

Indiana Health Coverage Program Policy Manual
Chapter 2000
Application Processing Sections 2000.00.00 – 2050.20.00

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2000.00.00 APPLICATION PROCESSING

At the end of the application registration process, client scheduling should take place 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 Federal Health Insurance Marketplace and the State Medicaid Agency will be coordinated in their eligibility determinations of individuals that follow the application process through the Marketplace or the DFR. The following sections are contained in this chapter:

- The Interview (Section 2005)
- 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)
- Reapplications (Section 2040)
- MSP Applications from SSA LIS Data File (MED 4) (Section 2050)

2005.00.00 THE INTERVIEW (MED 1, MED 2, MED 4)

This section does not apply to the following applicants who are exempt from the personal interview requirement.

- Applicants for MAGI coverage (any MED 3 category)
- LIS/MSP applicants sent electronically to the eligibility system via data exchange from SSA.
- Effective June 1, 2014] SSI recipients.
- MASI recipients adding a buy in category

An interactive interview is required for all other individuals who apply, including a paper application for QMB/SLMB/QI/QDW coverage.¹

It may not be known at application point whether the applicant will have eligibility determined under a MED 3 category or another applicable category. Once it is known that MED 3 is not applicable, an interview appointment notice must be sent to the applicant and any authorized representative. Refer to IHCPPM 2005.05.10.

The interviewee being considered for MED 1 or MED 4 coverage may choose to be evaluated for either or both categories during the interview.

Applicants who fail to keep the initial interview for MED 1 must be assessed to determine if they qualify for coverage under a MAGI category before an application is denied. Such applicants (unless a LIS/MSP application was sent from SSA) should *not* be selected for QMB/SLMB/QDW/QI coverage if the personal interview was not completed before the application expired.

Category changes: A data gathering interview must also take place for a category change in the following circumstances:

- A limited coverage category (Emergency Services Only, Family Planning Only, or QMB/SLMB/QI/QDW) changing to a MED 1 category
- A MAGI category (HIP, HHW) which disregards resources changing to a category which requires a thorough review of all applicable resources (MED 1, MED 4)
- MASI coverage based on receipt of SSI changing to another MED 1 category due to loss of SSI status or to the circumstances described in IHCPPM 2414.10.20 for widow/ers and Disabled Adult Children.

The only exception is for a member who was interviewed for a MED 1 category but was dual processed (conditionally authorized in HIP pending an MRT or SSA decision). If such a member completed the MA D personal interview within the past 90 days, a new interview is not required, and a pending verification request may be sent for updated resource amounts and any other changes.

2005.05.00 COOPERATION WITH THE ELIGIBILITY INTERVIEW AND RESCHEDULING (MED 1, 2, MED 4)

An application is to be denied if an individual does not cooperate with the interview requirement. Refusal is determined when the AG can cooperate but clearly demonstrates a refusal to be interviewed. 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 aid complete the interview requirement.⁵

If the individual contacts the DFR to reschedule, the interview should be rescheduled as soon as possible to stay within processing time frames. A copy of written notices to reschedule should be kept in the case record. Appointments scheduled by phone should be documented in Running Record Comments.

2005.05.10 WHO CAN BE INTERVIEWED

In addition to who can be interviewed for an applicant/recipient, this section may also be applied towards who DFR can discuss missing and needed verifications to determine Medicaid eligibility for an applicant/recipient.

An applicant or authorized representative may be the interviewee and can conduct all business related to the application process. The initial contact person (ICP) who makes the initial request for assistance cannot be interviewed or request an interview be rescheduled unless they are the designated Authorized Representative, or the applicant or member is also present and gives one-time permission.

For Authorized Representatives, the Authorized Representative for Health Coverage, State Form 55366 must be used to authorize someone to apply on behalf of an AG and must be filed in the case record.

Alternatively, the prospective authorized representative and the applicant/member may call DFR and jointly agree to the authorized representative relationship over the phone.⁶

Any individual other than the parent of an applicant/recipient under age 18 must be authorized in writing by the applicant unless medical documentation (such as a doctor's statement) is presented showing that the applicant is medically unable to provide such authorization.

