
APPLICATION

REVISED 02/01/2024 – CHANGE NO. 01-24

Change No. 01-24:

- **Section V. Updates**

- This section has been renamed: Electronic Pre-Assessment Screening Service (ePASS).
- Subsection headers have been added.

- **Section VI. Added**

Section VI. has been inserted to provide policy and procedures regarding Federally Facilitated Marketplace (FFM) applications. The following subsections have been added:

- Background
- Ongoing MAGI Applications Fully Verified (FFM Determination Evidence present)
- Ongoing MAGI Applications Not Fully Verified by the FFM (No FFM Determination Evidence present)
- FFM Referrals
- Appeals of an FFM Determination of Eligibility

I. INTRODUCTION

An individual must be afforded the opportunity to apply on the day they appear in the local agency requesting medical or financial assistance without being discouraged.

The type of contact made by the individual determines the procedure the local agency must follow. An individual or representative may apply at any local agency by any mode that an application may be submitted.

An application is considered complete when:

1. Signed by the applicant, and
2. Received by the local agency

Individuals must be advised that an eligibility determination cannot be made until the Medicaid application is complete.

An application may be submitted for ongoing and/or retroactive Medicaid. Retroactive coverage is 1, 2, or 3 months prior to the month of application.

The following sections outline the procedures for processing an application and all the possible outcomes.

II. HOW TO SUBMIT AN APPLICATION

Medicaid applications may be submitted: in-person, by mail/fax/email, online, or telephone.

- A. All applications must be accepted without prior screening or an interview.**
- B. All signed applications must be registered into NC Fast within three work days of receipt by the local agency.**
- C. In-person or telephone applications should be keyed into NC Fast during the interview.**
- D. The following individuals have the right to submit an application:**
 - 1. The applicant, including a minor who is applying on their own behalf.
 - 2. A representative who alleges that they are acting on behalf of the individual.

A representative may include, but is not limited to:
 - a. Relative
 - b. Friend
 - c. Medical facility staff

III. IN-PERSON

- A. An individual may submit an application by completing a face-to-face interview with a caseworker of the local agency.**
- B. The local agency must maintain a log to register and track ALL Medicaid/NCHC applications. The log may be:**
 - 1. Manual or automated [DMA-5093](#), Daily Reception Log for Medical and Financial Assistance, or
 - 2. Utilized in the reception function of NC FAST.
- C. Agency staff must explain and provide to the applicant a copy of:**
 - 1. The [DMA-5094 / 5094S](#), Notice of Your Right to Apply for Benefits
 - 2. The [DSS-8227](#), Important Information You Need to Know

3. The [DMA-5001](#) / [DMA-5001S](#), Notice on the Use of Social Security Numbers

D. Application date is the date the application is signed in the local agency.

E. The caseworker must:

1. Enter all information provided by the applicant or representative into NC FAST, and,
2. Review with applicant prior to signature that:
 - a. All information was given truthfully to the best of their knowledge, and
 - b. They understand the rights and responsibilities as an applicant,
 - c. They authorize the investigation of eligibility for assistance by the local agency, the State Division of Medical Assistance and the United States Department of Health and Human Services.

IV. BY MAIL/FAX/EMAIL

A. An individual may submit an application by forwarding to the local agency a [DMA-5200](#) / [DMA-5200S](#), Application for Health Coverage & Help Paying Costs.

A drop-off is considered a mail-in application.

B. If an applicant contacts the local agency and requests an application be mailed to them, prepare an application packet to include:

1. The [DMA-5200](#) / [DMA-5200S](#), Application for Health Coverage & Help Paying Costs
2. The [DSS-8227](#), Important Information You Need to Know
3. A pre-addressed return envelope

C. The local agency must maintain a log to register and track ALL mail/fax/email Medicaid applications. The log may be:

1. The [DMA-5105](#), Log for Adult Medicaid Mail-In Application, either paper or electronic
2. The [DMA-5066](#), Log for NC Health Choice/Medicaid Mail-In Applications, either paper or electronic

D. A complete application is one that meets the following criteria:

1. The information provided is legible.
2. The application is signed by the individual applying or signed by a representative.
3. The application includes:
 - a. The name and date of birth of at least one applicant, and
 - b. Mailing address

E. If any items above are missing, this is considered an incomplete application. Take the following actions within one workday:

1. The local agency should attempt to contact the applicant by phone or mail to obtain the necessary information to enter the application in NC FAST.
2. If the application is not signed, return it to the individual along with a [DMA- 5104](#) / [DMA-5104S](#), Notice of Incomplete Letter, indicating that the application needs to be signed. Document on the DMA-5066/5105.

F. The caseworker must enter all information provided by the applicant or representative into NC FAST.

G. Application date is the date the application is received during agency hours of operation. The application date is the next business day, when received after agency hours.

V. ELECTRONIC PRE-ASSESSMENT SCREENING SERVICE (EPASS)

A. Definition

ePASS is a secure, web-based self-service tool that allows individuals to submit a Medicaid application online.

B. Procedures

1. ePASS allows the applicant to do a pre-assessment to determine if the individual is potentially eligible for medical assistance.
2. An application submitted through ePASS is forwarded directly to the local agency.
3. NC FAST determines the date of application by when it is received/submitted.

VI. Federally Facilitated Marketplace (FFM)

A. Background

[Healthcare.gov](https://www.healthcare.gov), also known as the “Marketplace” or “exchange” is a secure web-based self-service tool that allows individuals to shop for and/or enroll in affordable health insurance.

Beginning February 1, 2024, the FFM will determine MAGI Medicaid and Marketplace eligibility for residents of North Carolina, when the individual applies for medical coverage at the FFM. The determination of eligibility and any FFM verifications included on the application case file are final and will not require any additional follow up.

