT COUNT:

- Income of Parent No. 2

Total countable income is measured against the total number of persons in the household of Parent No. 1 who are dependent on Parent No. 1's income (e.g., Parent No. 1's spouse and other children, if any). However, Parent No. 2 and his/her current family in Parent No. 2's household are not included in the child's Assistance Unit.

Section 800: Consideration of Earned & Unearned Income

The two basic types of income to be considered in determining eligibility are **earned income** and **unearned income**. Income which is not counted in determining eligibility is **excluded income**. The following chart details what types of income you must count and what types of income are excluded.

Counts	Does NOT Count
Taxable wages/salary (before taxes are taken out) <i>Exclude pre-tax contributions to dependent care accounts, transportation accounts, flexible spending accounts, and retirement accounts</i>	Temporary Assistance to Needy Families (TANF) and other government cash assistance
Self-employment (profit once business expenses are paid)	Child support received
Social Security benefits	Supplemental Security Income (SSI)
Unemployment benefits	Veterans benefits
Alimony received	Worker's compensation payments
Most retirement benefits	Proceeds from life insurance, accident insurance, or health insurance
Interest (including tax-exempt interest)	Federal tax credits and Federal income tax refunds
Net capital gains (profit after subtracting capital losses)	Gifts and loans
Most investment income, such as interest and dividends	Inheritances
Rental or royalty income (profit after subtracting costs)	
Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards	
Foreign earned income	

INCOME VERIFICATIONS

A case manager may find it necessary to request income verifications because he or she questions the information provided on the MCHP application. The type of Verification may vary depending upon the nature of work performed.

COMPUTATION OF INCOME

The following rules apply to computing income for all family members whose income must be counted, as declared by the applicant or recipient:

Income Documentation	Calculation
Weekly	Multiply by 4.3
Bi-Weekly	Multiply by 2.16
Semi-Monthly	Multiply by 2
Monthly	Use Reported Income
Annual	Divide by 12

Section 1000: Determining Financial Eligibility

An applicant is financially eligible for the MCHP if the applicant's countable net family income does not exceed:

- 211 percent FPL for the family for child applicants younger than 19 years old,
- for pregnant women applicants, 264 percent FPL for the family size involved.

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Section 1100: Certification Period

CERTIFICATION PERIODS

A certification period is the period of time a consumer can be active before the next redetermination is due. If the consumer is eligible, the certification period will begin in the first day of the month if application. A child born to a Medicaid eligible mother will have their certification begin on the day they were born.

RETROACTIVE ELIGIBILITY

Retroactive eligibility may be determined for both children and pregnant Women under MCHP for the period of one, two or three months immediately prior to the month of application. It may be considered only for those months in which there were incurred medical expenses.

On the Maryland Health Connection, the user must choose Retroactive Eligibility at the start of the application or it will take a special work-around to fix it in the system. See the rules applicable to Retroactive Eligibility in the Maryland Health Connection Worker Portal Guide.

LHD's will determine eligibility for retroactive MCHP coverage. Cases will not be transferred to the LDSS for a retroactive MCHP determination only.

For retroactive coverage, the following principles apply:

- The applicant may request determination of retroactive coverage at any time during the six-month period which begins with the month of application.
- The retroactive period under consideration can be no more than three months. It may be one or two months based on the applicant's request. The months requested must contain incurred medical expenses that remain the obligation of the applicant or other legally responsible relative.
- Eligibility is determined separately for each retroactive month for which the applicant applies. If eligible, certification is effective for the entire calendar month.
- Only income actually received in each retroactive month may be considered. For persons who do not receive the same income during each of the twelve months of a year, including self-employed persons, farmers, and teachers whose salary is paid over less than a twelve-month period, the prorated annual amount for the retroactive month will be considered.
- Only persons who have coverable medical expenses during the period under consideration may be certified.
- All technical factors of eligibility, including age, residency, pregnancy, and health insurance must be met for each retroactive month. For example, a pregnant woman applicant may not have been pregnant in the retroactive month(s). Conversely, a child applicant may be covered in the month of application but under age 19 in the retroactive month(s).

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Section 1300: Post-Eligibility Requirements

The local department may not terminate benefits unless adequate and timely notice has been given to a recipient.

