Medicaid Application Process Technical Assistance and Guidance

Question	Response
Do people who have no dependents, who are living with non-family members fill out as if they are a family of one?	Yes.
If the person is 18 and still claimed on parents taxes do you include parents' income?	Not for Medicaid based on disability or blindness. Once the person turns age 18, the only income and assets that are considered are those of the person and their spouse.
If a client has a retirement account at their job, such as a 403(b) or 401(k), does it count against their asset limit?	Retirement accounts (such as 403(b), 401(k), and IRAs) which belong to the Medicaid client or their spouse are an available asset regardless of whether a withdrawal has ever been made. The amount considered as available as a resource to the client is the amount the person could receive after any applicable penalty for early withdrawal. For children under the age of 18 applying based on disability, retirement accounts belonging to the child's parents are not counted.
Are MO ABLE accounts considered available resources?	ABLE accounts are never considered an available asset.
If a client is under the age of 18 and living with a guardian, such as a grandparent, is the guardian considered the parent for the purposes of the application?	Any income and assets belonging to a non-parent guardian are not considered when determining Medicaid eligibility based on disability for a child under age 18. Only the income assets of the child and the natural or adoptive parents in the home are considered.
Does the client need to list an estranged spouse on the application?	The applicant only needs to list the spouse if they are living together or are only separated for medical reasons. If they are living apart, the applicant does not need to provide the spouse's address. An exception to this would be if FSD has a valid reason to suspect that the spouse is actually living with the applicant.
In the event that the client has a guardian, do both the client and the guardian need to sign the application?	If the guardian is not a conservator, either the guardian or the applicant can sign but the signature of both is not required. If the guardian is a conservator, only the conservator can sign the application.

Question	Response
What can be done if the applicant is physically unable to sign an application?	If an applicant without a conservator is unable to sign, either a relative or a guardian may sign the application. In the event that a client is unable to sign other paperwork please contact Anna Leonhard or Charles Bentley so we can see what needs to be done on a case by case basis.
Are you going to cover the pregnancy protocols for women in CSTAR who are pregnant or who becomes pregnant during treatment?	This webinar was only intended to cover Medicaid eligibility based on being aged (65 and over), blind, or disabled. A pregnant woman can be eligible for Medicaid if her gross family income does not exceed 196% of the FPL. So, if a woman in CSTAR is pregnant you should assist her in submitting a Family Medicaid application to FSD.
Can IEP records be a substitute for medical records, if individual has a documented Intellectual Disability?	To establish a disability based on an intellectual disorder for a child ages 3 through 17 MRT needs medical records that show the child has • Significantly sub-average general intellectual functioning evidenced by: a full scale IQ of 70 or below, or 71-75 with either a verbal or performance IQ of 70 or below; OR a cognitive inability to participate in standardized testing. AND • Significant deficits in adaptive functioning evidenced by: an extreme limitation in one or marked limitation in two of the four areas of mental functioning; OR the dependence on others for personal needs. An IEP could be included with the medical records submitted to MRT for review. After reviewing the IEP and any other records submitted, MRT would decide whether or not they were adequate to make a disability determination or if other records or evaluations are needed.
How does the client get their case number?	The client's DCN is used as the case number (unless it is a couple case, and the spouse submitted the application). The DCN also serves as the individual's Medicaid number. The case number and individual DCN can be found on any documents mailed to them. They can also call 1-855-373-4636.
Where do you find the case status site?	https://apps.dss.mo.gov/BenefitReview/BenefitSummary.aspx Or: go to https://mydss.mo.gov/healthcare Click "Check my Status"

