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2000.00.00 APPLICATION PROCESSING

At the end of the application registration process, client scheduling takes place in order to schedule an interactive interview.

The policies in this chapter pertain to the processing of new applications after the application registration and interviewing scheduling processes have occurred.

The following sections are contained in this chapter:

The Interview (Section 2005);

RESERVED (Section 2010);

Responsibilities of the Applicant/Recipient (Section 2015);

Application Time Standards (Section 2020);

Verification (Section 2025);

Concluding the Interview/Providing Information (Section 2030);

Determination of Initial Eligibility (Section 2035);

Rescission (Section 2040);

Reapplications (Section 2045); and

Footnotes for Chapter 2000 (Section 2099) .

2005.00.00 THE INTERVIEW

An interactive interview is required for all individuals who submit an application with the exception of Food Stamp only applicants who applied for FS in conjunction with SSI at the Social Security Administration and Hoosier Healthwise only applications. The interviewee may select additional programs of assistance during the interview.

2005.05.00 COOPERATION WITH THE ELIGIBILITY INTERVIEW

An application is to be denied if an individual does not cooperate with the interview requirement. Refusal is determined when the AG is able to cooperate, but clearly demonstrates a refusal to be interviewed. For Food Stamps, applications are to be denied on the 30th day (or next business day when the 30th day is a non-business day) when the applicant has failed to keep scheduled appointments or to reschedule an appointment by the 30th day.

If there is any question as to whether the household has merely failed to cooperate, as opposed to refused to cooperate, the household should not be denied, and the agency should provide assistance. (f1)

2005.05.05 Reserved

2005.05.10 Who Can Be Interviewed

An applicant or authorized representative may be the interviewee and can conduct all business related to the application process. State Form 53460 must be used to authorize someone to apply on behalf of an AG and must be filed in the case record. However, the requirements as to who can apply without written consent on behalf of an AG vary slightly, depending on the program, as explained below.

For Food Stamps and TANF, a participating AG member can be the interviewee without a written authorization. A non-AG member must be authorized in writing by an AG member. (f2)

For Medicaid, any individual other than the applicant's spouse or parent of an applicant under age 21 must be authorized in writing by the applicant unless medical documentation is presented showing that the applicant is medically unable to provide such authorization. (f3)

In spite of the availability of an authorized representative, the Local Office may require personal contact with the applicant if such contact is necessary in order to determine eligibility under any program. Legal guardians and powers of attorney may apply for assistance on behalf of the applicant and must present the appropriate documents verifying their status. A power of attorney document must be general enough to encompass applying for assistance. If it is specific to only a certain activity, it does not suffice for application purposes and a POA crafted for the sole purpose of applying for Medicaid is not acceptable.

The chief of social services (or his/her designee) of any institution under the control of the Family and Social Services Administration may apply for assistance on behalf of patients in the institution. The social services staff person may apply for assistance for an individual who will remain in the facility or for whom plans are in process to move to an alternative placement. (f4) The most common usage of this procedure will occur with state institutions under the supervision of the Division of Mental Health. While the social worker at the facility can be interviewed, the caseworker should also contact any family member who may have information concerning the applicant's financial circumstances.

The authorized representative must be familiar with the AG situation to represent them properly. The caseworker will determine if the authorized representative is representing the AG appropriately.

Generally, the caseworker will not know until the end of the interactive interview whether or not written authorization is required. Once the AGs are formed, the caseworker must determine if there are any AGs for which authorization is required.

Authorized representatives assume responsibility for the accuracy of the information provided. AGs who utilize an authorized representative are subject to the same disqualification penalties and possible prosecution as AGs representing themselves.

For Food Stamps, AGs will be held liable for any over issuance that results from erroneous information provided by the authorized representative. An exception exists when a drug and alcohol treatment center or a group living arrangement acts as an authorized representation.

For Medicaid, employees of nursing facilities may not be interviewed on behalf of a resident in their facility unless the client is incapable of being interviewed and there is no one else to act on the client's behalf.

2005.05.15 Rescheduling The Interview

If the interviewee fails to appear for the first eligibility interview, the application is pended, and the client will be mailed a Notice of Missed Interview (see section 2020.05.20). The individual may schedule another appointment.

For Food Stamps, if the individual does not keep an appointment within 30 days of the application date, the caseworker must then take action to deny the application.

An entry in Running Record Comments should be made to explain the denial.

If the individual contacts the Local Office to reschedule the missed appointment, the interview should be rescheduled as soon as possible in an attempt to stay within processing time frames. A copy of written notices to reschedule should be kept. Appointments scheduled by phone should be documented in Running Record Comments.

2010.00.00 RESERVED

2010.05.00 RESERVED

2015.00.00 RESPONSIBILITIES OF THE APPLICANT/RECIPIENT

The Local Office must advise each applicant/recipient of his rights and responsibilities as indicated in the following sections.

2015.05.00 PROVIDE PROOF OF INFORMATION

The applicant/recipient must consent to the release of any information necessary to determine his initial and continuing eligibility for assistance. (f5) He must supply required documents and records and must assist the Local Office in obtaining verifications, (f6) including proof of incapacity. Failure or refusal by an applicant to provide the Local Office with information or verification of information required to determine eligibility will render the AG ineligible for assistance. (f7)

If the individual is doing all that he can to cooperate in verifying the information, but is unable to do so, the Local Office should assist the AG in verifying the information.

In cases where the individual is a victim of domestic violence, it is important to understand the barriers that can exist in the process of obtaining verifications. This is especially important where the abusing party is in possession of the needed documentation and any attempt to obtain said documentation would pose a threat to the individual applicant/recipient.

When neither the worker nor the individual is able to secure the necessary documentation, the individual's statement is to be accepted as sufficient documentation upon the approval of a supervisor. However, it is important that the worker document the reason for the use of client statement.

2015.10.00 UNDERGO MEDICAL EXAMINATION (C, MED)

A pregnant, blind or disabled applicant or incapacitated parent must undergo a medical examination necessary to establish categorical eligibility for Cash or MA.(f8) A blind, disabled, or incapacitated recipient must undergo subsequent medical examinations, if required, to establish continuing eligibility.(f9)

2015.15.00 COOPERATE IN TREATMENT PLAN (C, MED)

The blind, disabled, or incapacitated recipient must cooperate in any treatment plan which has been recommended by the examining physician and approved for payment by the Medicaid program's Prior Approval Process. The goal of such treatment must be full or partial alleviation of his visual impairment, incapacity, or disability.(f10) Failure to cooperate in such plan without good cause will render the recipient ineligible for assistance.(f11)

"Good cause" includes, but is not limited to:

The treatment is contrary to the applicant's religious beliefs;

Previous surgery of the same type recommended was unsuccessful;

The recommended treatment is very risky because of its magnitude or unusual nature; or

Amputation of a major limb is involved.(f12)

2015.20.00 REPORT CHANGES IN CIRCUMSTANCES

The applicant/recipient must report any changes in circumstances affecting TANF and/or Medicaid eligibility to the Local Office within 10 days of the date on which the change occurred or became known to the recipient. (f13) Food Stamp reporting requirements are explained in Section 2015.20.05. Caseworkers should encourage applicants/recipients to report all changes. Whether each change affects eligibility can be determined by the worker after the change is reported. A Change Report Form can be provided to the client at application and redetermination points to further encourage the timely reporting of changes.

