Section 400 Table of Contents
Application Requirements

400.17 Steps Taken to Complete Form
- **(a)** Demographic Information
- **(b)** Income
- **(c)** Resources
- **(d)** Life Insurance
- **(e)** Real Property

400.18 Verification for Deductions from Available Income for the Cost of Care
- **(a)** Health Insurance
- **(b)** Residential Maintenance Allowance
- **(c)** Spousal Maintenance Allowance

400.19 Good Faith C, Concept

400.20 Post Eligibility
- **(a)** For Eligible Person
- **(b)** For Ineligible Person

Attachment A- Notice of Ineligibility Due to Excess Income

Frequently Asked Questions (FAQs) and Answers

Objectives for Section 400

1. Explain the Application Process in detail;
2. Provide requirement for establishing eligibility;
3. Clear explanation for the application procedures for institutionalized persons.

400.1 Introduction -Application Process (Form)

An individual interested in applying for Medical Assistance (MA), or a representative may contact the Local Department of Social Service (LDSS) or Local Health Department (LHD) or go online at www.marylandsail.org to complete the appropriate application form, based on the type of coverage requested. The MA application form is the instrument which information pertinent to the determination of eligibility is gathered from the Applicant/Representative (A/R) or the A/R's representative. DHMH designates which forms may be used as MA applications and which forms establish the application date. Screening forms, such as the DHR/FIA Cares 9711 Request for Assistance, are not approved by DHMH as MA application forms.

A person requesting to file an MA application must be given an opportunity to apply without delay. The application must be made available to the person upon request.

The individual must complete the application and mail, fax or hand delivers it to their LDSS or LHD where they live. Addresses of the LDSS or LHD are located in Appendix A and Appendix B.

Applicants can also send your applications electronically through the Service Access & Information Link (SAIL) system at www.marylandsail.org.

An individual who temporarily leaves the state but intends to return may apply by mail.

In the case of a deceased person who did not apply before he/she died, a representative may complete, sign, and file an application on his or her behalf. Example: Died 7/2/2007 has bills for April, retro would be for April/May/June (retro would only be for the requesting month). Certification would end the date of death 7/2/2007.

If an individual need help applying for benefits, have questions, or do not speak English and need free translation services, please call 1-800-456-8900 or 1-800-332-6347.
Si necesita ayuda para Llenar el formulario favor de llamar al 1-800-456-8900 o 1-800-332-6347. The individual must be made aware of the significance of the date of application and its effect on retroactive eligibility, and be provided a list of basic information required.

(a) Provisions of Public Information

If anyone request public information about their MA eligibility or the process, the Case Manager (CM) must provide the following information orally or in writing:

- Available MA services
- MA requirements
- Income
- Policies/Spend down explanation

Case manager never make a determination over the phone or without gathering all of the information.

(b) Representative

A representative may assist the A/R in the application and redetermination process and in other matters related to the A/R's MA eligibility. Only one designated representative at a time may be recognized as authorized to act on the A/R's behalf. Designation of a representative is indicated in writing on the MA application form or a letter submitted to the Department or its designee.

- An A/R who is at least 18 years old and mentally competent to provide information required by the Department is **not required** to have a representative, but may choose to designate a representative to provide assistance or act on the A/R's behalf in matters related to MA eligibility.
- A pregnant woman of any age is **not required** to have a representative and may sign the application and attend the interview on her own behalf, even if she is younger than 18 years old.
- A child younger than 18 years old (unmarried and not pregnant), or an individual who is not mentally competent to provide required information. **Must have** a representative designated writing to act on the individuals' behalf in matters related to MA eligibility.
- A representative may be one of the following individual who is at least 18 years old:
    - An individual who is related to the A/R by birth or marriage;
    - The A/R's legally recognized guardian or representative with power-of-attorney;
    - The caregiver with whom an A/R younger than 18 years old lives, if the child does not live with the child's parent or other caregiver relative;
    - An individual designated by the A/R if the A/R is at least 18 years old;
    - A provider's representative/hospital/institution
    - The A/R's legal counsel
    - A governmental representative who is not involved with determining the A/R's MA eligibility (e.g. social services social worker)
    - Anyone that can provide the required information
    - The representative must be 21 years of age to sign the application for someone under 21.

(c) Application Date

A written, signed application received by the LDSS/LHD (either by mail, fax, or in person) must be registered with an application date upon receipt. The LDSS/LHD must date stamp the application on the day it is received, even if the application is filed in a Maryland jurisdiction where the applicant does not live, as long as the applicant lives in another Maryland jurisdiction. There can be no delay in registering the application for any reason.

The application date is the date that the LDSS/LHD or other designated entity receives a MA application with appropriate signature on a form approved by DHMH. Mail in or faxed applications and signatures are accepted. Applicants may also apply online at www.marylandsail.org.

Following the initial eligibility determination, communication between the LDSS/LHD and the recipient or representative is usually by mail or telephone. Faxes and emails are not used to request or provide information. Redeterminations are conducted through a mail-in process. A redetermination package, including an application form and a notice with the due date, is mailed to the recipient or representative, who completes and returns the package with any required verifications to the LDSS/LHD in mail.

400.2 Persons Eligible for MA without Filing a Separate Application

(a) Recipients of Public Cash Assistance

Recipients determined eligible for the following types of public cash assistance (Even if they are in a no-pay status) are eligible for MA without filing a separate MA application.

- Supplemental Security Income (SSI) coverage groups L01 and S02
- Temporary Cash Assistance (TCA) coverage groups F01-F03
- Public Assistance to Adults (PAA) coverage groups S01
- Foster Care or subsidized adoption under Title IV-E of the Social Security Act (Coverage group E01); and
- (Refugee Cash Assistance (RCA) coverage groups G01 and G02

(b) Child Born to a MA-Enrolled Mother

Newborn (NB) are presumptively eligible for MA for a period up to **15 months** if the mother is enrolled as a Maryland MA recipient on the date of the newborn's birth. The NB's MA coverage is tied to the mother's MA enrollment for the date of birth. Therefore, an application and determination of the newborn's eligibility are not required in order to add the newborn to the mother's currently eligible Assistance Unit (AU). Coverage of the newborn under this policy applies irrespective of any ineligibility factor that may pertain to the newborn, except that the newborn must be a Maryland resident.

If the mother is determined eligible for MA or the Maryland Children's Health Program (MCHP) for a certification period including the newborn's birth, the child is certified in coverage group P03, unless the mother was eligible in coverage group P11. Then, the newborn is certified in coverage group P12. The presumptive eligibility for the newborn applies even if:

- The mother is determined eligible for the date of birth after the fact; or
- The mother is eligible in the X-track for ineligible or illegal aliens.

The newborn continues to be presumptively eligible in coverage group P03 or P12 for one year from the month of birth, unless the newborn moves from Maryland, dies, or becomes eligible in a different MA coverage group (e.g., T-track for long term care or E-Track for foster care or subsidized adoption). Therefore, the newborn retains eligibility in P03 or P12 even if the mother loses MA eligibility or the baby moves out of the mother's household during the baby's 15-month certification period. After 15 months of MA, a Redetermination must be conducted.

Requirement: Baby must reside in Maryland

If the newborn is added to a TCA AU (coverage groups F01-F03), the newborn's eligibility may be affected by a change in circumstances of any family member; including the newborn, which makes the TCA AU ineligible. Then, each AU member, including the newborn, must have their MA eligibility determined for the most appropriate coverage group. The newborn's automatic eligibility in the TCA AU is also lost if the newborn ceases living with the mother.
Upon expiration of the newborn's presumptive eligibility period, a redetermination must be conducted to determine the child's continued eligibility, applying regular policies and procedures. Timely redeterminations are required to assure that coverage is not continued inappropriately. Eligibility factors pertaining to the newborn which could not be considered during the 15-month presumptive eligibility period must be considered at this time. A MA ineligible child must be considered for possible coverage under MCHP.

(1) Certification Procedure for the Newborn

Certification of a NB on MA master file is initiated by the DHMH office of Eligibility Services (OES). This procedure expedites certifications of newborns and must be followed by both hospital and LDSS/LHD. The procedure is as follows:

- OES is notified by hospital via the DHMH form 1184(Hospital report of NB), that a child has been born to a mother who is a MA or MCHP recipient.
- OES certifies NB on MA Eligibility Verification System (EVS) master file using the mother's case number to establish a temporary case number until the CARES interface assigns a permanent case number for the child. Therefore, the child will not have a CARES IRN at this point.
- OES sends a completed 1184 to LDSS/LHD, as appropriate, for eligibility processing
- Upon receipt of an 1184, the LDSS/LHD case manager must make determinations on their own:
    a. Was the mother eligible for the date of the NB birth
    b. If eligible, add the NB to the mother's AU# (add program/add person-more members).
    c. Review the 1184 for any errors or inconsistencies (name, address, eligibility, dates, category codes, etc) and take necessary corrective action as needed
    d. If there is a discrepancy between the CARES and MMIS as to whether the mother was MA/MCHP eligible for the date of the child's birth, the LDSS/LHD case manager reviews the case record to determine the correct eligibility status and then takes the appropriate action.
    e. If mother's eligibility ends, the baby (PO3) will received MA for 15 months.
    f. Note: No application is needed to add the NB
    g. If the mother gives up legal custody of the NB and the child does not go home with the mother, the NB does NOT automatically qualify for the MA/MCHP. The caretaker for the child would have to apply for the child

h. The newborn's eligibility should terminate, however, if the child moves out-of-state. Then, terminate eligibility in accordance with timely and adequate notice requirements
i. If an LDSS or LHD is informed of a newborn's birth but the hospital or clinic failed to initiate the DHMH 1184 process, the LDSS/LHD must take action on its own to determine if the infant is automatically eligible for MA. The LDSS/LHD must determine if the mother was eligible for the date of the newborn's birth and if that eligibility currently exists. If the mother continues to be eligible, the LDSS/LHD case manager adds the newborn to the mother's unit.

