Examples

Expired PAS Example: Mr. Birch is a patient in a hospital. The physician recommends nursing facility care to Mr. Birch's family and completes a PAS dated June 5, 2016. The family is undecided about placing Mr. Birch in a nursing facility and takes him home to provide care. They do not apply for Medicaid until August 16, 2016, which is the date Mr. Birch enters the nursing facility. Medicaid eligibility is established beginning August 1, 2016. The original PAS has expired. A new PAS is not completed until August 22, 2016. The Worker can request the physician's notes to verify Mr. Birch's medical necessity from August 16, 2016, through August 22, 2016. Medicaid nursing care payments begin August 16, 2016 using physician's notes.

Delayed Entry Example: Same situation as above except that the PAS is dated June 25, 2016. A new PAS is not required, but nursing facility payments cannot begin until August 16, 2016, which is the date Mr. Birch entered the nursing facility.

Excess Assets Example: Ms. Dahlia enters a nursing facility on August 16, 2016, and the PAS is signed August 16, 2016. However, she does not become Medicaid eligible until September 1, 2016, due to excess assets. Payment for nursing facility services begins September 1, 2016.

Backdating Example: Mr. Pine enters a nursing facility on October 10, 2016, and a PAS is signed on that date. On November 25, 2016, his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to August 1, 2016, to cover the cost of his recent hospitalization. Payment for nursing facility services begins on October 10, 2016.

24.4.1.C.11 The Benefit

A Medicaid Medical ID card is issued for each eligible individual.

Ongoing Benefits

Each January, Medicaid clients will receive one Medicaid card per case.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.
Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

➤ Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

24.4.2 REDETERMINATION PROCESS

Redeterminations are completed once a year annually, and no interview is required. The Worker receives an alert in the eligibility system when a redetermination is due. The eligibility system alerts the Worker when a redetermination is due and automatically sends a redetermination form to the client.

The redetermination is completed with the individual who is responsible for handling the client's affairs may be completed by the client or his authorized representative.

24.4.3 SPECIAL CONSIDERATIONS FOR THE AUTHORIZED REPRESENTATIVE DUE TO RESIDENCY

SPECIAL PROCEDURES RELATED TO APPLICATION AND REDETERMINATION PROCESSING

24.4.3.A Authorized Representative Resides in Another State

If the authorized representative does not reside within the state of West Virginia, a nursing facility staff member who has knowledge of the client's financial circumstances may choose to be interviewed.
If the authorized representative does not reside within the state of West Virginia, he may submit any required documentation electronically, or by mail, to the appropriate Worker in the appropriate county office. The authorized representative may also ask a nursing facility staff member who has knowledge of the client's financial circumstances to communicate with the Department and submit documentation on the client's behalf. However, applications and redeterminations must still be signed by the applicant, the spouse or the authorized representative.

24.4.3.B Authorized Representative Resides in Another County

Every effort must be made to accommodate an authorized representative who chooses to complete the interview. When the authorized representative to be interviewed resides in another county, the interview may be conducted in the office of the county in which he resides, at the nursing facility or in the office of the county in which the nursing facility is located. When the office in the county in which he lives agrees to conduct the interview, the procedure is as follows:

- The Worker must send an email to the county office in which the authorized representative lives. The following information is included:
  - The month the redetermination is due;
  - The amounts and sources of the patient’s income as shown in the case record;
  - The amount of the client’s resource and his total contribution;
  - Type and amount of the client’s assets; and,
  - Amount of the Community Spouse Maintenance Allowance (CSMA) and Family Maintenance Allowance (FMA) determined as part of the post-eligibility process.

- The Worker who receives the information completes the interview with the authorized representative if applicable, and obtains required verification. He must explore all financial aspects of the case. See Section 24.5 and Section 24.6.

- When the Application for Benefits (DFA-2) or Application for Long Term Care Medicaid and Children with Disabilities Community Service Program (DFA-MA-1) is completed, the Worker in the county in which the authorized representative resides records all pertinent information and returns the form to the originating county.

- The Worker in the originating county completes the redetermination. If the client is no longer eligible for Medicaid, the case is closed. If the client remains eligible for nursing care services, the eligibility system is changed to reflect current circumstances and the appropriate notification is sent.
When the authorized representative resides in another county, he may submit any required documentation electronically, or by mail, to the Worker in the county responsible for the case. The authorized representative may also choose to communicate with and submit documentation to the Department in his own county of residence. In this situation, the county receiving the documentation should forward it securely to the county responsible for the case the same day it is received.

