CHAPTER 102 – Non-Financial Requirements

102.08 GENERAL ELIGIBILITY REQUIREMENTS

The eligibility requirements common to both ABD and FCC are discussed in this section. When the requirement also has a program-specific application, it is discussed separately with ABD discussed first, then FCC.

Basic Eligibility Requirements

An eligible individual must be in one of the categories of assistance discussed in 102.07; and,

- A citizen of the United States or a qualified alien (102.04 and 102.05); and,
- A resident of Mississippi (102.03); and in addition,
- Have income and resources, when applicable, within specified program limits; and,
- File an application.

Reasons for Ineligibility

Notwithstanding the above, an individual is not eligible in any program if the person:

(1) Fails to apply for any and all other benefits for which he may be eligible; (102.08.04)

(2) Fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments; (102.08.05) or

(3) Is a resident of a public institution. (102.11)

Additional Factors Causing Ineligibility

- A person who refuses to accept vocational rehabilitation services is ineligible in the ABD programs.

- A resident of a long term care facility is ineligible in the FCC programs.
Eligible Individuals

Aged, Blind and Disabled Programs

The eligible ABD adult or child is one who meets all basic program requirements. An eligible spouse is a person who (1) meets all of the basic program requirements, (2) is the husband or wife of an eligible individual and (3) lives with the eligible individual. This includes a man and woman who hold themselves out as husband and wife. The individual and spouse must each apply and meet all of the basic program requirements to establish eligibility as a couple.

Eligible Individuals

Families, Children and CHIP Programs

Children under age 19, pregnant women of any age and parents or needy caretakers, within the specified degree of relationship, are eligible individuals for the FCC programs if they apply and meet program requirements.

For family coverage in the Medical Assistance Program (85), the married couple must live together, have a qualifying child, apply and meet all of the basic program requirements. Couples in “holding-out” situations are unrelated adults for FCC purposes.

However, if the unmarried couple has a common child, the adults’ eligibility is established in the same way as a married couple with a qualifying child, i.e., both legal parents must live with the child, both apply and meet all basic program requirements.
102.08.01 VERIFICATION OF AGE

The age of an individual must be verified in the following situations:

- The applicant is an adult or child applying for benefits which are based on age;
- There are ineligible children in an ABD deeming household;
- A disabled or blind applicant under age 21 applies for ABD and any of the following conditions exist:
  - Deeming
  - Student earned income exclusion
  - Support from absent parent exclusion

Examples of acceptable sources of age verification are:

- Birth certificate or other birth records
  (Must be established during the first 5 years of life and certified by the custodian of the record. This could include a statement signed by the midwife or physician who was in attendance at the birth and who attests to the date of birth.)
- Social Security records
- BENDEX System
- SDX Listing
- Religious records
  Family Bible or other family record – must examine the entire publication Baptismal or confirmation certificate
- Hospital, school or physician/clinic records
- State or Federal Census records established near date of birth
- Marriage record which shows age or date of birth
- Insurance policy which shows age or date of birth
- Passport
- Employment records
- Military records
- Child’s birth certificate which shows parent’s age

Records which might be available to those born in foreign countries include the documents listed above and the following:

- Foreign passport
- Immigration record established upon arrival in the U. S.
- Naturalization papers
- Alien registration card
102.08.02 MARITAL RELATIONSHIPS

Aged, Blind and Disabled Programs

Definition of a Marital Relationship

A marital relationship is one in which members of the opposite sex are:

- Married under State law;
- Married under common law, provided the couple began holding out prior to April 1, 1956;
- Married for Title II purposes, meaning one member of the couple is entitled to spouse's benefits on the record of the other;
- Living in the same household in a “holding out” relationship as man and wife.

  - A man and woman who live in the same household are married for SSI/Medicaid purposes if they hold themselves out to the community in which they live as husband and wife.
  - It is possible for a couple to live together and not be “holding out” as man and wife, depending on economic and social circumstances. The only way to make a determination of marital status is for the Specialist to examine how the couple holds themselves out to the community.