AGs will be advised at the time of the initial interview and at each subsequent interview of their responsibility to report changes. This provision is applicable at any time after the interview, regardless of whether the application has been approved.

2015.20.05 Changes That Must Be Reported (F)

Food Stamp AGs are subject to simplified reporting

requirements and must only report whenever the AGs monthly income exceeds the gross monthly income limit for the AG size. Other changes may be reported by the AG and if reported, must be acted upon.

A change which results in the AG exceeding the gross income limit for their AG size must be reported by the 10th day of the month following the change to be considered timely.

2020.00.00 APPLICATION TIME STANDARDS

Due to federal requirements, applications must be processed within specific time standards. The time allowed varies depending on the program. The time standard is counted beginning with the day following the date of application, and ending with the date on which the eligibility notice is mailed.

Time standards for application processing as required by the individual programs are explained in the following sections.

2020.05.00 APPLICATION TIME STANDARDS (F)

The application time standard discussed in this section applies to initial applications and any AG whose entitlement period has expired.

If all required verification is provided and the AG is eligible, the Local Office must provide assistance no later than 30 calendar days after the date of application. (f14) If the 30th day falls on a non-business day, approvals must be completed no later than the last business day prior to the 30th day. Denials can be completed on the next business day. **Exception:** If all verifications have been received except those for deductions, the application should be processed no later than the 30th day without the deductions included. The AG may verify the deductions later and they may be included in a future month according to change processing rules.

When additional verification is needed to complete the application, the AG is allowed 13 days from the date of request unless there is a client delay in being interviewed. When a client has caused a delay in the interview process, the due date for verifications is 2 business days prior to the 30th day. If an interview is delayed (client caused) to one of the 2 business days prior to the 30th day, or on the 30th day, the due date for verifications is the same day as the request.

If the AG is found to be ineligible, written notice will be provided no later than 30 days following the date of application.

Client and agency delay for the purpose of determining the verification due date is defined as follows:

Client delay: When the client refuses to accept an initial appointment within 12 calendar days from application file date or requests to reschedule the appointment after 12 calendar days from application file date and the appointment is scheduled within 30 days from the application file date.

Agency delay: When the agency, due to no appointment slots being available, schedules the initial appointment after the 12th calendar day from application file date or appointment is rescheduled to a date after 30 days from the application file date.

If the verification is provided within 30 days from application file date, the AG is entitled to assistance from the date of application, if determined eligible.

For applications which have been denied for not providing all requested verification(s): If all requested verifications are submitted after denial but before the 60th day from the application file date, the denial is to be rescinded. If determined eligible as part of the rescind action and verifications are provided after the 30th day from application file date, benefits are to be prorated from the date verifications were provided. If all requested verifications were provided and result in an ineligible case (such as over income), the rescind action should be taken to deny with the new reason and the applicant would be provided with a new denial notice.

Even though denied for the month of application, the AG does not have to reapply in the subsequent month. The same application will be used for the determination of eligibility for subsequent months.

EXCEPTION: For residents of institutions who apply for Food Stamps prior to their release from the institution, an opportunity to participate must be no later than 30 calendar days from the date of release from the institution.

For instructions regarding FS timely reapplications, refer to Section 2210.05.00. For untimely filed applications (a recertification filed after the 15th calendar day of the last month of the certification period), refer to Section 2210.05.05.

2020.05.05 Time Standards For Expedited Service (F)

The Local Office will make Food Stamp benefits available to AGs entitled to expedited service no later than the close of business on the seventh calendar day following the date of application. There are no exceptions to the seven

calendar day processing standard to allow for holidays or weekends. If the seventh day falls on a holiday or weekend, Food Stamp benefits must be issued on the work day prior to the holiday or weekend. (f15)

The first calendar day following the date of application is the first day of the time frame. If the seventh calendar day falls on a non-business day, the AG must have their Food Stamp benefits available the last business day before the deadline.

EXAMPLE:

AG submits an application on December 22 they must receive their Food Stamp benefits by December 29, to meet the expedited time frame.

Expedited service is not allowed for AGs that file recertification applications during the redetermination month. If the prescreening during application registration fails to identify an AG as being entitled to expedited service, the Local Office will provide expedited service upon discovery of the error, and the processing standard will be calculated from the date the error is discovered. If, at anytime, it is discovered that the AG is not entitled to expedited service, the case reverts to 30 day processing.

2020.05.10 Time Standards For Residents Of Institutions (F)

For residents of public institutions who are determined eligible for Food Stamps prior to their release, the Local Office must provide assistance no later than 30 calendar days from the date of release of the applicant from the institution.

2020.05.15 Combined Month Issuance Time Standard (F)

AGs which apply after the 15th calendar day for initial month's assistance and fulfills all eligibility requirements, are eligible for the month of application and the subsequent month and must be issued the initial month's prorated allotment and the second month's allotment simultaneously. All expedited AGs which apply after the 15th calendar day and receive a prorated allotment for the month of application will also receive the second month's allotment within the expedited time standard.

2020.05.20 Notice Of Missed Interview (F)

When a client has an application on file for Food Stamps and misses the appointment, a notice must be sent to the client

informing him of the missed appointment. This applies to initial applications, reapplications and redeterminations.

ICES will automatically send this notice (CS11) if both requirements are met.

1. The Food Stamp appointment has been scheduled using the Client Scheduler in ICES.
2. The application is taken through Application Registration.

All other situations will require a manual notice to be sent to the client if a Food Stamp application is on file and the client misses the Food Stamp interview. Examples of these are if the worker adds Food Stamps as a program in an already existing case or if client scheduling was not used to schedule the appointment.

2020.10.00 APPLICATION TIME STANDARDS (C)

The Local Office must determine eligibility within a federally prescribed time standard and must so inform each applicant of this processing standard at the time of application, both verbally and in writing. (f16)

For Assistance Groups (AGs) meeting all conditions of eligibility:

If not required to participate in Applicant Job Search (AJS), assistance shall begin no later than 30 days from the date of application. (f17)

For AG's that are required to participate in Applicant Job Search (AJS), it shall be no later than 60 days from the date of the application.