24.4.3.C Correct County of Residence for Nursing Facility Applicants

Nursing facility residents are considered to reside in the county where the nursing facility is located. However, there may be instances when the client applies before entering the nursing facility.

The county in which the individual resides on the date of application will accept responsibility for processing the application.

- When the applicant resides in a nursing facility at the time of application, the county where the facility is located accepts responsibility for processing the application.

- When the applicant still resides in their home county at the time of application, the current county of residence accepts responsibility for processing the application. Once eligibility has been determined, the case and record should be transferred to the county of the nursing facility.

The county responsible for the application responds to all inquiries related to the application until an eligibility decision is determined. Once the application process is complete and eligibility is determined, the case is housed in the county of the nursing facility.
24.8.2.C  Transfers That Are Not Permissible

All transfers not specified as permissible result in an application of a penalty. This also applies to jointly-owned resources. The jointly-owned resource, or the affected portion of it, is considered transferred by the client when any action is taken, either by the client or any other person, which reduces or eliminates the client's ownership or control of the resource.

24.8.2.D  Transfers Related to a Life Estate

24.8.2.D.1  Transfer of Property with Retention of a Life Estate

A transfer of property with the retention of a life estate interest is treated as an uncompensated transfer.

To determine if a penalty is assessed and the length of the penalty, the Worker must compute the value of the transferred property and of the life estate, then calculate the difference between the two.

Step 1:  To determine the value of the transferred property, subtract any loans, mortgages or other encumbrances from the fair market value (FMV) of the transferred property.

Step 2:  Determine the age of the life estate holder as of his last birthday and the life estate factor for that age found in Chapter 5, Appendix A. Multiply the FMV of the transferred property by the life estate factor. This is the value of the life estate.

Step 3:  Subtract the Step 2 amount from the Step 1 amount. The result is the uncompensated value of the transfer.

Step 4:  Divide the Step 3 amount by the State's average monthly nursing facility private pay rate of $6,789. The result is the length of the penalty.

NOTE: The value of a life estate may be excluded as a homestead property, if the individual intends to return to it.
24.8.2.E.1 Annuity-Related Transfers

NOTE: When an individual is approved for LTC Medicaid and has an excluded annuity described below, for which Medicaid must be the beneficiary, the Worker must securely forward a copy of the trust document and the Medicaid recipient’s name, case number, and name of the recipient’s Power of Attorney or legal representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Chapter 24, Appendix E.

Institutional Spouse is Annuitant

An annuitant is defined as a person who receives an annuity.

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

- The individual disclosed to the State any interest the individual or his spouse has in any annuity;
- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant/client or spouse;
- The annuity was purchased by or on behalf of the individual and one of the three following situations applies:
  1. The annuity is considered either:
     - An individual retirement annuity (according to Section 408 (b) of the Internal Revenue Code of 1986 (IRC); or
     - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408§ of the IRC).
   OR
  2. The annuity is purchased with proceeds from one of the following:
     - A traditional IRA [IRC Section 408 § (a)]; or
     - Certain account or trusts which are treated as traditional IRAs [IRC Section 408§(c)]; or
     - A simplified retirement account [IRC Section 408 § (p)]; or
24.8.2.H Treatment of Transfer of a Stream of Income or Right to a Stream of Income

When the client fails to take action necessary to receive income or transfers the right to receive income to someone else for less than CMV, the transfer of resources penalty is applied. The Worker must follow the steps described below.

Step 1: Verify the amount of potential annual income.

Step 2: Using the client’s age as of his last birthday, determine the Remainder Interest Value in Appendix A.

Step 3: Multiply the Step 2 amount by the Step 1 amount to determine the uncompensated value.

Step 4: Divide the Step 3 amount by the average monthly nursing facility private pay rate of $6,789 to determine the penalty period.

NOTE: A partial month’s penalty is imposed for the transfer of an individual or single income payment that is less than the monthly nursing facility private pay rate. See Transfer Penalty Section below for instructions about how to determine and apply partial month penalties.

24.8.2.I Treatment of Jointly-Owned Resources

Jointly-owned resources include resources held by an individual in common with at least one other person by joint tenancy, tenancy in common, joint ownership or any similar arrangement. Such a resource is considered to be transferred by the individual when any action is taken, either by the individual or any other person that reduces or eliminates the individual’s ownership or control of the asset.

