October 17, 2025

GENERAL LETTER NO. 8-B-76

ISSUED BY: Bureau of Medicaid Eligibility Policy
Division of Community Access and Eligibility

SUBJECT: Employees' Manual, Title 8, Chapter B, **Medicaid Application Processing**, Title Page, Contents 1, pages 1-36, revised.

Summary

This chapter is revised to

- Change ABC to the correct system acronyms where appropriate
- Updated DHS to HHS
- Correct the spelling of non-MAGI throughout the chapter
- Update Division of Inspections and Appeals (DIA to their new name Division of Inspections, Appeals, and Licensing (DIAL) throughout the chapter
- Update Child Support Recovery Unit (CSRU) to their new name Child Support Services (CSS) throughout the chapter
- Update return mail policy
- Removed reference to cooperation with the Health Insurance Premium Payment (HIPP) program, since cooperation is no longer required with HIPP
- Updated Voter Registration section
- Removed requirement of acceptance of Other Income Benefits
- Update accessibility, style, formatting, and branding throughout.

Effective Date

October 15, 2025.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

Page	Date
Title Page	April 19, 2019
Contents 1	December 18, 2020
1-36	December 18, 2020

Additional Information

Refer questions about this general letter to your area eligibility determinations manager.

IOWA Health and Human Services

Employees' Manual
Title 8, Chapter B

Revised October 17, 2025

Medicaid
Application Processing

Page

Overview

This chapter explains the procedures for processing Medicaid applications. The mechanics of filing and handling applications are covered first, followed by interview and verification procedures. Timelines for processing applications and effective date of eligibility are given in the next sections.

The remaining pages of the chapter address eligibility for the retroactive period, referrals to Child Support Services (CSS) and representation.

Filing a Medicaid Application

Legal reference: 42 CFR 435.403, 435.906, 435.908, Iowa Code Section 249A.3, 441 IAC 76 (Rules in Process) and 86.3(2)

All people have the right to apply, without delay, for Medicaid for themselves or on behalf of another. Give an application to anyone who asks for one regardless of the person's county of residence. If the request is by mail or telephone, send the application in the next outgoing mail.

See **8-F, FMAP-Related Coverage Groups- Express-Lane Eligibility** for children under age 19 who are eligible without an application under the express-lane eligibility process.

An application for SSI benefits is automatically considered an application for Medicaid if SSI is approved. A denied SSI application is not considered a Medicaid application, and the filing date is not protected for Medicaid purposes. See Collecting Eligibility Information from SSI Recipients.

When requested, assist the applicant with completing an application. Applicants can authorize other people to represent them during the application process. Other people can also help the applicant during the application process.

An application may be filed on behalf of a deceased person. Eligibility is based on whether the person would have been eligible had application been made on or before the date of death and whether there are unpaid medical bills. However, eligibility cannot be established any earlier than three months before the month of application.

An application may be filed on behalf of a person temporarily out of the state. This situation usually happens when someone is visiting outside the state and has an accident or sudden illness. Apply all of Iowa's policies regarding application processing

and eligibility. See **8-C, Residency** for more information about determining when a client is a resident of Iowa.

Which Application Form to Use

Legal reference: 42 CFR 435.907, 435.909, 441 IAC 76 (Rules in Process)

Determine which of the following application forms to use based on the assistance the applicant is requesting:

Application Form	Who Should Use the Form
Application for Health Coverage and Help Paying Costs, forms **470-5170** or **470-5170(S)**	▪ Medicaid (MAGI-related and non-MAGI-related) ▪ Hawki (Children's Health Insurance Program or CHIP) ▪ Iowa Health and Wellness Plan (IHAWP) ▪ State Supplementary Assistance ▪ Help paying for health insurance costs ▪ Women who need treatment for breast or cervical cancer.
Application for Foster Care and Subsidized Adoption Medicaid, forms **470-5535** or **470-5535(S)**	A child in foster care or subsidized adoption

Application Referrals from and to the Federally Facilitated Marketplace (FFM)

Legal reference: 42 CFR 435.1200(d) and (e), Iowa Code Section 249A.4, 441 IAC 76 (Rules in Process) and 76.3

Electronic application referrals that the Federally Facilitated Marketplace (FFM) (also known as healthcare.gov) has screened as potentially Medicaid eligible must be accepted. Medicaid eligibility shall be determined based on the referral without requiring submission of another application.

When an applicant or member is determined to be ineligible for Medicaid but may be eligible for assistance at the FFM, the case shall be referred to the FFM for a determination of eligibility for financial assistance in paying for healthcare coverage.

Who Must Sign the Application

Legal reference: 42 CFR 435.907 and 435.909, 441 IAC 76 (Rules in Process) and 76.9

To be considered a valid application, an application must have the following:

- A legible name,
- An address, and
- A signature under penalty of perjury.

Before eligibility can be **approved**, the application form must be signed by:

- The applicant (including a child living independently), or
- An adult in the applicant's household or family, including:
  - A spouse,
  - A parent of an applicant child, including either parent of an unborn child,
  - A non-parental caretaker of an applicant child,
  - A tax-filer who claims the applicant as a dependent
- A responsible person acting on behalf of a minor applicant or an incompetent, incapacitated, or deceased applicant, such as:
  - A guardian or conservator,
  - A friend or relative with knowledge of the applicant's circumstances, or
  - A person or organization that has signed form **470-3356, Inability to Find a Responsible Person**.
- An authorized representative.

If an authorized representative signs the application on behalf of the applicant, the signature of the applicant or responsible person must be on the application before eligibility can be approved. See Representation.

NOTE: If the applicant is under a guardianship or conservatorship that was established voluntarily, the applicant may sign the application. When a person voluntarily asks the court to appoint a guardian or conservator, the court may do so without making a determination that the person is incompetent.

Applications that are filed electronically, whether signed and faxed or scanned and e-mailed, do not have to be signed again.

Where the Application Must Be Filed

Legal reference: 441 IAC 76 (Rules in Process) and 86.3(3)

An application may be filed online at https://hhsservices.iowa.gov/apspssp/ssp.portal or any local HHS office; or any HHS outstation at a disproportionate share hospital, federally qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided (i.e., mental health institute or hospital school).

Applications may be submitted in person, by mail, by telephone at 1-855-889-7985, or by email or fax to a local HHS office.

An application may also be filed at the office of a qualified entity under the Presumptive Medicaid program, a WIC office, a maternal health clinic, or a well-child clinic.

Date of Application

Legal reference: 441 IAC 76 (Rules in Process) and 86.3(4)

Policy: An application is considered filed on the date when the application containing a legible name, address, and signature of the client or representative is received at a location defined under Where the Application Must Be Filed.

For SSI recipients, the date the SSI application was filed with the Social Security Administration, as shown on the SDX, is the date of application for Medicaid. See Effective Date for SSI Recipients and **14-E, SSI State Data Exchange** for SDX information.