FFM Determination state means the FFM is attempting to make an eligibility determination for NC Medicaid. The FFM determination will not provide the specific Medicaid program category. NC FAST receives the application and eligibility determination from the FFM and then completes the STP application process and attempts to authorize the application in the appropriate MAGI Medicaid program category (i.e., MIC/N/1, MAF, MPW, MXP). Refer to NC FAST Job Aid FFM Determination Processing for more information regarding how FFM and NC FAST exchange information.

FFM applications with FFM Determination evidence present, may also include FFM referrals for non-MAGI programs (i.e., disability, emergency services, medically needy). Applications received with a referral for a non-MAGI program must be evaluated by the local agency following the applicable application policy.

All applicants will have a separate eligibility determination. One or more applicants may have FFM Determination Evidence present. For any applicant who does **not** have FFM Determination evidence, the caseworker may be required to complete a full eligibility determination if the application falls out of the NC FAST Application STP.

B. Ongoing MAGI Applications Fully Verified (FFM Determination Evidence present)

1. If the FFM is able to complete a full eligibility determination for all applicants, there will be FFM Determination evidence present on the Medicaid case.
 - a. The FFM will send the secure file transfer to NC FAST, and NC FAST will attempt STP application process to determine the applicable MAGI program category and authorize the application and create a Medicaid case.
 - b. If the application is able to be authorized, NC FAST will authorize the application, create the case, and send the automated approval

notice DHB-8030 Notice of Medicaid Application Determination.

- c. No action is required by the caseworker.
2. If NC FAST is **unable** to authorize the application in the STP process due to a system issue:
- a. The application will fall out of the STP application process.
 - b. The caseworker must resolve any outstanding system issues to authorize the appropriate MAGI Medicaid program category (i.e. person match issue, one or more applicants are active on another Insurance Affordability Case).
 - c. The FFM Determination of eligibility and any verifications verified by the FFM are final. **Do not** attempt to redetermine eligibility or reverify any FFM verification received.
 - d. The caseworker should resolve the outstanding system issue(s) that prevented the case creation.
 - e. The caseworker must take the appropriate action based on the system issue that prevented the case creation.
 - f. For some system issues (i.e., person match), the caseworker must authorize the application once the issue has been resolved. For other system issues (i.e., one or more applicants are on an active Insurance Affordability Case), the caseworker must take appropriate steps for reported changes in circumstances.
 - g. Send the applicable notification. (DHB-8030 Notice of Medicaid Application Determination, DSS-8110, Your Medical Assistance Benefits are Changing/Continuing, or other as appropriate).

C. Ongoing MAGI Applications Not Fully Verified by the FFM (No FFM Determination Evidence present)

1. If the FFM is **unable** to fully verify the application and determine eligibility:
 - a. There will **not** be FFM Determination Evidence present.
 - b. NC FAST will attempt to complete the eligibility determination and verify any outstanding verifications in the STP application process.
 - c. If the application is authorized, NC FAST will send the automated approval notice DHB-8030 Notice of Medicaid Application

Determination.

- d. No action is required by the caseworker.
2. If NC FAST **is** able to verify any outstanding verifications and determine eligibility but is **unable** to authorize the application in the STP process due to a system issue (i.e. person match, one or more applicants are on an active Insurance Affordability Case):
 - a. The application will fall out of the STP application process.
 - b. The caseworker must resolve any outstanding system issues (i.e. person match issue, one or more applicants are active on another Insurance Affordability Case).
 - c. Any verifications verified by the FFM are final. **Do not** attempt to reverify any FFM verification received.
 - d. For some system issues (i.e., person match), the caseworker must authorize the application once the issue has been resolved. For other system issues (i.e., one or more applicants are on an active Insurance Affordability Case), the caseworker must take appropriate steps for reported changes in circumstances.
 - e. Send the applicable notification. (DHB-8030 Notice of Medicaid Application Determination, DSS-8110, Your Medical Assistance Benefits are Changing/Continuing, or other as appropriate).
 3. If NC FAST is **unable** to verify any outstanding verifications via electronic sources, the caseworker will follow normal application policy procedures in sections XI and XII, below.
 - a. All electronic verifications verified by the FFM will be accepted and are final.
 - b. The caseworker must not reverify any information already verified by the FFM.
 - c. The caseworker may only request outstanding verifications from the applicant(s) when the information:
 - Is not available via an electronic source.
 - Is not located within another program.
 - And is not in the local agency case file.
 4. Application date is the date the application is received at the

Marketplace. Refer to section XIII., below for application processing time limits and procedures.

D. FFM Referrals

In some circumstances, an FFM application cannot be authorized by NC FAST (i.e., evaluation for a non-MAGI program, or retro coverage, etc.). In these limited circumstances, there may be an FFM application, FFM referral and/or a case review. Refer to NC FAST Job Aid: FFM Determination Processing and the Learning Gateway training: FFM-D Overview and Demos.

For Applications which are processed straight through, any FFM referrals received will be created as a case review. Refer to NC FAST Job Aid and NC FAST Case Review Report. Supervisors must monitor the case review report located on the O&M.

For manually authorized applications, the FFM Referral folder should be viewed to determine if a referral is received which may require a non- MAGI application to be keyed.

1. **Retro:** The FFM does not provide the requested retro month(s). The local agency must evaluate and determine retro eligibility. There will be both a retro FFM application and a referral in the referral folder.
2. **Emergency:** The FFM does not provide emergency services dates. The local agency must evaluate and determine if the applicant is eligible for emergency services. There will be an FFM application, and a referral in the referral folder.
3. **Non-MAGI:** The local agency must determine non-MAGI program eligibility. This will not be determined via STP. There will not be an FFM application, but there will be a referral in the referral folder. The caseworker must key an application. Non-MAGI determinations include:
 - a. Disability
 - b. Medically Needy
4. **Medicare Entitled:** When the applicant indicates Medicare entitlement, the local agency must evaluate to determine non-MAGI eligibility.