Under this policy, merely placing another person’s name on an account or resource as a joint owner might not constitute a transfer of resources, depending upon the specific circumstances involved. In such a situation, the client may still possess ownership rights to the account or resource and, thus, have the right to withdraw all of the funds at any time. The account, then, still belongs to the client. However, actual withdrawal of funds from the account, or removal of all or part of the resource by another person, removes the funds or property from the control of the client, and, thus, is a transfer of resources. In addition, if placing another person’s name on the account or resource actually limits the client’s right to sell or otherwise dispose of it, the addition of the name constitutes a transfer of resources.
**Penalty for Transfers during the Look-Back Period Examples**

**Example 1:** Mr. Ivy enters the nursing facility and applies for Medicaid in July 2017. The individual transferred $50,000 in April 2016. Based on the average private pay nursing facility rate of $6,789 a month, the penalty is seven whole months, beginning July 2017 when Mr. Ivy was otherwise eligible for and receiving an institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month’s penalty of $2,477 is imposed for February 2018. Mr. Ivy is required to pay this amount to the nursing facility, in addition to the calculated monthly contribution. See Length of Penalty below.

**Example 1.1:** Same situation as above, but during the penalty period the Worker discovers an additional, undisclosed transfer that occurred during the look-back period. The penalty period is recalculated to include the undisclosed transfer of resources.

**Example 2:** Ms. Fern enters a nursing facility in January 2017 and applies for Medicaid in September 2017 with a request for backdated coverage to August 2017. Ms. Fern transferred $19,000 in January 2016, $19,000 in February 2016 and $19,000 in March 2016. The Worker must calculate the penalty period by adding the transfers together. The total of $57,000 is divided by the nursing facility cost of $6,789. The penalty period is eight whole months, beginning in August 2017, because the individual requested backdated coverage to August 2017, and was otherwise eligible for and receiving institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month’s penalty for April 2018 of $2,688 is also imposed. Ms. Fern is required to pay this to the nursing facility, in addition to his calculated monthly contribution. See Length of Penalty below for partial month penalties.

**Example 2.1:** Same situation as above, but after the penalty period ends and Ms. Fern is receiving Medicaid, the Worker discovers an undisclosed transfer occurred during the look-back period. A penalty is assessed and advance notice of an additional transfer penalty is sent to Ms. Fern.

**Transfers During a Penalty Period**

When an individual is in a penalty period and transfers additional resources during the penalty, a new penalty period begins as soon as the previous penalty ends.

All penalties for resources transferred on or after March 1, 2009 run consecutively.
**Transfers During a Penalty Period Examples**

**Example 1:** Mr. Oak transfers $70,000 and is serving a 10-month penalty beginning July 2017 through April 2018 with a partial month's penalty of $2,110 for May 2018. In October 2017, Mr. Oak receives an inheritance of $6,800 which he gives to a nephew. There is an assessed penalty of one whole month and a partial month's penalty of $11. The new penalty begins June 2018.

**Example 2:** Ms. Orchid, approved for and receiving institutional level of care services, receives an inheritance of $100,000 in 2017 and gives the money to her grandson. Advance notice of the transfer penalty is sent in November and the penalty period begins December 1, 2017.

---

**24.8.2.J.2 Length of Penalty**

There is no maximum or minimum number of months a penalty may be applied. The penalty runs continuously from the first day of the penalty period, whether or not the client leaves the institution.

A partial penalty or extra payment is only applied in the last/partial month of the penalty period. The penalty period lasts for the number of whole and/or partial months determined by the following calculation:

- Total amount transferred during the look-back period divided by the State's average, monthly nursing facility private pay rate of $226.29 per day or $6,789 per month.

- When the amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a dollar amount and added to the individual's calculated contribution to his cost of nursing facility care for his first month of eligibility.

The partial month's penalty is determined as follows:

**Step 1:** The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $6,789.

**Step 2:** Multiple the number of whole months from Step 1 by the average private pay rate of $6,789.

**Step 3:** Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount which is added to the individual's calculated contribution.
Penalty Calculation Example: Mr. Cactus makes an uncompensated transfer of $24,534 in the month of application for Medicaid coverage of nursing facility services.