Procedure: An application left at a closed office will be considered received on the first day that is not a weekend or state holiday following the day that office was last open.

> County A is a less-than-full-time office and open on Monday and Wednesday. The office was last open Wednesday, April 24. When the office re-opens on the following Monday, staff find several applications that have been left under the door. All applications are date-stamped as being received Thursday, April 25.

A faxed or electronic application shall be considered as an original application. A faxed or electronic application is considered filed on the date it is received when it comes in during normal business hours.

If the application comes in after normal business hours (during the evening, weekend, or holiday), the application is considered received on the first day that is not a weekend or state holiday following the day that office was last open.

When a person fills out an incorrect application form, the person must complete the correct form before eligibility can be established. Use the filing date on the incorrect application as the filing date when the correct application is received. Attach the incorrect application to the correct application and file it in the case record. On all applications, use the filing date as the application date.

Withdrawal of Application

Legal reference: 42 CFR 435.907 and 435.914(b)(1), 441 IAC 76.10(249A) and 86.3(5)

Applicants may withdraw the application entirely or for any month covered by the application, if the request is made before the eligibility determination has been made.

EXCEPTION: The Medically Needy coverage group requires that concurrent months be included in the certification period. A Medically Needy applicant may withdraw the application for the month in which the application is filed, if the applicant wants to have the certification period begin the following month.

The request to withdraw the application may be oral or in writing. Document the withdrawal in the case record. Issue an adequate notice of decision if the entire application is withdrawn. If only a month of the application is withdrawn, and a notice of decision will be issued when the remaining application is processed, a separate notice is not necessary.

Procedures for SSI Applicants or Potential SSI Eligibles

Legal reference: 441 IAC 76.5(249A)

Persons who would be eligible for Supplemental Security Income (SSI) may apply at the Social Security Administration district office for both SSI and Medicaid. Normally it is to a low-income person’s advantage to apply for SSI because of the money payment. However, application for SSI is not a condition of eligibility for Medicaid.

If a person applying for Medicaid at an HHS office has income less than the SSI payment standard for the person's living arrangement, refer the person to the Social Security Administration district office to apply for SSI benefits:

- If the person chooses not to apply with the Social Security Administration, process the application as you would any non-MAGI-related application. See **8-F, Non-MAGI-Related Coverage Groups: People Eligible for SSI Benefits But Not Receiving Them**.
- If the person has already applied for or intends to apply for SSI or Social Security disability benefits (SSDI) within ten working days of the Medicaid application, see Concurrent Medicaid and Social Security Disability Determinations.

If the Social Security Administration has made an SSI eligibility determination, the information is sent to the Department via the SSI State Data Exchange (SDX) system. Information from the SDX is used to process SSI recipients for Medicaid. Chapter 14-E explains the SDX system and how to use and interpret the fields.

If the individual is not active on Medicaid, the worker will receive the **Notification of SSI Approval** in WISE.

If the individual is currently active on Medicaid, the worker will receive an alert.

The Social Security Administration may presumptively determine an SSI applicant to be disabled. "Presumptive" disability is indicated by code "P" in the disability field on the SDX. If all other Medicaid eligibility criteria are met, the person is eligible for Medicaid for a maximum of six months. See **8-C, Presumptive Disability**.

When more than 60 days have passed since the person filed for SSI, you can send form **470-0363, Certification of Eligibility of SSI Applicant** to determine the status of the person's SSI eligibility determination. You may also use this procedure before 60 days have passed if the applicant has an urgent need. Form **470-0363** completed by the Social Security Administration indicating that a person is eligible for SSI may be accepted as verification in place of an SDX.

Concurrent Medicaid and Social Security Disability Determinations

Legal reference: 42 CFR 435.909 and 435.541, 441 IAC 75 (Rules in Process)

Policy: When a person has applied concurrently for both Social Security disability benefits and non-MAGI-related Medicaid, the Department is required to await the outcome of the Social Security Administration disability determination.

If the applicant is eligible only for Medically Needy, see **8-J, SSI-Related Medically Needy**.

Procedure: If a non-MAGI-related applicant has not been determined to be disabled by the Social Security Administration, take the following actions:

1. Ask the applicant to apply for SSI and Social Security disability (SSDI) benefits from the Social Security Administration. The applicant will either:
   - State that an application has already been filed, or
   - Agree to apply for benefits within ten working days of the Medicaid application date.
2. When the applicant has already applied or agrees to apply for SSI and SSDI, complete form **470-2631, Notice of Pending Medicaid Applications**, and send it to:
   - The Social Security Administration, and
   - Disability Determination Services (DDS).

   DDS completes the status of the disability determination on Section II of the form and returns the form to the IM worker within 15 calendar days.
3. If DDS does not have a referral from the Social Security Administration, follow up on the DDS response by contacting the applicant to verify that the benefit application has been filed with the Social Security Administration.
4. If DDS has a pending disability determination for this person:
   - Make a note in the narrative, and
   - Set a reminder to check completed disability determination on the Data Sources in WISE
5. If DDS has already completed the disability determination for Social Security, check the Data Sources in WISE
   - If the SDX shows SSI was approved, then approve Medicaid if all other eligibility requirements are met.
   - If the SDX shows SSI was denied due to disability, deny Medicaid as “not disabled.”
6. If the SSI was denied due to other eligibility requirements, such as income or resources, contact the Social Security Administration to see if an eligibility decision for SSDI will be made within 30 days.
   - If so, wait for the Social Security Administration decision on SSDI.

- If not, then get a copy of the disability determination from the Social Security Administration and get the income and resource verification from the applicant. Complete the application processing.

7. When a final Social Security disability determination has been made, contact the Social Security Administration to see if the full eligibility determination will be made within ten days.
   - If so, wait for the Social Security Administration decision.
   - If not, get a copy of the Social Security Administration disability decision and determine Medicaid eligibility.

Medicare Savings Program Applications

Legal reference: 441 IAC 76.6

Policy: When the Social Security Administration (SSA) sends data on an **Application for Extra Help with Medicare Prescription Drug Plan Costs** to the Department, that data is considered an application for the Medicare Savings Programs.

Medicare Savings Programs (MSP) include qualified Medicare beneficiaries (QMB), specified low-income beneficiaries (SLMB), expanded specified low-income beneficiaries (E-SLMB), and qualified disabled working persons (QDWP).

The date that SSA received the Extra Help application is the application filing date for purposes of establishing eligibility for the Medicare Savings Programs. The date the Department receives the data from SSA begins the 30-day processing time to determine eligibility.

The applicant's signature on the Extra Help application from which the data was generated shall be treated as the signature for the MSP application. Income and resource data provided by the SSA shall be considered verified unless the applicant provides different information.

The Department will issue form **470-4846, Medicare Savings Programs Additional Information Request** which the applicant must complete and return within ten days to provide the rest of the information needed to establish eligibility.