For AGs not meeting all conditions of eligibility:

If not participating in Applicant Job Search (AJS), the authorization to deny the application should occur no later than 31 days from the date of application. If the 31st day falls on a non-work day, the denial should be authorized on the next available work day. (f18) ICES will generate the notice.

For AG's participating in Applicant Job Search (AJS), the authorization to deny the application should occur no later than 61 days from the date of application. If the 61st day falls on a non-work day, the denial should be authorized on the next available work day. ICES will generate the notice.

2020.10.05 Time Standards For Paroled, Transitioned or Released Prisoners (C)

All efforts will be made to ensure that the normal time processing standards will allow for assistance to be available when the prisoner, if eligible, is released, transitioned or paroled. (f18a)

2020.15.00 APPLICATION TIME STANDARDS (MED)

The Local Office must determine eligibility within federally prescribed time standards and must so inform each applicant both verbally and in writing at time of application. These time standards are: (f19)

45 days for all MA categories except the Disabled categories (MA D and MADW), which is 90 days.

The time standard covers the period from the date of application to the date the eligibility notice is mailed. (f20)

The Local Office must not utilize the time standard as a waiting period before granting MA. Additionally, the fact that a case is going to pend beyond the time standard cannot be used as the basis for denying the application. (f21)

2020.20.00 APPLICATION PROCESSING DELAY

Delay exists when an application is not processed within the federally prescribed time standards. The caseworker is to determine the reason for delay and whether the delay was caused by the AG or the Local Office by using the information in the following sections.

2020.20.05 Application Processing Delay (F)

The caseworker should determine the cause of delay in processing an application or in the return of information/verification. Delay is defined as any period of time exceeding the time standard required to determine eligibility. Delay may be either AG or Local Office delay, as discussed in the following sections. (f22)

2020.20.05.05 Assistance Group Delay (F)

The delay is considered the responsibility of the applicant and the AG is not entitled to assistance for the month of application if the AG:

Has not met the application time standards with available information despite an offer of assistance from the caseworker; or

Has failed to register for work after the caseworker has informed them of the requirement to register by the deadline; or

Has not provided the necessary verification by the deadline given on the caseworker's initial written request listing necessary items to be verified, after the caseworker has offered to assist them; or

Failed to appear for an interview and was notified of the initial missed interview as required in Section 2020.05.20.

If the AG has missed scheduled interviews and requests another interview, any delay will be the fault of the AG. If by the 30th day the AG has failed to appear for any scheduled interview the case will be denied as of the 30th day.

If the AG was denied for failing to provide the requested verifications and provides all of the required verifications within 60 days following the date of application, the case denial is to be rescinded without requiring a new application. If the AG was at fault for the delay in the initial 30 day period, was denied and later provided the requested verifications during the second 30 day period, benefits are to be prorated from the date requested verifications are provided.

2020.20.05.10 Expedited Service/Assistance Group Delay (F)

If an AG which is entitled to expedited services misses a scheduled appointment and contacts the office to reschedule after the missed appointment but before the end of the 30th day after the application date, the AG must be given the next available expedited appointment time. The local office will determine a new expedited time frame following applicant delays as follows:

The AG must have eligibility established by the 7th calendar day following the rescheduled appointment as long as the AG completes the rescheduled interview.

EXAMPLE:

Applicant submits an application on Monday, April 16 and is scheduled for an appointment on Wednesday, April 18. The applicant misses the scheduled appointment, but contacts the agency on April 26th and reschedules an appointment for Friday, April 27th. Saturday the 28th is day one of the seven day processing standard. The AG is entitled to have benefits authorized by May 4th.

These procedures apply if the applicant still meets expedited criteria. If he does, then the AG is allowed expedited verification procedures.

2020.20.05.15 Agency Delay (F)

The delay is considered the responsibility of the agency when the caseworker fails to complete a task which causes the application process to extend beyond the application time standard. This delay may occur when the caseworker delays in requesting verification, completing the eligibility determination or processing documents that the AG submitted timely, or when the ICES system is down or incorrectly configuring benefits.

When a delay in the initial 30 day application time standard is the fault of the agency, the AG is entitled to assistance retroactive to the date of application. The worker must complete a manual notice to the AG on the 31st day with information that the application is still pending, state the reason and the action the AG must take to complete the application process. The caseworker will provide assistance if needed.

2020.20.10 Exceptions To Application Time Standard (C, MED)

Every effort must be made by the Local Office to process all applications within the time standards. If an application pends beyond the time standard, the reason must be clearly documented in the Running Record Comments section of the case record and entered on AEFPY. (f23) Reasons are as follows:

Awaiting documentation of life insurance cash value from life insurance company;

Awaiting medical or visual information from the examining physician;

No extenuating circumstances;

Receipt of hearing decision (ICES will require a delay code to be entered on AEFPY if a denial was overturned by the ALJ).

2025.00.00 VERIFICATION

In order to determine eligibility for assistance, the Local Office is required to verify information to support the eligibility determination process such as:

Non-financial factors of eligibility;
Resources;

Income; and
Claimed expenses

These factors will vary by program.

The use of client statement should be used only as a last resort.

2025.05.00 VERIFICATION REQUIREMENTS

The Local Office must have adequate factual information on which to base case eligibility decisions. Therefore, at least one source of verification must be obtained for each eligibility factor. Verification is the use of third party information or documentation to establish the accuracy of statements on the application as well as statements obtained during the interactive interview. Verifications must be reasonable and limited to those that are necessary to ensure an accurate eligibility determination. For example, financial and demographic information is required only for those individuals living in the home who are members of the AG (as participants or non-participants). Therefore, when dealing with a household made up of AG members and excluded persons, the caseworker may **not** require the AG, as a condition of eligibility, to provide information and verify the circumstances of the non-AG members. (See Chapter 3200 for information concerning AG membership as a participant or non-participant and exclusion from AG membership).

Verifications may be secured by one of the following methods:

- Telephone contact;
- Personal contact (including home visits); or
- Written (hard copy) documentary evidence; including verifications received by fax or other electronic devices where the authenticity of the source of the verification along with the verification itself can be validated.

Running Record Comments must contain all telephone or personal contacts and documentary evidence used as verification. At a minimum, the following must be recorded:

- The eligibility factors verified;
- The name of the contact person;
- The date of the contact; and
- The information obtained from the contact.

This entry in Running Record Comments (CLRC) should be in sufficient detail to support the determination of eligibility or ineligibility.

**2025.05.05 Verification Of Questionable Information (F,
C, MED 2, 3)**

All eligibility factors that are questionable must be verified prior to the approval of the AG. To be considered questionable, the information on the application must be inconsistent with:

Statements made by the applicant;
Information on previous applications; or
Information available to the caseworker

When determining if the information is questionable, the caseworker will base the decision on the circumstances of the AG. Further verifications may be necessary if the following situations occur:

A report of expenses that exceed income;

The AG reports no income and/or no assets, yet is managing financial affairs; or

Information has been received that individuals not included on the application reside with the applicant/recipient and, therefore, the composition of the AG is questionable.