Question	Response
Is having a physical address still a requirement?	It is not and never was a requirement. A person who is "homeless" can be eligible for Medicaid. FSD does need to have an address to mail requests for information, action notices, etc. This can be a mailing address, such as a PO Box or the address of a DMH Regional office, DMH case management agency, CMHC, a relative's address, or in some cases a FSD office. Having an authorized representative will help to make sure that in the event that the client does not have a reliable place to get mail that copies of any requests or action notices will go to someone who can review them and assist the client when needed.
What is SGA?	SGA stands for substantial gainful activity. SGA is defined as the ability to be employed and earn over $1,180 per month (2018).
Will there be a training for people applying who do not have a disability or DMH caseworker?	We will look into the possibility doing training on the application procedures for the Medicaid categories for children, pregnant women, and parents.
Due to the detailed nature of the MRT packets, why are the applicants given such a short time to get this packet completed & mailed back in?	When you are assisting the client in completing an application, the MRT Packet should be completed and submitted with the application whenever possible. When FSD mails out a request for any verification, including the MRT Packet, they allow the client 10 days to return the verification. If the verification is not returned, FSD allows another 10 days. The client is given 20 days to provide any verification requested, regardless of complexity. In the event additional time is needed, the client can request an extension which will be considered on a case by case basis. None of forms in the MRT packet need information from anyone other than the client, and only the MO 650-2616 – "Authorization for Disclosure of Consumer Medical/Health Information" requires the client's signature. Often the other 3 forms in the MRT packet can be completed based on information the client has already provided to the DMH agency assisting them.
Where do we send the MO HealthNet for Adults application?	When using the RUSH coversheet for applications based being aged (65+), blind, or disabled (ABD) send the application to the FSD Office on the top of the RUSH coversheet. Included on the coversheet is a mailing address, a fax address, and an email address for scanning the application and emailing it in. If you are submitting an application which is not a RUSH the application should be sent to your local office.

Question	Response
Would the provider submit the medical expenses or does the consumer submit these?	Either the provider or the consumer can submit the expenses. If DMH services (DD waiver, CPR, etc.) will be used to meet the spend down it is usually most efficient if the provider submits them directly to the FSD spend down unit.
When do you check the "help paying Medicare premiums and co-insurance" box on the application?	You check this box when an applicant is enrolled (or conditionally enrolled) in Medicare Part A wants a determination of their eligibility for MO HealthNet payment of their Medicare premiums and co-insurance.
Do you have to check one of the boxes in the bottom section of the 1st page on the application?	No, you do not have to check any of the 5 boxes (age 63 and need in-home nursing care, help paying Medicare premiums, want coverage under Ticket to Work, help with medical bills from the past 3 mos., have a conservator). You only check these boxes if appropriate, such has having unpaid medical bills in the prior 3 months or needing a Ticket to Work Medicaid eligibility determination due to having a disability and being employed. You must check at least one of the preceding 5 boxes (over 65, disabled and get SSDI/SSI, disabled but do not get SSDI/SSI, blind, live in a nursing home).
If a person is moving to Missouri from another state where they currently receive SSI and Medicaid, do we need to get a termination letter from the other state's Medicaid program?	No, the person should just apply for Missouri Medicaid and let FSD know that they were receiving Medicaid in the other state. FSD will then notify the other state to discontinue their coverage.
Is there a "test" application process that new employees can learn the process?	Not at this time.
What if the client has been emancipated, or under age 18 but married with a child, and they live with the parent?	When a person under age of 18 applying for Medicaid based on disability is married and living with his/her spouse and parents, the parents' income and resources are not considered. The spouse's income and resources would be considered in this case.
If a consumer is working in a sheltered workshop, should the income be listed on the application?	All income of the consumer (client) should be listed on the application, including earnings from a sheltered workshop. Sheltered workshop income is excluded when FSD does the budget for the eligibility determination, but FSD will need to verify that the income is from a sheltered workshop. Also, shelter workshop income does qualify a client for the impairment related employment expense deduction if receiving Medicaid in the Ticket to Work Health Assurance (TWHA) category.
How long is the Authorized Representative held on file for?	The authorized representative remains in effect until the client or authorized representative requests in writing that it be ended.