For a spouse of an applicant/recipient to be interviewed, the spouse must either be an authorized representative for the applicant/recipient or be given verbal permission by the applicant/recipient to be interviewed on behalf of the applicant/recipient. Verbal permission can occur in person or over the phone. If it is done over the phone, DFR must ensure that the applicant/recipient giving the verbal permission is in fact the applicant/recipient by asking that person to verify a few things about themselves including but not limited to last four digits of SSN, date-of-birth, address, case number, and RID number. An applicant/recipient may also give verbal authorization to someone other than a spouse.

Someone who is merely given verbal permission is not an authorized representative and is not authorized to speak with the DFR about the applicant/recipient's case beyond that occurrence. Despite the availability of an authorized representative, the DFR may require personal contact with the applicant if such contact is necessary to determine eligibility under any program.

Note: If an applicant/recipient is failing to cooperate with the Authorized Representative or third party, then the worker must reach out to the applicant/recipient.

The authorized representative must be familiar with the AG situation to represent them properly. The worker will determine if the authorized representative is representing the AG appropriately. If the applicant/recipient is failing to cooperate with the Authorized Representative, and the Authorized Representative is unable to obtain the required verifications needed to complete an eligibility determination, then contact should be made with the applicant/recipient to obtain verifications.

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.

Unless there is a valid Authorized Representative form, employees of nursing facilities may not be interviewed on behalf of a resident in their facility unless the client is medically incapable of being interviewed and there is no one else to act on the client's behalf. A doctor's statement verifying the incapacitation is required in these instances.

Legal guardians and powers of attorney may apply for assistance on behalf of the applicant and must present the appropriate documents verifying their status to be interviewed. 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 and be interviewed. 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 and be interviewed. The most common usage of this procedure will occur with state institutions under the supervision of the Division of Mental Health.

When an application is received for a deceased applicant, the application must be processed, and an eligibility determination completed. If an interview is required, then the data gathering interview can only be completed with a verified Authorized Representative or Court appointed Personal Representative. The interview cannot be completed if a valid AR or Court appointed Personal Representative Form is not in the file nor can any information be released to an interested party that is not a verified AR or Court appointed Personal Representative. An interested party that has information specific to the applicant's situation can provide required verifications including the death certificate, but the interested party's ability to intervene begins and ends with providing documentation or verification. Each situation must be evaluated to determine, if necessary, information to complete the eligibility determination can be obtained. Any application processing questions for this scenario should be sent to the Central Office Policy Unit for clarification.

2005.05.15 WHEN AN INTERVIEW IS REQUIRED

When a member applies for a non-MAGI category (MED 1, MED 2 or MED4), then a data gathering interview must be completed. The only exceptions to this are:

- LIS/MSP applications sent electronically to the eligibility system via data exchange from SSA
- SSI recipients
- SSI recipients that are adding a Medicare buy in category, such as MA L

If a member is ongoing in a MAGI category but requests a non-MAGI category, then a data gathering interview is required. This includes:

- Members that turn 65
- Members that state that they are disabled and request to pursue a disability category
- Members ongoing in a HIP category that receive a disability approval through SSA
- Members in a limited coverage category (Emergency Services Only, Family Planning or QMB/SLMB/QI/QDW) changing to a MED 1 category
- Paper QMB application.

The only exception is for a member who was interviewed for a MED 1 category but was dual processed (conditionally authorized in HIP pending an MRT or SSA decision). If such a member completed the MA D personal interview within the past 90 days, a new interview is not required, and a pending verification request may be sent for updated resource amounts and any other changes.⁷

2005.10.00 AUTHORIZED REPRESENTATIVES

An authorized representative is a designated individual or organization acting on the client's behalf to assist with application and renewal services. The agency permits applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. There are no restrictions on who can serve as an authorized representative including navigators, or individuals working for an enrollment center, if the member permits. Any individual working for the authorized agency may serve as the "qualified authorized representative", regardless of which associate signs designated form.

An authorized representative may be appointed at the time of application, renewal or any other times designated by the applicant or beneficiary. Likewise, a court order establishing legal guardianship, or a power of attorney should be recognized and documented as a written consent by the applicant or beneficiary for lawful representation.

Applicants and beneficiaries may authorize their representatives to:

- Sign an application on the applicant's behalf
- Complete and submit a renewal form
- Receive copies of the applicant or beneficiary's notices and other communications from the agency
- Act on behalf of the applicant or beneficiary in all other matters with the agency.

Authorized representatives must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

The authorization will remain valid until the applicant or beneficiary modifies the agreement or notifies the agency that the representative is no longer authorized to act on his or her behalf. Similarly, the authorized representative may inform the agency that he or she no longer representing the client, or there is a change in the legal authority upon which the individual or organization's authority was based. Notification should include the applicant or authorized representative's signature as appropriate.

