



Medicaid Eligibility Overview



Presentation to: Key Stakeholders NOW/COMP

Presented by: Brian Dowd, Program Director Waiver Programs



Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

We are dedicated to A Healthy Georgia.

Questions about Medicaid and Waiver Programs

- *Can Individuals be admitted to waiver programs with no active Medicaid in place?*
 - Yes. Medicaid Waiver Programs offer special categories of eligibility not available until the person is admitted to the Program. This most often is used when the person's income falls above the typical income limit.
- *How are providers reimbursed when Medicaid is not active?*
 - Medicaid is determined based on the date of application. This is the first day of the month in which the application was received. An individual can request coverage for up to three months prior to the application date. Providers can retroactively bill for services rendered during this time unless the person was institutionalized during this time.
 - Note: The NOW/COMP Waiver Programs allow support coordination reimbursement 90 days prior to discharge from an institution billable following date of discharge.

Questions about Medicaid and Waiver Programs

- *What if the individual suddenly loses eligibility?*
 - *One of the most common causes of loss of eligibility occurs when a “disabled child” experiences an increase in income which results from a parent’s retirement or death.*
- *What resources can the individual have and still be eligible?*
 - *Medicaid applicants can hold \$2,000 in “cash resources” and an additional \$10,000 in funds specified for burial purposes. Excess income can be held in various special needs trust accounts typically established by trust attorneys.*

Types of Medicaid

- **Q Tracks**
- **Medically Needy**
- **FBR/Public Law**
- **SSI**
- **Waiver**
(Hospice, CCSP, NOW/COMP, ICWP, Katie Beckett)
- **Nursing Home**
- **30-day Hospital**



Categories of Medicaid Eligibility:

Eligibility types you might see at admission

Category	Description	*Compatible with Waiver
133	IV-E Foster Care	no
134	IV-E Adoption Assistance	no
152	Former Foster Children	no
153	Waiver Child in Foster Care	no
155	Wavier Child w/ Adoption Assistance	no
210	Nursing Home – Aged	no
211	Nursing Home – Blind	no
212	Nursing Home – Disabled	no

- *Categories not compatible with waivers require application with request to determine eligibility*
- *If income eligible for Supplemental Security Income, DFCS must deny the Medicaid application and advise the applicant to apply through the Social Security Administration*



Categories of Medicaid Eligibility:

Eligibility types you might see at admission

Category	Description	*Compatible with Waiver
224	Pickle - Aged	yes
225	Pickle – Blind	yes
226	Pickle – Disabled	yes
227	Disabled Adult Child - Aged	yes
228	Disabled Adult Child – Blind	yes
229	Disabled Adult Child – Disabled	yes
460	Qualified Medicare Beneficiary	no
466	Spec. Low Inc. Medicare Beneficiary	no
660	Qualified Medicare Beneficiary	no
661	Spec. Low Income Medicare Beneficiary	no

Categories of Medicaid Eligibility:

Eligibility Types You Might See at Admission

Category	Description	*Compatible with Waiver
250	Deeming Waiver (Katie Beckett)	yes
251	Independent Waiver	Yes
252	Mental Retardation Waiver	Yes
259	CCSP	Yes
280	Hospice – Aged	Yes (service limits)
281	Hospice – Blind	Yes (service limits)
282	Hospice - Disabled	Yes (service limits)
301	SSI – Aged	Yes
302	SSI – Blind	Yes
303	SSI - Disabled	Yes

Categories of Medicaid Eligibility:

Eligibility types you might see at admission

Category	Description	*Compatible with Waiver
410	Nursing Home – Aged	no
411	Nursing Home – Blind	no
412	Nursing Home – Disabled	no
424	Pickle – Aged	yes
425	Pickle – Blind	yes
426	Pickle – Disabled	yes
427	Disabled Adult Child – Aged	yes
428	Disabled Adult Child – Blind	yes
429	Disabled Adult Child – Disabled	yes
915	Aged MAO	yes
916	Blind MAO	yes
917	Disabled MAO	yes

Establishing Eligibility at Admission

When the individual is found eligible for NOW/COMP, if they do not already have Medicaid established through a billable category:

- Submit Medicaid application to the county DFCS office in the individual's county of residence
 - Can be submitted in person or online at <https://gateway.ga.gov/access>
 - If submitting in person, have the application date stamped
 - Retain copied of all documents provided to DFCS
- Planning List Administrator submits the application with copies of the following:
 - DMA-6 completed by the person's physician (approved by GMCF)
 - 3 months' of bank statements (include all pages of the statement even if they are blank!)
 - Current benefit letter from SSA re: the person's award
 - Copy of any life insurance policies or burial plan
 - The MAO Communicator found in the NOW/COMP policy manual
- When DFCS completes eligibility determination, the communicator is returned to the Regional Office/Support Coordination Office with approval date noted
 - Note: Eligibility determination standard of promptness is 60-90 days from date of application



Applications

- **When to apply**

- CMD
- Protected months

- **How to apply**

- Methods
- AREP
- Faster approval

- **General Process**

- Interview
- Verification



Applications

coverage, the Medicaid Specialist will contact you for more information and verifications.

PERSONAL INFORMATION: You may have someone help you complete this application.

Applicant's Name (Last, First, Middle Initial)	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial)
Mailing Address	
Street Address	Mailing Address
City State Zip	City State Zip
Do you own/are you purchasing home? <input type="checkbox"/> Y <input type="checkbox"/> N	
Phone County	Phone
E-Mail Address	E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual

COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.

Name (Self):	Birthdate	Sex	Race	U.S. Citizen (Yes or No)	Social Security Number	Marital Status
Maiden/other name(s):						
Name (Spouse):						
Maiden/other name(s):						

Are you applying for your spouse, too? Yes No

Are you blind or disabled? Yes No - Is your spouse blind or disabled? Yes No

LIVING ARRANGEMENT: Check the box(es) that best describes your current situation.

Living In Own Home	Nursing Facility	Another's Home	Hospice	Hospital	Katie Beckett	Community Care	Assisted Living	Other/Renting
	Date Admitted:			Date Admitted:		Date Admitted:		



Applications

HEALTH INSURANCE:

<p>Do you have Medicare?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you enrolled in a Medicare HMO or Medicare Drug program?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Type of Coverage</p> <p><input type="checkbox"/> Part A (hospital) <input type="checkbox"/> Part B (doctor)</p> <p><input type="checkbox"/> Part D (RX)</p>	<p>Effective Date: _____</p> <p>Medicare Number: _____</p>	<p>Have you ever received SSI?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, when did it end? _____</p>
<p>Does your spouse have Medicare?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Type of Coverage</p> <p><input type="checkbox"/> Part A <input type="checkbox"/> Part B</p> <p><input type="checkbox"/> Part D</p>	<p>Effective Date: _____</p> <p>Medicare Number: _____</p>	<p>Has your spouse ever received SSI?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, when did it end? _____</p>

Do you have other health insurance?

Yes No

Does your spouse have other health insurance?

Yes No

If you answered yes to either of these questions, please complete the following information:

	Health Insurance Company Name, Address, and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical,)	Effective Date	Policy Number
Self				
Spouse				

Attach copies (front and back) of Medicare and insurance cards if applicable.



Applications

RESOURCES: Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?

Checking account	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Funeral plans/ prepaid burial item	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Savings account	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burial plots or contracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Government bonds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stocks and bonds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trust funds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (IRA, CD, promissory note, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you or your spouse given away any assets for less than its value?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

Do you or your spouse have a life insurance policy? Yes No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Applications

INCOME AND EARNINGS: List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

Social Security SSI Wages/ Self-Employment
 Railroad Retirement Benefits Veterans' Benefits Trust or Annuity Payments
 Pensions/ Retirement Benefits ~~Rental Income Paid to You~~ Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)

Are you a veteran? Yes No Is your spouse a veteran? Yes No

Where did you and spouse work in the past? _____

Do you or your spouse have any unpaid medical bills ? Yes No

Applications

BY APPLICANT AND REPRESENTATIVE:

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	Date:
Signature of Applicant's Spouse or Representative:	Date:

DHR 700 (R. 05/11)

Applications

(PRINT NAME) (PRINT NAME)

ADULT(S) SEEKING BENEFITS				
Name	Place of Birth(city,state,county)	U.S. Citizen (check whichever applies)	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)

I, _____
(PRINT NAME) certify under penalty of perjury, that the information written and checked above is true.