Question	Response
Do we need to complete the authorized representative form to email Anna Leonhard or Charles Bentley about a client?	You do not have to be an authorized representative to assist a person with a Medicaid application or to contact Charles or Anna about problems DMH consumers are having with Medicaid. However, if at all possible it is advantageous to become the authorized representative as copies of all requests and action notices will be mailed out to you, and allows you to fill out the annual review form and other information as needed.
Do we need to write down the name of an employee on the authorized representative form?	Best practice is to have a facility or organization assigned as the authorized representative. If the client is assigning a facility or organization, section 3 should be left blank and only section 4 should be completed.
If an adult (age 18 or over) is still covered on a parent's health insurance plan, do they need to include this insurance in section 7 of the application?	Yes, if the applicant has any health insurance it needs to be reported. FSD will usually request a copy of the front and back of the insurance card as verification.
Do the medical records need to be within the past year?	To do a disability determination MRT needs current medical records from the past year. You can also submit older records if you feel they are pertinent and/or informative, however MRT will still need current records. Records signed by a doctor within the past 6 months are the most useful. A doctor can sign older records along with a note that the information remains relevant.
Does psychiatric diagnoses count as a disability?	For both Social Security and Medicaid disability can be established by a mental disorder, which include psychiatric diagnoses. The listed mental disorders for adults (age 18 and over) and children ages 3-17 are: • Neurocognitive disorders; • Schizophrenia spectrum and other psychotic disorders; • Depressive, bipolar and related disorders; • Intellectual disorder; • Anxiety and obsessive-compulsive disorders; • Somatic symptom and related disorders; • Personality and impulse-control disorders; • Autism spectrum disorder; • Neurodevelopmental disorders; • Eating disorders; • Trauma- and stressor-related disorders For children under age 3, the only listed mental disorder is: Developmental disorders in infants and toddlers

Question	Response
Can Public Administrators use the RUSH coversheet?	The RUSH coversheet is only to be used by Community Mental Health Centers, CSTAR providers, and DMH DD case managers. When a public administrator is the conservator/guardian for a DMH client, they can submit the application to the appropriate DMH agency and the DMH agency can submit it as a RUSH application if appropriate.
Is the Rush Application open to all counties?	The RUSH coversheet can be used by any DMH facility/agency/provider for DMH consumers living in any county who need coverage as soon as possible for their wellbeing.
What is a GAF score?	GAF stands for Global Assessment of Functioning. For DMH clients in the community psychiatric rehabilitation (CPR) program, the Community Mental Health Centers (CMHCs) complete a comprehensive evaluation and treatment plan which includes a psychosocial assessment and GAF score based the DLA20.
Do I submit MRT package with all Annual Review forms for clients who do not receive SSDI or SSI?	The MRT packet is not needed for the annual review. The MRT packet is needed for disability redeterminations, which are completed separately from the annual review. The FSD MRT will send the client a request for the packet when they begin the disability redetermination process.
If child and disabled, should they use this application?	If a child with a disability is applying based on the disability, this is the form to use. Depending on the parents' income and the number of other children in the home, many children with a disability receive Medicaid in a Family Medicaid category, in which case the MO HealthNet for kids, pregnant women, and families application (https://mydss.mo.gov/healthcare) should be used.
Most of our DMH Inpatient consumer discharges go to a Residential Care Facility (RCF) so does that mean that is a Supplemental Nursing Care application and that their asset limit is 999.99?	When person is living in a Residential Care Facility (RCF) or Assisted Living Facility (ALF) licensed by the Department of Health and Senior Services, they typically apply for the Supplemental Nursing Care (SNC) program which provides both a cash grant and non-spend down Medicaid coverage. The asset (available resource) limit for SNC for those persons aged 65+ (ME code 14) or disabled (ME code 16) is still $999.99 for a single individual and $2,000.00 for a married couple. A person in a RCF or ALF with assets above those limits but below the Medicaid limit could receive Medicaid coverage in ME code 11 or 13, but might have a spend down.
If someone's income changes because of a pension/retirement being awarded to a married couple, is it likely for the person receiving Medicaid will be kicked off if their assets total less than $4,000.	If a couple's assets stay below the limit ($4,000 currently, $6,000 effective 7/1/18), an increase in income could cause the eligibility to change from non-spend down to spend down (or result in the spend down increasing), but it would not cause the Medicaid case to close.