For authorized representative agreements which are not based on an existing legal authority, the official AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE (State Form 55366) form must be signed by both the member and the authorized representative. Alternate forms or letters will not be accepted. Authorized representative agreements can be accepted via mail, fax, submission via the benefits portal, agreement on the telephone, or may be dropped off at a local DFR office. See below for more information on telephonic AR agreements and electronic signatures.

Authorized Representative relationships agreed to over the telephone

A verbal authorization is acceptable from the member for any Authorized Representative (AR). A three-way call will need to be completed between the member and AR to obtain and confirm the specific AR details. The information must be entered on the Authorized Representative or Legal Guardian Detail page during the call. After the AR information is entered into the eligibility system and the applicant and AR agree on the terms of authorization, it will remain in the system as an authentic and verified agreement unless/until the AR or applicant/recipient withdraws the authorization. AR details must be documented in case notes.

One-time call permissions

One-time only verbal authorizations are for that specific moment in time. AR should not be added to eligibility system and should only have access to information authorized by member. When a member is on the telephone, he or she may provide verbal authorization for anyone to act as the authorized representative for that individual call only. Subsequent phone calls will again require member's verbal permission for information to be shared.

Electronic signatures

Electronic signatures for authorized representative agreements will only be accepted if it is completed with the DocuSign, Adobe Acrobat, E-SIGN or UETA or other such official software. If the name is added in a script font in word-processing software such as Microsoft Word, this is not allowable. Electronic signatures submitted via email, faxed directly to the DFR office (rather than to the Document Center at 1-800-403-0864) or sent by other non-secured formats will not be accepted; however, if sent through the portal, mailed or faxed to the Document Center, or dropped off at the DFR local office, this is allowable.

The authorized representative must be familiar with the AG situation to represent them properly. The worker will determine if the authorized representative is representing the AG appropriately. If the applicant/recipient is failing to cooperate with the Authorized Representative, and the Authorized Representative is unable to obtain the required verifications needed to complete an eligibility determination, then contact should be made with the applicant/recipient to obtain verifications.

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.

2015.00.00 RESPONSIBILITIES OF THE APPLICANT/RECIPIENT

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

Each applicant will receive this information as part of the submitted application. When an application is completed over the phone, the Rights & Responsibilities must be read orally to the person completing the phone application. (An audio recording of the Rights and Responsibilities is acceptable.) This is only during the application process, not during a data gathering and/or redetermination interview.

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.⁵ They must supply required documents and records and must assist the DFR in obtaining verifications⁶, including proof of incapacity. Failure or refusal by an applicant to provide the DFR with information or verification of information required to determine eligibility will render the AG ineligible for assistance.⁷

If the individual is doing all that they can to cooperate in verifying the information, but are unable to do so, the DFR must 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 can 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 (MED 1)

A blind or disabled applicant or incapacitated recipient must undergo a medical examination necessary to establish categorical eligibility for MA.⁸

A blind, disabled, or incapacitated recipient must undergo subsequent medical examinations, if required, to establish continuing eligibility.⁹

2015.15.00 COOPERATE IN TREATMENT PLAN (MED 1)

The blind or disabled 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 Authorization Process. The goal of such treatment must be full or partial alleviation of his visual impairment, incapacity, or disability.¹⁰

Failure to cooperate in such plan without good cause will render the recipient ineligible for assistance.¹¹ "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
- Amputation of a major limb is involved.¹²

2015.20.00 REPORT CHANGES IN CIRCUMSTANCES

The applicant/recipient must report any changes in circumstances affecting Medicaid eligibility to the DFR within 10 days of the date on which the change occurred or became known to the recipient.¹³

AGs will be advised at the point of application in the Rights & Responsibilities of their responsibility to report changes. This provision is applicable at any time after submission of the application, regardless of whether it has been approved or not.

2020.00.00 APPLICATION TIME STANDARDS

Due to federal requirements, applications must be processed within specific time standards. The time allowed varies depending on whether the applicant is alleging a disability. 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.