(2) Certification Procedure for the Newborn of a Temporary Cash Assistance recipient

The TCA policy in regard to adding a newborn to the TCA grant is outlined in the TCA manual. The client will be given a copy of the DHMH form1184 by the hospital. The DHMH form 1184 can be used for birth verification so that the newborn may, if otherwise eligible, be added to the TCA assistance unit. If a child is born to a TCA applicant in the month of application and the mother is found eligible in that month, certifications of the newborn's MA and certifications for the mother and other eligible members of the TCA unit begins the first day of the month in which they were found eligible for TCA. If the child was born prior to the month of the applicant/mother's eligibility for TCA and there are outstanding medical bills, refer to the policies for Non-Public Assistance for Adults (NPAA) MA or MCHP for determination of retroactive eligibility.

400.3 Person Required to File an Application

All persons requesting MA (or for whom MA is requested) who are not SSI or TCA recipients are required to file an written, signed, application with the LDSS/LHD in order for an eligibility determination to be made.

CM must provide the following information to customer:

- Application date
- Retroactive months (retro)
- List of information needed and why
- Due date for information
- Customer must report any changes that come about within 10 business days

400.4. General Requirements for Establishing Eligibility

A signed application which is not completed to full specifications is still acceptable for the purpose of registering the application date. However, an application which has no signature does not constitute a valid application even if it is otherwise complete. Such an application must be immediately returned to the person with an explanation of the reason for the return and will not be registered with an application date until it is signed and returned to the LDSS/LHD. Listed below are application requirements for an application to be completed:

(a) Signature Requirements for Establishing Eligibility

- No signature, application can NOT be completed-return to the customer.
- Signed but not complete can be pended
- An applicant is required to sign the application under penalty of perjury
- Applicants include both spouses (relaxed to one signature)
- Applicant include both parents of children if both parents are in the home (this has been relaxed and only one signature is necessary)
- The Care Taker Relative other than Parent (CTROP) and spouse of the CTROP if the spouse of the CTROP wants to be included for the program and resources and income would be counted
- Spouse to spouse
- Parent to child

(1) Family and Children (FAC) Unit Signature Requirements

- Both parents must sign if they are both in the home. This has been relaxed so that only one signature is necessary.
- Married couples with children-both to sign (Flexible signature so only one signature is necessary)
- 18 years old or older not living with parent-or CTROP emancipated minor child may sign the application for both filing and eligibility purposes. In this instance the LDSS must make efforts to contact the parents and verify child's living arrangement and insurance coverage.
- Child living with CTROP-CTROP to sign
- An authorized representative who is 21 years old or older must sign the application for an unmarried child younger than 18 years old that is not living with a parent or CTROP. They can be one of the following:

    a. A person with court order
    b. Legal guardianship or custody of the applicant
    c. The adult with whom the child lives
    d. A person chosen and authorized by the applicant to represent him when no one else is available.

(2) Aged, Blind, or Disabled (ABD) Unit Signature Requirements

- A blind or disabled child who is 18 years old or older and competent may sign for his/her own application.
- An ABD applicant, if competent and able to do so **must** sign his/her own application
- For the purpose of establishing only the date of application, the applicant or a person acting on behalf of the applicant may sign the application form.
- If the applicant is not competent or is unable to sign, the application must be accompanied by an affidavit from a physician that verifies that the applicant is not

competent or is physically unable to sign the form. If the application is accompanied by such an affidavit than an authorized representative can sign

- If a child is blind or disabled and because of age or incompetence is not abele or permitted to sing, the parent with whom the child lives must sign for the child
- The representative must sign for a blind or disabled child who does not lie with his/her parents and is unable to sign because of age or incompetence

400.5 Voluntary Withdrawal

A person who has filed an application may voluntarily withdraw that application. The application form however remains the property of LDSS/LHD. The withdrawal of an application does not alter a penalty period associated with the disposal of a resource.

Note: If customer applies again and includes the month of the prior w/d, the original application is reactivated and sets the period under consideration (eliminates applying for retro).6 months to consider income and verifications. Customer will be eligible for a year.

When an applicant formally withdraws an application, they cannot subsequently be forced to apply for Medical Assistance for a prior month for which they do not want coverage. Therefore, any applicant who formally withdraws an application and subsequently applies for a later period only should have their period under consideration set by the latter, not withdrawn application. If a subsequent application includes the month of the prior withdrawn application, the original application is reactivated and sets the period under consideration.

400.6 Eligibility Determination Process

Once an application has been filed with the LDSS/LHD and the date of an application has been established, the process of determining eligibility, with its time limitations, begins.

The LDSS/LHD CM must make a prompt decision on each application that is filed. The decision must be made no later than 30 days from the date of the application or, if the case involves a determination of disability, no later than 60 days from the date of application. Refer to section entitled: Extension of Time Standards" for exceptions to this rule. The 30 and 60-day time limits refer to the date the notice of decision is actually mailed to the applicant.

A decision of eligibility or ineligibility is based on MA policy and procedures. Persons who apply as ABD are SSI-related and the eligibility requirements are basically those of the SSI program. People who apply as FAC are TCA related and the eligibility requirements are basically those of the TCA program a single assistance unit may not be a combination of the two.

The eligibility determination process involves a number of steps and procedures:

- Interviewing the A/R by phone or (in person)
- Obtaining appropriate signatures on application
- Establishing the period under consideration; and
- Obtaining necessary documentation and verification

(a) Face to Face Interview (no longer required)

1. The face-to-face interview is no longer mandatory, but may be required at the discretion of the CM or at the request of the A/R.
2. When it is determined that a face-to-face interview is required, the LDSS/LHD CM or at the request of the A/R.
3. When it is determined that a face-to-face interview is required, the LDSS/LHD CM shall arrange for the interview
4. The primary purpose of the interview should, shift from filling out the application to reviewing the filed application, interviewing for its accuracy and completeness, and making the necessary adjustments.

The CM should prepare for the interview in advance of the scheduled time. It is reasonable to assume that some filed applications will not be accurate or complete. The expectation is that those who are able to complete the application themselves should do so in a setting that is independent of the interview. Local departments must decide on a case-for-case basis whether to require a person to finish an incomplete application from before the interview or whether to assist the person in completing the application form during the interview.

(1) Telephone Interviewing Tips

An interview, whether face-to-face or by telephone, is structured communication for the purpose of gathering necessary customer information to assist in determining eligibility. Its success depends on the skill of the interviewer and the rapport that develops between the interviewer and the customer.

a) Plan the telephone interview. It requires preparation.
    1. Get organized
    2. Decide the objective of the call
        a. What is it you need to know?
        b. Why are you calling the customer?
    3. Familiarize yourself with relevant past and current information
    4. Write down all information needed
    5. Gather complete and accurate information

b) During the interview
    1. Confirm your understanding of the circumstances
        a. Ask questions until you are clear on all issues,
        b. Request the customer repeat them back to you
    2. Use a good closing statement to prevent unnecessary and time-consuming phone calls to and from customers.
        a. Examples:
        "Is there anything else you need to tell me before we hang up?
        "Do you have any questions for me?

"Do you know what information you need to send/bring in?
"Do you understand all that we talked about?"

CM must report on the number of telephone interviews completed, it is important that CM code and document to capture when the interview is completed by phone

(2) Interviewing Responsibilities of the CM

The CM has both the authority and responsibility to ask questions beyond those stated on the application form when appropriate for an accurate determination of eligibility. The questions should better enable the CM to:

- Analyze the information provided
- Collect additional information (letter will be mailed describing additional information to bring) (Appendix A)
- Reconcile inconsistencies
- Discuss potential entitlement to benefits not being received and to refer for an application of benefits
- Inform the A/R of his/her responsibility for the accuracy and completeness of the information provided
- Explain the various assistance unit choices and exclusion options to the A/R and engage him/her in the decision-making process
- Make the necessary adjustments on the application form based on the A/R's selection options;
- Obtain all required signatures on the application;
- Establish separate cases as needed based on the choices of the A/R and the provisions of Regulation .06; and
- Perform whatever other tasks are needed.

It is important that:

1. The CM's time be used in the most efficient manner:
2. Persons who are capable, take responsibility for the completion and signing of original application is reactivated and sets the period under consideration and their Application; and
3. Appropriate assistance is provided to persons who are not capable of taking responsibility for completing their own application.
   The CM may, however, apply reasonable and practical measures to encourage applicants to speed up the application process for their own benefit and that of the LDSS CM assisting those applicants who need help in establishing their eligibility and who have no responsible person to act on their behalf. Local departments will need to:
   - Provide applicants with a clear explanation of the information needed to establish eligibility, why it is needed, and how it will be used;

- Set time limits for applicants to provide the required information. The due date should be reasonably related to the types and amount of information to be collected and the source(s) of the information; and
- Provide applicants with a written list of the required information and the types of acceptable verifications.

The last part of the interview should be devoted to a discussion of

- The general use of the MA card;
- The rights and responsibilities of applicants;
- Fraud and abuse, and the consequences of committing either or both;
- The requirements to report changes in family circumstances, including changes in household makeup;
- The spend-down provision;
- The redetermination process: and
- Other subjects as needed on a case-by-case basis, including a clear explanation and a written statement of additional required information.