SIGNATURE (PARENT/GUARDIAN)

(DATE)

SIGNATURE (PARENT/GUARDIAN)

(DATE)

MAO Communicator: where to find it

<https://www.mmis.georgia.gov>

The screenshot shows a web browser window with the URL <https://www.mmis.georgia.gov/portal/PubAccess.l>. The page features the Georgia Department of Community Health logo on the left and the GAMMIS logo in the center. A search bar is located in the top right corner. Below the logos, a blue banner displays the date "Tuesday, July 11, 2017" and a session expiration warning: "Refresh session | You have approximately 14 minutes until your session will expire." The main navigation menu includes links for Home, Contact Information, Member Information, Provider Information (highlighted), Provider Enrollment, Nurse Aide/Medication Aide, EDI, Pharmacy, and HFRD. A secondary menu lists various resources such as Home, Provider Notices, Provider Manuals (highlighted), Provider Messages, Fee Schedules, Forms for Providers, Reports for Public Access, and FAQ for Providers. A bookmarked link for "GAMMIS:Provider Manuals" is visible, along with a help link. The "User Information" section contains a "Login/Manage Account" button and a "Login" button. Below this, a "PDF Reader Required" notice states that Adobe Acrobat Reader is needed to view documents, with a link to download the latest version. A "File Download Issues" section is also present at the bottom.

https://www.mmis.georgia.gov/portal/PubAccess.l Provider Manuals

Edit View Favorites Tools Help

Suggested Sites Web Slice Gallery Page Safety Tools

Title	File Type	Category	Size (KB)	Release Date
UB-04 Billing Manual	PDF	ALL CATEGORIES	4878	05/12/2017
Adult Protective Services Targeted Case Management	PDF	CURRENT POLICY MANUALS	654.7	07/01/2017
Adults with Aids Targeted Case Management	PDF	CURRENT POLICY MANUALS	691.5	07/01/2017
Advanced Nurse Practitioner Services	PDF	CURRENT POLICY MANUALS	3688.4	07/01/2017
Affordable Care Act for Presumptive Eligibility Pregnant Women Medicaid	PDF	CURRENT POLICY MANUALS	16960.3	04/01/2017
Affordable Care Act for Presumptive Eligibility Women's Health Medicaid	PDF	CURRENT POLICY MANUALS	10149.5	04/01/2017
Ambulatory Surgical and Birthing Center Services	PDF	CURRENT POLICY MANUALS	1092.1	07/01/2017
At Risk of Incarceration Targeted Case Management	PDF	CURRENT POLICY MANUALS	577.9	07/01/2017
CCSP Adult Day Health Services_Chapter 1100	PDF	CURRENT POLICY MANUALS	614.8	07/01/2017
CCSP Alternative Living Services_Chapter 1200	PDF	CURRENT POLICY MANUALS	800	07/01/2017
CCSP Care Coordination Documents	PDF	CURRENT POLICY MANUALS	4195.8	07/01/2017
CCSP Care Coordination_Chapter 1800	PDF	CURRENT POLICY MANUALS	1825.3	07/01/2017
CCSP Emergency Response Services_Chapter 1600	PDF	CURRENT POLICY MANUALS	277.4	07/01/2017
CCSP General Services_Chapters 600-1000	PDF	CURRENT POLICY MANUALS	3390.2	07/01/2017
CCSP Home Delivered Meals_Chapter 1700	PDF	CURRENT POLICY MANUALS	540.2	07/01/2017
CCSP Home Delivered Services_Chapter 1300	PDF	CURRENT POLICY MANUALS	281.5	07/01/2017
CCSP Out of Home Respite_Chapter 1500	PDF	CURRENT POLICY MANUALS	545.8	07/01/2017
CCSP Personal Support Services_Chapter 1400	PDF	CURRENT POLICY MANUALS	524.6	07/01/2017
CCSP Skilled Nursing Services by Private Home Care Providers_Chapter 1900	PDF	CURRENT POLICY MANUALS	249.2	07/01/2017
Childbirth Education Program	PDF	CURRENT POLICY MANUALS	1196.5	07/01/2017
Children's Intervention School Services (CISS)	PDF	CURRENT POLICY MANUALS	1029.9	07/01/2017
Children's Intervention Services	PDF	CURRENT POLICY MANUALS	2499.5	07/01/2017
CMS 1500 Billing Manual	PDF	CURRENT POLICY MANUALS	4428.2	05/12/2017
Community Based Alternatives for Youth	PDF	CURRENT POLICY MANUALS	889.2	07/01/2017
Community Behavioral Health and Rehabilitation Services	PDF	CURRENT POLICY MANUALS	1940.6	07/01/2017
Comprehensive Supports Waiver Program (COMP) and New Options Waiver Program (NOW) Chapters 600-1200	PDF	CURRENT POLICY MANUALS	4988.2	07/01/2017
Comprehensive Supports Waivers Program (COMP) - Part III, chapters 1300-3500	PDF	CURRENT POLICY MANUALS	1216.6	07/01/2017
Comprehensive Supports Waivers Program (COMP) - Part III, chapters 1900-3500	PDF	CURRENT POLICY MANUALS	975.2	07/01/2017
Dental Billing Manual	PDF	ALL CATEGORIES	3548.3	05/12/2017
Dental Services	PDF	CURRENT POLICY MANUALS	1176.3	07/01/2017
Diagnostic Screening and Preventive Services	PDF	CURRENT POLICY MANUALS	1309.3	07/01/2017
Dialysis Services	PDF	CURRENT POLICY MANUALS	1530.2	07/01/2017
Durable Medical Equipment Services	PDF	CURRENT POLICY MANUALS	2541.2	07/01/2017
Early Intervention Case Management Program	PDF	CURRENT POLICY MANUALS	747	07/01/2017
Emergency Ambulance	PDF	CURRENT POLICY MANUALS	1179	07/01/2017
EPSDT Services - Health Check Program	PDF	CURRENT POLICY MANUALS	4718.7	07/01/2017

