# SECTION 200: ELIGIBILITY CRITERIA AND APPLICATION PROCESS

REVISED: 02/01/2013

Section 200 outlines eligibility criteria and procedures for county departments of social services workers and Social Workers for the Blind to use when accepting applications for Medical/Eye Care Services. Instructions are formatted to illustrate various types of individual circumstances that may be presented at time of application. A copy of the DSB-2001: Application for Eye Care Certification is in Section 400: Reporting Requirements, Part A.

## I. PROGRAM ELIGIBILITY

Medical Eye Care Services are available to North Carolina residents based on their need for the service, their income and their Medicaid status. **An individual is considered a resident if he/she is in North Carolina voluntarily with the intent to remain and is not an illegal alien. He/she must present a Green card as verification. The Green Card is not green but is an I-551. This is also called a Permanent Resident Card. An I-94 with a temporary I-551 stamp can also be accepted as verification. A Social Security card does not document legal residence**. Please note that the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 made significant changes in Medicaid eligibility for individuals who are not citizens of the United States. For detailed definitions in this area, refer to the Medicaid Manual issued by the Division of Medical Assistance.

### A. Need for Service

Those individuals having a need for medical eye care services may have symptoms or conditions such as pain or discomfort in their eyes, blurred vision, or obvious ophthalmological disorders, including eye pathology. Other individuals having need for medical eye care services include school-age children who are having difficulty reading from the blackboard or reading textbook print.

The needed service cannot be a service that is reimbursable through any insurance program or any State or Federal program. The Medical Eye Care Program is funded with all State funds and as such **must** be used as a last resort.

### B. Income

Applicants for medical eye care services must meet income criteria based on established net income scales. **The income scale represents 100% of the Federal Poverty Level (FPL) and is used to determine eligibility.** This scale is based on total cash resources of the family in which the applicant resides including interest/dividends earned from savings accounts, certificates of deposit, and any other resource. The interest/ dividend **is counted** as income even if the applicant/ recipient does not receive a payment but allows the earned funds to be added to the principal. The family's total cash resources or net income is defined as the amount remaining after allowable deductions are subtracted from the family's annual gross income.

### C. Medicaid Status

A North Carolina resident who meets financial eligibility criteria would only be eligible for medical eye care services based on Medicaid status if:

1. the services are not covered by the NC Medicaid Program; or

2. the resident is a Medicaid recipient on a spend-down who qualifies under the appropriate income criterion; or

3. the services cannot be reimbursed by any other state or federal program providing eye care.

## II. INSTRUCTIONS FOR COMPLETING DSB-2001: APPLICATION FOR EYE CARE CERTIFICATION

A. Voter Registration

DSB is one of several state agencies in North Carolina required to offer voter registration services (G.S. 163-82.20 effective January 1, 1995). We are required to offer all individuals the opportunity to register to vote or update their voter registration records each time an individual applies for services, for renewal or re-certification of services, or to provide a change of address or name. Please refer to Appendix F in this manual for the agency policy. In the INTERVIEWER USE ONLY SECTION on page 3 of the DSB-2001: Application for Eye Care Certification please check the box that voter registration services have been offered. The link to the Voter Registration policy is http://info.dhhs.state.nc.us/olm/manuals/dsb/VR/man/Voter%20Registration.htm

B. Completing DSB-2001

An individual may apply for medical eye care services in person at their county department of social services (Exception: Forsyth, Mecklenburg, Pitt and New Hanover Counties apply at district DSB office; in Beaufort County apply at The Blind Center, and in Lenoir County at Lions Industries for the Blind) or by mail by completing **the following (1) DSB-2001: Application for Eye Care Certification; (2) DHHS-1000: Authorization to Disclose Health Information, and (3) Voter Registration Preference Form.** Remind the applicant to complete all applicable sections, to sign the application and other required forms and to mail all items to the county department of social services or the office which mailed forms to him/her.

All completed applications will be reviewed and eligibility determined by the county DSS worker or the Social Worker for the Blind according to program policy. **The applications may also be reviewed by the Nursing Eye Care Consultants in the District Office, the Area Social Services Supervisors, and the Chief of the Medical Eye Care program or a designee. If errors are found or if fraud is confirmed, the certification can be canceled at any time. Bills already accrued will be paid but no additional bills will be paid after the revocation.**

A copy of the revised DSB-2001 is in section 400.