2020.15.00 APPLICATION TIME STANDARDS (MED)

The DFR must determine eligibility within federally prescribed time standards and must so inform each applicant both verbally and in writing at time of application. Notification to applicant may also be electronic. These time standards include the following:¹⁴

- 45 days for all MA categories except the Disabled categories (MA D and MADW), which is 90 days. ¹⁵

- The time standard covers the period from the date of application to the date the eligibility notice is mailed.¹⁶

The DFR must not utilize the time standard as a waiting period before granting MA. Additionally, the fact that a case is going to spend beyond the time standard cannot be used as the basis for denying the application.¹⁷

2020.20.00 APPLICATION PROCESSING DELAY

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

2020.20.10 EXCEPTIONS TO APPLICATION TIME STANDARDS

Every effort must be made by the DFR to process all applications within the time standards. If an application pends beyond the time standard, the reason must be clearly documented in the case notes. Reasons are as follows:

- Awaiting documentation of life insurance cash value from life insurance company.
- Awaiting medical or visual information from the examining physician.
- Receipt of hearing decision .

2025.00.00 VERIFICATION

To determine eligibility for assistance, the DFR is required to verify information to support the eligibility determination process such as:

- Non-financial factors of eligibility
- Resources
- Income
- 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 DFR must have adequate 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 worker 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:

- Electronically (if an interface or data exchange is available)
- Telephone contact
- Personal contact (including home visits)
- 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.

Case Notes 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
- The information obtained from the contact.

This entry in Case Notes should be in sufficient detail to support the determination of eligibility or ineligibility.

2025.05.05 VERIFICATION OF QUESTIONABLE INFORMATION

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
- Information available to the worker.

When determining if the information is questionable, the worker will base the decision on the circumstances of the AG. Further verifications may be necessary if any of 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
- Information has been received that there are 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 AG's 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 category cannot be terminated solely because benefits under another category are terminated.

Note: All written and attested statements must include a signature, date, and give specific monetary/frequency terms of actual/anticipated projections of income and or resources when applicable (Refer to 2025.05.00 and 2025.10.05).

For example: My husband earns \$500/month, or I have \$50.00 in cash on hand. This information will need to be provided for applicants/household members. The worker must document the reason for the signed statement.

If there is question as to whether a submission or statement is sufficient, send to PAL for review before taking an adverse action on the case.

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 necessary to obtain the information being sought. Disclosure that the AG has applied for or is receiving Medicaid should not occur.

2025.10.00 RESPONSIBILITY FOR OBTAINING VERIFICATION

The applicant or authorized representative has the responsibility for providing adequate data to substantiate the request for assistance.

The applicant or authorized representative is not required to present evidence in person at the DFR. The evidence may be supplied in person, through the mail, by facsimile or other electronic devices as listed in IHCPPM 2025.05.00. Some information may be obtained electronically through interfaces or other databases as specified in the State's Verification Plan.

Assistance in Obtaining Verifications: 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 worker must help. This assistance includes collateral contacts, faxing the signed Authorization for Release of Financial Information to the financial institution (State Form 53677/FI 0014) or sending the signed Request for Earnings Information (State Form 54092/DFR 0065) to the employer.

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

the statements on the application. When neither the worker nor the applicant/recipient can secure the necessary documentation, the applicant/recipient's written statement may be acceptable information, except for certain eligibility factors (Refer to 2025.10.05).

Note: This does not apply when an applicant/recipient is failing to cooperate with the Authorized Representative or third party in securing required documentation. In these cases, the worker must reach out to the applicant/recipient to determine whether the applicant/recipient has attempted to cooperate with obtaining verifications and needs assistance. An Authorized Representative's statement that they cannot obtain the verifications from their client cannot stand in for the required documentation.

Special Circumstances Requiring Flexibility¹⁸: 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.

Similarly, members who are homeless or have experienced a natural disaster should be allowed to self-attest when documentation does not exist at the time of application or renewal or is not reasonably available to them.

Because members who are in treatment for Substance Abuse Disorder (SUD) are at very high risk for relapse if they lose their medical coverage, workers should be especially sensitive to the challenges these members face in obtaining documentation and make every effort to work with the member and accept client attestation when it is the best available information.

If there is question as to whether a submission or statement is sufficient, send to PAL for review before taking an adverse action on the case.

2025.10.05 Client Attestation and Written Statements

When all reasonable attempts have been made but neither the worker nor the applicant/recipient can secure the necessary documentation, the applicant/recipient's signed statement is to be acceptable information. The signed statement will serve as documentation of why DFR took action and is protected for future audits. The document could also be used for possible investigations if the attestation is later found to be questionable.