Comment: Medicare beneficiaries apply to the SSA for Extra Help. The **Application for Extra Help with Medicare Prescription Drug Plan Costs** tells beneficiaries that:

- They may be able to get help from Medicaid with their Medicare costs under the Medicare Savings Programs; and
- By completing the Extra Help application, they also start the application process for a Medicare Savings Program benefit, unless they check the 'No' box on the application form indicating they do not want to apply for MSP.

Procedure: SSA sends HHS data on a daily basis for all Iowa Medicare beneficiaries who do not check the 'No' box for the Medicare Savings Program on the Extra Help application. SSA does not forward the data to HHS until it has made a decision on eligibility for Extra Help. The application data is forwarded to HHS regardless of whether Extra Help was approved or denied.

When data sent by the SSA indicates the applicant is not a Medicare beneficiary or is over income or over resources for MSP, the MSPS system automatically denies the application and generates a *Notice of Decision* sent to the applicant.

For all other cases, MSPS generates form **470-4846, Medicare Savings Programs Additional Information Request** populated with the data from SSA. (See 6-Appendix for a list of this data.) The form is sent to the applicant at the mailing address the applicant provided to the SSA.

When the applicant returns the form:

1. Determine if the mailing address and living address are the same. If the addresses are different and the living address is in another state, deny the application on the basis of the applicant's residency.
2. Determine eligibility for MSP using the policies in Employees' Manual 8-F.
   IMPORTANT:
   - A "V" following the case number printed on page 1 of form 470-4846 indicates that the Department accepts the information that was printed on the form as verified. If the applicant has made changes to the printed income or resource information, verify the change.
   - An "NV" behind the case number indicates that the information on the form is not verified and must be verified.

3. Make ELIAS system entries to approve or deny the application. If no decision has been entered by the 30th day, the system will automatically send a **Notice of Decision** denying the MSP application for failure to return form 470-4846.

The Medicare Savings Programs (MSPS) screen displays data from the SSA that was used to deny the application. Use this information to support a denial of eligibility for MSP in the event the applicant appeals the denial decision. See **14-B(4), MSPS = LIS-Application History**.

1. SSA receives Ms. Z's application for Extra Help on January 15. SSA determines that Ms. Z is eligible for Extra Help on March 1. Ms. Z indicated that she wanted to also apply for the Medicare Savings Program.

   On March 1, SSA sends Ms. Z's data from the Extra Help application to the Department. The Department receives the data on March 1. Ms. Z's application date for MSP is January 15. The Department has 30 days beginning March 1 to determine Ms. Z's eligibility for MSP.

   On March 1, the Department sends her form **470-4846, Medicaid Savings Programs Additional Information Request**. The cover letter tells Ms. Z to return the form by March 11.

   Ms. Z reviews the forms and does not make any changes to the data printed in the form. She returns the form on March 8. The worker determines that Ms. Z is eligible for QMB effective April 1.

2. Same situation as above except that Ms. Z is determined to be eligible for SLMB. Ms. Z's eligibility is effective January 1.

   If Ms. Z indicates that she has medical expenses for the three months before January 1 and she meets the SLMB eligibility requirements before January 1, Ms. Z would need to meet a category of eligibility for the retroactive period as defined in **8-A, Definitions**. If she does, Ms. Z could be eligible for SLMB benefits effective October 1.

Interviews

Legal reference: 42 CFR 435.905 through 914; 441 IAC 76 (Rules in Process) and 76.5

An interview shall not be required when determining Medicaid eligibility for MAGI households. Applicants or members who are being evaluated for non-MAGI-related Medicaid may be required to attend a face-to-face or telephone interview to:

- Clarify information on the application,
- Clarify questionable information, or
- Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the "prudent person concept." See **8-A, Definitions** for "prudent person concept."

An interview shall not be required for children as defined by the Medicaid program.

Grant an interview if the applicant, member, or authorized representative requests one.

Procedure: To require a face-to-face interview or a phone interview, you must request a scheduled time with the applicant or member. When an interview is needed or is requested by an applicant, a member, or an authorized representative, schedule a date, time, place, and method of the interview (in the local office, home visit, or by phone, etc.).

Grant requests to reschedule when you determine that the applicant, member, or authorized representative is making every effort to cooperate with the interview process. Interviews rescheduled at the request of the applicant, member, or authorized representative may be agreed upon verbally and documented without written confirmation.

Failure to attend the interview you requested, including a scheduled phone interview, is cause to deny or cancel the adults on the application.

Contact the applicant or member whenever you need to clarify information in order to determine eligibility.

When you ask a client to come in to the local office for an interview, do not deny or cancel the children if the adult fails to attend the interview. However, if you request information at the same time as you set up an interview and the information is not provided within ten days, you may cancel or deny the entire household for failure to provide requested information.

Information Provided

Legal reference: 42 CFR 435.905

When conducting the interview or by other means, explain to the client:

- The programs for which the client may be eligible such as:
  - MAGI-related Medicaid
  - Non-MAGI-related Medicaid
  - Medically Needy
  - Home- and community-based service waivers
  - State Supplementary Assistance
  - FIP
  - Food Assistance
- The policies and procedures for the client's coverage group.
- The factors of eligibility that must be verified, including what is needed as verification, and that documents that are the property of the client are not returned to the client.
- The penalties for giving false information.
- The client's right to receive a ten-day advance notice of adverse actions and the right to appeal any decisions on Medicaid eligibility.
- The social service programs available. Make referrals when necessary.
- The client's responsibility to:
  - Report changes within ten days of the change and report any changes in medical resources. See **8-G, Reporting Changes**.
  - Cooperate with the Quality Control and Economic Assistance Fraud Bureaus. See **8-C, Cooperation with Investigations and Quality Control**.
  - Apply for and accept other benefits for which the client is eligible. See **8-C, Benefits from Other Sources**.
  - Cooperate with the Third-Party Liability Unit and refund third-party payments for services paid by Medicaid. See **8-C, Cooperation with the Third-Party Liability Unit**.

Give or mail to applicants or anyone inquiring about the Medicaid program the following pamphlets that explain coverage, conditions of eligibility, benefits of the program, related services available and client rights and responsibilities:

- **Comm. 020, Your Guide to Medicaid, Fee-for-Service**

- **Comm. 030, Medicaid for the Medically Needy**
- **Comm. 051, Information Practices**
- **Comm. 123** and **Comm. 123(S), Important Information for You and Your Family Members About the Estate Recovery Program**
- **Comm. 209, Information About Your Privacy Rights**
- **Comm. 233 and Comm. 233(S), Rights and Responsibilities**
- **Comm. 255** and **255(S), Benefits of the Health Insurance Premium Program**
- **Comm. 258** and **258(S), Verifying Citizenship/Identity and/or Immigration Status**
- **470-0306** or **470-0307(Spanish), Application for Food Assistance.**

EXCEPTIONS: Do not give this application to people living in a medical institution or to children entering foster care unless supervised apartment living is the first foster care placement.