Specific instructions for completing DSB - 2001: Application for Eye Care Certification:

C. Identifying Information (self-explanatory)

D. Insurance Information

1. Check each applicable response. Be sure to include policy numbers where applicable.

2. Enter type of Medicare, if applicable.

3. **If the applicant/recipient has applied for Medicaid and is then certified for the Medical Eye Care Program, the interviewer must inform the applicant/recipient that it is his/her responsibility to notify the interviewer or the Nursing Eye Care Consultant in the DSB District Office immediately if he/she is approved for Medicaid. If an individual is approved for Medicaid, he/she may also be eligible for limited services with the Medical Eye Care Program. The interviewer should provide the applicant/recipient with phone numbers for both the interviewer and the NECC. Verify the applicant's Medicaid status. Print a copy of the Medicaid eligibility screen and attach the verification to the applicant's MEC application, DSB-2001.**

4. If a person has medical insurance, including Medicare Parts A, B, C (Advantage Plans), and D* and the requested service is an allowable plan benefit, no Medical Eye Care authorization will be issued. The individual is responsible for the deductible, co-insurance and co-payments required by their medical insurance policy.

If the applicant or eye care provider provides documentation from the insurance carrier that the applicant's policy does not include the eye-related service as a plan benefit, prior approval may be requested to determine if the Medical Eye Care Program can provide the service.

The applicant should provide a copy of their insurance card(s). Verification of applicant's Medicare status (OLV printout or a copy of the Medicare card) will be maintained in the applicant's file.

Special Note: If the applicant is eligible for Medicare Part D, he/she will no longer be eligible for prescription drug coverage through the Medical Eye Care Program. If the Medicare Part D plan does not cover a particular drug, the applicant may talk with their provider about selecting a drug that is approved by their plan and/or appeal to their plan.

5. If an applicant/recipient has any third-party Insurance please record the company and policy number on the application on page one. Please maintain a copy of the insurance information in the applicant's file.

6. Refusal to Apply for Medicare Benefits- With the exception of qualified aliens who have not lived in the United States for five consecutive years, all Medicaid recipients age 65 or older are required to apply for Medicare coverage. If a Medicaid recipient is entitled to Medicare benefits, but refuses to apply for and accept benefits, he will be responsible for payment of claims that would have been covered by Medicare.

E. Family Members in Household

1. The names and incomes of all family members will be used in computing the net income available to the applicant. List in spaces provided. If additional space is needed, use bottom of page or on back of page .

a. **Family** is defined as the basic unit consisting of one or more adults and children, if any, related by blood, marriage, or adoption, and residing in the same household. Included in the family unit are its children age 18 through 22 who are listed on the family’s income tax return as dependents.

b. Where related adults (other than spouses) or unrelated adults reside together, each is considered a separate family.

c. **Examples of one-person families**:

(1.) Children living with non-legally responsible relatives

(2.) Children living with individual(s) unrelated to them

(3.) Emancipated minors

(4.) A foster child living with a foster family. The income available solely to the child, such as foster care payments, would be the only income used in computing net income.

(5.) An applicant living with his/her adult son's or daughter's family. Only the income of the applicant and **not** that of the son's or daughter's family would be counted.

d. **Definitions of Child and Adult:**

**(1.)** A **child** is defined as an individual 0 through 18 years of age and not an emancipated minor.

**(2.)** A **adult** is defined as an individual 19 years of age or over, or an individual who is an emancipated minor.

F. Income Listings

**All income of the family unit** must be considered in determining eligibility for medical eye care services. **Income is defined as cash or in-kind resources received for labor, services, government or private benefits, or any money available to the a/r and his/her family unit for maintenance.** The types of income listed below are examples of income that the applicant must report, where applicable.

1. **Gross Annual Income**: Total money received in the twelve months preceding application date for medical eye care services if self employed.

2. **Gross Monthly Income**: Computed on income for the six months preceding the date of application. However, the applicant may present written documentation of one month's income and attest to the fact that income has been constant for the other five months.

3. **Gross Wages**: Gross monthly wages (if income is determined on a weekly basis, multiply the weekly amount x 4.3; if bi-weekly, multiply x 2.16). See examples under item F: Computation of Gross Income.

4. **Pensions (SSI, SSDI, VA, Social Security, other retirement, etc.)**: Record the full monthly payment received by all individuals included in the family unit.