The above items need to be discussed in all cases except those whose technical (non-financial) ineligibility is determined prior to or during the interview. Every effort should be made to avoid the necessity of more than one face-to-face interview. Good planning and effective interviewing can result in considerable time saving and improved case management.

The A/R may be assisted by a person or persons of his choice in the application process and may be accompanied by this person or persons to the interview.

When it is determined, the interview may be conducted with an authorized rep or a person responsible, when it cannot be conducted with the applicant because of unusual circumstances such as severely incapacity disabilities, which preclude the applicant's appearing at the local department. All institutionalized persons are presumed to meet this criterion.

The waiver also generally applies to chronically, ill, housebound, immobile persons who may not be aged and who are largely dependent upon others to perform their required day-to-day activities for an indefinite period of time.
Many persons who are unable to meet the face-to-face interview requirement are able to provide information about them. In these situations, the representative who completes and signs the application for the person and appears for the face-to-face interview should make every effort to enlist the person's aid.

In the case of an unmarried person younger than 18 years old who is not living with a parent or a Caretaker Relative Other than Parent (CTROP), the face-to-face interview may be conducted with one or more of the following persons, 18 years or older:

a) The parent or other knowledgeable relative of the child;
b) The non-related person with whom the child is living; or
c) Another designated responsible person who is knowledgeable about the child's circumstances.

If the interview cannot be conducted with any of these persons, then another designated responsible person who is knowledgeable about the child's circumstances is acceptable. In either case, the parents, if living in the state, should be contacted by CM to verify the child's physical separation from the parents, the child's income and resources, and whether or not the parents have the child covered under any health insurance plan. Whoever acts on behalf of the child must provide all information that is pertinent to an accurate determination of eligibility.

For a child in the custody of a public or private agency, a representative of the agency may complete and sign the application. The representative must insofar as possible, include the parents, foster parents, or other knowledgeable persons in the collection of information. Many of these children have income, resources, and health insurance coverage, all of which are pertinent to the eligibility determination process and are usually not known unless there is contact with those who are knowledgeable about their situation.

Attachment A-Request for Information to Verify Eligibility

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Family Investment Administration
Request For Information To Verify Eligibility

1. LOCAL DEPARTMENT	2. DATE
	3. CASE NAME
	4. CATEGORY & AU NUMBER
	5. CASE MANAGER
	6. TELEPHONE NUMBER

DEAR APPLICANT/RECIPIENT:

To get benefits you must give us the proofs **MARKED BELOW** for you and **ALL PERSONS FOR WHOM YOU ARE APPLYING.** If you have any questions or need help to get the proofs, please call me. Thank you.

☐ Bring the proofs to an interview on . . . . DATE:

☐ Bring or send them to me no later than . . .

	PROOF OF INCOME		PROOF OF IDENTITY		MOST RECENT PROOF OF EXPENSES... BILLED OR PAID BY YOU OR OTHERS FOR YOUR HOUSEHOLD
☐	Paystubs - last _____	☐	Social Security Cards	☐	Heat, Lights, Telephone, Water, Sewerage, Trash Removal, Other Utilities
☐	Statement on Employer's Letterhead	☐	Birth or Baptismal Certificates	☐	* Rent, Mortgage Receipts
☐	Tax Return: 20_____	☐	Driver's Licenses	☐	* Amount of Shared Expenses
☐	Unemployment Benefits	☐	Alien Registrations	☐	* Child or Adult Dependent Care
☐	Union/Strike Benefits	☐	Marriage License/Divorce Decree	☐	Property Taxes/Homeowners' Insurance
☐	Child Support or Alimony			☐	Medical Bills
☐	Social Security Benefits				
☐	SSI/SSDI Benefits				
☐	Veteran's Benefits or Other Pensions		**PROOF OF ASSETS**		**OTHER PROOFS**
☐	Education Loans/Grants/Scholarships	☐	Checking and Savings Accounts	☐	School Attendance and Financial Aid Form 604 or 690
☐	Military Allotments	☐	Certificates of Deposit (CD's, IRA's and Keogh Accounts)	☐	Address of Absent Parents
☐	* Payments From Others for Expenses	☐	Stocks, Bonds, Mutual Funds	☐	Pregnancy/Prenatal Care
☐	* Contributions Received	☐	Dividends and Interest	☐	Disability/Incapacitation
☐	* From Roomers or Boarders	☐	Life and Health Insurance	☐	Application for Other Benefits
☐	Rental/Mortgage Income	☐	Cars and Other Vehicle Loans	☐	Proof of Who Lives With You
☐	Self Employment Records	☐	Make, Model and Year: for all Cars, Trucks, & Other Licensed Vehicles	☐	Report Cards
☐	Workman's Compensation	☐	Transferred Assets in Last 3 months	☐	Health Care Forms
☐	Wage Form	☐	Property: House, Land, Other	☐	Type of Housing
☐		☐		☐	

* IMPORTANT: These proofs must include the name, address and telephone number of the person making the statement.

OTHER INSTRUCTIONS with Box Reference Number:

DHR/ FIA *1052 (Revised 12/01) Previous editions obsolete.*

(b) 401 Waiver of Face to Face Interview with the Representative

The LDSS/LHD may waive the requirement for a face-to-face interview with a representative of a public or private agency who files on application for Medical Assistance (DHMH 115B (7/83)) on behalf of a child under 21 committed to the agency.

- Public and private agencies including the department of Juvenile services (DJS), Social Service Administration (SSA), Mental Retardation/Developmental Disabilities Administration, Associated Catholic Charities, and Family and Children's Society.

It may waive the requirement if, in gathering information required for the child's placement, the representative has had recent face-to-face contact with his parent or guardian or, in the absence of one of these, some other responsible person who is knowledgeable about the child's circumstances. Face-to-face contact between a representative and a parent or a guardian may be deemed to satisfy the face-to-face interview requirement. Provided the LDSS meets the additional requirements which follow.

The LDSS/LHD must contact the person who completed the application and determine:

1. If the information contained in the MA application was gathered from recent contact with the parents or other responsible persons; and
2. The dates and type(s) of contact (e.g., face-to-face, letter, or telephone).

In the context of this requirement, "recent" means the month of the application or the month prior to the month of application.

The LDSS/LHD must also discuss with the representative the responsibility to report all changes, proper use of the card, etc.

If, based on this contact, the LDSS/LHD is not satisfied that the information necessary to determine eligibility has been recently gathered and is complete and accurate, waiver of the face-to-face interview may not be allowed.
(For persons residing in or entering a long-term care facility, see section entitled "Application Procedures Specific to Institutionalized Persons").

(c) Exploring Alternative Avenues of Eligibility

The MA program has numerous eligibility coverage groups. For eligibility determinations, local departments must have systems and processes in place that explore all reasonable avenues of eligibility. At application, these systems must ensure that eligibility is tested beyond the first designated coverage group. At redetermination, these systems and processes must first consider whether the individual continues to be eligible under the current coverage group and, in the case of a negative finding, explore eligibility under other possible coverage groups. The extent to which, and the manner in which, other possible coverage groups must be explored will depend on the circumstances of the case and the information available to the local department.

In the event that an applicant fails to qualify in the first coverage group in which they are tested, the local department must test the applicant in other possible coverage groups for which they may qualify. This may include testing eligibility beyond a CARES-generated sprout, as from F99 to the P-track. In order to conduct this additional test, the local department must gather enough information from the applicant to establish which coverage groups may be possibilities. Possible questions for the applicant include, but are not limited to:

- Does the ABD applicant have a related minor child in his/her care?
- Does the FAC applicant (adult or child) have a disabling condition or visual impairment?
- Is the FAC applicant a Medicare recipient?

Information gathered from questions such as these will enable the local department to test the applicant in alternative coverage groups for which the applicant may qualify. Where there is more than one potential coverage group and the applicant chooses one over another in the Informed Choice discussion, this should be noted in the case narrative.

The declaratory statement (medical coverage statement), ordinarily completed in MCHP applications, should also be completed for TCA and FAC applications. Eligibility in the F- track would not be precluded if it is missing. However, eligibility in coverage group P14 would be precluded if the case trickles to that group and the declaratory statement is missing.

(d) Screening Applications for Medical Assistance Extensions (F02 and F03)

Previously, TCA cases reached the Earnings Extension (F02) and Child Support Extension (F03) only through the "trickle" process. Now CM may initiate F02 and F03 cases through screening process. Screening for the MA extensions is appropriate when the TCA case was closed without the earnings or child support information which would have automatically allowed the case to trickle. A new field (MA EXT) on the MISC screen will be used to initiate the extension. If valid value "D" is used the MA EXT field, the case will not trickle through the F- Track.

For most people, the application should be processed within 45 calendar days of the date you apply. If an applicant is pregnant, their application should be processed within 10 work days, if the case manager has all of their required information. If an applicant is referred to Disability Determination Services for a disability determination, their application will be processed within 90 calendar days, or as soon as possible after your disability determination is complete if the disability determination takes more than 90 days.