For all applicants under the age of 21, discuss the availability and benefits of the EPSDT "Care for Kids" program. Make sure the client understands the program and the advantages of screening. Give or mail to the applicant **Comm. 004, Early and Periodic Screening, Diagnosis, and Testing Program (EPSDT) Brochure**. See **8-M, Care for Kids (EPSDT)**, for more information.

To MAGI-related applicants, also give:

- **Comm. 027, Medicaid for Families and Children**
- Iowa WIC Program income guidelines

The Department of Public Health revises the WIC flyer annually in March to incorporate updated WIC income guidelines. The revised flyer is effective April 1. Public Health sends a blanket supply of the revised flyer to local offices. Destroy previous versions of the flyer. Get additional supplies of the WIC flyer cost-free by calling 1-800-532-1579.

To applicants who are aged, blind, or disabled, also give:

- Comm. 28, Medicaid for SSI-Related Persons.
- Comm. 60, Medicaid for the Qualified Medicare Beneficiary.

- **Comm. 121** and **Comm. 121(S), Important Notice to Property Owners and Renters.**
- **Comm. 180, Medicaid for Employed People with Disabilities**.

To applicants who are in a nursing facility, also give **Comm. 052, Medicaid for People in Nursing Homes and Other Care Facilities**. If the applicant has a spouse at home, also give **Comm. 072, Protection of Your Resources and Income**.

Voter Registration Procedures

Legal reference: National Voter Registration Act (NVRA) of 1993, Section 7, Iowa Code Section 48A.19, 721 IAC Chapter 23

The Department is responsible for helping clients complete voter registration forms and for mailing the forms to the county election office. (The actual voter registration occurs at the election office.) Issue voter registration forms:

- With all applications,
- With all Medicaid/Hawki Review and Medicaid/State Supp Review forms, and
- When the client moves within Iowa.

When an interview is held, ask if the client wants to register to vote. If the client wants to register and has not filled out the voter registration form, have the client complete it at the interview. Offer to help the client complete the form. Be careful when helping the client that you do not influence the client's voter registration options in any way.

If you are conducting a phone interview, ask the questions and send the form to the client for signature. No follow-up is necessary after the form has been mailed.

Review the client's rights as listed on the form. If the client chooses not to check "yes" or "no," leave the section blank and consider that the client has chosen not to register to vote. If the client chooses not to sign the form, print the client's name and the date where indicated, and initial the form.

If there isn't an interview, and the client indicates they would like to register to vote on the electronic application, mail the form to the client and document your actions.

If the client returns the form, follow your office procedures for handling it. Tear off the voter registration information section and give it to the client. Keep the declination part of the form. See 6-Appendix for a copy of the **Voter Registration** form and for office procedures for handling the form after completion.

Verification

Legal reference: 42 CFR 435.907(e), 435.911(c)(2), and 435.952(c)–(d); 441 IAC 76 (Rules in Process) and 86.3(7)(c)

Applicants must provide requested verification. Notify the applicant in writing what additional information or verification is needed. Provide this notice to the applicant personally, by mail, or by facsimile. Give the applicant ten calendar days to supply the information.

Explain the following to the applicant in writing:

- An applicant who must obtain information from a third party should not leave the information with the expectation that the third party will return it timely.
- The applicant is responsible for following up with the third party to be sure the third party has the information ready to pick up or has mailed the information to the Department in time to be received by the due date.
- The applicant may ask the Department for more time to get the information if the third party does not have the information ready or it will not arrive by the due date.

When the applicant is making every effort to obtain the information from a third party but is unable to do so in ten days and notifies you about the problem, you can allow additional time. Help the applicant to get the needed information, as requested.

An applicant who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification to give you permission to get it. The general release does not meet this requirement unless the applicant asks for help.

Before denying a MAGI-related application, a request must be sent to applicants and members for information that cannot be obtained electronically, or is obtained electronically but is not reasonably compatible with information provided by or on behalf of an individual.

Deny the application if the applicant does not provide the requested information by the specified due date and does not authorize the Department to obtain the information within the requested time.

If the applicant is unable to get information from a spouse who is no longer in the household, do not deny the application. Contact the applicant to obtain the best information available. Ask the applicant about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the applicant to provide information that would help to verify what the applicant is telling you about a spouse who is no longer in the home. From the information provided, determine eligibility. If the applicant fails to provide the requested information, deny the application.

Pregnant Women

Legal reference: 42 CFR 435.956(e), 441 IAC 75 (Rules in Process)

When establishing Medicaid eligibility for pregnant women, attestation of the date of conception, due date, and number of children expected shall be accepted unless questionable.

IRS Tax Information

Legal reference: Sections 1137(a)(6) and 1942(b)(1) of the Social Security Act, Iowa Code Section 249A.4,

By signing the application, applicants authorize HHS to verify application information with electronic data sources including IRS tax information. When redetermining eligibility, such as at annual review, HHS shall not attempt to verify income with IRS tax information unless the member provides written permission on an appropriate form.

Reasonable Opportunity Period (ROP) for Verifying Citizenship or Alien Status

Legal reference: 42 CFR 435.956(a)(5) through (b)(1) through (3) and 435.911(c), 42 U.S.C. 1396a(46)(B)(i)-(ii); Iowa Code Section 249A.4; 441 IAC 75 (Rules in Process)

An applicant or member whose attested U.S. citizenship or eligible alien status cannot be verified through an electronic data match shall be allowed a 90-day Reasonable Opportunity Period (ROP) to provide proof. Medicaid shall be provided during the ROP if the person is otherwise eligible. If proof is not received by the end of the 90-day ROP, benefits end subject to timely notice requirements.

Moving and Returned Mail

Legal reference: 441 IAC 75.10(249A)

Policy: A member must remain an Iowa resident for Medicaid eligibility purposes.

Procedure: When mail is returned to the Department, handle the mail as follows:

- When the Post Office has attached a forwarding address and it is in Iowa:
  - Use this address and update the HHS systems.
  - It is not necessary to contact the member.
  - Send any returned mail to the member at the correct address and keep a copy in the case record.
- When the Post Office has attached a forwarding address and it is out-of-state, contact the member to ensure they are no longer an Iowa resident.
- When there is no forwarding address (i.e., address unknown, undeliverable), deny the case for unable to locate using the only address HHS has on file.
- When there is hand-writing on the returned mail, attempt to contact the member to resolve the issue. Deny the case for unable to locate if you are unable to contact the member.

Comment: Reporting a change in a mailing or living address is required.

Processing Standards

Legal reference: 42 CFR 435.912(c)(3)(i)-(ii), Iowa Code Section 249A.4

The following sections explain:

- Processing guidelines that apply to all Medicaid applications.
- Grace period following the denial of an application.
- Guidelines for processing applications for children.