Client Attestation cannot be used for any or all the following:

1. Citizenship status
2. Social Security number
3. Valid exception to applying for SSN (i.e., when client's stated SSN is not verified by data match, or when proof of application or for SSN is not provided for an applicant/member who is not a newborn).
4. Legal documentation that includes but limited to trusts, wills, court orders, or contracts.
5. Disability status
6. Waiver approvals

A written statement must be submitted to the DFR detailing what steps were taken to gather the required documents. The statement must include the applicant or member's best estimate of the information that was requested (for example, an estimate of income received or when the income ended). The statement must be dated and signed by the applicant/recipient or authorized representative. All written and attested statements must include a signature, date, and give specific monetary/frequency terms of actual/anticipated projections of income and or resources when applicable. For example: My husband earns \$500/month, or I have \$50.00 in cash on hand. This information will need to be provided for applicants/household members. The worker must document the reason for the signed statement.

Note: This does not apply when an applicant/recipient is failing to cooperate with the Authorized Representative or third party in securing required documentation. In these cases, the worker must reach out to the applicant/recipient to determine whether the applicant/recipient has attempted to cooperate with obtaining verifications and needs assistance. An Authorized Representative's statement that they cannot obtain the verifications from their client cannot stand in for the required documentation.

If there is question as to whether a submission or statement is sufficient, send to PAL for review before taking an adverse action on the case.

2025.15.00 REQUESTS FOR INFORMATION

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

- A written list of specific information required to complete the application process
- The date the information is due.
- Information on the consequences of not returning additional information by the due date.¹⁹

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 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 worker 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. However, any delay may affect potential benefits.

The worker must 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. IEDSS will not automatically generate this notice.

If there is electronic data available from the federal data services hub or other electronic resources, the worker must first use the available electronic data before requesting additional information from the individual.

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, the AG must be notified and given 13 calendar days to comply with the request.

For all, 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.

Effective June 1, 2014, applicants stating they are disabled will be required to apply for disability benefits through the Social Security Administration (SSA) within 45 days after the 2032 is sent, unless the disabled applicant is under 18 years of age or for another acceptable reason. Please, refer to IHCPPM 2404.00.00 and IHCPPM 2432.00.00. MRT will determine disability for children who are disabled unless SSA has already made such a determination.

2030.00.00 PROVIDING INFORMATION TO THE APPLICANT/RECIPIENT OR PARENT OF APPLICANT/RECIPIENT

Applicants will receive Rights & Responsibilities when submitting a Medicaid application, and annually at each successful redetermination. If at any time an applicant or member or their Authorized Representative requests that the Rights & Responsibilities be mailed to them, or read to them, the worker should do so at the time of such request.

The following are helpful items that the worker should be prepared to verbally explain to each Medicaid interviewee if they ask for this information. At a minimum, workers should conclude an interview by informing the interviewee of the next steps to be taken by both the applicant/member and the DFR.

- That the AG will receive written notices stating the actions that must be taken to stay eligible. (If the AG cannot comply, the client should call before the deadline to explain the reason.)
- All eligibility factors pertaining to the Medicaid categories which have been chosen
- That there is an Appeals and Hearings process available
- The applicant's Rights & Responsibilities are outlined within the Indiana Application for Health Coverage and can be mailed again if requested
- The fact that the application will be processed for the category with the most benefits that the individual may be eligible to receive
- 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 applicable timeline standards to determine eligibility for the application
- That if the AG disagrees with any action taken by the DFR, 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
- The fact that the individual may withdraw their application at any time during the application process or request that his assistance be discontinued.

2030.10.00 PROVIDING INFORMATION TO APPLICANTS

The following information must be provided:

- If an applicant 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. Also, coverage under MA L cannot begin any month earlier than the month of application.
- 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 or²⁰, if he is in a managed care category, he must select a health plan.
- 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 MEDWorks 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.
- 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.

2035.10.00 REASONABLE COMPATIBILITY OF INCOME (MED 3)

Reasonable compatibility standard will be used to address situations where an applicant/recipient's self-attested information and electronic sources of information are inconsistent.²¹

Self-Attested Income	Income Obtained from the Work Number or other electronic sources	Worker Action
Below the Standard	Below the standard	Use the reported income. No further proof is needed.
Below the standard	Above the standard	Refer to the Reasonable Compatibility section below.
Above the standard	Below or above the standard	Use the reported income. No further proof is needed.