  If the couple is determined to be living separately and apart, each is treated as an individual. However, when evidence does not support that a couple is living separately and apart, couple rules and deeming applies.

  - When a couple lives together, but denies “holding out”, the Specialist must obtain as many items of evidence as possible to make a determination as to the couple’s relationship and living arrangement.

Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs (SSA, public housing, food stamps, etc.), and statements from friends, relatives and neighbors.
Aged, Blind and Disabled Programs

Termination of a Martial Relationship

For ABD programs, the marital relationship no longer exists as of the date that:

- Either individual dies;
- A final decree of divorce or annulment is issued for the marriage;
  - If a divorced couple resumes living together, the specialist must develop whether they have a holding-out relationship.
- Either individual begins living with another person as their spouse;
- The couple is determined not to be married for Title II purposes if that was the basis for considering the couple married;
- The couple begins living in separate households.
  - When a married couple claims to be living apart, the Specialist must obtain as many items of evidence as possible to make a determination as to the couple’s relationship and living arrangement.
    Such evidence may include mortgages, leases, rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs (SSA, public housing, food stamps, etc.), and statements from friends, relatives and neighbors.
  - If the Specialist determines the couple is living apart, each person is treated as an individual.
  - A man and woman who are still legally married and resume living together after having lived apart is a married couple, regardless of the reason for having resumed living together.
A marital relationship is presumed for an ABD couple unless the client states otherwise and provides the types of evidence listed above which indicate the relationship does not exist or has terminated.

Changes in Marital Status

A man and woman are married for a month if they meet any of the criteria for a marital relationship within the month. When a change occurs and an individual marries, resumes living with a spouse, enters a “holding out” relationship, etc., use couple budgeting beginning the month of the marriage. An increase in benefits can be effective immediately if policy otherwise allows it. Adverse action rules apply when ineligibility or a decrease in benefits results for a recipient.

Termination of marriage is effective the month after the month of a death, divorce, annulment or separation.

NOTE: For the spousal impoverishment allocation, the couple must be legally married under state law or in a common-law marriage which began prior to April 1, 1956. The spousal impoverishment allocation is not applicable to couples in “holding-out” situations which began on or after April 1, 1956.
102.08.02A MARITAL RELATIONSHIPS

Definition of a Marital Relationship

A marital relationship is one in which members of the opposite sex are:

- Married under State law;
- Married under common law prior to April 1, 1956 as recognized by MS.

Couples in “holding out” situations are unrelated individuals for FCC purposes. However, when the couple has a child, the applicant child and both legal parents are included in the budget group. Consequently, each adult can impact the eligibility of the other when an application is filed for family coverage in the Medical Assistance Program.

Example: Sally Jones and Ben Johnson are an unmarried couple. They are the legal parents of one minor child, Brittany Johnson. Sally is not pregnant, but she needs Medicaid for herself and Brittany. An application for Medical Assistance/85 is filed for the parents and the child. Based on SFU requirements, both parents and the child must be included in the application. Ben earns $2700 per month so his income exceeds the 85 gross income limits for a family of 3. In this example, Brittany is the only qualifying child. Based on Ben’s income, Brittany is not deprived. Ben is ineligible and Sally is also ineligible even though there is no marital relationship. Brittany will be assessed for placement in another Medicaid program or CHIP.

Termination of a Martial Relationship

The marital relationship no longer exists for FCC purposes as of the date that:

- Either individual dies;
- A final decree of divorce or annulment is issued for the marriage;
  - If a divorced couple resumes living together, the adults are unrelated; however, if they are the legal parents of the applicant children, both adults are included in the Assistance Unit (AU) or Standard Filing Unit (SFU) together.
- The married couple begins living in separate households.
Families, Children and CHIP Programs

Termination of a Marital Relationship (Continued)

- A legally married man and woman who resume living together after having lived apart are treated as a married couple, regardless of the reason for having resumed living together.

NOTE: Legal parents must be included in the AU or SFU with their children.

