CHAPTER 3-000 APPLICATION PROCESS

3-001 INTERVIEW: An interview shall not be required for either an application or a renewal.

3-002 APPLICANT/CLIENT RIGHTS: An applicant/client has the following rights:

1. The right to have the Medicaid application process and the Medicaid requirements, responsibilities, and benefits reasonably explained to him/her by the Department, including by written translations, oral interpretation, and taglines for individuals with disabilities or limited English proficiency;
2. The right to have other potential sources of assistance explained to him/her by the Department, including, as applicable: income that may be currently or potentially available such as Retirement, Survivors, and Disability Insurance (RSDI);, Supplemental Security Income (SSI);, or, Veteran's Assistance benefits (VA); social and other financial services available through the Department, such as social services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and family planning; and, receive a referral to other agencies, if appropriate.
3. The right to have his/her civil rights upheld. No applicant/client may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, political belief, or any other classification protected by law;
4. The right to be offered the opportunity to register to vote (see Appendix 477-000-061).
5. The right to submit an application for him/herself or have an application submitted by his/her authorized representative;
6. The right to have his/her application and any personal information treated confidentially according to the applicable privacy laws;
7. The right to receive reasonably prompt action on his/her application that is pending. A determination of eligibility must be made by the Department about an application within forty-five (45) days of the date the complete and signed application has been received by the Department; except for applications under the disability category, for which a determination of eligibility must be made within ninety (90) days;
8. The right to receive adequate notice of any action affecting his/her application or benefit; and
9. The right to appeal to the Director for a hearing about any action or inaction regarding his/her application, or failure to act with reasonable promptness. Any appeal must be filed with the Department in writing within ninety (90) days of the decision date.

3-003 APPLICANT/CLIENT RESPONSIBILITIES: Each applicant or client is required to

1. Provide complete and accurate information. State and federal law provides penalties that may include a fine, imprisonment, or both, for persons found guilty of making false statements or failing to report promptly any changes in their circumstances to obtain assistance or services for which they are not eligible;

2. Report a change in circumstances no later than ten (10) days following the change. This may include information regarding
   a. Change or receipt of a resource including cash, stocks, bonds, or a motor vehicle. Changes in resources do not apply to clients whose eligibility is determined using MAGI-based methodology;
   b. Change in unit composition, such as the addition, loss of, or temporary absence of a unit member;
   c. Change in residence;
   d. Living arrangement;
   e. Disability status;
   f. New employment;
   g. Termination of employment; or
   h. Change in the amount of monthly income, including
      (1) All changes in unearned income, and
      (2) Changes in the source of employment, in the wage rate, or in employment status, such as part-time to full-time or full-time to part-time.

   For reporting purposes, full-time employment is considered at least thirty (30) hours per week. The client must report new employment within ten (10) days of receipt of the first paycheck, and a change in wage rate or hours within ten (10) days of the change. To avoid adverse action, a Client must prove good cause for any failure to report a change to the Department within ten (10) days. Unconfirmed statements do not constitute good cause;
3. Present his/her Medicaid card to providers;
4. Inform the medical provider and the Department of any third-party resources that may be liable for his/her medical expenses, in whole or in part, and cooperate in obtaining these third-party resources;
5. Enroll in a health plan and maintain enrollment if
   a. One is available to the client,
   b. The client is able to enroll on his/her own behalf, and
   c. The Department has determined that enrollment in the plan is cost effective;
6. Reimburse to the Department or pay to the provider any third-party resources received directly for services that are payable by Medicaid;
7. Pay any unauthorized medical expenses;
8. Pay any required medical copayment;
9. Meet the requirements of Managed Care, if applicable; and
10. Cooperate with state and federal quality control.

3-004 APPLICATION

3-004.01 Application Submittal: An application may be submitted by an applicant or his/her authorized representative. An application may be signed in writing, by telephonic acknowledgment, or by electronic signature. An application may be submitted in person, by mail, by telephone, by fax, or by electronic submission.

3-004.02 Application Date: An application is considered valid the date it is received by the Department if it contains

1. Applicant's name,
2. Address, and
3. Proper signature of the applicant or authorized representative

An application may be taken on behalf of a deceased person (including a miscarriage or a stillborn). If there is no one to represent a deceased person, the administrator of the estate may sign the application.