Step 1: $24,534  
$6,789  
\[ \div \]  
3.6  
Number of months for penalty period

Step 2: $6,789  
\[ \times \] 3  
Whole months in penalty period

$20,367

Step 3: $24,534  
\[ \text{-} \] $20,367  
$4,167  
Partial month’s penalty amount

If Mr. Cactus applies in July and is otherwise eligible, the penalty period runs for three full months from July through September, with a partial month’s penalty calculated for October of $4,167. The October partial month’s penalty amount of $4,167 is added to the calculated October contribution for his cost of care. If Mr. Cactus had a $500 monthly contribution, he would be required to pay $4,667 for the cost of care in October.

24.8.2.J.3  Who is Affected by the Penalty

The institutionalized client is affected by any transfer described above when he or his spouse or any entity acting on their behalf or at their direction transfers an asset.

When the three following conditions are met, any remaining penalty period is divided equally between the institutionalized person and spouse:

- The spouse transferred resources which resulted in ineligibility for the institutionalized client;
- The spouse either is eligible for or applies for Medicaid and is, then, an institutionalized individual; and,
- Some portion of the penalty against the original institutionalized spouse remains when the above conditions are met.

If the penalty period is not equally divisible, the extra month in the penalty period is assigned to the spouse who actually transferred the resource.
24.13 SPECIAL PROCEDURES RELATED TO COVERAGE GROUPS

Individuals already receiving full coverage Modified Adjusted Gross Income (MAGI) Medicaid, who become eligible for Medicaid payment of nursing facility services, must be dually coded in the data system as receiving nursing home coverage.

24.13.1 SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

The Worker must notify the Social Security Administration (SSA) using the DFA-HS-3 when the SSI recipient enters or leaves a nursing facility.

When the institutionalized SSI recipient has an Essential Spouse (See Chapter 23) who is included in the assistance group (AG) and who appears on the same Medicaid Medical ID card, the Essential Spouse remains eligible for SSI Medicaid, unless the State Data Exchange (SDX) information indicates the SSI is terminated. The Worker must use appropriate procedures to provide Medicaid to the nursing facility client and the Essential Spouse.

24.13.2 DEEMED SSI RECIPIENTS

Deemed SSI recipients can be Medicaid clients even though they do not receive SSI. When the Deemed SSI recipient enters a nursing facility and is eligible for payment for his care, his coverage group does not change.
Applicant Asset Transfer Example 2: Mr. Orchid, a 67-year-old man, applies for TBI waiver services in August 2016, but transferred cash from his bank account to his son in February 2017. Mr. Orchid is subject to a seven-month penalty. He never begins receiving waiver services because Medicaid never begins payment for these services due to the penalty. Mr. Orchid never entered a nursing home or equivalent institutional level of care, so the penalty period never began.

24.31.2 TRANSFER OF RESOURCES PENALTY FOR A CLIENT

When a waiver services client transfers resources without receiving fair compensation, a penalty is applied after advance notice. The penalty period is determined using the following procedure and lasts for the number of whole and/or partial months determined by the following calculation.

The total amount transferred during the look-back period is divided by the State's average monthly nursing facility private pay rate of $226.29 per day, or $6,789 per month.

When the remaining amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a number of days for which the individual is ineligible for payment for waiver services.

The partial month's penalty is determined as follows:

Step 1: The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $6,789.

Step 2: Multiply the number of whole months from Step 1 by the average private pay rate of $6,789.

Step 3: Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount used to determine the number of days the individual is ineligible for waiver services in the partial month of the penalty period.

Step 4: The Step 3 amount is divided by the average daily rate of $226.29 to determine the number of days of ineligibility in the last month of the penalty period.
24.31.2.A  Client Asset Transfer Examples

**Client Asset Transfer Example 1:** Mr. Alder makes an uncompensated transfer of $24,534 after approval for ADW services and Medicaid.

Step 1: $24,534  Uncompensated transfer amount

+$6,789  State's average monthly nursing facility pay rate

3.6  Number of months for penalty period

Step 2: $6,789  State's average monthly nursing facility private pay rate

x 3  Whole months in penalty period

$20,367

Step 3: $24,534  Total uncompensated transfer amount

-$20,367  Amount for three whole months in penalty period

$4,167  Partial month penalty amount

Step 4: $4,167

+$226.29  Average daily rate

18.41  Number of ineligible days for partial month

The partial penalty is imposed for the number of whole days only. If an ADW client transfers resources in July and advance notice is provided for August closure, the penalty period runs for three full months from August through October, with a partial month penalty of 18 days calculated for November. The individual becomes eligible for ADW on November 19 if he meets all other requirements.