Question	Response
Can funds in an able account be used to cover funeral costs? What happened to the funds if the individual passes away?	Yes, an ABLE account may be used for funeral and burial expenses. When an individual passes away, the funds remaining in the account should become part of the person's estate. If the person received Medicaid benefits during the time the account was open, Medicaid can file a claim for the repayment of some Medicaid benefits just as they can against any estate. This does not mean Medicaid automatically has first rights to the money remaining in the ABLE account.
Does the Ticket to work program only apply to the individual applying for Medicaid or does it apply if a person's spouse is working and makes over the $1,080.00/month?	To be eligible for the Ticket-to-Work Health Assurance (TWHA) Medicaid category a person has to be both disabled (except for SGA) and employed. For married couples both might be disabled or only one might be disabled. Also when both are disabled, only one might be working or both might be. The budget to determine income eligibility is always done jointly, even if only one spouse is disabled or only one spouse is working. If both are disabled and working, both will be eligible if they are eligible on income. If both are disabled, but only one is working only the one who is working would receive TWHA coverage if eligible on income (the other spouse could be eligible with a spend down). If only one spouse is disabled, that spouse has to be employed to receive coverage (whether or not the non-disabled spouse is employed). Either spouse earning above the SGA of $1,080 per month has no effect on whether or not a disabled spouse will be eligible for TWHA. The only effect of earning above SGA is that it means the person would not be considered disabled for the Medicaid for the Disabled non-spend down/spend down category.
What is the maximum someone can earn while on TWHA?	The gross income limit for TWHA is $3,035/mo. for a single individual, so an unmarried disabled person with no other income could earn up to that amount and qualify. The gross income limit for married couples is $4,115/mo., so a disabled person and their spouse with no income could earn up to the amount and qualify.

Question	Response
What if you have filled disability forms out for Social Security and the person has been approved for Social Security Disability. Can that form be pulled? Or do I need to request the form from Social Security and just transfer the information over?	If a person has been approved for and is receiving a Social Security Disability Insurance (SSDI) or SSI disability benefit, FSD does not need medical records or disability forms to establish a disability for Medicaid. If a person has been approved but is not yet receiving, FSD's Medical Review Team (MRT) still needs medical records to do their own disability determination. In that case the client could sign a release to authorize FSD to request the medical records from the Social Security Disability Determinations agency.
Are there income limitations for MO HealthNet for Disabled?	There are no income limitations for this program, though a client will have a spend down if their income is above the non-spend down income limits.
What are the income limitations for parents applying for a child deemed to have a disability under SSI but not receiving benefits due to income of the parents? Does that also apply for people with IDD?	If a child with a disability is not receiving SSI due to the parents' income, FSD MRT would have to do a disability determination and the child would likely have a spend down. Yes, this also applies for people with IDD.
Does being adjudicated incapacitated by the Probate Court meet the definition of disabled?	It has no effect. To be considered disabled for Medicaid a person has to either be receiving SSDI, SSI, in Section 1619(b) status, or determined disabled by the FSD Medical Review Team (based on Social Security's definition of disability).
I heard when the physicians went from using the DSM-IV to the DSM-5 manual, the GAF (Axis V) was dropped from DSM-5. Therefore, the physicians/nurse practitioners no longer provide a GAF on their Medical/Psychiatric Assessments and Discharge Summaries. There is also no longer a place to enter a GAF in CIMOR.	CIMOR still includes a GAF score, at least for clients in the community psychiatric rehabilitation (CPR) program. For DMH clients in the CPR program, Community Mental Health Centers (CMHCs) are required to complete a comprehensive evaluation and treatment plan which includes a psychosocial assessment and GAF score based the DLA20.
Is the RUSH cover sheet used when we are applying for 22-64 inpatient with a discharge in 90 days or less.	No, continue to use the pre-discharge application process. https://dss.mo.gov/fsd/iman/memos/memos_13/im89_13.html The pre-discharge form can be downloaded here: https://dmh.mo.gov/ada/provider/rapidmedicaideligibility.html In the event that the client is being discharged within a matter of days, that would be an appropriate time to use the RUSH coversheet.