Note: below is applicable at any time, including application, redetermination, reported change, etc.

- If an individual attests to income below the Medicaid or S-CHIP applicable income standard and if electronic data on income is unavailable, further documentation will be required from the applicant.
- If an individual attests to income above the Medicaid or S-CHIP applicable income standard and the electronic data indicates income below the applicable income threshold, the individual is determined ineligible with no additional information sought. The individual is screened for eligibility for other insurance affordability programs.
- If an individual attests to income below the Medicaid or S-CHIP applicable income standard and the electronic data indicates income above the applicable standard, documentation will be required from the applicant to resolve. In this situation, the worker needs to send a Pending Verifications for Applicants/Recipients (DFR Form 2032) to the client to verify the income before the case is closed/denied.
- If the difference between what an individual attests to and the electronic data results in a different category or cost-sharing amount, documentation will be required from the applicant to resolve.

Refer to Chapter 3000 for the applicable MED 3 income standards for everyone.

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. A "yes" should be entered on the drop-down menu for Pre-Admission Screening field on the Facility Details page in the Eligibility system. The date is either the date the screening was initiated, if known, or the date the individual entered the facility.

The DFR will not receive a copy of the Form 450B (Physician Certification for Long Term Care Services) when the level of care determination is made. DFR 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 worker, the information on Facility -Details page 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 18 years of age who are being considered for Home and Community-Based Services (HCBS). 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 for those retroactive months. As each screen is completed, the questions will relate to the situation of the child only, if retroactive coverage is not desired.

2035.30.00 DETERMINATION OF MEDICAL CATEGORY (MED)

In the absence of a stated preference by the applicant²², Eligibility System 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 worker on Program Request Summary screen. 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 MEDWorks.

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. Workers must ensure that the applicant is in fact eligible for 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 1620.72.00 and 2035.30.10 regarding MA10 determinations, and to Section 2035.30.05 which explains the special considerations for MA 9, children aged 1 – 19.

- MA SI SSI Recipient – full coverage, HCC or FFS

- MA X Newborn – HHW Package A, full coverage
- MA Y Children under age one - HHW Package A, full coverage.
- MA Z Children aged one through five - HHW Package A, full coverage
- MA 2 Children aged 6 through 18 - HHW Package A, full coverage
- MAGF Parent/Caretaker and Refugee Parent/Caretaker -FFS, full coverage
- MA F Transitional Medical Assistance (TMA) - HHW Package A, full coverage
- MAMA Pregnant women – HIP Maternity, full coverage
- MAGP Pregnant women - HHW Package A, full coverage
- MA O Children aged 19-21 residing in inpatient psychiatric facilities – full coverage, FFS
- MA 15 Former Foster Care ages 18 through 25 – full coverage, HCC or FFS
- MA 9 Children aged one through 18 - HHW Package A, full coverage
- MA R RCAP related - full coverage, HCC or FFS
- MA A Aged - full coverage, HCC or FFS
- MA B Blind - full coverage, FFS
- MA D Disabled – full coverage, HCC or FFS
- MADW MEDWorks, Basic category – Medicaid for Employees with Disabilities; full coverage, HCC or FFS
- MADI MEDWorks, medically improved category – Medicaid for Employees with Disabilities - full coverage, HCC or FFS
- MA Q Refugee Medical Assistance (RMA) - full coverage, FFS
- MA L Qualified Medicare Beneficiary (QMB) - limited coverage
- MA J Specified Low-Income Medicare Beneficiary (SLMB) – limited coverage
- MA I Qualified Individual (QI) – limited coverage
- MA G Qualified Disabled Working (QDW) - limited coverage
- MA10 Children birth through 18; HHW Package C, comprehensive coverage, some services subject to limits
- MA E Family Planning Services for Women and Men – limited coverage, FFS.

2035.30.05 DETERMINATION OF MA 9 CATEGORY (MED 3)

This category, established effective July 1, 1998, includes 141% - 158% of the Federal Poverty Level, and children aged 6 through 18 with income between 106% - 158% of the poverty level.²³ 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 aging from birth through the age of 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 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 is applicable to MA 10. Refer to the previous section, 2035.30.05.

2035.30.15 DETERMINATION OF MEDWorks 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 their total countable income or resources exceed the MA D limits listed in Chapter 3000, they will then be considered for eligibility in MEDWorks. MADW is considered first.