Guidelines for All Applications

Process applications on the earliest possible date. Determine eligibility and issue a written notice of decision for MAGI-related, non-MAGI-related, and Medically Needy Medicaid by making system entries no later than the 45th day following the date of application.

If the 45th day falls on a weekend or holiday, process the application by making system entries the next working day.

When the application is for non-MAGI-related Medicaid, including non-MAGI-related Medically Needy, and a blindness or disability determination is pending, the time limit is 90 days. See Concurrent Medicaid and Social Security Disability Determinations.

If a person's eligibility is dependent upon a 30-day period of residency in a medical institution, delay the eligibility decision until the 30-day period has been met, unless the person is ineligible due to some other factor.

The time limit for approving or denying a Medicaid application can be waived in unusual circumstances. Examples of unusual circumstances include:

- You and the applicant have made every reasonable effort to get necessary information but have not been able to do so within the time frames.
- Retroactive Medicaid was requested for a person whose proof of citizenship and identity has not yet been provided as described in **8-C, Reasonable Opportunity Period**.
- Emergencies, such as fire or flood.
- Other conditions beyond the administrative control of the local office.

You must document the reason for the delay.

You cannot deny an application because of the time period alone. To deny the application, there must be either failure to act on the part of the applicant or a determination of ineligibility.

An applicant must cooperate with the application process. This may include providing information or verification, attending required interviews or signing documents. Failure to cooperate with the application process shall serve as a basis to deny an application.

Unnecessary Application

Legal reference: 42 CFR 435.912, Iowa Code Section 249A.4, 441 IAC 441 7.7(1)

A Notice of Decision or a Notice of Action must be issued to approve or deny all applications, including unnecessary applications.

Grace Period Following the Denial of an Application

Legal reference: 42 CFR 435.902, 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specified period of time during which an applicant has the opportunity to "cure" the reason for the denial of an application. The grace period is defined as the 14 calendar days immediately following the date of denial.

"Day one" of the 14-day grace period is the day following the date printed on the notice of decision. If the 14th day falls on a weekend or a state holiday, the 14th day is extended to the next working day for which there is regular mail service.

A previously denied application shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the date of denial. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the applicant is eligible, the original filing date of the application establishes the effective date of eligibility. The effective date of eligibility is the first day of the month an application was filed or the first day of the month in which all eligibility factors were met, whichever is later.

Comment: The grace period does not apply to late payment of premiums or noncooperation actions. Denial reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to locate the applicant.

If the application was denied because mail was returned or the Department was otherwise unable to locate the applicant, a new application is not required if the household contacts the Department within the 14 days, provides a current Iowa address, and eligibility can otherwise be established.

Procedure: Based on the circumstances of your case, take appropriate action as follows:

- **No information provided:** When no information is provided by the 14th day after the date of denial, no further action is required.

- **Partial information provided:** When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received so that a decision can be made by the end of the grace period, the household will have to reapply. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred:** If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the applicant that you cannot reconsider the application unless the change is verified by the end of the grace period. If a generic release is on file, use it to obtain the information if possible. A written request for the new information is not required.
  - If the new information is not verified so that an eligibility determination can be made by the end of the 14-day grace period, send a manual "remain denied" notice (see below for language). This is because the original reason for denial has been cured, but you cannot process the application due to a change in circumstances that is required to be verified.

> Your application for Medicaid is still denied because you did not give us the information we asked for. We cannot determine if (insert persons name) (is/are) eligible. 441 IAC 74.3 and IAC 76 (Rules in Process)

- **Unable to verify change within grace period:** When an additional change is reported and it is unlikely the information can be verified and eligibility established by the end of the 14-day grace period, attempt to notify the applicant that they will need to file a new application.

1. Mr. A, a Medicaid applicant, fails to provide an employer's statement of earnings that was requested by the Department. The IM worker issues a denial notice on April 1, which is dated April 2. Mr. A provides the employer's statement on April 16. There have been no other changes in the household circumstances. The IM worker reopens Mr. A's application and processes it.

2. Ms. B, a Medicaid applicant, fails to provide an employer's statement of earnings that was requested by the Department. The IM worker issues a denial notice on April 5, which is dated April 6. Ms. B provides the employer's statement on April 21. Since the 14-day grace period has expired, Ms. B must file a new application and the original denial stands.
3. Mr. C, a Medicaid applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 10, which is dated May 11. Mr. C provides two of the items on May 13.

   The worker attempts to contact Mr. C since not all the items needed to determine eligibility came in. The third item is received on May 25. There have been no other changes in the household circumstances. The IM worker processes the application.
4. Mr. D, a Medicaid applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 15, which is dated May 16. Mr. D provides two of the items on May 17.

   The worker attempts to contact Mr. D since not all the items needed to determine eligibility came in. The third item is received on May 31. Since the 14-day grace period has expired, the original denial stands and Mr. D must file a new application.
5. Ms. E, a Medicaid applicant, fails to provide three pieces of information that were requested by the Department. The IM worker issues a denial notice on July 21, which is dated July 22. Ms. E provides two of the items on July 31 and the third item on August 1.

   Also on August 1, Ms. E reports that she has changed jobs. The IM worker explains that in order for the original application to be reconsidered, Ms. E has until August 5 to provide verification of the old job ending and the beginning of the new job. Otherwise, Ms. E will have to reapply.

   Ms. E does not provide verification of the end of the old job or the beginning of the new job. The IM worker issues a "remain denied" notice since Ms. E had provided the original requested information but did not provide the new verification.

6. Mr. F, a Medicaid applicant, fails to provide three pieces of information that were requested by the Department. The IM worker issues a denial notice on August 30, which is dated August 31. Mr. F provides two of the items on September 2 and the third item on September 6.

   Also on September 6, Mr. F reports that he has changed jobs. The IM worker explains that in order for the original application to be reconsidered, Mr. F has until September 14 to provide verification of the old job ending and the beginning of the new job. Otherwise, Mr. F will have to reapply for Medicaid.

   Mr. F provides verification of the old job ending and the beginning of the new job on September 7. The application is processed with the new information and a notice is sent informing Mr. F of the decision.

Effective Date of Eligibility

Legal reference: 42 CFR 435.915(b), 441 IAC 76.13(249A) and 86.5(514I)

The effective date of eligibility for Medicaid is the first day of the month an application was filed or the first day of the month all eligibility factors were met, whichever is later. EXCEPTION: Eligibility under the qualified Medicare beneficiary coverage group begins the first day of the month after the month of decision.

See **8-F, Express-Lane Eligibility** for the effective date of eligibility for children under age 19 who are eligible without an application under the express-lane eligibility process.

For **MAGI-related** coverage groups, eligibility for Medicaid begins on the first day of the month when eligibility was established any time during the month.