Questionable information alone does not serve as a basis for a denial or termination of the case.

When unclear information is received from a third party or from the AG, clarification and verification of the AGs circumstances must be pursued. A written request, which clearly advises the AG of the verification needed and actions needed to clarify the circumstances must be sent. The notice must advise the AG it has 13 days to respond and clarify its circumstances and that failure to respond will result in denial/closure.

If the AG does not respond to the written notice or does respond but refuses to provide sufficient information to clarify the circumstances, adverse action is taken to terminate the case. A new application is required if the AG wishes to continue to receive benefits.

If the AG responds and provides sufficient information, the reported information must be acted upon.

Benefits for one program cannot be terminated solely because benefits under another program are terminated.

2025.05.10 Collateral Contacts

There are some institutions such as banks, insurance companies, and medical institutions which will not release information without the written consent of the individual. If information from such sources is essential to the determination of eligibility, and the individual does not or cannot provide the necessary information and refuses to sign a release form, eligibility cannot be established and consequently, the application must be denied.

When contacting collateral contacts, disclosure of information should be limited to that which is absolutely necessary to obtain the information being sought. Disclosure that the AG has applied for or is receiving Food Stamps should not occur.

2025.10.00 RESPONSIBILITY FOR OBTAINING VERIFICATION

The applicant or authorized representative has the responsibility for providing adequate data to substantiate his request for assistance insofar as it is possible. The applicant or authorized representative is not required to present evidence in person at the Local Office. The evidence may be supplied in person, through the mail, by facsimile or other electronic devices as listed in IPPM 2025.05.00.

Good judgment is required on the part of caseworkers when determining what, if any, verifications can be furnished by the applicant or authorized representative. The caseworker will accept any reasonable evidence and will be primarily concerned with how adequately the evidence proves the statements on the application.

If it is difficult or impossible for the individual or authorized representative to obtain the evidence in a timely manner or the AG has presented insufficient documentation, the caseworker will offer assistance.

In cases where the applicant/recipient is a victim of domestic violence, it is important to understand the barriers that can exist in the process of obtaining verifications where the abusing party may be in possession of the needed documentation and any attempt to obtain said documentation would pose a threat to the applicant/recipient.

When neither the worker nor the applicant/recipient is able to secure the necessary documentation, the applicant/recipient's statement is to be acceptable information.

2025.15.00 REQUESTS FOR INFORMATION

If the caseworker requires information or verification from the individual, he must provide the individual with:

A written list of specific information required in order to complete the application process;

The date the information is due; and

Information on the consequences of not returning additional information by the due date. (f24)

When asked to release information necessary to process an application, the date and the name of the person or organization from which information is being requested must be listed on the release form prior to requesting the client's signature. This policy applies to the Authorization for Release of Information Form, or any of the other forms such as the FI-0014 and FI-0065 used to document the client's authorization for the release of confidential information. All of these forms must show the date signed by the client and may not be honored if more than 90 days old. The client may also revoke this authorization at any time prior to the expiration of the release.

The caseworker must provide the verification checklist for all AGs within the household.

The individual is responsible for providing as much of the required information as possible and must be informed that time extensions can be requested for TANF and Medicaid. However, any delay may affect potential benefits. The caseworker will assist the individual when the individual is unable to act wholly on his own or when the individual requests assistance obtaining information.

When additional information or verifications are required, the individual must be informed of the above specifications. ICES will not automatically generate this notice.

2025.20.00 TIME STANDARDS FOR PROVIDING INFORMATION

If it is determined at the interview or at any time during the application process that additional information or verification is required or that an AG member is required to register for employment, the AG must be notified and given 13 calendar days to comply with the request.

For all programs, the verification due date is 13 calendar days from the date the pending verification checklist is provided. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day.

2030.00.00 PROVIDING INFORMATION TO THE ASSISTANCE GROUP

The caseworker must verbally explain the following information to each interviewee:

That the AG will receive written notices stating the actions that must be taken to stay eligible. (If the AG cannot comply, the payee should call before the deadline to explain the reason.);

All eligibility factors pertaining to the categories of assistance which have been chosen;

That pamphlets regarding the Food Stamp, TANF, and Medicaid programs and Appeals and Hearings process are available; (f25)

The applicant's rights and responsibilities that are outlined in Sections 1425.00.00 through 1435.00.00, and Sections 2015.00.00 through 2015.20.05;

The fact that the application will be processed for the most assistance available;

The applicant's freedom of choice as to the type and number of categories under which he applies, including the QMB category for applicants entitled to Medicare Part A;

The latest date by which the Local Office must deliver the AG's assistance (if they are eligible);

That if the AG disagrees with any action taken by the Local Office, it may request a fair hearing;

That the AG's SSNs will be matched against the records of other agencies to detect unreported income and resources and that failure to provide either an SSN or proof of application for one will mean that the person cannot be on Food Stamps with the exception of the first month for expedited Food Stamps;

The next steps to be taken by both the applicant and the Local Office; and

The fact that the individual may withdraw his application at any time during the application process or request that his assistance be discontinued.

2030.05.00 PROVIDING INFORMATION TO THE ASSISTANCE GROUP (F)

The following should be explained verbally:

That all persons required to participate in the Employment and Training program must comply with the program requirements or the AG may lose Food Stamps;

Those AG members are expected to keep any suitable job they might have. (Quitting without good cause might make the entire AG ineligible.);

Those AGs under simplified reporting are only required to report when their total calendar month income exceeds the gross income limit for their AG size.

That the AG has the right to request a telephone interview (See IPPM 1835.05.00);

That there are rules regarding the use of Food Stamps:

- Food Stamps may be used to purchase food items and garden seeds at retailers approved by USDA. They may not be issued for hot, ready-to-eat foods or food marketed to be heated in the store. They also may not be used to purchase paper products, cleaning supplies, cigarettes, alcoholic beverages, firearms, ammunition, explosives and other non-food items.
- Sales tax may not be charged on any item purchased with Food Stamps.
- Food Stamp benefits on an EBT account may not be bought or sold.

Those Food Stamp applications may not be denied solely on the basis that an application to participate in another program has been denied. Ongoing Food Stamp benefits may not be terminated solely because benefits under another program have been terminated.

2030.10.00 PROVIDING INFORMATION TO APPLICANTS AND FAMILY MEMBERS (MED)

The following information must be provided:

If the individual or family is approved, a Hoosier Health Card will be sent to each enrollee within two weeks after the approval is authorized. This is a plastic identification card expected to be retained throughout the person's eligibility for Hoosier Healthwise or traditional Medicaid in Indiana. If a person is discontinued and reapplies, the same card can once again be used if the person is re-enrolled.