**Client Transfer Example 2:** Ms. Ivy is receiving TBI services and transfers her home to her daughter without compensation in June 2016. The value of the home is $100,000. After advance notice, the penalty period is July 2016 through August 2017 for 14 whole months. A partial month penalty is calculated for September 2017, the 15th month, based on $4,954 remaining of the total penalty amount. $4,954 + $226.29 = 21.89 days of ineligibility in September 2017. Any fractional days are dropped and the length of the penalty is based on the number of whole days. If otherwise eligible, payment for TBI services is approved effective September 22, 2017.

**Client Transfer Example 3:** Mr. Juniper enters a nursing facility in October 2016 and applies for long term care services. He has a transfer penalty of 1.17
24.37.1.H The Benefit

A Medicaid card is issued for each eligible client. Each January, Medicaid clients will receive one Medicaid card per case. In situations where retroactive eligibility is established, the Medicaid card will be validated appropriately for each back-dated month.

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

ADW services will only be paid on or after the ADW approval date.

24.37.2 STEPS IN THE APPLICATION PROCESS

Steps in the application process are as follows.

24.37.2.A Step One: Receipt of the DHHR Referral Form for Medicaid Aged and Disabled Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM will originate from the ADW Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.

24.37.2.A.1 Expired Yellow DHS-2.FRM
and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.41.1.D Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. See Section 24.4 for more information on authorized representatives.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

24.41.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.41.1.F Application Processing Limits

Data system action to approve, deny, or withdraw the application must be taken within 30 days of the date of application.

24.41.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is the later of the following:

- The date of initial medical eligibility which is established by the BMS contract agency; or
- The date on which the applicant was approved for financial eligibility.

24.41.1.H The Benefit

A Medicaid card is issued for each eligible client. Each January, Medicaid clients will receive one Medicaid card per case. In situations where retroactive eligibility is established, the Medicaid card will be validated appropriately for each back-dated month.
Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

I/DD waiver services will only be paid on or after the I/DD waiver approval date.

NOTE: When the applicant’s eligibility for or enrollment in this program is pending he must not be refused the right to apply due to his pending status for the I/DD group, but must be evaluated for any or all Division of Family Assistance (DFA) programs.

---

24.41.2 REDETERMINATION PROCESS

I/DD cases are redetermined financially once a year. An interview is not required. The same financial criteria used at application applies at each annual redetermination.

The Worker receives an alert in the eligibility system when a redetermination is due. The Worker must manually schedule the redetermination for SSI and Deemed SSI I/DD waiver clients. SSI and Deemed SSI clients must complete the DFA-LTC-5 to complete an I/DD waiver redetermination.

Medical necessity must be verified annually at redetermination with a letter from the Utilization Management Contractor (UMC) stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the BMS.

Medicaid is continued when the case is in hearing status or an extension has been granted by the Office of I/DD Waiver Services in the BMS due to circumstances beyond the individual’s control.

Information about I/DD Waiver Services is found on the BMS website on the Office of Home and Community Based Services page. The I/DD Waiver application (WV-BMS-IDD-01) needed to determine medical eligibility can be found on the BMS website and on the DFA intranet forms page.
24.45.1.H The Benefit

A Medicaid card is issued for each eligible client. Each January, Medicaid clients will receive one Medicaid card per case. In situations where retroactive eligibility is established, the Medicaid card will be validated appropriately for each back-dated month.

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

TBI waiver services will only be paid on or after the TBI waiver approval date.

24.45.2 STEPS IN THE APPLICATION PROCESS

Steps in the application are as follows.

24.45.2.A Step One: Receipt of the DHHR Referral Form for Medicaid Traumatic Brain Injury Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

For Step One of the application process, the yellow DHS-2.FRM will originate from the TBI waiver Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.
received, and the client is eligible, medical coverage is retroactive to the time eligibility would have been established had the DHHR acted in a timely manner.

Reimbursement for out-of-pocket expenses may apply. See Chapter 10.

24.50.1.H PAYEE

The CDCSP child is the payee.

24.50.1.I EFFECTIVE DATES OF ELIGIBILITY

Eligibility is retroactive to the later of these two dates:

- The date of medical need, established by the BMS, and conveyed by memorandum to the CSM; or
- The date all eligibility requirements were met, up to three months prior to the application date.

Eligibility ends the last day of the effective calendar month of closure.

24.50.1.J THE BENEFIT

A Medicaid card is issued for each eligible client. Each January, Medicaid clients will receive one Medicaid card per case. In situations where retroactive eligibility is established, the Medicaid card will be validated appropriately for each back-dated month.

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.