Question	Response
On a spend down case, if there are no medical expenses for the month can they just not pay and choose to do it the next month if they know they are going to have medical expenses?	The client receives an invoice from the MO HealthNet Division in the month prior to the month the spend down is for giving them the option of paying in or meeting the spend down with incurred medical expenses. Each month the client can choose whether or not to pay the spend down amount to the MO HealthNet Division, no matter what choice was made for past months or will be made for future months. If a client does not expect to have any expenses for the next month, they can just not pay-in. Then if they do have unexpected expenses for that month, they can pay-in later or submit the expense to the FSD Spend Down unit.
A consumer is over the age of 21 and Medicaid was closed. Consumer has a legal guardian and minor children. Do the names of the minor children have to be listed under household members on the application?	No. The guardian should not be listed, the guardian's children should not be listed. Only the client and his/her spouse should be listed. If the client has minor children in the home they should be put on the application but the box requesting coverage should be left blank.
Under the ticket to work for Medicaid, do they have to be on ticket to work with SSD/SSI? Or are there different rules for Medicaid?	There are two things referred to as Ticket to Work: • There is the Ticket to Work program run by Social Security Administration, where they issue a "ticket" for SSDI and SSI recipients to use to receive services from an employment network. • There is the Ticket-to-Work Medicaid category, called the Ticket-to-Work Health Assurance (TWHA) program in Mo. The two programs are not related, though some people may qualify for both programs. Receiving SSDI or SSI is not a qualifying factor for the TWHA Medicaid category, but in order to qualify one must meet Social Security's medical definition of disability and the other Medicaid eligibility requirements.
If someone already has Medicaid and they get a job, can they qualify for Ticket to Work?	If a client who has been approved for MO HealthNet for Disabled coverage is or becomes employed, FSD will verify income and do a budget to determine if they are eligible for the Medicaid TWHA category. In the event a client qualifies for Ticket to Work and are also eligible for spend down, FSD would allow them to choose which category they want to be in.

Question	Response
How can I help a client decide between Ticket to Work and Spend Down?	A TWHA premium is typically significantly lower than the spend down would be. There is a TWHA calculator on the DMH website's Medicaid Eligibility page: https://dmh.mo.gov/ada/provider/rapidmedicaideligibility.html This calculator allows you to enter income information to determine if a client will be eligible under TWHA and the premium. When a person receiving Medicaid and SSI goes to work, they should qualify for Medicaid as a non-spend down in the Section 1619(b) category. There is a PowerPoint, which can be downloaded here: https://dmh.mo.gov/ada/provider/documents/Medicaid-Facts-Fiction-Updates_Training10-17-17.ppt This PowerPoint provides more information on effect of employment on Medicaid eligibility for persons with a disability.
Under assets, it says that a person can have $2000. I have a family with two adults, two children and both the parents have $300 spend down. The only income and assets they have is $1800 total between all 4, in SSD benefits. I am unsure if this is correct and was wondering if this needed to be reassessed?	For Medicaid under the categories for the aged (65+), blind, and disabled) the income and assets of the children are not considered (unless the child is the person applying based on disability). For adults (age 18 and over), only the income and assets of the applicant and their spouse (if in the home) are considered. In a household like you describe (assuming the parents are married), the asset limit is $4,000 ($6,000 eff. 7/1/18) and the non-spend down income limit is $1,166. Assets are things like checking accounts, savings accounts, stocks, bonds, life insurance policies, etc. Income is either earned income from employment, or unearned income from things like Social Security, unemployment benefits, or Veterans benefits. The spouse's income and assets are considered together. Provided their combined available assets (minus monthly income) are below the $4,000 limit, they are eligible on assets. A $300 spend down means that the combined countable income is $1,466.00. Any income or assets that belong to the children are not considered. The couple do not get any type of income deduction based on the children.