Coverage under traditional Medicaid and all benefit packages of Hoosier Healthwise except Package C, may be retroactive up to three months prior to the month of application, if all requirements are met. Coverage under Package C can begin no earlier than the month of application.

For Hoosier Healthwise applications, discuss the application attachment "Important Information about Hoosier Healthwise" and the distinctive features under Package C. The person filing the application must be informed that coverage under the premium-free packages will be explored first and if the person wishes coverage under Package C, payment of the premium is required.

Annual redeterminations of eligibility are required for all enrolled persons.

If determined to be eligible for Medicaid, the person will be able to select a Medicaid provider(s) of his choice or, (f26) if he is in a managed care category, he must select a health plan.

The Healthwatch pamphlet must be provided to all families with children under age 21.

Discuss the medical assignment and explain that the free service of paternity establishment is not available for children who are found eligible under Package C.

Discuss the premium requirements of M.E.D. Works for disabled applicants who are working.

2035.00.00 DETERMINATION OF INITIAL ELIGIBILITY

This section discusses policy for:

Disposition:

- The initial determination of eligibility or ineligibility; and

Date of entitlement:

- The initial date of eligibility for assistance.

Refer to Chapter 2200.00.00 for determination of on-going eligibility, redeterminations and certification periods.

2035.05.00 EXPEDITED SERVICE (F)

The circumstances that qualify destitute AGs for expedited processing may not qualify them for assistance. For example, non-cash resources are not considered in determining expedited status but are considered in determining eligibility; therefore, an AG might be ineligible based on resources. AGs which qualify for expedited processing but are determined ineligible for benefits must receive a denial notice by the seventh calendar day from the day the application is filed.

The caseworker will accept any readily available verification in order to determine eligibility of an assistance group under expedited services criteria. Identity is the only factor that must be verified prior to receiving expedited benefits. The caseworker cannot delay the authorization of expedited benefits pending the receipt of other verification. Other verifications that are not received during the expedited processing time frame must be postponed and completed before the AG's next issuance. If the AG fails to provide postponed verifications by the due date, the case should be closed.

When an AG moves to Indiana from another State the worker will question the applicant to determine if benefits were issued in the other State for the month of the current application. If benefits were issued from the other State the AG is not entitled to benefits in Indiana for the month of application unless the applicant signs a statement that the benefits were returned to the other State.

Pending verification of the applicant's statement of non-receipt by the other State agency must be postponed if not completed during the expedited time-frame.

The caseworker must accept any readily available verification of an AG's income, including a statement of no income, within the expedited processing time frame and record the results of such attempts in Running Record Comments. The caseworker must be aware that verification of a "no income" statement is as important as verification of reported income.

An applicant AG is not currently eligible for expedited processing unless previously postponed verifications have been provided or the AG has been certified under normal processing standards since a previous expedited certification.

2035.10.00 (RESERVED)

2035.15.00 PRE-ADMISSION SCREENING IS PENDING (MED 1)

When pre-admission screening (PAS) is pending on an individual who has entered a nursing facility, ICF/MR or

CRF/DD, it is to be assumed that the individual will be approved, absent evidence to the contrary. An "S" for screened should be entered in the Pre-Admission Screening field on AEIII. If any other code is entered, ICES will determine a spend-down instead of a liability. The date is either the date the screening was initiated, if known, or the date the individual entered the facility.

The Local Office will not receive a copy of the Form 450B (Physician Certification for Long Term Care Services) when the level of care determination is made. Local Offices should arrange a procedure with Medicaid facilities so that the facilities will notify the caseworker if a level of care is denied. When a denial is received by the caseworker, the information on AEIII must be updated accordingly.

2035.20.00 HOME AND COMMUNITY-BASED SERVICE WAIVERS (MED 1)

Parental income and resources are not considered when determining the Medicaid eligibility of individuals less than 21 years of age who are being considered for Home and Community-Based Services (HCBS). When entering the application in ICES for children who have HCBS applications pending, enter everyone who lives in the household on AEIID. Parents should be asked early in the interview if they want retroactive Medicaid coverage for the child. If retroactive coverage prior to the waiver effective date is requested, the parents must provide verification of their income and resources. Generally most parents do not want retroactive coverage for the child prior to the waiver and are resistant about being asked any questions about themselves. If the parents do not want the retroactive coverage, they are not required to provide information about their own finances.

As each screen is completed, the questions will relate to the situation of the child only, if retroactive coverage is not desired.

2035.25.00 DETERMINATION OF CASH ASSISTANCE CATEGORY (C)

When Cash Assistance is indicated as a program choice, ICES automatically determines (through a process called failure logic) the category under which the Assistance Group (AG) may receive benefits, according to the hierarchy listed below. The Cash Assistance categories are discussed in Section 1600. If the AG fails for a particular category, the system will explore eligibility under other Cash Assistance categories. If the AG fails to meet the eligibility requirements of all Cash Assistance categories, assistance is to be denied.

Cash Assistance Hierarchy:

ADCR: TANF based upon absence of a parent;

ADCQ: Refugee Cash Assistance when categorical TANF eligibility does not exist for an AG with refugee status.

ADCU: TANF based on a two-parent AG;

2035.30.00 DETERMINATION OF MEDICAL CATEGORY (MED)

In the absence of a stated preference by the applicant, (f27) ICES will determine the category according to the hierarchy listed below. A brief description of the categories can be found in Chapter 1600. The hierarchy is designed so that the applicant is first considered under the category which provides the most comprehensive scope of coverage in the most expeditious manner. If the client states an intention to apply for the Aged, Blind, or Disabled category, the preferred category can be entered by the caseworker on AEICP. However, a person who is eligible in a mandatory category cannot choose to be in an optional category. Therefore, individuals who are working and eligible in the Disabled category cannot choose to be in M.E.D. Works. Additionally, applicants do not have the option to choose the MA 10 category when eligible under another category. An individual who is eligible for MADW (not MADI) can choose to be enrolled under MA D. Caseworkers must ensure that the applicant is in fact eligible in MA D. For example, if the applicant's gross earned income minus impairment-related work expenses is more than the SGA limit, MA D cannot be approved. Refer to Sections 1620.87.00 and 2035.30.10 regarding MA10 determinations, and to Section 2035.30.05 which explains the special considerations for MA 9, children age 1 - 19.