Verification of a Marital Relationship

Marital status is verified by client statement or self-declaration. Refer to 102.01.01 when determining if information is considered questionable and requires additional verification.

Changes in Marital Relationship - Applications

Marriage or termination of marriage, including separation, is effective the month the event occurs. In application situations, individuals must be in the home at least one day of the month to be included in that month.

Example: A household applies May 27. At the interview on June 5, the head of household reports her spouse and the father of the children returned to the home on May 30. The spouse is considered part of the household effective May 1. If the spouse had moved back in the home on June 3, he would be included in the household effective June 1.

However, when a head of household reports prior to the eligibility determination that a person moved out, that person is not considered part of the household in the month the change occurred.

Example: A household applies on July 30th and is interviewed August 8th. During the interview, the head of household reports that her husband and the father of the children abandoned the family on August 3rd and she does not expect him to return. The spouse would not be included in the household effective August 1.
Families, Children and CHIP Programs

Changes in Marital Relationship – Active Cases

A change in marital status must be reported by adult recipients eligible in the Medical Assistance Program. When an adult becomes ineligible due to a change in marital status, eligibility is terminated after allowing 10-day (plus 2 days mailing time) notice of the adverse action. Any changes resulting for the children will be handled at review.
102.08.03 DEFINITION OF A CHILD

Aged, Blind and Disabled Programs

In the ABD programs, a child is defined as someone who is neither married nor head of a household and is either:

- Under age 18; or
- Under age 22 and a student regularly attending school or college or training that is designed to prepare him for a paying job.

Verification

A child’s age must be verified. For a list of acceptable verifications, refer to 102.08.01. If the document used to verify a child’s age does not also verify the parent/child relationship, self-declaration of relationship is permissible.

As indicated above, someone who is married cannot meet the definition of a child for ABD Medicaid purposes; however, he may meet the definition of an “eligible individual” as discussed in 102.08.

Termination of Child Status

Status as a child ends:

- Effective with the month the child becomes age 18 or age 22, if a student, or
- The month he last meets the definition of a child.

Developing ABD Student Status

No development of student status is necessary for a child under age 18 who does not expect to earn over $65 in any month. However, school attendance must be explored whenever an applicant or recipient between the ages of 18 and 22 alleges being a student.

An individual meets the definition of a child for purposes of allocation and budgeting if he is under age 22 and regularly attending school, college or training designed to prepare him for a paying job. Obtain the following information to develop student status:
Aged, Blind and Disabled Programs

Developing ABD Student Status (Continued)

- Name and address of school or institution furnishing the training;
- Name of the person to contact for verification, if necessary; and
- Information on the course or courses of study dates of enrollment, number of hours of attendance, and other activities of the child.
- Verify enrollment by examining a student record such as an ID card, tuition receipt or contact with the school.

Regular attendance means the individual takes one or more courses of study and attends classes:

- In a college or university for at least 8 hours a week under a semester or quarter system; or
- In grades 7 – 12 for at least 12 hours a week; or
- In a course of training to prepare him for a paying job for at least 15 hours a week if the course involves shop practice or 12 hours a week if it does not involve shop practice.

**NOTE:** This kind of training includes antipoverty programs, such as Job Corps and government-supported courses in self-improvement.

- For less than the time indicated above for reasons beyond the student’s control, such as illness, if the circumstances justify the reduced credit load or attendance.

**Example of school attendance less than required hours:** A paraplegic is forced to limit vocational school attendance to one day a week due to the unavailability of transportation. Although the student is enrolled for attendance of less than 12 hours a week, he qualifies as regularly attending school because lack of transportation is a circumstance beyond his control.

- Student status is also granted to homebound students who have to stay home due to a disability.

- Student status is granted if the child studies courses given by a school (grades 7 – 12), college, university or government agency and a home visitor or tutor directs the study or training.

A child remains a student when classes end if he attends classes regularly prior to school vacation and intends to return when school reopens.

Effective Month: May 2009
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102.08.03A DEFINITION OF A CHILD

Families, Children and CHIP Programs

To be categorically eligible as a child in the FCC programs, the individual must be under the age of 19. Age must be verified. For a list of the acceptable verification methods, refer to 102.08.01.