5. **Zero (0) Income**: If applicant states that he/she has no income (zero money received), **the worker** must inform the applicant that even though their income may presently be zero, income must be averaged for at least six months preceding the medical eye care services application date. The applicant or the interviewer should indicate in the space at the bottom of the application on page one how the applicant survived with no income. *The interviewer will need to*

*verify all sources of cash and/or in-kind contributions.* **A written statement must be provided giving the value of cash and/or in-kind contributions, and it must be signed and dated by the person who provides the applicant's support and maintenance. The value of in-kind contributions must be listed and documented in the 'Support from family/friends' column on page 2 of the application. All other cash or financial contributions are listed and documented in the 'Other' column.**

6. **Other**: All other income received by individuals included in family unit, such as workman's compensation, unemployment benefits, child support, alimony, veterans benefits, interest or dividends (regardless of whether A/R receives a check or has this income added to the principal), support from friends or family members, or other income including the proceeds from the sale of real or personal property, or an insurance settlement.

7. If you have questions regarding financial issues please consult the Adult Medicaid manual. The link is: http://info.dhhs.state.nc.us/olm/manuals/manuals.aspx?dc=dma

G. Verification of Income (Use the "Documentation" column on page 2.)

1. **Employer Statement**: Income may be verified by a written statement from the applicant's employer or written proof of other sources of income.

2. **Food Stamp Records**: Excellent source of income verification. If income is verified by food stamp records, also enter the eligibility date for food stamps.

3. **Verification from the Social Security Administration**: The worker must list the most recent date of the verification on the application in the Documentation column on page 2. The verification may be in various forms: a telephone call to SSA with date and SSA Worker's name as well as income amounts documented, information obtained in an on-line inquiry or information received in a print document (current award letter or a special inquiry). The OASDI amount does not reflect the amount after Medicare has been withheld.

4. **Check Stub with Year-to-Date Income (does not reflect when employment began):** Date applicant began work must be verified in order to compute average monthly income. However, the applicant may present a stub for one pay period and attest that the pay has been constant for the past six months.

5. **Signed Statements**: The applicant may have a statement signed by a cashier at a bank or store verifying that the cashier cashed the check and the amount of the check. Social Security or Veteran's Administration pension recipients who have no check stub can use this type of verification. An award letter from Social Security or Veteran's Administration may be used if it shows current income. Cash contributions and in-kind income must be documented by a signed statement from the provider(s).

6. **W-2 Form or Tax Returns**: These tax documents can be a source of verification of income and may be the only source of verification for self-employed persons. Example: A farmer may only have the previous year's tax return to provide an accurate evaluation of his/her income. The total taxable income line number 43 on the 1040 Form would reflect some of the deductions allowed by the Medical Eye Care Program. **Do not deduct an expense on the DSB-2001 Application for Eye Care Certification if it has already been deducted in the computation of a person's taxes. If itemized deductions are listed on Line 40a of the Form 1040, the applicant must attach a copy of Schedule A. If an unallowable deduction is listed on Schedule A please disregard that deduction.**

**7. If no other sources of documentation are available then the a/r's statement would be accepted as fact.**

8. **Maintaining Verification:** The worker should maintain verification of all financial information in their client files.

H. Computation of Gross Income ( Show the amount after the interviewer has changed all income to reflect total monthly income.)

1. Applicants with Weekly Income:

Determine the representative weekly amount by totaling the income from all pay periods in at least two consecutive months. Divide this amount by the number of pay periods and multiply by 4.3.

| | | | |
|---|---|---|---|
| January | 05 | $158.60 | |
| January | 12 | $169.30 | |
| January | 19 | $146.20 | |
| January | 26 | $152.60 | |
| February | 02 | $136.80 | |
| February | 09 | $137.10 | |
| February | 16 | $159.70 | |
| February | 23 | $150.70 | |
| | | $1,211.00 | Total for 8 consecutive weekly pay periods |
| $1, 211.00÷8= | $151.38 | $151.38 | |
| | | x 4.3 | weeks/month |
| | | $650.93 | average monthly income |

2. Applicants with Bi-Monthly Income:

Determine the bi-monthly amount by totaling the income from all pay periods in at least two consecutive months. Divide this amount by the number of pay periods and multiply by 2.16.

| | | | |
|---|---|---|---|
| March | 05 | $268.00 | |
| March | 19 | $240.00 | |
| April | 02 | $275.00 | |
| April | 16 | $246.00 | |
| April | 30 | $260.00 | |
| | | $1,289.00 | |
| $1289.00÷5 = | $257.80 | $257.80 | |
| | | x 2.16 | bi-monthly |
| | | $556.85 | average monthly income |

3. Applicants with Irregular Income:

For applicants working irregularly, such as 2 or 3 weeks and none the 4th week, the worker will

use either the Weekly or Bi-Weekly calculation method in 1 or 2 above of calculating monthly income, adding in zeros for pay periods in which no income is received.