For **non-MAGI-related** coverage groups and State Supplementary Assistance, the applicant must meet all eligibility criteria and be resource-eligible as of the first moment of the first day of the month in order to be eligible for the month.

Effective Date for SSI Recipients

Legal reference: 441 IAC 76.5(249A)

An SSI recipient is eligible for Medicaid as of the first of the month before the month that the person attains SSI eligibility, unless either:

- The person's Iowa residency date is later, or
- There is a Medicaid policy that precludes eligibility, as listed in **8-F, SSI Recipients**.

Mr. M lives in Nebraska and files an application for SSI in January. In March, Mr. M moves to Iowa. Social Security processes Mr. M's application in March and establishes SSI eligibility effective January 1.

Even though Mr. M was determined SSI-eligible in March, he is not eligible for Iowa Medicaid in January and February because he was not an Iowa resident. The earliest Mr. E's Iowa Medicaid eligibility can begin is March 1.

Beginning with determinations made on or after August 22, 1996, the effective date of approval under the SSI program is the later of:

- The month following the month of application for SSI, or
- The month following the month the client first meets all SSI eligibility factors.

1. Mr. A files for SSI on January 15. Mr. A meets all SSI eligibility criteria for January. SSI payment is approved effective February 1.
2. Mr. B files for SSI on January 15. Mr. B does not meet all SSI eligibility criteria until February (turns 65 in February). The earliest date that SSI payment will begin is March 1 (the month following the month that all SSI eligibility factors are first met).

For the month immediately before the effective date of approval, the Social Security Administration has already determined that the client meets all SSI eligibility factors. (The client does not receive an SSI payment due to SSI's effective date of approval policy.) Thus, for Medicaid purposes, it is not necessary to verify eligibility factors independently for that month.

Determine Medicaid eligibility for that month in the same manner as if the client was an SSI cash recipient.

1. Mr. A files for SSI on June 15. SSI cash payments are approved effective July 1. In order for SSI payments to begin effective July 1, the Social Security Administration must have determined that Mr. A met all SSI eligibility criteria for the month of June. Thus, it is not necessary to verify information independently for June.

   Mr. A is eligible for Medicaid in the month of June and ongoing (and potentially the retroactive months if he meets a category of eligibility for the retroactive period as defined in **8-A, Definitions**).

2. Mr. B files for SSI on January 15. SSI cash payments are approved effective March 1. In order for SSI payments to begin effective March 1, the Social Security Administration must have determined that Mr. B met all SSI eligibility criteria for the month of February.

   Mr. B did not meet all eligibility criteria for the month of January (or SSI would have begun February 1). It is not necessary to verify information independently for the month of February. It is necessary to verify information and determine the reason that Mr. B was ineligible for January.

Use the SSI application date as the Medicaid application date. The effective date of eligibility can be no earlier than three months before the date of application for SSI if the individual meets a category of eligibility for the retroactive period as defined in **8-A, Definitions**. This date is on the SDX.

When the date of the SSI application is in a different month from the month that SSI eligibility begins, determine if there is Medicaid eligibility for:

- The month of SSI application.
- All months between the date of application and the month of eligibility for SSI.
- The retroactive period.

Establishing Beginning Months of Eligibility for MEPD

Legal reference: 441 IAC 75.6(6)"b""4"and "6"

Policy: Medicaid for Employed People with Disabilities (MEPD) applicants may choose to have either MEPD or Medically Needy coverage for months between the date of application and the date that the case is approved on the ELIAS system.

Comment: Application processing may be delayed due to waiting for a disability determination decision. This may result in a delay of several months between the date of application and the date of approval. "Back months" are the months between the date of application and the month when the case is actually approved.

"Conditional eligibility" for MEPD means the member must pay a premium before getting Medicaid eligibility for a month.

If the member wants to have Medically Needy for some back months, see the procedures in **8-F, Relationship to Medically Needy**.

Procedure: The MEPD Billing System applies premium payments in a specified order. The person who enters the payments in the MEPD system cannot change the order of how the payment will be applied to pay for "back months."

Before entering conditional approval for back months, it is important to check with the applicant to see if the applicant wants Medicaid for each of the back months. Do **not** give the applicant conditional MEPD eligibility for a month when the applicant does not want MEPD benefits.

Corrections can be made on the MEPC screens after the initial and back months are assessed for MEPD premiums.

Changing Conditionally Approved Months for MEPD	
Situation:	Worker Action:
After conditional eligibility has already been entered for "back months," the member tells the worker that there are some months for which the member does not want to pay premiums.	Ask the member to sign a statement that lists the "back months" for which the member does not want Medicaid. Do not block months until the signed statement is received.
▪ If the premiums for those months have **not** been paid…	"Block" the months when the member does not want MEPD coverage so that payments are not applied to premiums for those months. Enter "B" for the months that need to be blocked on the member's MEPC screen.
▪ If the premiums for those months **have** been paid…	Do **not** block the month, as Medicaid eligibility was already given.

Situation:	Worker Action:
The worker needs to "block" a paid month due to an error in giving conditional eligibility for that month.	"Block" the month by entering "B" for that month on the member's MEPC screen. The system will: ▪ "Back out" the premium payment for the blocked month. ▪ Hold the premium payment as a credit or apply it to another unpaid month. ▪ Issue an alert from WISE requesting recoupment of the paid Medicaid claim for that month.
A month is blocked in error.	"Unblock" the month on the MEPC by entering a "U" for unblock over the "B" on the month line. Remember, once a month is blocked, the member will not be given Medicaid eligibility for that month until it is unblocked.

Comment: See **14-B(9), Change to MEPD Premium: Using MEPC** and **8-F, Relationship to Medically Needy**.

Determining Eligibility for the Retroactive Period

Legal reference: 42 CFR 435.914 and 435.915(a), 441 IAC 76.13(3) and 86.5

Medicaid benefits may be available for any or all of the three months before the month in which the application is filed. This time is called the "retroactive period." The person must meet a category of eligibility for the retroactive period as defined in **8-A, Definitions**. EXCEPTION: The following coverage groups do not have retroactive eligibility:

- Presumptive Medicaid benefits.
- Qualified Medicare Beneficiary (QMB).
- Home- and community-based services waivers.
- Program for all-inclusive care for the elderly (PACE).

Persons whose citizenship or alien status has not been verified, even though they are eligible during a 90-day reasonable opportunity period, are not eligible for retroactive coverage.

For children under age 19 who are eligible without an application under the express-lane eligibility process described at **8-F, Express-Lane Eligibility**, the "retroactive period" is any of the three months before the effective date of the child's express-lane eligibility.

To be eligible for retroactive benefits, an applicant must meet both of these conditions:

- The applicant has paid or unpaid medical bills for Medicaid-covered services received during the retroactive period, **and**
- The applicant would have been eligible for Medicaid benefits in the months services were received, if a valid application had been filed.