(e) Verification Requirements

When an application is received, the local department of social service conducts system clearance (e.g. Client Automatic Resources and Eligibility System (CARES), State Verification Exchange System (SVES), State on-line Query (SOQL) and Maryland Automated Benefits System (MABS) to determine whether the applicant has current Medical Assistance coverage group, to investigate what benefits or income the applicant or spouse is receiving, and to obtain or verify other information related to the application. Information provided by the A/R may be

contradictory or different than information obtained from the clearances. If the LDSS/LHD CM has any reason to question the information represented by the A/R on the application or at the interview, or if the information presented in contradictory, incomplete, vague, or incomprehensible, the case manager should request additional information or verification from A/R.

a. Verifications by the A/R of the following information is always required in addition to the declaratory information provided by the A/R on the Medical Assistance application form:

- **Income**: Verification of income is no longer mandatory for the F-Track coverage groups Income must be verified for all other coverage groups
- **Resources**: All resources will be verified for all coverage groups.
- **Resources** will not be verified for the F-Track group, except for F98 and F99.
- **Private health insurance** or other third party medical coverage (request a copy of the front and back of the insurance card)
- **Additional information as needed**
- **Age/Identity/Citizenship**
- **Note: F05 and MCHP are declaratory for income and most verification. Citizenship and Identity are still needed**

b. The CM should only ask the A/R for verification of other information if:

- The CM requires additional information in order to determine technical or financial eligibility (e.g. the information provided by the A/R is incomplete or unclear or there is a discrepancy)
- The CM has no other source to obtain the needed information or to verify certain information on the application; and
- The information or verification may have an immediate bearing on the case or may impact eligibility.

(1)Due Date for Verifications

The LDSS/LHD CM must inform the A/R in writing of the required information and verifications to determine eligibility and the due date. The A/R, in turn must provide all required information and verifications early enough for the LDSS/LHD CM to meet the 10-30 or 60 day-day limit. If an applicant does not provide the required information to enable the LDSS/LHD CM to determine eligibility within the applicable time frame, the applicant may be determined ineligible. However, an extension of time frame standards is required of the LDSS under certain circumstances. For Instructions or when to apply these standards refer to the section entitle "Extension of Time Standards."

(2)Required Verifications

The various factors affecting eligibility that may require verification are listed, along with the method of verification, in Appendix A of this section 400. While some factors can be verified in a number of ways, others (such as income and resources) require verification from a specific source. The following factors call for special comment.

As general rule, written verification should be signed and dated. The document should also include the name, address, and telephone number of the person providing the verification. LDSSs are authorized by the A/R's signature on a Consent of Release of Information form to contact a signatory and verify the validity of a statement.

SDX/SVES/SOLQ Verifications- The following information is verified by the LDSS through the State Data Exchange (SDX), State of Verification Exchange System (SVES), or State on-Line Query (SOLQ). Hard-copy verification from the A/R is only necessary if there is any discrepancy.

- Date of birth
- Social Security number
- Supplemental Security Income (SSI) benefits
- Social Security benefits
- Railroad Retirement benefits
- Medicare entitlement and enrollment
- Medicare number
- Citizenship and Identity (Please refer to chapter 500 verification of citizenship and identity for listings of acceptable verification)

SAVE Verification of Alien Status- If the applicant indicates that he/she is not a U.S. Citizen but is a legal entrant, the LDSS/LHD uses the Systematic Alien Verifications for Entitlements (SAVE) system in order to verify the alien status, most recent date of U.S. entry, and date of qualified alien status. If no discrepancy is found, hard-copy verifications by the A/R are not required. Verifications of Alien status either SAVE or from the A/R are not required for an alien applying for only emergency medical services.

Residence may be verified by a rent book, rent receipt, gas/electric or telephone bill, statement from the landlord, etc. Whatever is used, it is essential that the verifications source indicate that the applicant lives at a specific address. The address must be complete and the case manager must determine if the address is in Maryland. For the homeless person, the case manager must establish that the person has no permanent address in the Maryland or in any other state. Decisions as to whether or not such persons are Maryland residents must be evaluated on a case by case basis.

- Age-A birth certificate is only of the acceptable methods for establishing date of birth. There are a number of other methods such as insurance policies or baptismal, confirmation, marriage, Social Security, employment, school, or military service records. However, when an age limit is reached within the calendar year, the A/R must also provide proof of the actual month of birth.

Note: The Department of Juvenile Justice Services (DJS) representative for a child who is an applicant for medical Assistance is not required to provide verifications of the child's age. It may be presumed that the child is less than 21 years of age based on the child's commitment to the DJS.

- Earned income for person-other that the self-employed must be verified by pay stubs or a complete written, signed, and dated statement from the employer showing weekly, biweekly, etc. gross earnings and expenses and or a copy of the most recent valid tax return.
- Life Insurance- When the applicant has life insurance with cash value; a statement must be obtained from the insurance company on company letterhead that verifies all necessary information-current cash surrender value, policy number, policy owner. For the applicant's initial eligibility determination, however, the case manager may use the current cash value from an amortization table in the life insurance policy, if the policy has a table reflecting the estimated current value. Then, verification of the actual current cash value by the insurance company is required no later than the first redetermination of eligibility.

If mail to the insurance company is undeliverable and there is no way to contact the company, the Maryland Insurance Commission should be contacted to help locate the company or its successor. If the company cannot be found, any information available on the cash value of the life insurance may be used. If no information can be obtained on the cash value, the life insurance is excluded as a resource. If the A/A makes a good faith effort to obtain information on the cash value, the eligibility determination is not delayed or denied due to the inability to determine the current cash value of life insurance.

- Representative- Since the Medical Assistance program does not require a representative to be legally authorized by a court in order to act on the applicant's behalf, it is not necessary to obtain verification of guardianship or Power of Attorney. Signatures on the Medical Assistance application are sufficient to authorize a representative acting on the applicant's behalf.

(3)Declaration of Information if Confirmed Impediment to Timely Verifications

At times, an application for Medical Assistance is filed and verifications of a specific factor of eligibility cannot be promptly production for reasons beyond the applicant's control. When neither

the applicant nor the representative can obtain a specific required verification within 45 days after the date of application, the CM should determine whether an eligibility decision is possible based on the information and verifications provided to date and a written declaration by the applicant or representative of the facts related to the factor of eligibility that has not yet been verified. Au eligibility decision using this declaration for factor of eligibility means that information provided by the applicant or representative may be considerate as having temporarily met verification requirement if the MA case manager determines that the applicant/representative has satisfactorily demonstrated and documented in writing that all of the following conditions exists:

- The applicant/representative made a "good faith effort" to obtain the required verification in a timely manner;

The required verification cannot be obtained within 45 days for reasons beyond control of the applicant/representative, and there is no other way to verify the specific factor of eligibility;

- The A/R has provided information that he/she believes to be accurate;
- There is no other existing information that leads to MA case manager to believe that the statement of the A/R is inaccurate or incomplete; and
- The applicant/representative agrees to produce the required verification no later than the next scheduled redetermination

When all of these conditions are met, the worker may base the eligibility determination on the applicant/representative's written declaration of the facts related to the factor of eligibility.

Example 1:

An application is filed on 1/1/2004 on behalf of Ms. Smith. Ms. Smith daughter, Claudia, is representing her mother in the application process. Ms. Smith is in a nursing home due to a stroke, which has left her unable to communicate. Prior to her stroke, Ms. Smith handled her own affairs and did not appoint a durable P.O.A. Ms. Smith has two bank accounts. Claudia's name is on one account. Therefore, she is unable to obtain verification of the balance from the bank. The second account was with Shady Saving and Loan that merged 6 months ago with another financial institution, RCG Bank and Trust. Claudia has a 10-month old statement from Shady Savings and Loan showing a $600.00 balance, but has no account number or documentation from the new institution. She has contacted the new institution, but they refuse to releases any information to someone without a P.O.A. or guardianship. On 1/25/04, Claudia presents the following documents to the MA CM:

- A copy of her letter to RCG Bank and Trust, requesting the 1/1/04 balance from Shady account #12345
- A letter from RCG Bank and Trust, stating that records cannot be researched based on this information, and that the account information may only be released to the account holder P.O.A. or guardian.
- A letter from an attorney agreeing to represent Claudia in a guardianship case, but advising that this process will take 3 to 6 months to complete.
- The Shady Savings and Loan bank statement from February 2003 showing a $602 balance.

- A letter signed by Claudia, explaining her unsuccessful efforts to obtain a current statement, stating that she believes that RCG and Trust account does not exceed $650, and agreeing to submit to verifications of the 1/1/2004 account balance an current balance as soon a she gains guardianship and obtains the from Shady saving and Loan.
- In this case, the CM considers the $650 as a countable resource, which together with the other assets totals $1, 657. All other factors of eligibility are met. The ease narrated with regard to the outstanding verification, and Ms. Smith eligibility is approved. No later than the first annual redetermination, the MA case manager must obtain verification from Claudia of the account balance for the month of applications, as well as current month. If not received by the first annual redetermination, the case will be closed for failure to submit the required verifications.

Example 2:

Mr. Cheetum is confined to a nursing home and is represented by his (Power of Attorney) P.O.A., Mr. J. Jones, Esq. Mr. Jones provides bank balances as of the month of application, but states his client's assets prior to the last month are unknown, and that his client is in no condition to assist in the verification process. Since Mr. Jones was retained as P.O.A. prior to his client's incapacitation, it is reasonable to assume that Mr. Cheetum discussed his financial affairs with his attorney at that time. It is incumbent upon Mr. Jones to review records and request information to establish Mr. Cheetum's assets over the look-back period (60 months). Although this process may take longer than the timeliness standard, a decision of eligibility cannot be made because Mr. Jones states he cannot provide a written statement concerning his belief as to the value and disposition of his client's asset during and look-back period. Mr. Jones may request an extension of time limits. If he does not, the application may be denied for failure to submit verifications, and will be reactivated if Mr. Jones provides the verifications before the end of the period under consideration.

Note: Maryland is not changing its eligibility policy to permit presumptive eligibility or declaratory applications. All factors of MA eligibility must still be verified either by the A/R or by the MA case manager. However, the verifications requirement must be reasonable. Allowance must be given for unusual situations when the A/R is making a "good faith effort" but, due to a confirmed impediment outside his/her control, is unable to obtain the required verification within 45 days.