An individual’s status as a child ends effective the month after he turns age 19.

Emancipated Children

Most children are dependents of their parents or have another adult caretaker. However, some children may be emancipated. An emancipated minor is authorized to act on his own behalf. Though not a dependent child, the emancipated minor under age 19 is a categorically eligible child for FCC programs. Emancipation may occur the following ways:

- Court-Ordered Emancipation
  In certain situations, a court may grant an order of emancipation or relief of minority to remove a minor child from the parents’ supervision and financial responsibility and allow the minor child to live independently and act on his own behalf.

- Marriage
  When a minor child marries, he in effect emancipates himself. If the minor lives with a spouse, he is not considered a dependent of his parents. However, if the minor lives with his parents apart from the spouse, he returns to dependent child status for FCC purposes.

- Living Independently
  There may be instances in which parents relinquish supervision and financial responsibility for a child. When a child is living independently, he is an emancipated minor.

Minor Parents

An unmarried parent under age 19 who resides in the home with his children and his parents (the children’s grandparents) is a dependent child of his parents for purposes of determining the minor’s own eligibility. The minor’s children are dependent children of the minor parent for determining their eligibility.
Families, Children and CHIP Programs

Minor Heads of Household

There are instances in which it is permissible for a child to be the head of household. Children living independently, including those in group homes, orphanages and other situations in which parents have relinquished or abandoned custody, often have individuals filing on their behalf, such as a social worker, administrator or foster parent; however, it is also permissible for the child to file the application when he is capable of doing so.

In addition, a child living with parents can be the head of household, i.e., the person filing the application, under certain circumstances:

- A married minor living with a spouse can file an application as head of household, independent of parents;

- A pregnant pre-teen or teen can file an application as a pregnant woman, independent of parents;

- A minor parent can file an application for his/her children as head of household. However, a minor parent must have his own eligibility determined with his parents.
102.08.04 UTILIZATION OF OTHER BENEFITS – GENERAL

As a condition of eligibility, an ABD or FCC applicant or recipient must take all necessary steps to obtain all benefits to which they are entitled when the benefit(s) is one of the following types:

Medicare - Medicare-entitled individuals must enroll in the program.

Unemployment Benefits - Unemployment insurance provides income to those who have been laid off or are unemployed due to no fault of their own and are able to work and are available for work. Potential eligibles should be referred for these benefits.

Worker’s Compensation Benefits - If a client alleges either injury on the job or has what may be a work-related impairment, refer for these benefits.

Social Security Retirement, Survivors and Disability Insurance Benefits, Including Early Retirement At Age 62 - Any client who is not already receiving Social Security benefits or Railroad Retirement benefits at time of application must be referred to apply for either retirement benefits, including early retirement, disability benefits if under age 65 or survivor’s benefits, if a widow(er) or disabled child of a deceased parent.

Retirement or Disability Benefits Including Veterans’ Pensions And Compensation - Explore entitlement for VA benefits if a client is a veteran, the child or spouse of a veteran, a widow(er) or previous spouse of a veteran or the parent of a veteran who died from service-connected causes.

When a client is determined to be ineligible for VA benefits at home, the case must be documented that a referral to VA will be needed if the client subsequently enters a nursing facility. Use DOM-312, Notice of Potential Eligibility for VA Benefits, to notify the client of the requirement to file and follow through with an application.

NOTE: VA Aid and Attendance is not a required benefit under this provision.

Annuity Or Pension Such As Private Employer Pensions, Civil Service Pensions, Union Pensions, Railroad Retirement Annuities And Pensions, Municipal, County Or State Retirement Benefits - Explore entitlement for private sector benefits if the client or former/deceased spouse worked for a private sector employer with a pension plan and if not already receiving or has not received a pension based on that employment.
Annuity or Pension (Continued)

- Explore entitlement for benefits if the client or former/deceased spouse (or deceased parent if the client is a child) is not already receiving or has not received a pension based on such employment and was employed in one of the following:
  - Federal Civilian Employment for a minimum of five years;
  - Federal Uniformed Service (Military) for a minimum of twenty years;
  - State or Local Government employment.