An applicant does not need to be eligible in the month of application to be eligible for the retroactive period. If an application is submitted on behalf of a deceased person, determine the deceased person's retroactive eligibility using the same requirements.

When retroactive coverage is requested, evaluate the three months before the month of the current application to see if eligibility exists even if some of those months were denied on a previous application.

1. Ms. A, a pregnant woman, files an application on July 8. She indicates on the application that she wants retroactive benefits. The worker requests in writing that Ms. A provide income verification for the months April through June. Ms. A fails to provide the income information and is denied Medicaid for the retroactive period. The application is approved for ongoing eligibility.

2. Same as Example 1, except that Ms. A is also denied for ongoing benefits due to failure to provide requested information. She reapplies on August 15, and this time cooperates in providing information needed to establish eligibility. She is eligible for the retroactive period of May through July, the three months before the month of the reapplication, and also for ongoing benefits.

Determine eligibility for the retroactive period on a month-by-month basis. This includes using a third or fifth paycheck when calculating monthly income. The coverage group under which the person is eligible in the retroactive period may be different for each month. EXCEPTION: See Retroactive Eligibility for Medically Needy Recipients.

If the self-attested income that the household reported verifies with electronic data sources or is cohort approved and results in ongoing eligibility, this amount can be used to determine retroactive eligibility. If the self-attested income does not verify with electronic data sources, the worker will need verification of actual income to determine eligibility for the retroactive period.

Issue a notice of decision when retroactive eligibility is denied.

When approving an application for retroactive Medicaid only, include the month when eligibility ended on either the *Notice of Decision* approving the retroactive months or on a separate notice. The notice does not need to be timely when assistance is simultaneously approved and ended for retroactive eligibility.

A member who did not know that there were bills in the retroactive period at the time of application can ask to have eligibility for retroactive benefits determined at a later date. The retroactive period is the three months before the month of the most recently **approved and active** Medicaid application. Retroactive eligibility cannot be determined later on an application that was denied or canceled for ongoing benefits.

Also, a person may request retroactive coverage but may fail to provide the information needed to determine eligibility. Even though a notice of decision was issued, the member may request to have eligibility determined again for the same retroactive period if the application was approved for ongoing benefits **and** it remains the most recently approved Medicaid application.

Although a member may request retroactive benefits at any time, payment will not be authorized for services provided 23 months or more before the current month unless extenuating circumstances exist. See **8-M, Submitting Claims** for more information.

Benefits can be approved for SSI approvals beyond the two years by submitting special updates when the SSI eligibility determination went beyond the two years.

Verification Requirements

When determining retroactive eligibility, accept a client's statement that the client has paid or unpaid medical bills (unless questionable). See **8-F, Continuous Eligibility for Pregnant and Postpartum Women** for requirements when establishing continuous eligibility for pregnant women at the time of application.

Clearly document in the case record how eligibility or ineligibility for each month was established. Information to be documented includes:

- Verification of income and resources.
- Household composition for each month.
- Beginning date of disability, if applicable.

Retroactive Eligibility for Medically Needy Recipients

Legal reference: 441 IAC 75 (Rules in Process) and 76.13(3)

A Medically Needy certification period is considered as one unit. Even though the period may include one or more months, determine eligibility for the entire certification period only. The retroactive period for Medically Needy is a one-month, two-month, or three-month period, depending on which month the client first incurred a medical expense. See **8-J**.

1. Ms. S, a pregnant woman, applies for Medically Needy on March 5. The certification period is March and April. Ms. S claims to have unpaid bills for December and January, which are within the three-month retroactive period.

   The worker requests income and resource information for all three months of the retroactive period (December - February). If income or resource verification is not provided for December through February, eligibility for the retroactive period cannot be determined.

2. Ms. B, a pregnant woman, applies for Medically Needy on April 15. The certification period will be April and May. She states that there are no unpaid medical bills for the retroactive period (January - March). In June, Ms. B reports that there is an unpaid medical bill for January.

   The worker establishes eligibility for the three-month retroactive period. Income from all three months is used in computing spenddown. Spenddown for the retroactive period is $100. The unpaid bill is $500. The amount in excess of the spenddown ($400) is Medicaid-payable in the retroactive period.

Retroactive Eligibility for SSI Recipients

Legal reference: 441 IAC 76.13(3) and 76.13(3)"d"

For an SSI recipient to be eligible for retroactive benefits, they must meet a category of eligibility during the retroactive period as defined in **8-A, Definitions**. In addition:

- The person must have been eligible for Medicaid benefits in the months services were received (if an application had been filed), and
- The person must have paid or unpaid medical bills for Medicaid-covered services received during the retroactive period. The SDX shows unpaid medical claims in the UNPAID RETRO field.

A person who is presumptively disabled (disability code P on the SDX) is not entitled to retroactive benefits until a final determination has been made that the person is eligible for disability.

Examine retroactive eligibility for an SSI recipient as you would any other applicant. During the retroactive period, the person must have been either:

- At least 65 years of age, or
- Under 18 years of age, or
- Blind, or
- Disabled, and
- Meet a category of eligibility for the retroactive period as defined in **8-A, Definitions**.

Accept the member's statement regarding the date of onset of blindness or disability, unless there is evidence to the contrary.

Referrals to CSS

Legal reference: 42 CFR 433.145, 441 IAC 75.14(249A) and 75 (Rules in Process)

Policy: As a condition of eligibility, Medicaid applicants and members must assign their rights to payments for medical support to the Department unless good cause exists.

Child Support Services (CSS) seeks cash medical support as well as financial support for people in the Medicaid eligible group.

A child support referral is mandatory in the following situations:

- There is an active CSS case;

- The applicant requests CSS services;
- The applicant or member receives cash medical support;
- The application is for a child in foster care; or
- The applicant is also applying for FIP.

Do not make a referral to CSS:

- When the applicant does not want CSS services and CSS does not have an active case on the absent parent.
- When both parents are in the home, even when paternity has not been established.
- If the applicant or member has proven that good cause exists.
- On a parent whose parental rights have been terminated by the court.
- On the parents of an underage parent who is a payee.
- When a child in subsidized adoption is placed in foster care and no child support order currently exists.
- When a parent's absence is solely because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

  NOTE: A parent whose absence is solely because of the performance of active duty in the uniformed services of the United States is considered to be absent for purposes of determining Medicaid eligibility. (See **8-C, Absence**.) However, a parent who is absent for this reason is not referred to CSS.

See **8-C, Cooperation with Child Support Services**.

1. Ms. D applies only for Medicaid for herself and her daughter, Lisa. Lisa's father is not in the home. Ms. D says on the application that:
   - She does not want a referral to CSS, and
   - There is no court order for cash medical support.

   The IM worker checks ICAR and finds there is not an active child support case in the ICAR system. The IM worker processes the application and does **not** complete a referral to CSS.