- It is not acceptable for an application to remain pending indefinitely without an eligibility decision. The application should be denied if the A/R does not provide the required verifications by the due date, even if all of the conditions specified above are met, and the MA case manager either does not have enough information to determine eligibility, or the information that the MA case manager has received is questionable or contradictory.
- If the MA CM has enough information to be able to clearly ascertain the facts of the case, eligibility should be determined, even if specific verifications cannot be obtained until later.
- Eligibility is not guaranteed. If a verification subsequently shows that the recipient is ineligible, the MA case manager should promptly conduct an unscheduled redetermination for this change is information
- Existing policy relating to the extension of time limits may also be applied. However, such extensions should be utilized routinely and repeatedly to delay eligibility determinations beyond 45 days from the date of application.

- When the MA case manager permits declaration of the specific factor of eligibility, the MA case manager should set a "745" alert to follow up at the first redetermination or at the time that the verification is expected to be available. If the A/R has not provided the verifications, the MA case manager should call or write with a reminder of the verifications requirements. If the verification is not received by the first redetermination, MA eligibility should be terminated due to failure to provide verifications

(f)Reapplication(Reactivation Following Rejection of an Application)

Some applications disposed of may be reactivated, however is a case was denied due to excess resources it cannot be.
An applicant may not be determined ineligible due to administrative delays. Administrative delays include delays on the part of the State Review Team (SRT) to determine disability within the time frame as well s delays for any reason on the part of an LDSS.

When an applicant is determined ineligible due to a technical factor (citizenship, residence) or excess resources, the application is disposed of and that action is final since the applicant will remain ineligible for any month in which technical or resources ineligibility existed. (The reactivation period does not apply)

If the applicant reapplies, believing that the factor of ineligibility has overcome, a new application is required and a new period under considering established based on the new application date. The incurred medical expenses from a retroactive period during which technical ineligibility or excess resources existed may be applied to excess income, if any, for the current period.

Retroactive eligibility may concurred by requested with current eligibility upon reapplication, however, the retroactive period may not include any month(s) in which the applicant did not overcome the factor of prior technical or resource ineligibility.

Example:

Application is filed on 4/15/2011. An earlier application was filed on 1/15/2011 and rejected due to excess resources. The period under consideration has not expired but the applicant's resources were not reduced to an eligibility level until 4/15/2011; therefore, the earliest period that the applicant can become resource eligible is 5/2011. In this instance the period under consideration is 5/2011-10/2007. Since the applicant can never establish eligibility for the period prior to 5/2011, unpaid medical expenses incurred during that period which will not be covered by a third party may be applied to excess income for the new period.

(g) Extension of Time Standards

- The 30 to 60 day time standard must be extended to allow applicant sufficient time to provide the required information when:
    - The examining physician delays or fails to provide disability determination within the 60 day period

- The applicant is actively attempting to establish his/her eligibility but has been unable to provide the required information through no fault of their own
- There is an administrative or other emergency beyond the control of the LDSS

If any one of the above condition exist, the period of time allowed to complete the application must be extended.

- The CM shall document the reason for the delay in the applicant records
- The extension of time will continue as long as the requirements are met.
- The CM shall deny medical assistance when these requirements are not met

(1) Explanation

In order for an applicant to meet eligibility requirements, he/she must be told what information must be provided and the due date. This requirement presumes that the applicant has disclosed all information pertinent to his/her eligibility before or during the face-to-face interview. If an applicant fails to disclose pertinent information before or during the face-to-face interview and the failure cause local department delay in requesting verifications, the extension of time does not apply; however, if the applicant is determined ineligible and reapplies before the period expires, the case must be evaluated under the reactivation procedures.

If all pertinent information is reported to the local department no later that the date of the face-to-face interview, the local department is obligated to provide the applicant a written list of all the verifications(financial and non-financial) that are needed to determine eligibility. If the local department fails to do so, the local department must take that fact into account deciding whether or not the applicant can be expected to complete the requirements within the 30 or 60-day time frame.

The time standards are binding on both applicant and local department. It is necessary that local departments make decisions and send a written notice to applicants at the appropriate time, whether the standard time frames or an extension of time applies.

(2) Explanation of Justification Requirements for Extension of Time

The reactivation process may not be substituted for the extension of time standards when it is appropriate to extend the time standards. It is appropriate to extend the time standards when an applicant has been unable to provide the required information through no fault of his/her own and the applicant provides written documentation of that fact, or the local department is able to verify in some way that the applicant did not delay the request for information. Most required information is obtainable within a period of 7 working days or less. Some examples of the kinds of information, that may not be readily available to an applicant through no fault of his/her own are:

- The exact cash value of a life insurance policy when that information is not available in the local office of the insurance company;
- An independent appraisal of real property,
- A physician’s report for disability determinations; or

- Income information from a former employer

As documentation of efforts to obtain the required information, the applicant is expected to request a written, signed, and dated statement from the source of the requested information on letterhead stationary when the request for the information is made. Local departments may need to use some other type of evidence satisfactorily documents that the delay is not the fault of the applicants.

In the case of information needed on life insurance, the applicant should request assistance from the insurance agent who can likely obtain the information quicker through computer printout or other automated files.

If the time frame associated with the extension is not met, another extension may be granted if the applicant presents updated written proof that he/she has made follow-up requests for the information. The process may continue so long as the applicant presents current proof of his/her efforts to obtain the required information. Although the primary responsibility for providing information rests with the applicant, assistance by a local department is not precluded. If, however, a local department assumes full responsibility for obtaining the required information, the local department is obligated to retain that application in pending status. An applicant can only be held accountable for those activities that have been assigned to him/her.

(h)Retroactive Eligibility

- Retroactive eligibility may be considered for those months in the retroactive period in which the person has **incurred** medical expenses.
- The period under consideration is 1, 2 or 3 months immediately preceding the month of application
- Review each retro month separately
- **Example: Application date Jan 1, 2012**
  Retro months= October 2011, November 2011, December 2011
  Retro can be considered for all three months or just one or two months
- All technical and financial factors must be assessed for the months in which there are **incurred medical bills for which the person is applying for assistance**
- If the applicant requests MA for the retro and the current, separate eligibility determinations are required. The information may be collected on the same application
- NOTE: An applicant can be found ineligible for one period and not the other, eligible for both or ineligible for both.

(i) Retroactive and Current Periods

If the applicant request MA for the retroactive as well as the current period, separate eligibility determinations are required, though the information may be collected on single application form. An applicant may be found ineligible for one period and not for the other, eligible for both, or ineligible for both.

Examples:

1. A retroactive eligibility determination for an interrupted period within the retroactive period of an retroactive eligibility determination combined with a current eligibility determination equals two applications and /or eligibility determinations.
2. A retroactive eligibility determination for the first and third month of the retroactive period equals two applications and or/or eligibility determinations. (First and third months are interrupted periods). If accompanied by a current eligibility determination a third application and/or eligibility determination is required.
3. A retroactive eligibility determination for a continuous, uninterrupted period of one to three months equals one application and/or eligibility determination. If accompanied by a current eligibility determination, a second application and/or eligibility determination is required.

As a general rule, the number of applications and/or eligibility determination may be determined by the number of separate applications that are required. Separate calculation and decision sheets and separate form AMF-Is needed for each determination. Each determination is counted as an application.

400.7 Special Verification Requirements for Persons in or Planning to Enter an Long Term Care Facility

When an application is filed for a person who is already in or planning to enter an LTC facility for a general hospital, all necessary information and verifications should be requested. If all required information/verification is not submitted that fact needs to be included in the notice of ineligibility along with any other reason for ineligibility. For example, an applicant presents a book showing excess resources and the application shows that the person has other countable resources which would increase the amount of the excess, but the applicant fails to provide verifications of the exact value of the other resources. In this circumstance, the notice of ineligibility should include the fact that the applicant is ineligible based on the excess resources associated with the bank account. The notice should also include a statement that the applicant has additional resources (specify type) the values of which are unverified but which may increase the amount of the excess. This same principle applies regardless of the specific reason for ineligibility. This should be done only after the applicant has been given sufficient opportunity to provide all required information but fails to do so.
Because of the significant impact of excess resources and eligibility, it is important that eligibility determinations be made within the 30-day time frame, or earlier if possible so that applicants can take appropriate action to reduce the resources consistent with Program policy, and limit the period of ineligibility.

(a) Period Under Consideration

For an institutionalized person, the period under consideration must be adjusted when the person applies pending admission to a LTC facility or in the month of admission to a LTC facility. For details refer to procedures for institutionalized persons in chapter 1000.

(1) Summary of Requirements

1. A completed and signed application form is required when a person requests current or retroactive

coverage or both.
2. Verification-When an applicant files a completed application form for MA coverage, verification of all elements of current or retroactive eligibility or both are required.

a. Current eligibility- When an applicant meets the requirement to complete all application form and requests coverage for the current period, verification of all elements of eligibility is required for the current period.

b. Retroactive Eligibility- When applicant meets the requirement to complete the application form and requests coverage for the retroactive period only, but does not provide verification of elements for the current period, he/she may be determined ineligible for the retroactive period only if he/she fails to provide verification of elements are pertinent to the determination of eligibility for the retroactive period.

(2) Disposition of Application

An applicant must provide all required information/verification early enough to allow for a decision by the LDSS within the 30 or 60 day time frame. The applicant is determined ineligible when he/she fails to provide all required information/verification within the time frame.
If the applicant complete the application form and verifies all elements of eligibility for the retroactive period but does not verify all elements for the current period, certify for the retroactive period., if current ineligibility exists because of failure to verify, ODO the application for that period. If the person reapplies, follow the applicable procedures in Section F "Reapplication following a decision of ineligibility."