Starting the MAO Communicator

Rev. 01 2009

APPENDIX F
MR/DD WAIVER PROGRAM COMMUNICATOR
MAO DETERMINATION

Participant Name _____	County _____	MHID # _____
Address _____	Soc. Sec. # _____	Medicaid # _____
City _____ State _____ Zip Code _____	Date of Birth _____	(Area Code) Phone # _____

Provider _____ **Provide Support Coordination Agency Name and Phone #** Phone # _____

SECTION I COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR

LOC _____ Date participant was determined eligible for New Options Waiver (NOW)/Comprehensive Supports Waiver (COMP)
Date _____

Signature: _____ Date _____

MAO Communicator continued

SECTION II COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR (check those which apply)

Only for admission from institution _____ Participant currently resides in an ICF-MR which receives Medicaid reimbursement for his/her services. Please compute cost share. Discharge Date: _____ Also applies to nursing facility transition
 NOW/COMP Enrollment Date: _____

_____ Participant currently resides in the community and does not receive Medicaid. Please determine eligibility and cost share. Date services begin: _ Use LOC or support coordination agency acceptance date here

_____ Participant is currently receiving MAO. Please compute cost share.

_____ Participant needs annual re-determination of MAO status and cost share. Check here if submitting for annual redetermination

_____ Participant requires a home visit for application. (Reason in Remarks)

Signature: if annual recertification, SC signs _____ Phone No. _____ Date _____

*** SECTION III COMPLETED BY DFACS CASEWORKER**

_____ Date participant applied for MAO ELIGIBILITY DATE: Typically reflects date of application

* \$ _____ Participant's cost share Effective Date: _____

\$ _____ Participant's cost share due to liability change Effective Date: _____

_____ Date participant was determined INELIGIBLE. (Reason in Remarks)

Signature: _____ Phone No. _____ Date _____

Note: if admitted or readmitted to waiver from an institution, Communicator must be accompanied by a form DMA-59 reporting discharge from the institution.

At Termination

SECTION IV COMPLETED BY NOW/COMP PLANNING LIST ADMIN/SUPPORT COORDINATOR

This member has been released from the NOW/COMP effective Discharge for the following reason.
date

Signature: _____ Phone No. _____ Date _____

SECTION V COMPLETED BY NOW/COMP SUPPORT COORDINATOR OR DFACS CASEWORKER

REMARKS:

July 1, 2017

COMP/NOW Waiver Programs

F- 1



Authorized Representative

- **Can I Choose Someone to Apply for Food Stamps or Medicaid for me?**

Complete this section only if you want someone to fill out your application, complete your interview, and/or use your EBT

card to buy food when you cannot go to the store. If you are applying for Medicaid, you can choose more than one person to apply for medical assistance on your behalf.