3-004.03 Application with a Designated Provider: An applicant or his/her authorized representative may apply for Medicaid with a designated outreach provider or entity that has contracted with the Department to accept Medicaid applications at its location.

3-004.04 Alterations: The application, when completed and signed by the applicant or his/her authorized representative, constitutes the applicant's own statement regarding eligibility. Information may be added to an application up to the decision date.

3-004.05 Withdrawals: An applicant may voluntarily withdraw an application verbally or in writing, which will be confirmed by the Department sending a Notice of Action to the applicant or his/her Authorized Representative documenting this voluntary withdrawal.

3-004.06 New Application: A new application is required after ninety (90) days of ineligibility.

3-005 AUTHORIZATION FOR INVESTIGATION: The Department may request a release of information from the applicant or his/her Authorized Representative when it appears that information is incorrect or inconsistent, when the client is unable to furnish the necessary information, or for sample quality control verification.

3-006 RENEWALS

3-006.01 Renewal of Eligibility: A redetermination of eligibility for continued Medicaid benefits must be completed every twelve (12) months.

A renewal shall be completed on the basis of information available to the Department without requiring information from the individual. Information will only be required from the individual when not available through other sources (see Appendix 477-000-002).

A prepopulated renewal form shall be required every twelve (12) months for non-MAGI based eligibility renewals.

If information is not available to complete a renewal, a prepopulated renewal form shall be sent by the Department to the applicant or his/her authorized representative. The completed renewal form and necessary verifications shall be returned within thirty (30) days of the date the renewal form was sent.

If the renewal form and necessary information are submitted within ninety (90) days after termination, a new application shall not be required.

For the Medically Needy category, a client is ineligible if no medical need exists. The client shall be informed in writing that s/he may reapply if there is a medical need at a later date.

3-006.02 Renewal for SSI Recipients: An application is not required at the time of renewal for clients who are receiving SSI. If SSI is discontinued and

1. The last application was completed more than twelve (12) months from the last month of eligibility for SSI, a complete renewal of eligibility must be done within the next thirty (30) days, including completion of an application; or
2. It has been less than twelve (12) months since completion of the last application, a review of all eligibility requirements that are necessary for continued assistance must be completed.

A renewal is not required for periodic non-pay for income due to an extra pay period.

SSI clients who are determined eligible for Medicaid by the Social Security Administration (SSA) under the provisions of 1619(b) are not required to complete an application at renewal, and resources do not need to be verified.

3-006.03 Income Review for ABD Clients: For eligibility purposes, a review of income must be completed every twelve (12) months. An income review is completed by SSA for SSI clients, including those placed in 1619(b) status.

3-006.04 Disability Review for ABD Clients: A review of disability for ABD cases must be completed by the State Review Team.

3-007 CONTINUOUS ELIGIBILITY

3-007.01 Continuous Eligibility for Pregnant Women: Once a pregnant woman is determined Medicaid eligible, she remains continuously eligible through the post-partum period.

Continuous eligibility does not apply to pregnant women covered during a period of presumptive eligibility.

3-007.02 Continuous Eligibility for a Newborn: Children born to Medicaid-eligible mothers are deemed eligible for Medicaid and remain Medicaid eligible for one (1) year after birth. For 599 CHIP, see 477 NAC 19-004.07.

3-007.03 Six Months' Continuous Eligibility for Children: Children from birth through age eighteen (18) are eligible for six (6) months of continuous Medicaid from the date of initial eligibility.

Retroactive months do not count in the six (6) months of continuous eligibility unless there is no prospective eligibility. For 599 CHIP, see 477 NAC 19-004.07.

3-007.04 Exceptions to Continuous Eligibility:

The child turns nineteen (19) years old within the six (6) months,
2. The client moves out of state,
3. It is determined that the original eligibility was based on erroneous or incomplete information,
4. The client dies,
5. The client enters an ineligible living arrangement or
6. The child or child's representative requests voluntary disenrollment

3-007.05 Review After Six Months' Continuous Eligibility for Children: Once a household has received continuous eligibility for six (6) months, a desk review is completed by the Department and any information known to the Department shall be acted on, accordingly.