ADEQUATE NOTICE

"Adequate notice" means a written notice that includes:

- A statement of the intended action;
- The reason for the intended action;
- The specific COMAR citation supporting the intended action;
- Explanation of the right to request a hearing; and
- Explanation of the circumstances under which benefits will be continued if a hearing is requested (See Below).

TIMELY NOTICE

"Timely" means the notice is mailed at least 10 days before the action becomes effective. The local department may shorten the period of advance notice to 5 working days before the date of action if it has facts indicating that action should be taken because of probable fraud and the facts have been verified, if possible, through secondary sources.

Some adverse actions may be taken without giving timely notice. Timely notice does not have to be given in the following circumstances:

- The recipient dies;
- The recipient states in writing that she no longer wants assistance and that she understands her written request will terminate her benefits;
- The recipient gives information, such as confirmation of residency in another state that requires termination of assistance and states in writing that she understands her benefits will be terminated as a result of giving the information;
- The recipient is admitted to an institution (See Non-Financial Eligibility Requirements); or
- The recipient is accepted for Medical Assistance or MCHP services in another state, territory or commonwealth.

CONTINUATION OF BENEFITS PENDING APPEAL

If a recipient files a request for a hearing within 10 days from the date that the notice of action was mailed, the recipient's benefits may be continued, at the recipient's request, until decision is rendered after the hearing or until the request for a hearing is dismissed by the Administrative Law Judge (ALJ).

The local department must refer to the Division of Recoveries and Financial Services, Office of Operations, Eligibility and Pharmacy, MDH, on form DHMH-1169, all cases in which an otherwise ineligible recipient has benefits continued pending a hearing decision and the ALJ subsequently affirms the decision made by the local department. The Division shall institute procedures to recover the cost of any expenditures made on behalf of a recipient whose termination is upheld. This provision may not apply to a person who requested a hearing and continued benefits resulting from a bona fide belief that the local department took an adverse action erroneously.

Section 1400: Hearings

The Maryland Department of Health (MDH) must grant an opportunity for a hearing to any applicant who requests it because they believe the local department has denied their eligibility incorrectly or has not acted on their application in a timely manner (see Processing Applications-Time Limitations). Also, an opportunity for a hearing must be granted to any recipient who believes that the local department has canceled eligibility erroneously.

The local department may not deny an applicant or recipient the right to request a hearing. The local department must assist the applicant or recipient in filing an appeal if assistance is requested.

A person requesting a hearing must notify the local department or Office of Administrative Hearings (OAH) by letter or on Form DHMH 245, Appeal for Medical Assistance Hearing, within 90 days from the date the notice was mailed by the local department.

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Section 1500: Fraud and Abuse

Although the application is declaratory, the provisions of COMAR 10.09.24.14 (Fraud) apply to MCHP cases.

“Fraud” includes, but is not limited to, an applicant or recipient knowingly withholding pertinent information for an eligibility determination, knowingly giving false information for an eligibility determination or purposely misusing the Medical Care Program card.

The local department must report all cases of suspected fraud to the Division of Quality Control and Program Integrity, Beneficiary Services Administration, MDH, using form DHMH 4243, Investigation Referral.

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Appendix

Sample Forms

SUMMARY OF PROCEDURES FOR FAIR HEARINGS

If you are dissatisfied with the decision of the Local Department of Social Services or the Local Health Department, you have the right to appeal that decision to the Office of Administrative Hearings by writing to:

MDH Docketing - Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

You may obtain the necessary forms from the local department and if you wish, someone will assist you in filing your appeal. Your appeal must be filed within 90 days from the date of this notice. The appeal hearing will be scheduled by the Office of Administrative Hearings at a place and time that is convenient for you. You will be expected to be present; if for any reason you cannot be present, you must notify the Office of Administrative Hearings of the identity of the person who will attend in your place.

You may represent yourself, or if you wish, you may be represented by legal counsel or by a relative, friend or other person, although it is not required that someone represent you. You may bring any witnesses you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of persons of the general public may be admitted to the hearing if you so desire. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for its action.

You may obtain free legal aid help through the Legal Aid Bureau in many areas of the State. Consult your telephone directory for the address and telephone number of the Legal Aid Office nearest you, or contact your case manager at the local department for this information.