Benefits Exempt from Utilization Provision

The client is not required to apply for the following types of benefits:

- Temporary Assistance for Needy Families (TANF)
- General Public Assistance, including SSI
- Bureau of Indian Affairs General Assistance
- Victim’s Compensation payments
- Other Federal, state, local or private programs with payments based on need
- Earned Income Tax Credits

Exempt Individuals

This provision applies only to eligible individuals (applicants or recipients). It does not apply to non-applicants or ineligibles. This includes the ineligible spouse or community spouse in ABD and non-applicant or ineligible parents or caretaker relatives of children; however, the responsible adult is required to file on behalf of children potentially eligible for other benefits as a condition of the child’s eligibility.

Exception to the Utilization Provision

An individual is not required to accept another benefit if the resulting payment would be a reduction in current benefits payable to the individual. This does not include a reduction in Medicaid benefits.
Good Cause for Failure to Comply with Provision

The agency must require clients to take all steps necessary to apply for other benefits to which they are entitled, unless good cause can be shown for not doing so. A denial or dismissal of a claim for other benefits due to failure to submit required verification does not satisfy this requirement.

Good cause for not applying for other benefits may be found to exist if the individual does not apply due to:

- Illness and there is no authorized representative to apply on the client’s behalf; or
- The individual previously applied and was denied and the reason for the denial has not changed; or,
- The individual was unaware of the availability of a benefit and the agency did not advise him of its availability.

If good cause does not exist for failure to comply with this requirement, eligibility will be denied or terminated as discussed later in this section.

Applying the Provision

The utilization of other benefits provision is applicable at the time of application and for the duration of eligibility. The individual potentially eligible for the types of benefits listed above or the responsible person, if the client is a child, must take steps to apply for the benefits. If eligible, the individual must accept the payment regardless of the impact the additional income will have on Medicaid eligibility.

Client and Regional Office Responsibilities

It is the client’s responsibility to supply information regarding the possibility of other benefits. In addition the client must file for these benefits when informed by the regional office of potential eligibility and then follow through with all actions needed to obtain an eligibility decision. The case must be documented with actions taken and the award decision.
Client and Regional Office Responsibilities (Continued)

The Regional Office has the following responsibilities:

- Determining that the benefit is the type of benefit that must be pursued;
- Determining the likelihood of possible eligibility for the benefit;
- Providing the written notice of the actions the client must take in regard to the benefit;
- Referring the client to the proper agency; and
- Assisting the individual, as necessary, to comply with the requirement to file for the benefit and follow through to an eligibility determination.

Determination of Potential Eligibility

The Regional Office may become aware of potential eligibility for other benefits from:

- Responses to questions on the application;
- Interview discussion;
- Inquiries from other agencies;
- Staff knowledge of government and private pension plans and disability programs.

If staff determines an application for other benefits would not be beneficial, i.e., proof exists of a prior denial and there has been no change in circumstances, the individual should not be required to apply for the benefit. The case record must be documented with the reason for a decision not to require the client to file for the benefit.

If there is doubt about potential eligibility in a given case, the specialist must contact the agency or organization involved to determine if the client is potentially eligible. If the Specialist cannot determine that the client is not potentially eligible, the client must be notified of the requirement to apply for the benefit.
CHAPTER 102 – Non-Financial Requirements

Notification Requirements

The client must be furnished with written request notice explaining the responsibility to apply for the potential benefit within 30 days of the notice for ABD and within 15 days of the notice for FCC.

The DOM-307, Request for Information, will be used to inform the individual of the following:

- The type of benefit the client appears to be eligible for;
- The agency or organization where an application should be filed;
- That the client has 30 days (or 15 for FCC) from the date of the notice in which to file an application for the potential benefit; and
- Proof that that application has been filed must be provided to the Regional Office within the 30-day (or 15-day) timeframe.