An applicant is paid weekly and has the following income:

| | | | |
|---|---|---|---|
| January | 05 | $158.70 | |
| January | 12 | $169.30 | |
| January | 19 | $000.00 | |
| January | 26 | $152.60 | |
| February | 02 | $136.80 | |
| February | 09 | $137.10 | |
| February | 16 | $000.00 | |
| February | 23 | $150.70 | |
| | | $905.20 | |
| $905 ÷ 8 = | $113.15 | $113.15 | |
| | | x 4.3 | weeks |
| | | $486.55 | average monthly income |

I. Allowable Monthly Deductions

Allowable deductions apply to all applicants, regardless of adult/child status. Enter amounts of average monthly allowable deductions/expenditures in spaces provided on right-hand side of application.

1. Work-Related Expenses: Allow for Federal, State, FICA (Social Security) and Medicare taxes.

2. There are no special deductions for residents of rest homes or nursing homes. Total all allowable deductions and enter this amount on page 2 of application.

J. Net Income Scale for All Applicants: Effective Date 03/31/2014

**Children and Adults**

The worker will use the income scale below to certify financial eligibility for all applicants.

**INCOME SCALE**

| Family Size | Monthly Maximum Net Income | Annual Maximum Net Income |
|---|---|---|
| 1 | $ 973 | $ 11,670 |
| 2 | $ 1,311 | $ 15,730 |
| 3 | $ 1,649 | $ 19,790 |
| 4 | $ 1,988 | $ 23,850 |
| 5 | $ 2,326 | $ 27,910 |
| 6 | $ 2,664 | $ 31,970 |
| 7 | $ 3,003 | $ 36,030 |
| 8 | $ 3,341 | $ 40,090 |
| 9 | $ 3,974 | $ 44,150 |
| 10 | $ 4,312 | $ 48,210 |
| 11 | $ 4,650 | $ 52,270 |
| 12 | $ 4,908 | $ 56,330 |

For each additional family member beyond 12, add $4,020 to yearly Maximum Net Income to meet 100% of the poverty guideline.

K. Other Information

1. **Choice of Provider**: Explain Freedom of Choice statement to applicant and have applicant indicate his/her choice of provider.

2. **Signature and Date**: Obtain applicant's signature (or parent's signature if applicant is a minor) and indicate date on page 3 of application form.

3. Age Restrictions

a. **For recipients 0 through 24 years of age , refractions and eyeglasses are restricted to one annually.**

b. **For recipients age 25 or older, refractions and eyeglasses are restricted to one every two years.**

4. The worker will sign the application, add his/her title and telephone number, and complete the requested information at the bottom of page 3.

5. **Disposition of Application Form**: The worker will FAX or mail all original applications to the DSB District Office after completing the eligibility determination process. One copy of each application will be kept in the local office. The District Offices and the Department of Social Services will retain the applications for a minimum of three (3) years. Forms will be available upon request for auditing and evaluation purposes.

L. Determination of Eligibility for Certification Period

The interviewer will determine the eligibility of the applicant when all the financial information and supporting documentation has been received from the a/r, and verified by the interviewer. The certification period will be for six (6) months, beginning on the date financial eligibility is determined by the interviewer.

M. Incomplete Application

The worker will return any application that is incomplete or contains incorrect data to the applicant for completion or correction. See DSB-2032 in Section 400, Part A: Reporting Requirements.

N. Notification of Eligibility Status

Applicants may be notified of their eligibility status while at the office where he/she is making application as soon as the worker completes the required determination, including verification of income and resources or they may be notified by mail (see DSB-2033 in Section 400, Part A). The worker will maintain a copy of the applications eligibility documentation and notification letters for a minimum of 3 years.

When an applicant's initial eligibility for medical eye care services has been approved, an authorization for services will be printed. Depending on the computer access of the local issuing agent (either the county

DSS staff or the local Division of Services for the Blind staff), the consumer will receive the authorization which is for the eye exam only, in one of the ways listed below.

1. The authorization may be printed and given to the consumer when he/she is in the county DSS office.

2. The authorization may be mailed to the consumer from a DSB area office.

3. In some cases, it may be requested that the authorization be mailed from the DSB office to the provider selected by the consumer.