E. Appeals of an FFM Determination of Eligibility

An applicant has the right to appeal any Medicaid decision that they disagree with. This includes determinations of eligibility made by the FFM. When an applicant is requesting to appeal the eligibility decision made by the FFM, the applicant has the right to choose to have the appeal held at the FFM or with the

state.

The caseworker must explain the applicant's options and document their choice thoroughly and take the appropriate steps.

1. The applicant must request a hearing within 60 calendar days from the date the notice of action is mailed, unless they can show good cause for a later request. If good cause exists, the request must be no later than 90 calendar days from the date of the notice of action. Refer to [MA-3430, Notice and Hearings Process](#) for good cause reasons.
2. If the applicant chooses to appeal the FFM determination and have the hearing held at the FFM, instruct the applicant to request the appeal via the [Healthcare.gov](#) website.
3. If the applicant requests the appeal be held with the state, follow policy found in [MA-3430, Notice and Hearings Process](#) state hearing process:

Within five (5) calendar days of the request for a hearing, the county agency director or their designee must forward the DSS-1473, Request for State Appeal to the Chief Hearing Officer to schedule a state hearing. A State Hearing Officer will hold a state hearing and render a state hearing decision.
4. For applications where the county caseworker made the final eligibility determination, if the applicant requests an appeal, follow the policy found in [MA-3430, Notice and Hearings Process](#) for a regular hearing request.

VII. TELEPHONE

A. An individual may apply for Medicaid/NCHC by telephone. The local agency must have staff available to complete telephone applications the same day the request is received. The caseworker must complete the entire application over the telephone and enter it into NC FAST during the telephone interview.

1. Currently, North Carolina is not set up to receive telephonic signatures. Follow procedures below:
 - a. The caseworker must mail the signature page of the application to the applicant the same day the application was submitted into NC FAST.
 - b. Send the [DMA-5097](#) / [DMA-5097S](#), Request for Information, and the signature page of the application. In "Other" section on the DMA-5097, instruct applicant to only return the signed application signature page.
 - c. The date of the application is the date of the telephone interview.

- d. If the signature page is not returned by the processing due date, deny the application, and send appropriate notice.

B. OVS cannot be run until the signature page is returned to the local agency.

VIII. COURTESY APPLICATION

A. An individual or representative may apply at the local agency outside of the individual's county of residence, or an application may be submitted to a non-resident county.

B. The local agency in which the individual or representative appears does not have to verify with the county of residence that a courtesy application will be accepted. All courtesy applications must be accepted by the county of residence.

C. The non-resident county must key the application into NC FAST by the next work day, if received by mail, or during the interview, if in-person.

D. Once the application has been entered in NC FAST, the non-resident local agency must transfer the courtesy application to the resident local agency within two work days. If the non-resident local agency does not transfer the courtesy application by the third work day, the non-resident agency is responsible for determining eligibility and transferring, if approved.

E. The courtesy application will appear as a task in local agency work queue.

IX. INTERVIEW

When an individual appears at the local agency to apply for Medicaid, they must be allowed to see a caseworker that day to complete the application.

When conducting an interview at application, the individual must be provided with information about Medicaid eligibility requirements, explanation of other benefits and services, and their rights and responsibilities.

A. Appointments:

There may be circumstances when an interview may not be completed the same day the individual appears at the local agency, and an appointment may be needed.

1. An individual must be interviewed on the day assistance is requested in the local agency unless:
 - a. The individual arrives at the local agency an hour before close of business, AND there is insufficient time or staff to conduct the interview, or
 - b. The individual voluntarily leaves the local agency before they can be

- interviewed, or
- c. The individual voluntarily makes a request for an appointment on another day.
 - d. The individual voluntarily requests a mail-in application for a Medicaid/NCHC program. Document on the log the date of application for a mail-in was explained.
2. When an appointment is requested by the individual, the caseworker must:
- a. Have the individual sign a paper application.
 - b. Explain the date of application is protected when the application is signed.
 - c. Document the reason applicant requested an appointment.
 - d. Gather sufficient information and enter it into NC FAST:
 - (1) Name
 - (2) Date-of-birth
 - (3) Mailing address
 - (4) Telephone number
 - e. Give the applicant a [DMA-5097](#) / [DMA-5097S](#), Request for Information with a scheduled date and time, an application form may be given to be filled out.
 - f. If the individual fails to keep the scheduled appointment, send a [DMA-5097](#) / [DMA-5097S](#), Request for Information, scheduling a second appointment. The DMA-5097 may advise the applicant that they may return the application. Give at least 12 days from the date of the original request, scheduling a second appointment. Inform the individual an eligibility determination cannot be made without keeping the scheduled appointment or providing information on the application.
 - g. If the individual fails to keep the second appointment you must send the appropriate notice on the 45th/90th day.
3. If the contact is by telephone and the individual requests an appointment or a mail-in application:
- a. Schedule the appointment during the telephone contact, if the application interview cannot be completed by telephone.

- b. Mail the [DMA-5200](#) / [DMA-5200S](#), Application Health Coverage & Help Paying Costs, and the [DMA-5097](#) / [DMA-5097S](#), Request for Information, with the scheduled appointment.
 - c. Instruct the individual to call the agency if he decides to file an online application instead of keeping the scheduled appointment.
 4. If the request is made in writing, within three workdays of receiving the request, send the [DMA-5097](#) / [DMA-5097S](#), Request for Information, scheduling an appointment to complete an application. Instruct the individual to contact the agency by phone if there are any questions.
 - a. Mail the [DMA-5200](#) / [DMA-5200S](#), Application Health Coverage & Help Paying Costs, with an appointment notice and a written explanation of the mail-in process.
 - b. Explain on the DMA-5097 how the date of application for a mail-in is determined.
 - c. Instruct the individual to call the agency if deciding to file an online application instead of keeping the scheduled appointment.