Agreement to Comply

An agreement to comply does not negate any prior action to deny or terminate benefits. The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

Other Issues

- A client may be eligible for more than one type of benefit. All potential sources of benefits must be identified.
- The election of a lower benefit when the individual has an option between a high and low benefit will result in denial or loss of eligibility.
- When a client has a choice regarding payment as a lump sum or an annuity, the annuity must be selected. A one-time total withdrawal of pension plan funds in this situation does not comply with the statutory requirements that mandate application for the annuity or pension, i.e., money payment at some regular interval.
- Recommend conversion of lump-sum applications in appropriate situations to focus on maximizing the use of the other benefits to provide ongoing support.
102.08.04A  UTILIZATION OF OTHER BENEFITS

- Aged, Blind and Disabled Programs

If the ABD client has not provided the verification that the application has been filed or proof of ineligibility within the 30 days, the DOM-309 will be issued allowing 10 additional days (plus 2 days mail time) to provide the information. If the client still has not provided either evidence that an application has been filed or proof that the client is not eligible, the specialist will contact the agency in question to attempt to determine whether an application has been filed and the usual processing time involved for the application in question.

**Action When Application Has Been Filed**

If the application for other benefits has been filed, eligibility for Medicaid can continue or a Medicaid application may be approved while the application for other benefits is in process. A tickler will be set for the end of the usual processing time for the other benefits so the specialist can contact the individual or the other agency to determine the final decision.

The regional office must keep a control in this manner to make a determination at any point in time that the individual has taken all appropriate steps in pursuing the claim for other benefits.

**Action When Final Decision is Reached**

When the regional office is notified of the final decision, the record must be documented with the outcome of the application. A copy of the decision letter or other verification must be filed in the case record. If the specialist contacted the other agency to determine the final decision, the case should be documented appropriately.

The specialist will then determine the effect of the decision on the individual’s Medicaid eligibility. If the individual was approved for the other benefit, the payment must be included in the budget and the client notified of the resulting effect on Medicaid eligibility.
Aged, Blind and Disabled Programs

Failure to Comply without Good Cause

If the ABD individual has failed without good cause to take all steps to obtain the other benefits, the specialist will take action to deny or terminate benefits until the requirement is fulfilled. An agreement to comply does not negate any prior action to deny or terminate benefits.

The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency or provides proof of ineligibility for the benefit.
102.08.04B UTILIZATION OF OTHER BENEFITS

Families, Children and CHIP Programs

If the FCC client or responsible person has not provided either evidence that an application has been filed or proof of ineligibility within the 15-day request period, the Specialist will contact the agency in question to determine if an application has been filed and the usual processing time for the application. This information must be documented in the record.

**Action When Application Has Been Filed**

If the application for other benefits has been filed, coverage can be approved for the individual, if otherwise eligible. If the case involves an adult(s) receiving family coverage in the 85 program, a tickler will be set for the end of the usual processing time for the application for other benefits for the Specialist to contact the Head of Household or agency to obtain the final decision. If the decision is still pending, the RO must continue to maintain controls until a final decision is made and to ensure the client is taking all necessary steps to pursue the claim.

**Action When Final Decision is Reached**

When the final decision has been reached, the Regional Office must obtain documentation/verification for the case record. The Specialist will review the case to determine the effect the decision has on the 85 adult’s eligibility. If the benefit was approved, the payment must be included in the budget and the client notified of changes in the adult’s eligibility, if any.

Since children have 12 months continuous eligibility regardless of income changes, a child’s eligibility will not be impacted by approval for other benefits until review.

**Failure to Comply Without Good Cause**

When the application for other benefits has not been filed and good cause does not exist, the FCC adult or child who was potentially eligible for the other benefits cannot be approved for Medicaid. However, any other eligible children included in the application can be placed in an appropriate program. If the 85 program is involved, one ineligible parent or sibling will cause the children and parents/caretaker relative to be ineligible due to Standard Filing Unit requirements. Therefore, any eligible children must be placed in an appropriate FPL program.
102.08.05 ASSIGNMENT OF THIRD PARTY RIGHTS – GENERAL

Federal law requires that all Medicaid applicants and recipients must, as a condition of eligibility, cooperate with the Medicaid Agency in identifying, to the extent they are able, potentially liable insurers and other third parties who may be liable to pay for care and services covered by Medicaid. Cooperation includes repaying any monies to the Medicaid Agency received from a third party source to the extent that Medicaid has paid for the covered service.