2. Mr. W applies only for Medicaid for himself and his two children. He says on the application that:

   - He does not want to pursue child support, and
   - The absent parent **is court-ordered** to pay cash medical support.

   The IM worker explains to Mr. W that a referral will be made to CSS because of the cash medical support order; that he is required to cooperate with CSS to receive Medicaid for himself; and that if he does not cooperate, he will not receive Medicaid for himself.

3. Mr. Q applies for FIP, Medicaid, and Food Assistance for himself and his children. His children's mother is absent from the home. Mr. Q says on the application that:

   - He does not want to cooperate in obtaining medical support,
   - CSS is not helping him, and
   - There is no court order for cash medical support.

   The worker tells Mr. Q that as a condition of eligibility for FIP he must cooperate with CSS in obtaining financial support or the household will be subject to sanction of cash benefits. The worker completes a CSS referral and it will be "active" for both FIP and Medicaid programs.

   If Mr. Q later fails to cooperate with CSS, then CSS will notify the worker to apply the appropriate sanctions to the FIP, Medicaid, and Food Assistance benefits.

Referral Procedures

Procedures: If the household has more than one absent parent and there is no active CSS case, the applicant can determine which absent parents are to be referred, if any.

For foster care cases, link both parents. If the ICAR referrals have not been made, complete the referral.

Pregnant Women

Legal reference: 441 IAC 75 (Rules in Process)

Policy: As a condition of her eligibility, the woman must agree to cooperate in establishing paternity and obtaining support for the children for whom she receives Medicaid (except for pregnant women under MAC). However, a woman will be referred only as listed under Referrals to CSS.

Procedure: Do not make a referral regarding the father of the unborn child until the postpartum period has ended. Then refer only if the mother requests a CSS referral or is otherwise required.

See also **8-C, Cooperation With Child Support Services**, and **8-F, Mothers and Children (MAC) Program**.

1. Ms. A is pregnant and lives alone. She applies for Medicaid. No CSS referral is made and no information is requested regarding the father of the unborn child. The worker does not make a referral until the postpartum period has ended, and then only if Ms. A requests CSS services.
2. Ms. B is pregnant and lives with her two children. She applies for Medicaid for herself and the children. Eligibility is examined under the FMAP coverage group.

   The worker makes the referral to CSS only if Ms. B wants CSS services or if CSS already has an active ICAR case. When the postpartum period ends, the worker refers the newborn if a referral was made on the other children of this absent parent.
3. Ms. D is pregnant and receives Medicaid under the MAC coverage group for herself and her daughter. Ms. D wishes to have CSS establish paternity and support for her daughter. The worker makes the referral to CSS for the daughter.
4. Same as Example 5. The referral is made to CSS. However, Ms. D changes her mind and does not cooperate with CSS. Her Medicaid is not canceled, because she receives Medicaid under MAC as a pregnant woman, and is, therefore, exempt from the cooperation requirement.

Representation

Legal reference: 441 IAC 76.9

A Medicaid applicant or member may need or want to be represented by another person or organization.

- When an applicant or member is a minor, incompetent, incapacitated, or deceased, a “responsible person” is allowed to act on the client’s behalf.
- A competent person may name an “authorized representative” to participate in pursuing Medicaid eligibility.

The policies and procedures for these two types of representation are discussed in this section.

Responsible Person

Legal reference: 42 CFR 435.907(a), 441 IAC 76.1 and 76.9(1) and (3)

When an applicant or member is unable to act on their own behalf because they are a minor, incompetent, incapacitated, or deceased, another person may act responsibly for the client. The responsible person must be:

- A family member, friend, or other person who has knowledge of the client's financial affairs and circumstances, and a personal interest in the client's welfare,
- An adult in the child's household or family, or
- A legal representative, such as a conservator, guardian, executor, or someone with power of attorney.

A responsible person assumes the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

A responsible person may designate an authorized representative to represent the incompetent, incapacitated, or deceased applicant or member. (See Authorized Representative.) However, this does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

Provide copies of all correspondence and documents that you would normally provide to the applicant or member to the responsible person and to the representative, if the responsible person has authorized one.

When there is no person as described above to act as a responsible person, any individual or organization can act as the responsible person if the individual or organization:

- Conducts a diligent search for someone who meets the criteria for a responsible person but cannot locate such a person, and
- Completes form **470-3356, Inability to Find a Responsible Person**.

Authorized Representative

Legal reference: 42 CFR 435.907(a) and 435.923, 441 IAC 76.1 and 76.9(2)-(3)

Policy: A competent applicant or member or a responsible person (see Responsible Person) may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility. See Authorization to Represent for authorization requirements.

Authorized representatives may participate in the application process or in the ongoing eligibility process. Authorized representatives are allowed to:

- File applications.
- Check on the progress of an application or ongoing eligibility.
- Request reschedules of interviews or extensions for providing documentation or verification.

Appointment of an authorized representative does not relieve a competent applicant or member or a responsible person of the primary responsibility to cooperate with the application process or for establishing ongoing eligibility. The applicant, member, or responsible person is still required to:

- Attend interviews, when requested.
- Sign documents.
- Supply information or verifications.
- Meet all other requirements necessary to determine eligibility.

Procedure: When an applicant, member, or responsible person has named an authorized representative, send the authorized representative copies of all correspondence sent to the applicant or member that will affect eligibility.

When a competent applicant names an authorized representative, send all correspondence to the applicant and copies of all correspondence that pertains to the eligibility determination to the authorized representative.

For a minor, or incompetent, incapacitated, or deceased applicants, send correspondence to the responsible person and copies to the authorized representative.

For members under Medicaid for Employed People with Disabilities (MEPD), also provide a copy of each **MEPD Billing Statement, form 470-3902**, to the authorized representative.

Make entries on the member's MEPD STMT screen to generate a copy of the **MEPD Billing Statement**. See **14-C, STMT = MEPD Billing Statement Screen**, (REPRINT (WRKR) field) for entry instructions. After the entries are updated, the worker will receive the duplicate bill and send it to the authorized representative.

Authorization to Represent

Legal reference: 441 IAC 76.1(7)"b"

An authorization to represent is a written document or statement signed and dated by the competent applicant or member or by a responsible person that identifies the individual or organization that will act as the person's authorized representative.

If the authorization identifies the period or the dates of medical services it is to cover, the authorization is valid for the initial application and any additional application filed by the representative or applicant for the stated period or dates of medical services, as well as appeals relating to the application.

If the authorization does not indicate the period or dates of medical services it is to cover, the authorization shall be valid until the applicant, member, or responsible person modifies the authorization, or notifies the Department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the Department that the representative no longer is acting in such capacity.

If an applicant, member, or responsible person notifies the Department in writing that the client or responsible person no longer wants an authorized representative to act on the person's behalf, the Department will no longer recognize that individual or organization as the authorized representative.