B. Explanation of Other Benefits/Programs:

1. The caseworker must provide the applicant with the option to apply for any or all programs in the local agency.
2. The caseworker must inform the applicant that each program has specific eligibility requirements that may not apply to the other programs, and that loss of benefits under one program does not always mean that other program benefits will be lost.
3. It is the obligation of the caseworker to provide the applicant with sufficient information to allow them to make an informed choice.

Programs	Descriptions
Food and Nutrition Services	If an individual does not receive Food and Nutrition Services, inform them that the program is offered and provide instructions for applying.
Health Insurance Premium Payment (HIPP)	<p>HIPP is a program in which the Division of Medical Assistance (DMA) pays private health insurance premiums for Medicaid recipients when it is cost effective to do so. Cost effectiveness is established when the annual cost of the premiums, deductibles and coinsurance is less than the anticipated Medicaid expenditures.</p> <p>HIPP is most cost effective for Medicaid recipients with catastrophic illnesses such as:</p> <ul style="list-style-type: none"> • end stage renal disease • chronic heart problems • congenital birth defects • cancer • AIDS <p>To be eligible for the premium payment, the recipient must be authorized for Medicaid and have private health insurance:</p> <ul style="list-style-type: none"> • DMA only pays premiums on existing or known policies • DMA does not find new coverage for a recipient <p>Premiums may be paid for a family coverage policy when the policy is cost effective and it is the only way the recipient can be covered by the policy. Family members that are not Medicaid recipients do not receive Medicaid payment of deductible, coinsurance or cost sharing obligations.</p> <p>HIPP is not available to individuals in deductible status.</p>

	<p>DMA no longer pays the health insurance premium when a recipient is placed in deductible status at redetermination or due to a change in situation.</p> <p>When DMA determines that a group health insurance plan available to a recipient through an employer is cost effective, the recipient is required to participate in the plan as a condition of eligibility for Medicaid:</p> <ul style="list-style-type: none"> • The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer. • If it is determined that the policy is cost effective, DMA pays the cost of premiums, coinsurance and deductibles of non-group health plans if the recipient chooses to participate. <p>Referrals:</p> <ul style="list-style-type: none"> • Give the recipient the DMA-2069, Health Insurance Premium Payment Application Form, to any recipient who has a qualifying catastrophic illness as shown above. • Assist the recipient in completing the form and advise them to have the physician submit any requested medical records. <p>Ask the recipient to return the completed form to the local agency for submission to DMA. Submit the completed forms to: Attn: NC HIPP 4441 Six Forks Rd, Suite 106-227 Raleigh, NC 27609 mynchipp.com</p> <p>Recipients who request assistance through the HIPP program are notified in writing within 30 days of the outcome of the request.</p> <p>Recipients who are approved, health insurance premiums cannot be applied to the deductible or allowed as an unmet medical need effective the month DMA begins paying the premium.</p>
<p>Lifeline/Link-Up Assistance Program</p>	<p>The Lifeline Assistance Program is designed to promote universal service by helping low-income individuals afford telephone service and to receive a credit on their monthly telephone bill.</p> <p>If the individual receives any one of the public assistance benefits listed below, they can receive Lifeline/Link-Up benefits:</p> <ol style="list-style-type: none"> 1. Supplemental Nutrition Assistance Program (SNAP) 2. Medicaid 3. Supplemental Security Income (SSI) 4. Federal Public Housing Assistance (FPHA)

	<p>5. Veterans Pension and Survivors Benefit 6. Tribal Programs (and live on federally-recognized Tribal lands)</p> <p>Questions concerning telephone services must be referred to the Lifeline/Link-Up Assistance Program.</p> <p>Also, see FNS 630, Lifeline/Link-Up Assistance Program.</p>
<p>Woman, Infants, and Children Program (WIC)</p>	<p>WIC is a supplemental food and nutrition education program that provides supplemental foods to improve diets and reduce chances of health problems by poor nutrition.</p> <p>The program serves:</p> <ol style="list-style-type: none"> 1. Pregnant women 2. Postpartum women (up to 6 months after delivery) 3. Women who are breastfeeding 4. Children under six years of age 5. If the individual is interested in the WIC program, refer them to the local WIC agency

C. Explanation of Other Benefits:

The caseworker must explain to the applicant other benefits in the local agency.

Other Benefits	Descriptions
<p>Certificate of Creditable Coverage</p>	<p>The Health Insurance Portability and Accountability Act (HIPAA) requires that group plans and health insurance issuers, including Medicaid, who offer group coverage furnish certificates of creditable coverage.</p> <p>The purpose of the certificate of creditable coverage is to present evidence that the individual had prior creditable coverage that will reduce or eliminate preexisting exclusions under subsequent health coverage. The issuance of the certificates is automated and is done by DMA’s claims payor (CSRA).</p> <p>Individuals requesting verification of Medicaid coverage should be referred:</p> <ul style="list-style-type: none"> • For periods prior to 2015 or the current calendar year: CSRA (800) 688-6696 • For periods 2015 to the most recent 1095-B: The local agency can print the 1095-B from NC FAST.

Estate Recovery	<p>The IMC is responsible for explaining estate recovery to an applicant. Explain the following:</p> <ol style="list-style-type: none"> 1. Who is subject to estate recovery, 2. What Medicaid payments are subject to recovery, 3. Medicaid does not recover prior to the death of the recipient, 4. Medicaid never recovers more than what was paid by Medicaid on his behalf, 5. Estate Recovery Waiver rules, and 6. Appeal rights. If the recipient or representative has other questions regarding Estate Recovery, refer them to Third Party Recovery. <p>If an a/b chooses not to apply for Medicaid or withdraws his application after learning of possible estate recovery, treat this as an inquiry or withdrawal. Follow application processing rules.</p> <p>Refer to MA-2285, Estate Recovery</p>
Federally Facilitated Marketplace (FFM)	<p>If the applicant does not want financial assistance with health coverage, they may enroll and purchase coverage through the FFM.</p> <p>If the applicant does want financial assistance with health coverage, an eligibility determination must be made for all Medicaid/NCHC programs.</p> <p>If the applicant is determined ineligible for Medicaid/NCHC or there is an eligibility delay (e.g. disability must be determined), the account will be transferred to the Federal Marketplace.</p>
	<ol style="list-style-type: none"> 1. The individual must be ineligible for Medicaid/NCHC to get tax credits and cost sharing. 2. Immigrants who are ineligible for Marketplace coverage may still qualify to receive Medicaid for treatment of emergency medical conditions, including labor and delivery. 3. If a lawfully present immigrant is ineligible for Medicaid based on their immigration status, they may qualify for financial help through the Marketplace, even if their income is below the poverty level.