EMERGENCY SERVICES TO INELIGIBLE ALIENS

Date: _____

TO: Beneficiary Services Administration
Office of Operations & Eligibility
201 W. Preston Street
Baltimore, Maryland 21201

FROM: Local Department _____

Case Worker's Name: _____

Telephone #: _____

SUBJECT: Determination of Emergency Services - Aliens

Case Name: _____

Case Number: _____

Date of MA Application: _____

**I have checked and agree that the technical and financial information for the applicant
Has been reviewed and meets the MA requirements except for citizenship.**

Case worker Signature: _____
(Please sign your name)

The above-named applicant has submitted a Medical Assistance application for coverage
Of emergency services received from _____ to _____ at _____.
(date) (date)

Federal category for which the applicant is eligible, but for his/her alien status:
ف FAC ف MCHP ف Aged ف Disabled/Blind

A copy of the following must be attached:

- ف MMIS Screen 1 or MMIS/CARES screen showing results of search
- ف Discharge summary with admission and discharge dates
- ف ER admission
- ف Documentation showing the emergency nature of the medical services
- ف SRT Determination (if qualifying as disabled/blind)

***Note: No bills or other extraneous information should be submitted.**

MR-112
DES 401 (updated 8/03)

**MARYLAND MEDICAL ASSISTANCE PROGRAM
INVESTIGATION REFERRAL**

To: Head, field Investigation Section Div. of Utilization and Eligibility Review 300 W. Preston Street, Room 210 Baltimore, Md. 21201	From: _____ DSS Technician: _____ Telephone: _____
Re: _____ <div style="text-align: center;">Case Name</div> _____ <div style="text-align: center;">Address</div> _____ Case #/Category: _____ Representative/Address: _____	Case Status: ٢ Open, effective: _____ ٢ Change, effective: _____ ٢ Closed, effective: _____
A. Request for an investigation involving an unreported or untimely reporting of: <input type="checkbox"/> Resources <input type="checkbox"/> Income/Increase in Income <input type="checkbox"/> Change in Circumstance <input type="checkbox"/> A Disposal of Non-Excluded Resources for Less than Fair Market Value <input type="checkbox"/> A request for more than 1 Duplicate Card in a 12 month period <input type="checkbox"/> Other _____	
B. (Complete if known) Had the information now known been reported in a timely manner, the recipient would Have been: <input type="checkbox"/> Ineligible effective from _____ to _____ (Excess Income: \$ _____) <input type="checkbox"/> Eligible with Spend-down amount from \$ _____ to _____ beginning _____ to _____ Total Due State: \$ _____ <input type="checkbox"/> Eligible with monthly Available Income increased (Long Term Care recipient only): from \$ _____ to \$ _____ beginning _____ to _____, from \$ _____ to \$ _____ beginning _____ to _____, Total Due State: \$ _____	
C. Comments: _____ _____ _____ _____ <div style="text-align: center;">(Use separate sheets for additional information and check here ٢)</div>	
NOTE: Attach one copy of all documents relevant to the referral.	
_____ Supervisor's Name	_____ Signature
_____ Date	_____ Telephone #
DHMH 4243 (Revised 7/87)	

**MARYLAND STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE
MEDICAL ASSISTANCE PROGRAM
APPEAL FOR MEDICAL ASSISTANCE HEARING**

RETURN COMPLETED FORM TO:

MDH Docketing-Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Md. 21031

<p><u>To be completed by the local DSS</u></p> <p>MA No. or Case No. _____ (if assigned)</p> <p><input type="checkbox"/> Community MA</p> <p><input type="checkbox"/> Long Term Care (Please Check one)</p>

The Section below must be completed by the Applicant/Recipient.

_____		_____		_____	
(First Name)		(Middle Initial)		(Last Name)	
_____		_____		_____	
(Street, RFD, Box)		(City/Town)		(County)	
				(State)	
				(Zip code)	
I AM APPEALING THE FOLLOWING:					
<input type="checkbox"/> Rejection of my application for MEDICAL ASSISTANCE					
<input type="checkbox"/> Discontinuance of my MEDICAL ASSISTANCE					
<input type="checkbox"/> Undue delay in decision as to my eligibility for MEDICAL ASSISTANCE					
<input type="checkbox"/> Received Medical Assistance Card, but medical services not available or refused.					
<input type="checkbox"/> Other reasons (Specify):					
COMMENTS - Give any information, which you think has bearing on your appeal:					