A detailed explanation of the automated authorization and certification process is provided in Appendix B, Medical Eye Care Automation.

## III. EYE EXAMINATIONS AND REFRACTIONS

A. General Coverage Restrictions

1. The Medical Eye Care Program pays for routine eye exam with a refraction only once per year for a recipient 0 through 24 years of age (Medicaid receipients age 21 through 24 years of age), and an eye examination with refraction one every two years for a recipient 25 years and older. When justified by medical necessity, the provider may request prior approval for a second refraction. A change of power generally equal to or greater than one diopter in either eye (progressive myopia, cataract development, etc.) may justify approval for new lenses.

2. Replacement of lost, stolen, or damaged eyeglasses may be considered when the replacement is requested by the SWB or the worker at the local County DSS. A police report may be required if they have been stolen, a fire report if damaged in a fire or an accident/police report if damaged in an auto accident. The request should be forwarded to the NECC. Also, the Contractor provides a one year warranty which covers manufacturing defects and breakage or damage incurred during normal wear.

3. The Contractor with the Medical Eye Care Program supplies zylonite combination frames and metal frames for eligible recipients. Rimless frames will **not** be approved. The addition of nose pads on an approved zylonite frame may be approved if no contract frame will fit the recipient and if the medical necessity is documented. Other exceptions to contract frames will be considered on an individual basis when medical necessity is documented.

4. A recipient **cannot elect to purchase his/her own frame in lieu of those provided by the MEC Program.** If the recipient does elect to purchase a new frame privately, then he/she is also responsible for the purchase of the lenses. This will be private transaction between the provider and the recipient.

B. Specific Eye Conditions

1. Cataracts

Yearly evaluations for visual checks and cataract development may be necessary to determine when the recipient is ready for cataract surgery. These visits should not be billed as complete eye examinations. If the Recipient has lost significant vision, then a request should be made of the NECC for a second refraction within the allowed time frame. If acuity is diminished to the point of needing a change of lens

power and cataract surgery is not scheduled, then the NECC will determine whether the change meets the guidelines of the Program.

2. Eye Injuries

If a recipient requests an eye refraction at the time of an eye injury or if there is a condition present that could affect acuity (conjunctivitis, blepharitis, etc.), the refraction should be delayed until the problem is resolved and the acuity would not be affected.

3. Diabetic Patients

Diabetic recipients may require more frequent eye refractions or eyeglass lens changes than other recipients. If a new refraction is requested by the physician and the recipient's eye condition has changed, the opthalmologist or the optometrist may request approval from the NECC for an additional refraction and/or new lens if the change meets the Program's guidelines.

4. Glaucoma/Retinal Disease

Recipients with glaucoma/retinal disease may need more frequent eye exams than that allowed by the Program's guidelines. Retinal diseases (diabetic retinopathy, macular degeneration, etc.) are among the leading causes of blindness. Follow-up exams may be authorized by the NECC when recommended by the opthalmologist or optometrist and as long as the recipient remains eligible for the Medical Eye Care Program.

**IV. RETROACTIVE AUTHORIZATION FOR EMERGENCIES**

Under certain conditions, when emergency cases cannot be prior approved the Division will reimburse charges for services provided prior to authorization. For eye exams, surgery and hospitalization, **only emergency cases may be approved retroactively**. **The following guidelines will apply in all instances:**

A. The services provided are consistent with the scope of services covered by the Medical eye Care Program.

B. The service (s) must have been provided **no more than ninety (90) days before the date of application.**

C. The applicant must have been eligible for services had he/she made application at the time the services were delivered. Verification of income for the period preceding this must be provided by the applicant. **The six month certification period would begin the date services were delivered.**

D. **Approval for emergency eye exams can be given by the Nursing Eye Care Consultants. Prior approval for emergency surgery and treatment will only be given by the State Consulting Ophthalmologist.**

E. If emergency surgery is approved by the State Consulting Opthalmologist, and if the recipient needs eyeglasses the Nursing Eye Care Consultant can approve the request if the lens prescription meets the requirements of 0.62 diopters sphere or cylinder.

**V. REDETERMINATION OF ELIGIBILITY**

The Authorization and the Certificate for Fitting and Dispensing of Eye Glasses are valid for a six (6) month period from date of issuance. If the recipient does not use these forms within this time period, he/she must re-apply for medical eye care services if services are still needed.