Health Check	<p>Helps to coordinate health care for children under age 21, who are authorized for Medicaid in any aid program/category except M-QB and those who receive emergency Medicaid only.</p> <ol style="list-style-type: none"> 1. Letters are sent to the individual's home reminding them of services available through the Health Check program and of upcoming scheduled appointments. 2. If the local agency has a Health Check Coordinator, give the individual the name and phone number. Explain that the Health Check Coordinator can answer questions, help with locating a provider and help with scheduling appointments.
Managed Care	<p>Managed care provides for the delivery of Medicaid and North Carolina Health Choice (NCHC) health services as well as additional services through contracted arrangements between state Medicaid agencies and other healthcare agencies. Refer to IEM Section: 15080 Managed Care.</p>
National Voter Registration Act (NVRA)	<p>The purpose of the NVRA is to make available more opportunities for people to vote.</p> <ul style="list-style-type: none"> • Ensure voter registration forms are available to individuals during their visits. • If the individual asks for assistance in completing the voter registration form, provide the assistance. • Inform the individual that the Board of Elections processes applications to register to vote. • Ask the individual, are you registered to vote where you live, if not, would you like to apply to register to vote today? • If the individual wants to register to vote, a voter registration form is available at https://www.ncsbe.gov/ <p>Inform the individual:</p> <ul style="list-style-type: none"> • Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. • If you would like help filling out the voter registration application form, we will help you. • The decision either to see or accept help is yours. • You may fill out the application form in private.

	<ul style="list-style-type: none"> If you believe that someone has interfered with your right register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Board of Elections. <p>Questions concerning voter registration must be directed to the local Board of Elections.</p>
<p>Non-Emergency Medical Transportation</p>	<ol style="list-style-type: none"> 1. Inform the individual that if they do not have or cannot arrange medical transportation on their own, they may receive help from the local agency in arranging and/or paying for medical transportation if authorized for Medicaid. 2. It does not apply to individuals authorized for M-QB or NC Health Choice. 3. For Family Planning recipients, transportation may be provided only for Family Planning Services. 4. Explain to the individual that the local agency provides transportation to the nearest appropriate provider. 5. Give the individual the DMA-5046, Medical Transportation Assistance Notice of Rights. Explain the right to request assistance with medical transportation. Retain a copy. 6. Provide contact information for person or unit that handles transportation requests. 7. Refer to section 15200, NEMT policy and requirements.
<p>Pregnancy Medical Home (PMH)</p>	<p>PMH provides additional obstetric care to pregnant Medicaid recipients with the goal of improving the quality of maternal care, improving birth outcomes, providing continuity of care and 24-hour provider availability to the recipient.</p> <p>The caseworker will:</p> <ol style="list-style-type: none"> 1. Explain benefits of using a Pregnancy Medical Home (PMH). 2. Give a copy of the DMA-5076 / DMA-5076S, PMH handout, at each application and redetermination to all pregnant Medicaid recipients. 3. Encourage all pregnant Medicaid recipients to use a PMH.

X. PROCESSING TIMEFRAMES

The application processing time standard for Medicaid Assistance to the Disabled (MAD) is 90 calendar days. Application processing time standard is 45 calendar days for all other Medicaid programs, including NCHC.

A. All applications must be processed and eligibility determined when all information/verification needed to determine eligibility is received within the agency.

B. Do not deny an application for failure to provide information/verification needed to determine eligibility prior to the 45th/90th day.

C. Applications may pend past the 45th/90th day when:

1. The local agency is waiting on a DDS decision
2. The applicant requests additional time to information
3. Medical bills to meet a deductible
4. Receipt of Health Coverage for Workers with Disabilities (HCWD) enrollment fee and/or premium
5. Receipt of North Carolina Health Choice (NCHC) enrollment fee
6. Change in Situation

If a change in situation, which affects eligibility, becomes known after the exclusion of days begins, request the new or additional information following procedures and continue the exclusion.

D. The NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance:

1. Will be automatically generated by NC FAST and mailed to the applicant when:
 - a. The Medicaid application has not been processed by the 45th/90th day.
 - b. The stop processing time has been end dated by the caseworker in NC FAST on the 45th/90th day and the Medicaid application has not been processed.
2. Will not be generated by NC FAST when:
 - a. The application has been processed by the 45th/90th day.
 - b. The stop processing time begin date has been entered by the caseworker into NC FAST.
 - c. The stop processing time has been end dated by the caseworker by the 45th/90th day, and the Medicaid application processed.
 - d. A DMA-5098, Your Application for Medicaid is Pending, has been generated in NC FAST:
 - (1) The DMA-5098/DMA-5098S, Your Application for Medicaid is Pending, form is used to provide the applicant with information

regarding the status of their application and to allow the county to stop the application processing time.

(2) Refer below to XI. Requesting Information

E. The local agency cannot use the application processing time standards nor use the NC FAST stop processing time option:

1. As a waiting period before determining eligibility,
2. As a reason for denying eligibility, or
3. As a reason to keep the NCF-20023 notice from generating because the local agency has not determined eligibility within the application processing time standards.