An applicant may voluntarily withdraw his/her application for MA.

- Period under consideration (reactivation) expires

A request and application filed for MA after the expiration of the original period under consideration will be considered New Application. Nor part of the expired current period under consideration may be converted to a retroactive period since the person has already applied for those months as part of the current period. However, the incurred unpaid expenses from the expired period may, with the written consent of the applicant, be applied to excess income, if any for the new current period.
The DHMH form 4284, "Authorized to Apply Incurred Medical Expenses from an Expired Period to the Current Period", is signed and dated by the applicant and CM. This authorization is required in situations of ineligibility for reasons other than technical ineligibility or excess resources. Incurred expenses from a retroactive period of ineligibility for technical reasons or excess resources may be applied to excess income for a current period, if any without written authorization.

Example:

Application is filed on 9/15/2011. An earlier application was filed on 1/15/2011 and rejected due to insufficient income information. The initial period under consideration is 1/2011 through 6/2011 and has expired. Therefore, the new application, 9/15/2011, establishes both the date of application and current period under consideration (9/2011-2/2012).

Since the original period has expired, the unpaid medical expenses income during that period which will not be covered by a third party may with the applicant's written authorization per above, be applied to excess income for the new period.

(b)When verification is not Required

A determination of ineligibility may be made on the basis of unverified facts submitted by the applicant/representative if such facts clearly indicate ineligibility. There are, however, some exceptions to this policy. The following procedures apply to persons who are not in, or planning to enter on Long Term Care (LTC) facility or a general hospital:

1. When the only factor of ineligibility for an applicant is excess income, verification of income is necessary to establish the exact spend-down liability. If the required information is not submitted, a decision of ineligibility must be rendered based on failure to provide the required information.
2. When a recipient reports increased income, verification of the increase is needed if the person wants eligibility to continue for the remainder of the period under consideration. If continued eligibility is not requested, the case may be closed based on the person's statement of income. (Closed cases may not be preserved for spend-down. Preserved status applies only to application). If the required information is not submitted, a decision of ineligibility must be rendered based on failure to provide the required information.
3. When a determination of ineligibility for an applicant is due to excess resources, every effort should be made to have the applicant provide verification of the exact resource amount. If an applicant fails to provide at required information and or/verifications related to excess resources, it is appropriate to reject the application. However, if the exact amount of the excess is not known, that fact plus any other reasons for ineligibility should be noted in the letter. Refer to Policy Alert 08-1 for a detailed discussion of the treatment of the excess resources of an A/R who is in or entering on LTC facility or an acute hospital.

400.8 Requirements to apply for benefits

Applicants and recipients are required to apply for all income benefits to which may be entitled. Eligibility may not be established until they furnish proof that they have met this requirement. This applies to both members of the assistance unit and the non-assistance unit members whose income and resources are considered.

LDSS/LHD staff must have a general knowledge of various benefit requirements, be able to identify applicant and recipient circumstances which may indicate entitlement to certain benefits, and refer applicants and recipients accordingly. Refer to Chapter .07 for description of types of benefits and how to apply.

Applicants and recipients determined by the LDSS to be unable to perform the required activity because of the applicant's or recipient's physical or mental condition and far whom there is no other person to perform the activity are not themselves required to apply for income benefits. Under this circumstance, the LDSS/LHD must obtain from the agency determining entitlement to income benefits, a statement of the requirements for application for income be3enift and work cooperatively

with the agency and the applicant to meet those requirements. The requirement to apply for all income benefits to which there may be entitlement does not extend to requiring application for SSI or Public Assistance. The LDSS/LHD should advise an applicant of the existence of the SSI and Public Assistance Programs and where to apply, but cannot impose a requirement to apply or take any adverse action based on the applicant's failure to apply.

The requirement to apply for income benefits does not apply contributions to a pension system to which a person belonged for at least 5 years, but not longer belongs for reasons other than retirement or disability. Persons are not required to withdraw such finds as condition of eligibility. Refer to CR 559. However, if a person chooses to withdraw funds in a lump sum, the funds will be considered an income benefit for the period under consideration beginning with the month the month it is received.
Once a person verifies that application for potential benefits has been made, a determination of initial eligibility may not is delayed pending the results of the application filed for those benefits.
Each case involving pending application for income benefits should be flagged for the anticipated date of decision on entitlement. If that date cannot be readily established, the case should be flagged for contact within three months to determine if an anticipated date of decision has been established.
At the time of redetermination or reapplication, eligibility shall be determined on the basis of the applicant's or recipient's documented reasonable and continuous efforts to establish entitlement to income benefits. When an applicant or recipient cannot provide documentation from the source that this requirement has been met, eligibility is to be terminated. When the requirement has been met but no decision has been made, the LDSS must maintain follow-up activities until documentation of the final decision is received.

(a) Social Security Number

As a condition of eligibility, applicants and recipients must provide the LDSS with a Social Security Card (or cards if more than one number has been issued) for each member of the assistance unit and any person whose income and resources are considered in determining the financial eligibility of the assistance unit.
If the applicant or recipient cannot furnish a Social Security Card for each of these persons, he/she must apply for a card.

Application for the card and verification of that fact are requirements must be met before eligibility can be granted.

The Maryland Department of Juvenile Service (DJS) representative for a child is an applicant for Medical Assistance may act as a representative for that child in filing for a Social Security Card if the DJS representative shows the local department a copy of the court documents committing to the child to the DJS.
Once a card has been applied for (and that fact verified), Medical assistance may not be denied, delayed or discontinued pending the issuance or verification of the number. Failure to apply for a card, however or (failure to provide the required verification) will result in the ineligibility for the person whose Social security number has both been applied for.

If an applicant or recipient is physically or mentally incapable of acting for him or lacks the resources to meet the above requirements, the LDSS/LHD must assist him in obtaining the necessary

documents and ay costs incurred by the LDSS/LHD will be paid of administrative funds.

If the application indicates that a Social Security card was issued previously, the LDSS must request validation of the number by the Social Security Administration.

(b) Required Case Activity

It is unlikely that, upon receipt of a request for MA, the local department will search the files and determine if there is already an application on file for an unexpired period. The chances are that a new application form will be issued routinely. At the point the face-to-face interview is scheduled following receipt at the written and signed new application, the CM will need to have at hand all previous applications and determine which one, if any, is appropriate for use as the reactivated application for the unexpired period.

The reactivated application is the one to be retained in the case folder. If the other applications include information that is not a part of the reactivated application, the new information should be identified and transferred to the reactivated application. The applicant should initial and date each new entry. Once this is done, the other applications are not to be invalidated and discarded.

The case summary sheet should reflect a recording of all contacts and activities and the dates for some beginning with the filing date of the reactivated application and ending on the dates for some beginning with the filing date of the reactivated application and ending on the expiration date.

400.9 Public Assistance for Adults (PAA)-MA Retroactive coverage procedures

(a) General

To be eligible for retroactive Medical Assistance coverage, a person must apply for MA and be determined eligible. This requirement includes a Public Assistance to Adults (PAA) applicant who has medical bills incurred within 3 months before the month of the PA application.
In order for PAA applicants to avail themselves of this benefit, a question concerning past medical bills has been included in the PAA application (DHR/FIA CARES 9701 and MCHP application) on page 1 under the question

What type of assistance do you need now? (Check all that you need)
□ Cash Assistance □ Child Care Services □ Food Stamps
□ Medical Assistance - Do you have any unpaid medical bills from the past 3 months? □ Yes □ No

The CM must check to make sure that the question is answered. If the question is not answered, then the case manager must make a phone call to the applicant to:

1. Discuss past medical bills with the client and inquire as to whether he/she had medical care during the retroactive months which has not been paid for and for which there is no health insurance coverage.
2. If after discussion, the answer is “No”, no further action is taken regarding retroactive coverage. However if the answer is “Yes”,

The case manager will:

- Verify the client's indication of incurred medical expenses for the retro months by requesting to see the actual bills.
- The CM will proceed with the retroactive eligibility determination using current procedures.
- The CM must make the application date the date of the retro period month

400.10 Category Selection

A person may select any federal category for which technical eligibility may be established. This means that any person who qualifies as both FAC and ABD has a choice as to which of the two categories he/she wishes to apply for assistance in.

400.11 Third Party Liability

All applicants and recipients are require to :

1.Notify the LDSS/LHD 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 applicants or recipients medical expenses.
2. Cooperate with the LDSS/LHD in completing the form designated by the Department to report all pertinent information and in collecting available health insurance and other third party payments and
3. In accident situations, notify the LDSS/LHD of the time, date, and location of the accident, the name and address of the attorney, the names and address of all parties and witness to the accident, and the police report number if an investigation is made.

In addition to the above requirements, it is necessary that the LDSS/LHD question applicants at the time of applicant and recipients at the time of redetermination as to whether or not they have received treatment as a result of an accident. If they have, the LDSS/LHD must complete the appropriate reporting form and forward it to the following address regardless of how the fact became known:

Division of Recoveries and Financial Services
201 West Preston Street
Baltimore MD 21201-2301

400.12 Wage Screening Inquiry

The LDSS/LHD is required to conduct a wage-screening inquiry to determine wages, benefits, and claimant history for each of the following:

- Effective 7/1/2008 verification of income for FAC coverage is no longer mandatory however; income must be verified for all other coverage groups.
- An applicant shall sign consent forms as needed authorizing. The department or its designee is to verify other sources such as employer, banks, and public or private agencies. This information is needed to establish eligibility.
- All ABD person younger than 70 years unless the person:

a. Resides in an LTC facility;
b. Is chronically ill and non-ambulatory

400.13 Case Record Management

The LDSS/LHD must maintain a case record, including documentation of all requirement elements or eligibility, name of the applicant (and spouse, if any). The case record must be maintained while it is an active Medical Assistance case and for an additional period of 2 years after the case close then it may be destroyed.
If a case is being reconsidered or reapplication is made within a 2- year period, the prior case record must be reviewed before eligibility is determined in order to compare the past and present information, so that differences may be identified and reconciled.