_____			_____		
(Date)			(Signature)		
			()		

			(Phone Number)		
DHMH-245 Rev. 02/01/97					

Maryland Children's Health Program Manual

(USE DHMH 2583 INSURANCE REPORTING FORM TO REPORT HEALTH INSURANCE COVERAGE)					
RECIPIENT LAST NAME FIRST MIDDLE			REPRESENTATIVE LAST NAME FIRST MIDDLE		
APT. NO - STREET ADDRESS - P.O.BOX			APT. NO - STREET ADDRESS - P.O.BOX		
CITY		STATE	CITY		STATE ZIP CODE
MA NUMBER		SOCIAL SECURITY NUMBER		RELATIONSHIP TO RECIPIENT TELEPHONE NUMBER	
<input type="checkbox"/> THIRD PARTY ACTION (INJURY)		<input type="checkbox"/> DEATH DATE _____		<input type="checkbox"/> OTHER _____	
<input type="checkbox"/> OVERSCALE: \$ _____		DO YOU BELIEVE THAT THE RECIPIENTS ACTION OR INACTION WAS INTENTIONAL		<input type="checkbox"/> YES <input type="checkbox"/> NO	
COMPLETE THE APPLICABLE SECTIONS BELOW					
PROPERTY OWNED (ATTACH PHOTOCOPY OF DEED, IF DECEASED)					
DESCRIPTION		ADDRESS		APPROX VALUE	
BANK ACCOUNTS OWNED					
TYPE	OWNER (S)	INSTITUTION AND LOCATION		ACCT. NO.	VALUE
<input type="checkbox"/> SAVINGS <input type="checkbox"/> INDIV. <input type="checkbox"/> CHECKING <input type="checkbox"/> JOINT					
<input type="checkbox"/> SAVINGS <input type="checkbox"/> INDIV. <input type="checkbox"/> CHECKING <input type="checkbox"/> JOINT					
LIFE INSURANCE OWNED					
COMPANY		ADDRESS		POLICY NO.	NAMED BENEF? YES NO FACE C.V.
STOCKS/BONDS OWNED					
TYPE	DESCRIPTION	OWNER (S)	QUAN.	SERIAL NO. (S)	VALUE
<input type="checkbox"/> STOCK <input type="checkbox"/> INDIV. <input type="checkbox"/> BOND <input type="checkbox"/> JOINT					
<input type="checkbox"/> STOCK <input type="checkbox"/> INDIV. <input type="checkbox"/> BOND <input type="checkbox"/> JOINT					
CASH AND OTHER ASSETS OWNED					
DESCRIPTION		OWNER (S)		VALUE	
SOURCE - EXPLANATION					
DATE REPORTED	DATE OF INCOME		MONTHLY AMOUNT	TOTAL AMOUNT	
AUTO ACCIDENT	WORKMEN'S COM., EMPLOYED BY		OTHER		
PERSONAL ACCIDENT	ASSUALT				
DATE OF INJURY	LOCATION OF OCCURRENCE (ADDRESS)		HOSPITAL AND PHYSICIAN PROVIDING TREATMENT		
COMPLETE THE FOLLOWING SECTIONS, AS APPLICABLE					
VEHICLE DRIVE NAME		VEHICLE DRIVER ADDRESS		VEHICLE DRIVER LIC. #	
VEHICLE OWNER NAME		VEHICLE OWNER ADDRESS		VEHICLE OWNER LIC. #	
INSURANCE COMPANY NAME		ADDRESS		POLICY NO.	CLAIM NO.
LEGAL ACTION: <input type="checkbox"/> YES <input type="checkbox"/> NO		ATTORNEY NAME, ADDRESS, TELEPHONE			
DEPT. OF SOCIAL SERVICES NAME		WORKER NAME		TELEPHONE NUMBER	

DHMH 1169 (REVISED 4/81)

REQUEST FOR HEARING

**Fill out this form ONLY if you disagree with a decision concerning you benefits.
 If you disagree with the action of the local department, you are entitled to discuss it with a supervisor.
 We will help you fill out this form or you can ask for a hearing by calling –800-6347.**

1. Tell us who you are. Fill in the blanks in this box and complete boxes 2-4. Please print clearly.
 Name: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____ Phone Number () _____
 Your local office name: _____