- MA X Newborn - Package A, full coverage;
- MA C Low-Income Families - Package A, full coverage;
- MA F Transitional Medical Assistance(TMA) - Package A, full coverage;
- MA U SSI recipients who would meet TANF eligibility requirements were they not receiving SSI - Package A, full coverage;
- MA M Pregnant women - Package A, full coverage;
- MA T 18, 19 and 20 year olds - Package A, full coverage;
- MA O Children under age 21 residing in inpatient psychiatric facilities who would be eligible for TANF if they were living at home - full coverage,

traditional Medicaid;

MA Y Children under age one - Package A, full coverage;

MA Z Children age one through five - Package A, full coverage;

MA 2 Children age 6 through 18 - Package A, full coverage;

MA 14 Individuals age 18, 19, 20 Who Were In Foster Care - Package A, full coverage

MA 9 Children age one through 18 - Package A, full coverage;

MA R RBA related - full coverage, traditional Medicaid;

MA A Aged - full coverage, traditional Medicaid;

MA B Blind - full coverage, traditional Medicaid;

MA D Disabled - full coverage, traditional Medicaid;

MADW MED Works, Basic category - Medicaid for Employees with Disabilities; full coverage, traditional Medicaid.

MADI MED Works, Medically improved category - Medicaid for Employees with Disabilities; full coverage traditional Medicaid.

MA 3 Wards - full coverage, traditional Medicaid;

MA N Pregnant Women - Package B, limited coverage;

MA Q Refugee Medical Assistance (RMA) - full coverage, traditional Medicaid;

MA L Qualified Medicare Beneficiary (QMB) - limited coverage;

MA J Specified Low-Income Medicare Beneficiary (SLMB) - limited coverage;

MA G Qualified Disabled Working (QDW) - limited coverage;

MA E Pregnant woman who is income ineligible or in 60 day postpartum period but received MA during a prior month in MA M or MA N - Package B, limited coverage;

MA10 Children birth through 18; Package C, comprehensive coverage, some services subject to limits.

2035.30.05 Determination of MA 9 Category (MED 3)

This category, established effective July 1, 1998, includes children age 1 through 5 with income between 133% - 150% of the federal poverty level, and children age 6 through 18 with income between 100% - 150% of the poverty level. (27a) The MA 9 income standards are listed in Section 3010.30.15.

MA 9 is positioned in the hierarchy after MA 2 and before MA B and MA D. However, if a blind or disabled child is determined eligible for MA B or MA D, without a spend-down, she/he will be authorized in one of those categories not MA 9. New applicants will be considered first in MA 9 without being required to go through the medical determination process with the MMRT. If they fail MA 9 eligibility, then they will be considered under MA B or MA D. Recipients who are eligible in the MA B or MA D categories without a spend-down, but who meet the MA 9 financial requirements will remain in MA B or MA D. Recipient children in MA B or MA D who are in Medicaid certified facilities and who have liabilities will remain in those categories. A child who meets the MA 9 requirements, but would also be eligible for MA B or MA D with a spend-down, will be approved in MA 9.

2035.30.10 Determination of MA 10 Category (MED 3)

This category, established effective January 1, 2000, includes children birth through age 18 who are not eligible in any other medical category. MA 10 is Benefit Package C of Hoosier Healthwise. The income standards were set at 200% of the federal poverty guidelines until October 1, 2008 when they were increased under an MA 10 expansion to 250% of the federal poverty guidelines. The standards are listed in Sections 3010.30.20 and 3010.30.25. Information on budgeting under the expansion is found at Section 3460.15.05.

MA 10 is positioned at the bottom of the medical hierarchy after MA E, due to the requirement that eligibility be pursued under the other categories first. However, the same provision as in MA 9, that is applied to children who would be eligible in the Blind and Disabled categories with a spend-down, is applicable to MA 10. Refer to the previous section, 2035.30.05.

2035.30.15 Determination Of M.E.D. Works Category

A disabled individual will be considered under all applicable categories according to the hierarchy. If the individual's gross earnings, minus impairment-related work

expenses (IRWE) exceed the Substantial Gainful Activity amount specified in Section 3046.00.00, or his total countable income or resources exceed the MA D limits listed in Chapter 3000, he will then be considered for eligibility in M.E.D. Works. MADW is considered first. An applicant for Medicaid cannot be approved initially in MADI. If the Medicaid Medical Review Team determines that an MADW recipient is no longer eligible for MADW due to a medical improvement in his condition that does not constitute a medical recovery, they will determine MADI categorical eligibility.

2035.30.20 Determination Of MA 14 Category (MED 3)

This category includes 18, 19, and 20-year-olds who were in foster care when they turned age 18. MA 14 is positioned after MA 2 in the medical hierarchy.

Therefore, 18-year-old former foster children will first be considered for eligibility in MA 2. If their income exceeds the limit for MA 2 or when they turn age 19, MA 14 will be considered.

2035.31.00 DESIGNATION OF THE PACKAGE C PREMIUM PAYER

When an application is filed for Hoosier Healthwise, the person signing the application understands that if the child is eligible for Package C, there will be a premium due before the child can be enrolled. The premium payer is assigned according to the following default logic: mother, father, non-parent caretaker. The caseworker may override the system designation of payer in the following circumstances:

The mother is living in the home and the system has designated her, but it is the father (also in the home) who wants to be the payer.

The child is a ward of the DCS and is placed with someone other than the parents. (If the ward is placed with a parent, the parent will be designated premium payer.)

The child has a legal guardian and is placed with the parent. In this situation, it will be necessary to determine which of these individuals is financially and legally responsible for the child and enter that person as premium payer.

2035.32.00 ENROLLMENT PROCESS FOR MA 10

Once eligibility is established, a conditional approval for MA 10 is to be authorized. This means that the children meet all eligibility requirements of MA 10 except for

payment of the first premium(s). The first premium month is the month after authorization. The months of the application month through the month of authorization are premium-free. The children will be enrolled when the premium has been paid.

The billing process allows for an overdue billing, which gives the payer a subsequent opportunity to pay the premium before the application will be closed. If a payment is not received by the final due date, the conditional approval will be system denied.

2035.33.00 DESIGNATION OF M.E.D. WORKS PREMIUM PAYER ENROLLMENT PROCESS

MADW/I premium payer is set in the following default order:

Applicant/recipient age 18 and older

Mother of applicant/recipient under age 18

Father of applicant/recipient under age 18

Applicant/recipient under age 18, who is not living with a parent/caretaker.

The caseworker can change the payer of a child under age 18 from mother to father, as requested by the parent. In the case of a married couple, when both are applicants/recipients of M.E.D. Works, each spouse will be designated as his or her own premium payer. However, the premium will be a 'couple premium', meaning one premium is assigned to both spouses. Both will be enrolled when the one premium is paid and both will be denied if the premium is not paid. One billing statement will be sent to the couple.

Applicants who pass all eligibility requirements and based on income are required to pay a premium in order to be enrolled will be conditionally approved until the premium is paid. The first premium month is the month following the month of authorization. All prior months in which the individual is eligible are premium-free.

2035.35.00 DETERMINATION OF INELIGIBILITY

An AG is to be denied if just one eligibility requirement fails to be met causing the entire AG to be ineligible. However, if, in the course of the eligibility study the caseworker verifies that other requirements are not met; all reasons for denial must be entered on AEWAA.