400.14 Request to Add New Family Members

If after completion of an eligibility determination MA is requested for additional family members, a written, signed application is also required for these persons. Refer to section entitled "Child Born on or After 10/1/84" To a mother eligible for and receiving MA', instructions on automatic eligibility of the newborn of a currently eligible mother. Their eligibility for assistance will be determined in accordance with the provisions of Regulations.06.

(a) Disclosure of information

The LDSS/LHD must restrict disclosure of information concerning applicants and recipients to purpose directly connected with the administration of the Program. These activities include:

- Determining eligibility
- Determining the extent of coverage under Program Providing Services for Recipients; and
- Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

The release of information to any agency or administration which is any way responsible for an aspect of the administration of the Program does not constitute a violation of the Privacy Act.
A recipient's Medical Assistance number and certification dates may be given to an inquiring health care provider in those instances when, in the judgment of the LDSS/LHD, it is unreasonable to expect the recipient to provide the information.

400.15 Filing an Application for Medicare Part A

An applicant who is 65 years old or older, or blind or disabled, is not eligible until he/she furnishes proof that he/she has applied for or is receiving Medicare, Part "A". Once the application is filed and that fact is verified, determination of eligibility may not be delayed pending the results of the application. Periodic reviews of eligibility are necessary for those blind or disabled persons initially determined ineligible for Medicare because of the required waiting period.

An applicant must present proof from the Social Security Administration that an application has been filed. Although the applicant is required to apply for Medicare, Part "A" there is no requirement to purchase this benefit. Persons who have not earned sufficient quarters of coverage under Social Security are not eligible for free Part A coverage. Nevertheless, the applicant must apply for, but may reject this coverage if payment of a premium is required.

The above requirement also applies to a recipient who attains age 65 or becomes blind or disabled if he/she is not already covered as a disabled person. The LDSS/LHD will need to monitor birthdates at each redetermination and refer a potentially eligible person to the Social Security Administration for application.

400.16 Application Procedures Specific to Institutionalized Persons

The general application requirement and procedures of this chapter to both non-institutionalized and institutionalized persons at the time of application and redetermination. However, because of the physical and mental impairments of many institutionalized persons, it is sometimes necessary to qualify the general requirements. The following qualifications are worthy of note.

(a) Person/s who can complete the application

As with non-institutionalized persons, there is no specific rule as to who may or may not complete the application. However, since there is usually no face-to-face interview with institutionalized persons, it becomes important that the application form be completed by the person who is the most knowledgeable about the applicant's situation, and that same person, except in rare situations, must be the person with whom the face-to-face interview is conducted. The rare exception might be the situation in which the most knowledgeable person lives in another state and cannot visit this state at each redetermination. However, there must be same contact with the person who completes the application and provides the information.

(b) Person/s able to be representative

The representative should be the individual who normally handles the affairs of the institutionalized person. In most instances, that individual will be relative or legal guardian. However, if neither of these individuals exist, then a friend, hospital social worker, nursing home administrator, or other interested party may act on behalf of the person is considered the representative. This means that the same person who completes and signs the application and who appears for the face-to-face interview is also the person who has the responsibility of doing whatever is necessary to establish the person's eligibility. This includes, but is not limited to making home visits or other contacts necessary to

obtain required facts. “Unknown” as an answer to specific questions relating to income and resources is not acceptable.

A representative is also responsible for the accuracy and completeness of the application, for reporting changes to the LDSS/LHD and for establishing continuing eligibility. This responsibility continues until such time as a new representative is designated and the LDSS/LHD receives written notification of the change. The CM advises the representative of these responsibilities during the interview. An employee of an LTC facility, hospital or other agency or organization may not routinely assume the role of a representative by merely filling out the application and mailing it to the LDSS/LHD.

While the representatives are the primary source of information about the person, the LDSS/LHD must not routinely accept information presented by representatives whose source of information is at best questionable. The CM need to check out other possible sources of information and give guidance to the representative as to methods and sources that may be used to collect the required information. While it may be presumed that the institutionalized person cannot meet the face-to-face interview requirement, no such presumption should be made about the person’s ability to participate in other aspects of the application process.

(c) Face to Face Interview

Effective 12/1/2008, LTC CM should no longer require LTC applicant recipient, or their representative to participate in a face to face interview. Face to face interview should only take place by the case manager on a case by case basis or requested by an applicant recipient. If after review of the application, the case manager is unclear about an issue or need additional information, case manager are encouraged to conduct a telephone interview before requiring a face to face interview. Only if this is not possible, should a CM require a face to face interview.

(d) Application Signature Requirements

For the purpose of completing the application form and filing it for registration of the application date, the representative may sign and date it. However, since institutionalized persons are generally not seen by the CM, the institutionalized person, if competent, must sign the application before the LDSS determines eligibility. If the applicant did not sign the application before it is submitted to the LDSS, and the applicant is competent to sign, the LDSS/LHD must return the application to the institutionalized person for signature.

If the institutionalized person is incapable of singing the application but has a competent spouse with whom the person lived prior to institutionalization, the spouse must sign the application.

(e) Assistance Unit Requirements

- When an application is filed prior to institutionalization and there are other family members in home, the assistance unit will be structured in accordance with Chapter .06.
- When an application is filed for an institutionalized couple who share the same room in the LTC facility, separate case records and numbers as well as separate eligibility determinations are required.

(f) Period Under Consideration

Verification Requirements Specific to Long-Term Care (LTC) Eligibility

The DHR/ FIA 1052-LTC-Request for Information to Verify Eligibility form is sent by the CM to the A/R, specifying information or verifications need to determine LTC eligibility and giving the due date for receipt of the information. The following types of verifications are addressed on the form:

- Application-The DHR/FIA CARES 9709 is used as the application form for Medical Assistance LTC eligibility
- Representative-The DES 2000-LTC-Physician's statement of Incapacitation is no longer required to be completed and signed by the applicant's physician, in order for a representative to sign the application and participate in the application process on the applicant's behalf. Also, the DES 2004- Representative's Statement is no longer required to be completed and signed by the applicant and the representative, in order to authorize a representative to act on the applicant's behalf. Since the Medical Assistance program does not require a representative to be legally authorized by a court in order to act on the applicant's behalf, it is not necessary to obtain verification of guardianship or powers of Attorney. Signatures on the CARES 9709 application are sufficient to authorize a representative acting on the applicant's behalf.
- Consent to Release Information The DHR/FIA 704 form is used for applicants to consent to the release of information. For LTC applicants, the DES 2002 form is also signed by the A/R to authorize the long-term care facility (LTCF) to release information to the LDSS related to the LTC application. The DES 2005 form is signed by the A/R to authorize the LDSS to release information about the application to a designate LTCF.
- Medical Level of Care- In order for the LDSS to determine LTC eligibility, the applicant must be certified by DHMH's utilization control unit (UCA):

Delmarva Foundation
9240 Centerville Road
Easton, Maryland 21601
Fax #888-513-2202

400.17 Steps Taken to Complete Form

- The LTCF or client representative completes Part A of the DHMH 3871B for the Client and it is submitted to the attending physician.
- The attending physician completes Part B-E of the DHMH 3871 B-E of the DHMH 3871B and it is returned to the facility.
- The LTCF completes the top portion of the 257 and sends the 257 and 3871B to the UCA
- The UCA completes the bottom portion of the 257 and Part F of the DHMH 3871B
- The UCA sends a copy of the 257 and the DHMH 3871B to the LTCF, and the completed original 257 to the LDSS
- DHMH 257-Long Term Care Patient Activity Report
- DHMH 3871B-Medical Eligibility Review Form

(a) Demographic Information

- The LDSS/LHD verifies an applicant's Social Security Number and benefits and any Medicare number and enrollment by checking SDZX/SVES/SOLQ. It is only necessary to request verifications from the A/R (e.g. copy of social security card or Medicare card) if there is a discrepancy or the LDSS cannot otherwise obtain the required information.
- The A/R's declaration on the application that the applicant is a US citizen is accepted without verification, and only needs to be verified by the A/R if there is a discrepancy. If the A/R reports that the applicant is a legal alien, the LDSS verifies the applicant's alien status through Systematize Alien Verification Systems (SAVE), and only requests verification if there is a discrepancy or need for additional information.
- It is necessary for the A/R to provide verification of the applicant's marital status such as a copy of the marriage certificate or divorce decree. Maryland does not recognize common law marriage. A couple which is considered married under state law has a spouse to spouse financial responsibility until they have received a divorce decree or until one spouse dies.

(b) Income

SSI, Social Security, and Railroad retirement benefits are verified by the LDSS through SDX/SVES/SOLQ. MABS is available as an additional verification of the amount of each type of countable income received by the applicant. Earnings must be verified for the past month or 4 weeks. The CM may request additional verifications if necessary to determine the A/R's gross countable income. See the section "Verification/Documentation" in the Appendix of this Manual for examples of acceptable income verifications.

(c) Resources

If the spousal share has not already been calculated, resources of both the applicant and spouse must be verified for computation of the spousal share as of the beginning of the applicant's first continuous period of institutionalization. For determination of current LTC eligibility, the A/R is required to provide verification for the value of each type of countable resource owned by the applicant and /or spouse as of the 1st day of the month of application. Typically, the value of liquid assets (e.g. bank

accounts) must be verified for the past 3 months. For non-liquid assets, the current, accessible valued must verified. The CM "Verification/Documentation" in the Appendix of the Manual for examples of acceptable resource verifications.