For keying instructions, refer to NC FAST Job Aid:

[Entering a Begin Date on Stop Processing Time Record](#)

[Entering an End Date on Stop Processing Time Record](#)

F. 60/90-day Hearing Timeframe

Individuals have 60 days from the date of the notice to request a hearing and ask that a decision be made on their Medicaid application. That period is extended to 90 days for good cause. Refer to [MA-3430](#), Notices and Hearings Process.

XI. PROCESSING THE APPLICATION

To determine eligibility, a complete and signed application must be entered into NC FAST.

An Individual may be eligible for Medicaid ongoing and/or retroactive. Except for NCHC and MQB-Q, eligibility may be authorized 1, 2, or 3 months prior to the month of application.

The applicant can make an application for retroactive coverage only, ongoing coverage only or retroactive and ongoing coverage.

A. The caseworker must:

1. Check all electronic data sources and other available records – FNS, WFFA, etc.

Certain information can only be requested and/or verified post (after) eligibility determination. Refer to [MA-3205](#), Post Eligibility.

2. Only ask the applicant to provide documentation:
 - a. When unavailable within the local agency or from electronic sources
 - b. When income is not reasonably compatible with self-attestation

B. The caseworker must verify all financial and non-financial eligibility factors.

C. When all eligibility requirements are met, authorize Medicaid/NCHC eligibility for appropriate certification period.

D. The local agency must obtain the verification for the individual when:

1. There is a fee involved in obtaining the information
2. The information is available within the local agency
3. The individual requests assistance
4. The individual is mentally, physically or otherwise incapable of obtaining the information

Document in NC FAST.

E. For an applicant to receive retroactive Medicaid, there must have been a medical need in the retroactive period.

F. Separate Treatment of Retroactive Period

1. Evaluate eligibility for each retroactive month of need separately.
2. Consider the retroactive period separate from the prospective certification period which begins with the month of application.
3. If the income in any retroactive month exceeds the income limit, evaluate that month as Medically Needy (MN).
4. For MN coverage groups, compare the countable income and the income limit for each month of medical need to determine if excess income exists.
 - a. If the months of medical need are consecutive, combine the excess income for each month to obtain one deductible amount for the retroactive period.
 - b. If the months of medical need are not consecutive, consider each month separately and determine a deductible for each month.
5. For situations where the monthly income fluctuates in the retroactive period, treat months of CN eligibility separate from months of MN eligibility.

Authorize the CN month(s) and:

- a. If the MN months are consecutive, combine the excess income for each month to obtain one deductible amount for the retroactive period.
 - b. If the MN months are not consecutive, consider each month separately and determine a deductible for each month.
6. If excess reserve exists throughout the retroactive period and/or a deductible is not met during the retroactive period, the individual is ineligible for the retroactive period.

XII. REQUESTING INFORMATION

A DMA-5097 must be used when it is determined additional information/verification is needed to determine eligibility.

A. Provide the applicant with a [DMA-5097](#) / [DMA-5097S](#), Request for Information, requesting information/verifications that are needed to make an eligibility determination.

1. Do not request verification of items available to the local agency through electronic data sources or in other program records.
2. The caseworker must make at least two requests for information from the applicant or third party, using the appropriate verification form.
 - a. The DMA-5097 must be used when requesting information from the applicant.
 - b. There must be two requests for information from the individual with at least 12 calendar days between them.
3. Give individuals at least 12 days from the date you mail or give the [DMA-5097](#) / [DMA-5097S](#), request for information, to provide verifications.
4. If the due date is a non-business day or holiday, allow the applicant until the next business day to provide verifications.
5. Explain to the applicant an extension can be requested.
 - a. Allow at least 12 calendar days for the additional request.
 - b. The applicant must request more time prior to the application being processed.

D. When the only information needed to complete the eligibility determination is one of the following, use the [DMA-5098](#) / [DMA-5098S](#), [Your Application For Medicaid Is](#)

Pending:

1. Medical bills to meet a deductible, or
2. Disability determination, or
3. Medical records needed to determine emergency dates for nonqualified aliens, or
4. Receipt of the FL-2, or
5. Receipt of the CAP Plan of Care, or
6. Receipt of undue hardship documentation, or
7. Receipt of a Health Coverage for Workers with Disabilities (HCWD) enrollment fee and/or premium, or
8. Receipt of North Carolina Health Choice (NCHC) enrollment fee.

E. The DMA-5098, Your Application for Medicaid is Pending, should never be used as the initial request for medical bills. The DMA-5097, Request for Information should be used as the initial request.

F. The DMA-5098, Your Application for Medicaid is Pending, can be used as the second request or a follow-up request, provided all other information to determine eligibility has been received and eligibility has been established except for meeting the Medicaid deductible.

G. The DMA-5098, Your Application for Medicaid is Pending, is used to provide the individual with information regarding the status of the application and to allow the local agency to stop the application processing time.

H. When information needed to determine eligibility is returned, authorize the appropriate certification period, if eligible. Application processing time begins to count again on the date the individual provides the information.

I. When information needed to determine eligibility is not returned, deny on the 45th/90th day, as appropriate.

J. Document in the record.

K. Send appropriate notice.

XIII. APPLICATION OUTCOMES

A. Approval

1. Approve assistance anytime all factors of eligibility have been met and eligibility has been established in NC FAST:
 - a. Review the case to ensure the appropriate certification period was assigned for the program aid/category.
 - b. Authorize and activate Medicaid eligibility.
 - c. Send the [DMA-5002](#) / [DMA-5002S](#), or [DMA-5003](#) / [DMA-5003S](#) as appropriate and retain copy.
2. When an individual is not found eligible for a complete certification period, authorize and activate assistance open/shut for the period of time that eligibility was established.