By accepting Medicaid each applicant/recipient is deemed to have made an assignment to the Medicaid Program of his rights to medical support or any third party benefits, including hospitalization, accident, medical or health benefits owed to the individual, as well as rights to such benefits owed by any third party to the children or any other person for whom the applicant/recipient has legal authority to execute such an assignment.

Requirements

As a condition of eligibility each applicant/recipient must:

- Assign to the state his individual rights to medical support and other third party payments, and such rights of any other eligible individuals for whom he has legal authority;
- Cooperate in establishing paternity and obtaining medical support or payments, when applicable, and
- Cooperate in identifying and providing information to obtain third party payments.

Automatic Assignment Of Third Party Rights

Although assignment of third party rights is automatic, the applicant/recipient must be informed of the requirement. The ABD and FCC application forms contain the mandatory assignment of rights statement in the section of the form requiring the signature of the applicant, recipient, head of household or designated representative. When an interview is completed, an explanation must be provided to the individual who is assigning rights to third party payments for medical care as a condition of eligibility for Medicaid. The individual’s signature on the application form at initial application and each redetermination of eligibility acknowledges the automatic assignment of all third party rights.
Failure to Cooperate With Third Party Assignment

The Third Party Liability (TPL) Unit has the responsibility for determining if an individual has failed, without good cause, to cooperate with assignment of third party rights. If the TPL Unit determines there was good cause for failure to cooperate, the individual will be exempted from the cooperation requirement. However, a determination of failure to assign rights or lack of cooperation in obtaining third party payments, without good cause, will result in denial or termination of Medicaid benefits after affording the right to appeal.

If the TPL Unit determines an individual has failed, without good cause, to cooperate with third party assignment, Enrollment will be notified. In turn, the appropriate Regional Office will be notified of the action needed to deny or terminate eligibility.

Advance notice must be issued to terminate eligibility; however, the individual has the right to a hearing. All appeals regarding failure to cooperate with the TPL Unit must be handled through a state hearing request.

When benefits are terminated due to failure to cooperate with TPL, the Regional Office will be notified of the period of ineligibility. If the cooperation issue is resolved with TPL, the Regional Office will be notified of the action necessary to restore eligibility.
Families, Children and CHIP Programs

102.08.05A CHIP AND OTHER INSURANCE COVERAGE

There is no requirement for assignment of third party rights in the Children’s Health Insurance Program because the program is for uninsured children only. Children who are covered by creditable third party insurance at application are not eligible for CHIP. This is true regardless of who pay the health insurance premiums.

Termination of third party insurance must be verified when the application indicates insurance coverage will terminate within the 30-day application processing period or terminated within the six months prior to the application. As indicated above, a child covered by insurance at the time of application is not eligible; however, when insurance coverage will terminate within the 30-day application processing period, do not deny an otherwise CHIP-eligible child. If all other factors of eligibility will be met, hold the application and take action to approve the child after the insurance coverage has ended.

Example: An application is filed on February 2nd for an otherwise CHIP-eligible child whose verified insurance termination date is February 15th. Action can be taken to approve CHIP after insurance coverage has ended, beginning February 16th. Action is must taken within the 30-day timeframe; therefore, the effective date for CHIP eligibility will be either March 1st or April 1st, depending on the authorization date.

When a child’s eligibility changes from Medicaid to CHIP, there should be no break in coverage. However, there will always be a break in coverage between termination of third party insurance and the CHIP start date. The specialist must make a good-faith effort to approve a CHIP-eligible child for the earliest possible effective date. Notwithstanding, all FCC applications must be processed within 30 days.