The CM should require the A/R to provide resource verifications for selected months in the look-back period before the month of application if the A/R reports a disposal or if the CM has reason to suspect a disposal, and the disposal would result in a current penalty period. The CM decides how many months and aw what intervals to check for disposal of resource in the past 36 months (60 months for a trust). The CM should require no more moths of verifications than necessary to determine eligibility. To verify bank accounts or other investment accounts that closed during the look-back period, it may be sufficient to obtain only the final statement from the financial institution.

Effective Immediately: Individuals applying for MA-LTC no longer request 60 months of bank statements and financial statements for themselves and their community spouse in order to evaluate the look back period.

When it can be verified that the LTC applicant was a recipient of a needs-based public benefit at any time during the 5 year period before the month of application, verification of the value or resources during the look-back period is not required. Resources still need to be verified as of the month of application. However, when a disposal of resources is reported by the A/R or suspected by the LDSS, all pertinent verifications must be provided by the A/R Needs-based public benefits include but are not limited to:

- Supplemental Security Income (SSI)
- Cash public assistance (TCA, TEMHA, PAA)
- Community Medical Assistance
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB) I or II
- Maryland Pharmacy Assistance Program (MPAP)
- Food Stamps
- Energy Assistance
- Section 8 or other subsidized housing from the U.S. Department of Housing and urban Development(HUD)

(d) Life Insurance

When the applicant has life insurance with a crash value, a statement must be obtained from the insurance company on company letterhead paper that verifies all necessary information-current cash surrender value, policy number, policy owner. For the applicant's initial eligibility determination, however, The CM may use the current cash value from an amortization table in the life insurance policy, if the policy has a table reflecting the estimated current value. Then, verification of the actual cash value by the insurance company is required no later than the fist redetermination of eligibility.

If mail to the insurance company is undeliverable and there is no way to contact the company, the Maryland Insurance commission should be contacted to help located the company or its successor. If

the company cannot be found any information available on the cash valued of the life insurance may be used. If no information can be obtained on the cash value, the life insurance is excluded as a resource. If the A/R makes a good faith effort to obtain information on the cash value, the eligibility determination is not delayed or denied due to the inability to determine the current cash value of life insurance.

(e) Real Property

Excludability of Home Property
There are three situations in which a home property of an institutionalized person may be excluded when determine the persons countable resource:

- The institutionalized person or his/ her representative expresses the intent to return his/her home and resume living there. The intent is obtained in writing on the DHMH form 4255-Home exclusion statement of intent
- The spouse of the institutionalized person is resuming in the home. The home is excluded as a countable resource when determining MA eligibility, regardless of the institutionalized person's intent to return. However, the house must be evaluated under the lien provisions if applicant is determined eligible for MA.
- A dependent relative of an institutionalized person is residing in the home.

400.18 Verification for deductions from available income for the cost of care

(a) Health Insurance

In order for the CM to deduct only the institutionalized person's health insurance premiums from the available income towards the cost of care, the CM needs either a recent premium bill or a canceled check for a premium payment, as well s a copy of the front and back of the health insurance card. If the CM has reason to believe that the premium being paid is for someone other than the institutionalized person, the CM contact the insurance company to verify the policy's insured member(s).

(b) Residential Maintenance allowance

It is not required shelter expenses or obtains a copy of the mortgage, lease or rental agreement. However, the DHMH 4245 Physician's Report and the DHMH 4255 Home exclusions-Statement of Internet are required in order to deduct a residential maintenance allowance, if the institutionalized person intends to return to the home property.

(c) Spousal Maintenance Allowance

If the community spouse does not report shelter expenses on the DES 2003 form, the basic maintenance and shelter allowance is deducted for the spouse. The community spouse's income must still be reported**.**

400.19 Good Faith C, Concept

The concept of "good faith" ha a very specific meaning with regard to MA policy pertaining to the application process. This concept is applied when determining what verification standards are to be applied in a specific case. It is one step in a sequential decision making process.

Most factors of eligibility must be verified by hard copy documentation, electronic, verification or verbal communications between CM and an authoritative source. CM is trained to determine when it is appropriate to use these means of verifications for different factors of eligibility. For MA LTC cases, most factors or eligibility must be verified by written documentation from authoritative sources (e.g. bank statements) or electronically (e.g. Social Security Benefits). CM must request appropriate verifications from the applicant or the applicants authorized representative in writing, and in a time frame that will enable the CM to complete the eligibility determination within the required 30 days.

At times, verifications cannot be submitted within the required time frame. In that circumstance, an applicant or representative may request an extension of time limits. If an extension is requested and granted by the case manager at the end of that period, (generally 45 days from the date of application) the information still cannot be provided by the A/R, a CM may decide to process the application based on a declaration made by the applicant/representative about the eligibility factor in question. A declaration means that the A/R makes a written statement confirming the information to the best of their knowledge, even though written or electronic documentation cannot be obtained. This declaration may be substituted for written or electronic verification for a limited period of time, i.e. until the next redetermination is due. The declaration does not mean that the factor of eligibility is not being considered or is in any way waived. An application could either be denied or granted based on a declaration (e.g. excess resources.

The five (5) conditions below must be met in order for a case manager to decide to determine eligibility based on the declaration rather that a verification. The first of these is "good faith". The A/R made a "good faith effort" to obtain the required verification in a timely manner. In this context" good faith" means that the A/R has taken the reasonable steps to try to obtain the documentation, but has been unable to do so. If the case manager determines that this element of good faith has been met, the next four (4) factors must be considered:

- The reason for failure to obtain information is beyond the control of the A/R
- He/she believes to be accurate
- The CM has no other contradictory information or other reasons to doubt the statements
- The A/ R agrees to provide the written verification as soon as received but no later than the reason for failure to obtain information is beyond the control of the A/R
- The A/R made a "good faith effort" to obtain the required verification in a timely manner
- The required verification cannot be obtained within 45 days for reasons beyond the control of the A/R, and there is no other way to verify the specific factor of eligibility
- The A/R has provided information that he/she believes to be accurate;
- There is no other existing information that leads the MA CM to believe that the statement of the A/R is inaccurate or incomplete: and
- The A/R agrees to produce the required verifications no later than the next scheduled

redetermination

Note: CM will set up a 745 alert to follow up on needed information

" Good Faith" does not apply to:

- A provider rendering service in the belief that the individual is or will be eligible
- The provider's efforts to assist the applicant/representative in obtaining verification,
- The providers' administrative and/or legal efforts to insist that the applicant/representative provide the verification

Although all of these may be appropriate responses by a provider, they do not affect the verification requirements. Only the actions and the statements of the applicant/representatives are evaluated in deciding if a factor of eligibility can be considered based on declaration rather than verification.

400.20 Post eligibility

- LDSS/LHD shall inform an applicant of his rights and responsibilities
- LDSS/LHD must give the applicant written notification of the following:

(a) For eligible persons

- A finding of eligibility (the begin & end dates of the coverage)

(b) For ineligible persons

- LDSS/LHD must provide in writing the reason for ineligibility and the regulation supporting the finding
- LDSS/LHD must also advise of the right to request a fair hearing

Attachment A-Notice of Ineligibility

MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF INELIGIBILITY DUE TO EXCESS INCOME

Date:_____

Re: _____ CID# _____

Name

Dear _____,
This is to notify you that based on the application filed on , the above named person has been determined **ineligible** for Medical Assistance due to excess income. The income for the period to has been calculated as follows:

Source of Income Monthly Amount for Period
Social Security _____ **$**_____
Veterans Benefits _____ _____
Pension _____ _____
Other _____ _____ **Total Income** $_____
Deductions
Personal Needs Allowance _____ **$**_____
Spousal/Dependent Allowance _____ _____
Residential Allowance _____ _____
Cost of Long Term Care _____ _____
Other Medical Expenses _____ _____

Total Deductions -$_____
Total Available Income $_____
Cost of Care -$_____
Excess Income For Period _____

If medical expenses are incurred that will not be covered by health insurance or other sources and these expenses equal or exceed the amount of excess income, eligibility for Medical Assistance may be established under the spend-down provision. Enclosed is a sheet that tells you how to keep records of medical expenses. If incurred medical expenses equal the amount of excess income within the time period specified above, you should immediately report this to the Department of Social Services.
This decision is based on COMAR 10.09.___._____. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter. You have the right to reapply.
Sincerely,

_____ _____
Case Manager Telephone Number

_____
Department of Social Service

Section 400 Frequently Asked Questions and Answers
Application Requirements

1**.** Can an application be reactivated if the case was denied due to excess resources?

No, an application can't be reactivated if the case was denied due to excess resources.

2. A client can appeal an adverse decision of Medical Assistance anytime and have benefits continued pending the Appeal?

No, the client has to appeal an adverse decision of MA within 10 days

3**.** Where can an individual interested in applying for Medical Assistance (MA), get an application?

There Local Department of Social Services (LDSS), Local Health Department (LHD) or apply online at www.marylandsail.org

4. What is a representative?

A representative may assist the A/R in the application and redetermination process and in other matters related to the A/R's MA eligibility. Only one designated representative at a time may be recognized as authorized to act on the A/R's behalf.

5. How many months is a newborn presumptively eligible for MA if the mother is enrolled as a Maryland MA recipient on the date of the newborn's birth?

Newborn are presumptively eligible for MA for a period up to **15 months** if the mother is enrolled as a Maryland MA recipient on the date of the newborn's birth.