B. Denial

1. Before denying an application, the applicant must be evaluated for all Medicaid programs.
2. Deny the application anytime:
 - a. Ineligibility for Medicaid under all programs is established.
 - b. Individual cannot meet a Medicaid deductible.
 - c. Individual's statement of old, current, and anticipated expenses, will not be within \$300.00 of meeting the ongoing deductible.
 - d. The individual's statement and/or third-party verification of old and actual expenses during the retroactive certification period, if it is determined that the individual cannot meet the retroactive deductible.
 - e. The individual has excess resources and states verbally or in writing no intent to reduce resources within the 45th/90th day application processing.
3. Do not deny an application prior to the 45th/90th day if the individual states they intend to reduce their resources or says nothing.
 - a. Request verification using the [DMA-5097](#) / [DMA-5097S](#), Request for Information.
 - b. Hold the application until the 45th/90th day for proof that resources have been reduced. If the applicant requests additional time, resources must still be reduced by the 45th/90th day.

- c. Do not deny the case unless two DMA-5097s have been sent. There must be 12 days between the two notices.
4. When an individual cannot be located, attempt to contact the applicant by phone, mail, or electronic means before denying the application.
5. Never deny on the 45th/90th day for failure to provide information if two DMA-5097s have not been sent to the individual.
6. Document in the record.

C. Withdrawal

1. The applicant may voluntarily withdraw the application at any time before the eligibility determination is made.
2. Discuss with the individual the reason for the withdrawal.
3. Discuss with the individual the alternatives to withdrawal, such as:
 - a. Completing an open-shut application for a period of time when eligibility can be established, or
 - b. Reopening the application protecting the original date of application, or
 - c. Reapplying for retroactive coverage to reduce the deductible and allow for eligibility.
4. If the individual requests the withdrawal by mail, through ePass, or by leaving a message:
 - a. Make one attempt to contact the individual by phone to discuss alternatives.
 - b. Document the attempt to contact the individual and, if successful, document the discussion and results in NC FAST.
 - c. If contact with the individual cannot be made, withdraw the application.
5. The reason for withdrawal must be documented in NC FAST
6. Send appropriate notice.
7. Document all explanations and responses in NC FAST.

NC FAST Job Aids:

[Streamlined Application to Case Key Differences Checklist](#)

[Application to Case](#)

XIV. REOPENED DENIALS, WITHDRAWALS, APPROVALS OR INQUIRIES

Any time it is determined that an individual was discouraged, that an application was improperly or incorrectly denied or withdrawn, or that a state or local appeal decision reverses the denial of an application or the termination of a case, the county must take action to reopen the application or case. Additionally, some terminated cases may be reopened administratively when certain criteria are met. This section outlines the procedures to follow to reopen applications or cases.

A. Discouragement

1. Discouragement can occur with or without a signed application and can be discovered in several ways including a report by the applicant or potential applicant, through a second party review, or by the application monitor.
2. When discouragement is alleged, review the case records. If the case documentation shows that retroactive benefits, coverage for minor children and/or dual eligibility were offered and declined or that the client was afforded the opportunity to apply but declined, no discouragement occurred, and no further action is required.
3. When the agency learns from any source that an individual has been discouraged and the allegation cannot be refuted based on record documentation, follow the procedures in IV. By Mail/Fax/Email to reopen the application.

B. Reopening Denials, Withdrawals, and Approvals

A reopened application refers to an application that was originally denied or withdrawn but the denial or withdrawal is incorrect, improper or reversed. It can also refer to an application or inquiry when there is evidence of discouragement. The agency must re-assess the denial, withdrawal or inquiry and protect the original date of application for processing time.

1. An application must be reopened within 5 days as a result of any of the following
 - a. Local or state appeal reversal, or
 - b. Remanded appeal by the local or state hearings officer, or
 - c. Improper denial or withdrawal found by the county, monitors, or Medicaid Program Representatives, or
 - d. Misapplication of policy (incorrect denial), or

- e. Discouragement.
2. Follow these procedures when reopening an application due to local/state appeal reversals, remanded appeals, improper denials or withdrawals, incorrect denials, or discouragement with a signed application.
- a. A signed application is not required.
 - b. Enter into NC FAST
 - (1) Local/State Appeal Reversals or Remanded Appeals

Enter into NC FAST within 5 workdays of the date the Notice of Decision is final. The date of application is the reopen or current date.
 - (2) Improper Denials/Withdrawals or Discouragement

Enter into NC FAST on the date the agency learns of the improper denial/withdrawal or discouragement. The date of application is the date the agency learns of the improper action or discouragement.
 - (3) Incorrect Denials

Enter into NC FAST on the date the agency learns of the incorrect denial. The date of application is the reopen or current date.
 - c. Review the case record for missing information.
 - (1) Local/State Appeal Reversals or Remanded Appeals

For appeal reversals and remanded appeals, review the case record according to the hearing decision, considering additional information and/or policy as instructed in the decision.

 - (a) If no additional information is needed, dispose of the application within five workdays of reopening the case.
 - (b) If additional information is needed from the individual or a third party, including medical bills to meet the deductible, follow procedures in XI. Requesting Information and X. Processing the Application.
 - (c) Process the application within 5 workdays of receipt of the last piece of required information. For remanded appeal decisions, the application disposition decision may be the

same as or different from the original decision.