Creditable insurance coverage is full health insurance. Children covered only by the following types of insurance may qualify for CHIP: accident insurance, disability income insurance, liability insurance, supplemental policies for liability insurance, worker’s compensation, automobile medical payment insurance, credit-only insurance, coverage for onsite medical clinics or limited-scope dental or vision or long term care insurance.
102.08.06  CHILD SUPPORT REQUIREMENTS - GENERAL

State child support (IV-D) agencies are required to provide all appropriate child support services available under IV-D of the Social Security Act to families with an absent parent who receive Medicaid benefits and who have assigned rights for medical support to the State. State IV-D agencies are required to petition for medical support when health insurance is available to the absent parent at a reasonable cost.

In order for the IV-D agency to provide the services required by law, the Division of Medicaid must refer the following children to the Mississippi Department of Human Services (MDHS), Child Support Enforcement Office:

- Disabled children in an ABD program with an absent parent; and
- Children in the Medical Assistance Program (85) with an absent parent.

There are additional IV-D requirements in FCC as discussed in 102.08.06B.

102.08.06A  CHILD SUPPORT REQUIREMENTS

❖ Aged, Blind and Disabled Programs

The specialist will complete a manual referral using Form DOM-TPL-410, Absent Parent Referral, and forward to Child Support Enforcement within the Mississippi Department of Human Services (MDHS) for disabled children in an ABD program who have an absent parent. Non-cooperation with child support enforcement does not impact a disabled child’s eligibility.

102.08.06B  CHILD SUPPORT REQUIREMENTS

❖ Families, Children and CHIP Programs

The specialist will provide applicants with information about child support services available through the Office of Child Support Enforcement within MDHS to establish paternity and/or seek or enforce financial and medical support orders for minor children. Cooperation with child support activities is a requirement for the eligibility of adults in the Medical Assistance program. Cooperation is not required for the FPL programs; however, the HOH can volunteer for the child support services for children in the FPL Medicaid programs, but voluntary services are not available not for CHIP recipients.

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Voluntary Referrals

Referral to and cooperation with Child Support Enforcement is not a requirement for the FPL Medicaid categories or CHIP. However, the parent or responsible adult can voluntarily request child support services for children receiving Medicaid in the FPL programs (87, 88, 91). Voluntary referrals will be made through MEDSX/METSS child support interface.

As indicated previously, voluntary referrals cannot be made for CHIP children. The parent of the CHIP child must file an application for child support services with MDHS for the child.

Child Support Requirement for Medical Assistance Program

Referral to and cooperation with child support is required as a condition of the 85 adult’s eligibility if the deprivation reason for at least one child included in the Standard Filing Unit is continued absence. The 85 parent or caretaker relative must cooperate with child support requirements and assist the state by cooperating with enforcement of existing court orders or in obtaining at least medical support from the absent parent. A referral will be made whether or not there is an existing court order and regardless of whether child support is being paid by the absent parent.

Cooperation

Cooperation includes providing information about the absent parent, including name, SSN, current or last known address, current or last known place of employment, as well as helping to locate the absent parent and in establishing paternity or medical support.

Non-Cooperation and Good Cause Responsibilities

At time of application, if the 85 parent or caretaker relative refuses to cooperate with child support, the specialist will deny the adult and test the children for eligibility in an FPL program. After a referral has been made, MDHS child support staff determines satisfactory cooperation, good cause for failure to cooperate and satisfactory cooperation after a period of non-compliance.
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Handling Non-Compliance

When the Medicaid specialist is notified by child support of failure to cooperate, the adult’s eligibility will be terminated allowing adverse action notice. The child support sanction can only be removed when the adult has complied fully with child support requirements and the Office of Child Support Enforcement has notified DOM of the compliance.

The requirement to cooperate as a condition of eligibility impacts the eligibility of an adult receiving Medicaid in the 85 program only. The eligibility of children is not impacted by the adult’s sanction.

Lack of cooperation by the parent or responsible adult who voluntarily requested a child support referral for children in the FPL Medicaid programs does not result in any adverse action.