- Name: _____ Phone: _____

- Address: _____ Apt: _____

- City: _____ State: _____ Zip: _____
- Name: _____ Phone: _____

- Address: _____ Apt: _____

- City: _____ State: _____ Zip: _____

For Medicaid, do you want this individual to have a copy of your Medicaid card? Yes No

Reestablishing Eligibility Annually

- Submit Medicaid application to the county DFCS office in the individual's county of residence
 - *Can be submitted in person or online at <https://gateway.ga.gov/access>*
 - *If submitting in person, have the application date stamped*
- Support Coordination Agency submits the application with copies of the following:
 - *DMA-7 with Field Office Nurse or GMCF approved LOC determination*
 - *3 months' of bank statements (include all pages of the statement even if they are blank!)*
 - *Current benefit letter from SSA re: the person's award*
 - *Copy of any life insurance policies or burial plan*
 - *The MAO Communicator found in the NOW/COMP policy manual*

Renewals

- **General Process**
- **How to Submit**
- **“Failed to Cooperate” closure**



Common Errors

1. What are the most common errors clients make that slows down the process?
 - Not reporting income or assets (like direct express cards or “small” retirement checks)
 - Not signing application
 - Not thoroughly completing mandatory forms
 - Providing “some” verification but not “all”
2. What are the most common errors Waiver Programs make that slows down the process?
 - Not providing Communicator/LOC forms
 - Not understanding SSI vs. RSDI
 - Not understanding “not cooperating” notices



Verification

As a general rule, any asset or income that is “yes” on the application or renewal will need to be verified

- Current value of all assets – beginning the first month a Medicaid decision is needed through the “current” month.
- Proof of assets with transferred ownership – sold, gifted, quit claim, etc – within the last 60 months
- Proof of all income, including any deductions
- Proof of health insurance premiums + copy of both sides of insurance card



Notes about Annual Redetermination

- Occurs annually **from date of original eligibility determination**
 - *Notice is sent to the Medicaid member at the last known address*
 - *Notice includes date of recertification and deadlines for submitting the application and required documentation*
- Does not follow LOC date, ISP date or waiver participant's date of birth
- "Second Authorized Representative" status assures that support coordination agency receives all correspondence received by the waiver participant
 - Note: this is an important way to keep track of the annual recertification date and document requirements

Annual Redetermination and the MAO Communicator

- Tell the DFCS case manager the following:
 - Waiver participant remains in the NOW/COMP Waiver Program
 - Waiver participant current address (be sure to indicate new address if applicable)
 - Any change in status, e.g. move from NOW to COMP
 - Report change of address by phone through the Change telephone access (number found on the Medicaid card) within 10 days of the change
 - Any change in second authorized representative

Helpful Tips:

- Send the DFCS case manager your Agency Name and Agency Phone Contact as well as your direct contact information.

Starting the MAO Communicator

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APPENDIX F
MR/DD WAIVER PROGRAM COMMUNICATOR
MAO DETERMINATION

_____ Participant Name			_____ County	_____ MHID #
_____ Address			_____ Soc. Sec. #	_____ Medicaid #
_____ City	_____ State	_____ Zip Code	_____ Date of Birth	_____ (Area Code) Phone #

Provider _____ **Provide Support Coordination Agency Name and Phone #** Phone # _____

SECTION I COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR

LOC _____ Date participant was determined eligible for New Options Waiver (NOW)/Comprehensive Supports Waiver (COMP)

Date _____

Signature: _____ Date _____

MAO Communicator at annual recertification

SECTION II COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR (check those which apply)

_____ Participant currently resides in an ICF-MR which receives Medicaid reimbursement for his/her services. Please compute cost share. Discharge Date: _____
NOW/COMP Enrollment Date: _____

_____ Participant currently resides in the community and does not receive Medicaid. Please determine eligibility and cost share. Date services begin: _

_____ Participant is currently receiving MAO. Please compute cost share. Use this section to indicate recertification need.

_____ Participant needs annual re-determination of MAO status and cost share. Check here if submitting for annual redetermination

_____ Participant requires a home visit for application. (Reason in Remarks)

Signature: if annual recertification, SC signs _____ Phone No. _____ Date _____

*** SECTION III COMPLETED BY DFACS CASEWORKER**

Well reflect date of redetermination

_____ Date participant applied for MAO ELIGIBILITY DATE: redetermination _____

* \$ _____ Participant's cost share Effective Date: _____

\$ _____ Participant's cost share due to liability change Effective Date: _____

_____ Date participant was determined INELIGIBLE. (Reason in Remarks)

Signature: _____ Phone No. _____ Date _____

Entering/Discharging from Nursing Home with Active Waiver Status

- **Continuing Medicaid Determination (CMD)**
- **Submit proof of nursing home discharge (DMA-59 completed by the nursing facility)**



Questions?