2035.40.00 AUTHORIZATION

An AG must be authorized when all required eligibility information is documented and the determination of eligibility is complete. TANF AGs and their accompanying MA C AGs must be authorized at the same time. In all other instances, AGs are to be authorized whenever the eligibility determination is complete. Authorization of an AG is not to be delayed while awaiting completion of the eligibility determination for other AGs in the case.

Before authorizing an AG, the caseworker should carefully review all data and the case eligibility summary screen (AECES) eligibility results for accuracy. This involves reviewing every retroactive month as well as the recurring month.

2035.45.00 AUTHORIZING COMBINED MONTHS' BENEFITS (F)

AGs which apply after the 15th of the month and are determined eligible (for the month of application and the following month) in the month of application are to receive benefits for the initial month and the following month at the same time. This includes expedited AGs which apply after the 15th of the month and are determined eligible for initial month's benefits and the following month.

When the first month's benefit of less than \$10 is pro-rated to a zero benefit, the AG will not receive combined benefits. Benefits for the second month will be available on the first working day of the second month.

AGs which have postponed verifications cannot receive the third month's benefits until all required verifications are provided.

2035.50.00 EFFECTIVE DATE (F)

The effective date for Food Stamp assistance is the date of application unless the initial month(s) is denied or an AG delay has occurred which revises the effective date. Refer to Section 2020.20.05.05. Assistance is prorated from the date of application for first month benefits. If the AG causes a delay and provides verification after the 30th day, benefits are to be prorated from the day verifications are provided.

Since ICES prorates from the date the verifications are entered into ICES, the entry should be completed the same day the verifications are provided. If verifications are not entered on the day of receipt, an auxiliary must be done to provide benefit from the day of receipt.

If any Migrant/Seasonal Farm Worker AG was certified for the month prior to the application month in any state or county, benefits will not be prorated from the application date.

Instead, the AG will receive a full month's benefits. All other AG's benefits will be prorated from the date of application if there has been a break in certification.

2035.55.00 EFFECTIVE DATE (C)

The effective date of assistance is the first of the month following the date of application except when an application is filed on the first day of a month containing 31 days. In this instance, the effective date is the 31st day of the month. Benefits for this day are prorated by ICES. This means that if an application is filed on January, March, May, July, August, October, or December first, a benefit is calculated for the 31st day only. Refer to Section 3450.60.00.

A person applying for a Cash benefit in Indiana after living in another state will not be eligible for a Cash benefit from Indiana until the state of his former residence is contacted to determine if he is receiving Cash assistance from that state. If he is, the effective date of the Cash payment from Indiana can be no earlier than the date of discontinuance in the other state.

2035.60.00 EFFECTIVE DATE (MED 1, 2, 3)

The effective date of health coverage is determined in accordance with the following guidelines:

For traditional Medicaid and all benefit packages of Hoosier Healthwise except Benefit Package C, the effective date can be no earlier than the third month prior to the month of application if all eligibility requirements are met. (f28) This provision for retroactive coverage also applies to individuals who were deceased at the time of application. (f29) For Hoosier Healthwise Benefit Package C, the effective date can be no earlier than the first day of the month of application.

For spend-down AGs, Medicaid payment of medical care is available each month once the spend-down obligation has been met.

The effective date for an individual who was living in another state just prior to moving to Indiana will be no earlier than the month the individual became an Indiana resident.

2035.65.00 EFFECTIVE DATE OF QMB MEDICAID (MED 4)

The QMB category of assistance (MA L) has no provision for retroactive coverage. The effective date of QMB coverage

begins with the month after the month in which the QMB eligibility determination is made.

2035.70.00 EFFECTIVE DATE OF QDW MEDICAID (MED 4)

The effective date of QDW coverage (MA G) begins with the effective date of Medicare Premium Part A, but no earlier than three months prior to application.

2035.75.00 EFFECTIVE DATE OF SLMB MEDICAID (MED 4)

The effective date of SLMB can be no earlier than the first of the third month prior to the month of application, but not earlier than the date of entitlement to Medicare Part B. The effective date for a recipient who is already bought in and whose Medicaid coverage is being reduced to SLMB is the first day of the month following the closure of the other MA category. For example, if MA D terminates March 31st, the SLMB effective date is April 1st.

2035.80.00 EFFECTIVE DATE OF QI MEDICAID (MED 4)

The effective date of QI can be no earlier than the first of the third month prior to the month of application, but not earlier than the date of entitlement to Medicare Part B. The effective date for a recipient who is already bought in and whose Medicaid coverage is being reduced to QI is the first day of the month following the closure of the other MA category.

2040.00.00 REAPPLICATIONS

A reapplication may be made at any time by an individual whose application for assistance was denied or whose assistance was discontinued. If a recipient comes into compliance prior to the effective date of a discontinuance, it is appropriate to rescind the adverse action rather than to require a reapplication.

An individual who appeals a denial or discontinuance which had become effective may file a reapplication at any time. He is not to be denied the right to reapply pending the decision of the Administrative Law Judge (ALJ). If the hearing decision is in his favor, the Local Office is to take adjusting action as directed in the decision. If the Local Office action is sustained, the reapplication is to be processed in the usual manner. The Local Office is not to delay the processing of a reapplication taken under these circumstances until the hearing decision is issued as this is not considered an extenuating circumstance for pending a case beyond the time standard.

2050.00.00 MSP APPLICATIONS FROM SSA LIS DATA FILE (MED 4)

Beginning on January 1, 2010, in accordance with the Medicare Improvements for Patients and Provider Act of 2008 (MIPPA - P.L. 110-275), the SSA will begin using a revised application for the Medicare Part D Low-Income Subsidy (LIS) that tells applicants that their application will be sent to the State Medicaid agency unless the applicant checks a box opting out of the referral. Once SSA makes the LIS eligibility determination, the person's information will be transmitted to the State via the LIS/MSP data file. (f30). ICES will process this file daily and generate worker notifications for every application received.

The LIS/MSP data file acts as an application for the Medicare Savings Program (MSP). The applicant will not be asked to sign a separate MSP or Medicaid application. An eligibility interview is not to be scheduled.

2050.05.00 THE MSP APPLICATION DATE (MED 4)

The date of the LIS application is the protected date for establishing MSP eligibility. The date that is used to start the 45-day processing clock is the date that the file is received by ICES. (f31)

Example 1

The LIS/MSP data file is received on February 10 for Applicant Joe. The LIS application date recorded on the file is January 4. Based on Joe's income, he is approved for SLMB and authorized on March 15. MA J is effective October 1 which is 3 months retroactive based on the protected date of January 4. This application was processed within the allowable time standard as it was authorized within 45 days of the date that the LIS/MSP data file was received.