An applicant for Medicaid cannot be approved initially in MADI.

If the Medical Review Team or the Social Security Administration determines that an MADW recipient is no longer disabled due to a medical improvement in his condition, MRT will

determine whether the improvement does not constitute a full medical recovery. If there is not a full medical recovery, such individual will be determined for MADI categorical eligibility.

2035.30.20 DETERMINATION OF MA 14 CATEGORY (MED 3)

Note: Effective 1/1/23, Former foster care children enrolled in Medicaid (any state) on their 18th birthday will transition to MA 15 (Refer to 1620.74.00 and 2035.30.25).

2035.30.25 DETERMINATION OF MA 15 CATEGORY (MED 3)

This category includes individuals who were in Foster Care and enrolled in Medicaid (any state) upon attaining age 18 and who are less than 26 years of age.

This category is open to former foster care individuals who are Indiana residents and are not enrolled in another category of Medicaid. There is no income or asset test, and annual redeterminations are not required. Members who meet eligibility requirements and are receiving benefits in another full coverage category, can continue to receive Medicaid under existing category, but a new applicant or a person who is not currently passing in another category, can go directly to MA 15 (if eligible) without requiring an eligibility determination for any other category.

Note: The category of MA 14 for former foster children from states other than Indiana, which included an income test and covered individuals aged 18 – 21, will be phased out as of January 1, 2023, and eligible individuals will instead be covered under MA 15 rules.

2035.30.30 DETERMINATION OF MA E (MED 3)

A person must request that he or she wishes to receive family planning services for an eligibility determination under this category. Services under this category are limited to those related to family planning. Pregnant women who deliver or whose pregnancy is terminated will automatically be considered for MA E if not eligible for another category.

2035.31.00 DESIGNATION OF THE PACKAGE C PREMIUM PAYER

When an Indiana Application for Health Coverage is filed, 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 application and months through the month of authorization are premium-free. The children will be enrolled when the premium has been paid.

When processing the MA 10 application, the DFR worker must complete an off-line calculation to determine if the child would be eligible for retro Medicaid coverage in another category. Refer to Chapter 3405.00.00 on how to process retro benefits for a MAGI case.

It is not necessary to request retro income unless there is a significant change in income. If the child is found to be eligible for retro coverage, then the worker should open the category for those retro months and fully document what was completed in the case notes.

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.

If the individual is discontinued for nonpayment of premiums, then that individual may enter a lockout period up to 90 days in which the individual cannot be eligible for CHIP. The individual, however, may pay back all outstanding premiums during the lockout period which will allow for the Client to be eligible again for the MA10 Program and not have to serve the full 90 days. In this case the lockout period ends upon receipt of the outstanding premium payments. Once the Client is eligible again a new application needs to be submitted to be reopened.

If the individual does not make payment of the outstanding premium balance before the end of the lockout period, then the individual must re-apply for MA10 once the lockout period ends. If the individual re-applies after the lockout period ends the individual is not required to pay the previously owed premiums.

2035.33.00 DESIGNATION OF MED WORKS PREMIUM PAYER ENROLLMENT PROCESS

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

- Applicant/recipient aged 18 and older
- Mother of applicant/recipient under age 18
- Father of applicant/recipient under age 18

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 MEDWorks, 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 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 AG to be ineligible. However, if, during the eligibility study the worker verifies that other requirements are not met; all reasons for denial must be entered on the Eligibility Determination Results page

2035.40.00 AUTHORIZATION

An AG must be authorized when all required eligibility information is documented, and the determination of eligibility is complete. Please note the exception in section 2035.40.05. 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 worker should carefully review all data and the case eligibility results for accuracy. This involves reviewing every retroactive month as well as the recurring month.

2035.40.05 AUTHORIZING WHEN CITIZENSHIP OR IMMIGRATION STATUS IS NOT VERIFIED

If a person would be determined otherwise eligible for Medicaid under any category due to meeting all verification requirements of Medicaid, except for the verification of either citizenship or qualified immigration status, then the person must be determined eligible for Medicaid. Please refer to IHCPPM 2402.20.00 for individuals declaring to be immigrants.

Persons who do not have citizenship or qualified immigration status verified promptly by the DFR through an electronic match or by other means but can otherwise be determined eligible are given 95 days from intake date to provide proof of citizenship or qualified immigration status. The system will automatically generate a notice of Reasonable Opportunity if electronic interface verification for citizenship fails. Additionally, the Notification of Requirement to Provide Documentation of Citizenship” (FI 2326 or FI 2326 S, the Spanish version) should be completed and mailed. For more information including due dates, see IHCPPM 2402.15.10.