- (2) Improper Denials/Withdrawals, Incorrect Denials or Discouragement.
 - (a) If no additional information is needed, dispose of the application.
 - (b) If additional information is needed from the individual or a third party, including a disability determination or medical bills to meet the deductible, follow procedures in XI. Requesting Information and X. Processing the Application.
 - (c) If all necessary information (except a disability determination or medical bills to meet the deductible) is not received, deny the application on the 13th calendar day after the second request for information or once the application has pended a full 45/90 days, whichever occurs later.
 - 1) To determine if the application has pended the 45/90 days, subtract the number of days the original application pended from 45/90. The difference is the number of days the reopened application must pend to meet the 45/90-day requirement. Do not include any days the application was closed.
 - 2) For example, a MAA application dated June 10th was improperly denied on June 25th. The original application pended a total of 15 days. On August 30th, an administrative application was entered into NC FAST reopening the application. The reopened application must pend for at least 30 calendar days (September 29th) or until 13 calendar days after the second request for information, whichever is later.
 - 3) If the application has not pended a total of 45/90 days, hold the application until the 45th/90th day.
 - (d) If all necessary information (except a disability determination or medical bills to meet the deductible) is received, and the anticipated medical expenses are within \$300.00 of meeting the deductible continue to pend the application for up to 6 months.
 - 1) To determine if the application has pended 6 months, subtract the number of days the original application pended from 180. The difference is the

number of days the reopened application must pend to meet the 6-month requirement. Do not include any days the application was closed.

- 2) For example, a MAA application dated June 10th was improperly denied on June 25th. The original application pended a total of 15 days. On August 30th, an administrative application was entered into NC FAST reopening the application. A review of the case record indicates that anticipated medical expenses are within \$300.00 of meeting the deductible and this is the only information needed to complete the application. The reopened application must pend for at least 165 days (February 11th) or until 13 calendar days after the second request for information, whichever is later.

- (e) If all necessary information (except a disability determination or medical bills to meet the deductible) is received, and the anticipated medical expenses are not within \$300.00 of meeting the deductible, deny the application.

C. Discouragement Without A Signed Application

Follow these procedures to reopen a case when cited for discouragement and there is no signed application.

1. Send the [DMA-5097 / DMA-5097S](#), Request For Information, to the individual scheduling an appointment to complete an application along with a letter explaining that it has been determined that he has been discouraged and that eligibility will be evaluated back to the date of discouragement.
2. If you can determine from the case documentation that the individual was discouraged from applying for a program for which a [DMA-5200 / DMA-5200sp](#), Application for Health Coverage & Help Paying Costs Medicaid application is acceptable, enclose the mail-in application with the [DMA-5097 / DMA-5097S](#).

Instruct the individual that he can either keep the scheduled appointment or return the completed mail-in application by the appointment date. Refer to IV. By Mail/Fax/Email, for mail-in application procedures.

3. If the individual fails to keep the scheduled appointment or if applicable, does not return the application form, send another [DMA-5097 / DMA-5097S](#) to schedule a second appointment. There must be at least 12 calendar days

between the two appointments.

- a. If the individual fails to keep the second scheduled appointment or if applicable, does not return the application form by the second appointment date, no other action is needed.
- b. If the individual does file an application by the established deadline, follow procedures in X. Processing the Application to key and process the reopened application.
- c. If the application form is received after the 12-12 date, the date of application is the date the completed form is received. Do not treat as a reopened case due to discouragement.

D. Reopening Terminated Cases

1. Certain actions that require entering an application in NC FAST may be done administratively. No signed application is required. Application processing time standards do not apply. These actions include:
 - a. Moving an individual from one case to another, in the same or different Medicaid program, or
 - b. Posting eligibility to a terminated case, or
 - c. Reopening cases terminated in error, or
 - d. Reopening a terminated case as the result of a state/county appeal reversal or remanded appeal. See [MA-3430](#) / [MA-2420](#), Notice and Hearings, or
 - e. Reopening Medicaid terminations. See 3.
2. To reopen terminated Medicaid cases, follow these procedures.
 - a. All of the following criteria must be met for a terminated case to be reopened. If these criteria are not met, the individual must reapply for Medicaid.
 - (1) The case must have been terminated for one of the following reasons:
 - (a) Failure to complete a redetermination of eligibility,
 - (b) Unable to locate the beneficiary(s) in the case,
 - (c) No eligible child in the home,
 - (d) The beneficiary(ies) in the case moved out of state,

(e) The beneficiary(ies) in the case became a resident of a public, non-medical institution.

(2) The request to reopen the case must be received no later than the 10th calendar day of the month following the month of termination. The request may be made in person, by telephone call, in writing, or by receipt of information needed to complete the review.

If the 10th calendar day falls on a non-workday, allow the individual until the next work day to request his case be reopened. All information needed to reopen the case must be received by the 10th calendar day of the month following the month of termination.

This includes, but is not limited to:

(a) The re-enrollment form and any required verifications;

(b) The HCWD enrollment fee when applicable;

(c) The HCWD premium when applicable.

(3) All of the individuals included in the case when it was terminated must be included in the reopened case.

(4) The individuals must be eligible in the same aid program/category as the terminated case.

b. Verify that eligibility continues.

(1) If the case was terminated for failure to complete the recertification, gather all the required information and follow verification requirements in [MA-2320](#), Redetermination.

(2) If the case was terminated for unable to locate, no eligible child in the home, moved out of state, in a public institution, accept the client's statement as verification of current residence/living arrangement for the household.

c. Reopen the case.

(1) Enter administrative application into NC FAST.

(2) The date of application is the first day of the month following the effective date of the termination.

(3) Enter the certification period as follows:

- (a) When reopening a case that was terminated at the end of a certification period and a recertification is being completed, begin the certification period with the month following the effective date of the termination.
- (b) When reopening a case that was terminated during the certification period, the certification begin date is the first day of the month following the month of termination. The certification end date is the end date of the certification period in the original case.

For example, a case being reopened was originally certified from January 1 through December 31. The case was terminated effective June 30. Reopen the case with a certification period of July 1 through December 31.

- (c) When reopening a medically needy case with a deductible, do not re-compute the deductible if the certification period entered is less than six months unless there was a change in income.
- (4) The Medicaid effective date must be no earlier than the first day of the month following the month of termination.
- d. If, at any time during the reopening process, it is determined that the case cannot be reopened a signed application is required.
 - (1) The date of application is the date of the first initial contact.
 - (2) Follow all requirements for an application.
 - (3) The application does count in the county's report card.