Example 2

The LIS/MSP data file is received on February 10 for Applicant Lou. The LIS application date recorded on the file is January 4. Based on Lou's income, she is approved for QMB and authorized on March 15.

MA L is effective April 1 which is the month after eligibility is determined. The MIPPA legislation did not change this rule for QMB which does not offer retroactive coverage. This application was processed within the allowable time standard as it was authorized within 45 days of the date that the LIS/MSP data file was received.

**2050.10.00 INITIAL SYSTEM PROCESSING OF LIS/MSP
APPLICATION (MED 4)**

There are 3 possible LIS decision types:

Adjudicated LIS denial.

In this situation, SSA collected and verified all income and resource information and denied the LIS application. MSP will be denied and a system-generated notice will be sent to the applicant without further follow up by a worker. The MSP denial notice provides the website address for more information on the MSP and also the telephone number of the Area Agency on Aging (AAA) which has an outreach grant for the MSP. The AAA will send the individual an MSP application upon request.

Non-adjudicated LIS denial.

In this situation, the SSA has accepted self-declaration that the applicant and spouse, if applicable, have resources in excess of the LIS limit. Question 3 on the LIS application asks if the applicant's resources exceed the LIS limit. If the applicant checks "yes", a non-adjudicated LIS denial results. If the applicant does not opt out of applying for the MSP, then SSA will send the application to the State. Follow up processing of the application for MSP is required by the worker as explained in Section 2050.20.00.

LIS approval.

In this situation, the SSA has collected and verified information and issued a determination that the applicant is eligible for the LIS. Follow up processing of the application for MSP is required by the worker as explained in Section 2050.20.00.

A system generated acknowledgment letter will be sent to the individuals who received LIS approvals and non-adjudicated denials. For applicants with no previous or current case, the notice will explain that an MSP application has been received and they may be contacted for verifications. Applicants who have a current application pending will be advised that processing on their case will continue including eligibility for MSP. For individuals already receiving MSP benefits, the notice will state that they are already covered by the MSP and to call the office if they have any questions.

**2050.20.00 VERIFICATION AND ELIGIBILITY DETERMINATION
(MED 4)**

Applications received via the LIS/MSP data file are to be

processed for MSP eligibility. An individual can file an application for full coverage Medicaid as desired. If a Medicaid application is already pending, the processing will continue including the MSP determination as usual. If a full coverage Medicaid application for the individual is received after the MSP application is set up, the date of the application for full coverage Medicaid would be the date that the full coverage application was received.

For LIS approvals, SSA's verification of the following income types is acceptable verification unless there is a known discrepancy: Social Security, retirement pension, VA, and Railroad Retirement. A discrepancy would include differing information from SSA than existing information on the individual from a previous case or the DEBN match. All discrepancies must be resolved. If the total of these income types for the applicant and spouse cause MSP to fail and there is no discrepancy, the application can be denied for excess income without follow up. **EXCEPTION:** If the household size is more than 2 if there is a spouse, or more than 1 if there is no spouse, then household composition must be obtained from the applicant to determine if there are dependent children under the age 18 and thus the applicant might be financially eligible. Income of the dependent children must be verified as well.

All other income and resources listed on the LIS/MSP data file must be verified, and for non-adjudications, none of the LIS income or resource information is acceptable verification for MSP.

If the application cannot be denied for excess income as explained above, follow up verification must be obtained. The information from the LIS/MSP data file other than the aforementioned unearned types is considered leads data, but it is not complete in all circumstances to make an accurate eligibility determination for the MSP.

The new form, Medicare Savings Program - Application Information, must be included with the Form 2032 when requesting verifications. This form includes the program rights and responsibilities.

Citizenship does not have to be verified under existing Medicaid rules. However, it may be possible for an applicant to be a lawful immigrant, and this is not denoted on the LIS/MSP data file. Therefore, the following question must be entered on the 2032: "Are you a citizen of the U.S.? If you answer no, please attach a copy of your immigration document showing your lawful resident status".

The LIS/MSP data file transmits mailing address not residence address. Therefore, Indiana residence must be

verified. In addition to checking the "residence" box on the 2032, enter the following: "Is your households address the same as your mailing address? If no, please provide your household address".

The LIS program does not ask for or count the cash value of life insurance so verification of the CSV must be requested of all applicants.

The LIS application does not ask for race/ethnicity, so this must be requested.

If the applicant's first response to the first request for verification is timely but incomplete or causes the need for additional clarification, a second request must be sent to clarify. An application is not to be denied based on a partial response to the first verification request. If a response is not received at all by the first due date, a reminder must be sent.

Whenever an MSP-only recipient subsequently asks for full coverage Medicaid, another application is not required.

If the LIS/MSP applicant has full coverage Medicaid already open, an MSP decision can be made based on the information already in the Medicaid case, even if MSP was previously denied or discontinued. However, discrepant information must be resolved.

2099.00.00 FOOTNOTES FOR CHAPTER 2000

Following are the footnotes for Chapter 2000:

- (f1) 7 CFR 273.2(d);
405 IAC 2-1-2
- (f2) 7 CFR 273.1(f) - FS
470 IAC 10.1-1-2.1 - TANF
- (f3) 405 IAC 2-1-2
- (f4) IC 29-3-3-5
- (f5) 470 IAC 2.1-1-2
- (f6) 470 IAC 2.1-1-2
- (f7) 470 IAC 2.1-1-2
- (f8) 470 IAC 2.1-1-2
- (f9) 470 IAC 2.1-1-2
- (f10) 470 IAC 2.1-1-2
- (f11) 470 IAC 2.1-1-2
- (f12) 470 IAC 2.1-1-2
- (f13) 470 IAC 2.1-1-2
- (f14) 7 CFR 273.10(g)
- (f15) 7 CFR 273.2(i)
- (f16) 45 CFR 206.10
- (f17) 45 CFR 206.10
- (f18) 470 IAC10.3-2-3
- (F18a) IC 11-10-12-5

(f19) 42 CFR 435.911
(f20) 42 CFR 435.911
(f21) 42 CFR 435.911
(f22) 7 CFR 273.2(h)
(f23) 42 CFR 435.911;
45 CFR 206.10
(f24) 470 IAC 2.1-1-2
(f25) 45 CFR 206.10
(f26) Social Security Act, Section 1902(a)(23);
42 CFR 431.51;
405 IAC 1-1-2
(f27) 42 CFR 435.404
(f27a) Title XXI of the Social Security Act; IC 12-15-2-
15.6 as added by SEA 19
(f28) Social Security Act, Section 1902(a)(34);
42 CFR 435.914
(f29) Social Security Act, Section 1902(a)(34);
42 CFR 435.914
(f30) Section 1144(c) (3) of the Social Security Act
(f31) Section 1935 (a) (4) of the Social Security Act