If such person has not verified citizenship or qualified immigration status after 95 days, the person is to be discontinued from eligibility, with the exception being a child in a CE period.

If a person who received appropriate notices reapplies after being denied for not verifying citizenship during their Reasonable Opportunity Period, they will only get 13 days to verify citizenship a second time. During that second time, the case will need to remain pending until citizenship is verified. Refer to IHCPPM 2402.15.10 regarding what documents can be used to verify citizenship.

Note: For individuals who state they are not qualified immigrants or that they are undocumented, do not require more documentation of their immigration status. No 95-day Reasonable Opportunity Period applies to individuals who are not attesting to a qualified immigration status. Client statement is all that is needed and if passing, Medicaid can be authorized as Emergency Services Only.

2035.60.00 EFFECTIVE DATE (MED 1, 2, 3)

See 1825.15.00 regarding the date of the application.

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.

This provision for retroactive coverage also applies to individuals who were deceased at the time of application.²⁴ For Hoosier Healthwise Benefit Package C, the effective date can be no earlier than the first day of the month of application.

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.

SSI recipients are automatically eligible upon receipt of SSI. SSI recipients can obtain three months of retroactive eligibility from the date verification is received by the DFR (including data exchange or award letter). For ongoing members in another category, change processing rules apply (see 2220.05.00).

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. *See 1825.15.00 regarding the date of the application.*

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. *See 1825.15.00 regarding the date of the 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. *See 1825.15.00 regarding the date of the application.*

2035.80.00 EFFECTIVE DATE OF QI MEDICAID (MED 4)

The effective date of QI (MA I) 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. *See 1825.15.00 regarding the date of the application.*

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 discontinuance, it is appropriate to rescind the adverse action rather than to require a reapplication.

If assistance was discontinued at the point of redetermination for failure to provide required information, the person will not be required to submit a new application if the Medicaid mailer and/or the missing information is provided within 90 days from the effective date of discontinuance. Further, eligibility should extend back to the date of discontinuance. Refer to IHCPM 2238.25.00.

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 DFR is to take adjusting action as directed in the decision. If the DFR action is sustained, the reapplication is to be processed in the usual manner. The DFR 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)

On January 1, 2010, in accordance with the Medicare Improvements for Patients and Provider Act of 2008 (MIPPA – P.L. 110-275), the SSA began 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.²⁴ IEDSS 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 for the LIS/MSP applications that come from Social Security, but the MSP/paper applications require an interview.

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 match date that the file is received by IEDSS. The application date is the date the applicant applies for LIS through SSA. Retroactive eligibility is determined from the application date.

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. The This application was processed within the allowable time standard as it was authorized within 45 days of the date that the LIS/MSP match 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 match was received.

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

There are three possible LIS decision types: adjudicated LIS denial, non-adjudicated LIS denial, and LIS approval.

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 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 more than 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 DFR 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 BENDEX 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 two 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 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 (State Form 54211), 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 of 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. This would not affect the person’s eligibility, however, if not provided.

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.

¹ 405 IAC 2-1-2

⁵ 405 IAC 2-1-2

⁶ 42 CFR §435.923(f))

⁷ 405 IAC 2-1-2

⁵ 470 IAC 2.1.-1-2

⁶ 470 IAC 2.1.-1-2

⁷ 470 IAC 2.1.-1-2

⁸ 470 IAC 2.1.-1-2

⁹ 470 IAC 2.1.-1-2

¹⁰ 470 IAC 2.1.-1-2

¹¹ 470 IAC 2.1.-1-2

¹² 470 IAC 2.1.-1-2

¹³ 470 IAC 2.1.-1-2

¹⁴ 42 CFR 435.911

¹⁵ 42 CFR 435.912

¹⁶ 42 CFR 435.911

¹⁷ 42 CFR 435.911

¹⁸ 42 CFR 435.952

¹⁹ 470 IAC 2.1.-1-2

²⁰ 405 IAC 1-1-2; SSA 1902(a)(23); 42 CFR 431.51

²¹ 42 CFR §435.603

²² 42 CFR 435.404

²³ Title XXI of the Social Security Act

²⁴ SSA 1144(c)(3)