2. Which Programs do you want to appeal? (Check all that apply)

<p>Medical Assistance (MA)</p> <p>_____ Community MA</p> <p>_____ Long Term Care MA</p> <p>Your Representative's Name: _____</p> <p>_____ Maryland Children's Health Program (MCHP)</p> <p>Parent or Guardian's Name: _____</p> <p>_____ I receive other benefits</p> <p>_____ I do not receive any other benefits</p> <p>_____ Qualified Medical Beneficiary (QMB/SLMB)</p> <p>_____ Other _____</p>	<p>Family Investment/Social Services Program</p> <p>_____ Temporary Cash Assistance (TCA)</p> <p>_____ Food Stamps (FS)</p> <p>_____ Purchase of Care (POC – Child Care)</p> <p>_____ Transitional Emergency Medical and Housing Assistance (TEMHA)</p> <p>_____ Foster Care (FC) and/or Adoptions</p> <p>_____ Emergency Assistance (EA)</p> <p>_____ Public Assistance to Adults (PAA)</p> <p>_____ Overpayment of TCA</p> <p>_____ Over issuance of Food Stamps</p> <p>_____ Other _____</p>
--	--

3. What are the reasons you want a hearing?

_____ I was not allowed to apply.	_____ The amount of assistance I receive is wrong.
_____ My application was turned down.	_____ My assistance has been incorrectly
_____ My application was not handled properly.	Suspended, reduced, or terminated.
_____ I am not receiving the services that I need.	_____ I do not agree that I should pay back assistance
	I received.

If you received a notice about this, what is the date on the notice? _____

Why do you want a hearing: Please tell us what happened. _____

4. I understand if I ask for a hearing within 10 days from the date of the notice and I was receiving benefits, I can still get them while I wait for my hearing unless my benefits period ends. I may have to pay back the benefits if I lose my appeal.

Check here if you do **not** want benefits while you wait for your hearing.

_____ Signature _____ Date _____

FOR AGENCY USE ONLY

Department: _____ Local Office: _____ Date Appeal Received: _____
 Case Name: _____ Case Number: _____
 Appeal based on notice sent: _____ Effective: _____ Conference Held? Y _____ N _____
 Benefits pending: Y _____ N _____ Reason: _____
 Case record attached? Y _____ N _____ Reason: _____
 Worker: _____ Supervisor's Approval: _____ Date: _____

FOR APPEAL UNIT USE ONLY

Appeal Rep: _____ Date: _____
 Category: _____ Transmitted by: _____
 DHR/FIA 334 (Revised 04/02)

Administrative Law Building
11101 Gilroy Road
Hunt Valley, Md. 21031-1301

Office of Administrative Hearings
Administrative Law Building
11101 Gilroy Road
Hunt Valley, Md. 21031-1301

HOW TO HAVE A HEARING IF YOU THINK WE ARE WRONG

- **How do I request a hearing?**

Use the form on the back of this page.

Bring the form to your local office

The name of your local office is in the upper right corner of the notice.

OR, mail the form to the Office of Administrative Hearings.

Use the enclosed envelope.

Make sure the address at the top of this page shows through the envelope window.

If you don't want to fill out the form

Come to your local office. We will help you.

Call your case manager or call 1-800-332-6347.

- **How long do I have to request a hearing?**

You must ask for a hearing no later than **90 days** after the date of the notice.

- **How can I still get my benefits while I wait for my hearing?**

If you ask for a hearing no later than **10 days** after the date of the notice and you were getting benefits, you can get your benefits while you wait, unless your benefit period ends.

- **Will I owe any money if I get my benefits while I wait?**

Yes, if the judge agrees with us and you lose your appeal, you may have to pay back benefits.

- **When and where will the hearing be?**

The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

- **Do I have to come to the hearing?**

Yes, you will lose if you do not come. If you can't come, call the Office Of Administrative Hearings and they will let you know how to reschedule your hearing.

- **Can I bring someone to help me or speak for me?**

You can bring a lawyer, friend or relative. If you want free legal help, call your local office or call Legal Aid at 1-800-999-8904.

- **How can I prepare for the hearing?**

You can see your file, including your computer file, at your local office and talk with us about this decision.

Please call to make an appointment. We will send you our reasons for the decision you are appealing at least 6 days before the hearing.

Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347