Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**FIA ACTION TRANSMITTAL**
Control Number: #02-54	**Effective Date: April 1, 2002** **Issuance Date: March 15, 2002**

TO: **DIRECTORS, LOCAL DEPARTMENT OF SOCIAL SERVICES**
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS/ELIGIBILITY STAFF

FROM: **CHARLES HENRY, EXECUTIVE DIRECTOR, FIA**
JOSEPH DAVIS, EXECUTIVE DIRECTOR, DHMH/OOE

RE: **SIMPLIFIED REDETERMINATION PROCESS FOR COMBINED QMB/SLMB AND FOOD STAMP HOUSEHOLDS.**

PROGRAMS AFFECTED: MEDICAL ASSISTANCE (MA), FOOD STAMPS (FS)

ORIGINATING OFFICE: OFFICE OF POLICY, RESEARCH AND SYSTEMS

BACKGROUND:

For the past two years the Departments of Aging (DOA), Health and Mental Hygiene (DHMH) and Human Resources (DHR) have worked together conducting extensive outreach to the Medicare eligible population. The goal is to increase awareness of other Medical Assistance programs available for individuals who receive Medicare. In addition, the outreach hoped to increase the number of individuals receiving Qualified Medicare Beneficiaries (QMB) or Specified Low-Income Medicare Beneficiaries (SLMB) benefits. In March 2000, interviewers began using a streamlined application in community and home-based settings. The outreach effort was successful and substantially increased QMB/SLMB participation.

A form was specifically designed for Medicare Beneficiaries entitled, “Redetermination for Medicare Beneficiaries,” (DES 9201). The simplification of the redetermination process for QMB/SLMB recipients who also receive Food Stamp benefits has expanded the outreach effort. A redetermination for Food Stamp Benefits form is included with the Medicare Beneficiaries redetermination form. This change provides customers with the opportunity to file one form for both programs eliminating the duplication of the redetermination process in local departments. The new form is yellow.

ACTION REQUIRED:

Beginning with the redetermination packages mailed out at the end of March, QMB/SLMB recipients will receive the DES 9201 Medicare Beneficiaries redetermination application including the Food Stamp redetermination form. Medical Assistance policy **does not** require a face-to-face interview for QMB/SLMB customers filing redetermination applications. The customer completes the combined **redetermination application** and forwards it to their local department of social services.

Upon receiving the combined application for QMB/SLMB and FS, the case manager initiates the redetermination on CARES for **both** programs.

NOTE:

Customers who have completed the DES 9201 Medicare Beneficiaries redetermination application are not required to complete a separate 9707 Rights and Responsibilities form.

FOOD STAMPS

There is **no change** in FS policy. This process simplifies the redetermination procedures within the specified policy guidelines for combined QMB/SLMB and FS applications. It does not replace the food stamp application process.

If a customer who does not already receive food stamps completes the one page FS redetermination form, the case manager should mail the customer a 9701 application form to give them an opportunity to apply for benefits.

Policy Reminders

The case manager must review the application and determine the household composition and status prior to scheduling a redetermination interview. Food Stamp policy allows face to face interviews to be waived in favor of a telephone interview under certain circumstances, which include:

1. Illness,
2. Transportation difficulties,
3. Residency in a rural area,
4. Care of a household member,
5. Prolonged severe weather, or
6. Work or training hours that prevent a household from participating in a face-to-face interview.

Many of these households will qualify for a hardship exemption. There is no requirement to verify the hardship situation in order to waive the face to face interview.

In addition, local departments have the option of not interviewing households at the interim recertification. This cannot be on a case-by-case basis. Local departments choosing this option must establish who will be required to have a face to face interview and who will not.

The case manager will certify households for the appropriate length of time and can certify households, in which the adult household members are aged or disabled individuals, for up to 24 months following guidelines set in each local department. Households certified for FS for 24 months must have contact with the LDSS every 12 months. The certification date for the QMB/SLMB and the FS may be matched so that the FS contact and the QMB/SLMB redetermination occur at the same time.

For additional clarification regarding hardship determinations for waiving the face to face interview please refer to Section 402.4 of the Food Stamp manual. For clarification regarding 24-month certifications please refer to Section 410.1 of the Food Stamp manual.

INQUIRIES:

Please direct QMB/SLMB questions to Barbara Washington at (410) 767-1480, Food Stamp inquiries to Marilyn Lorenzo at (410) 767-7333 and policy inquiries to Deborah Weathers at (410) 767-7994.

Attachment

cc: DHMH Management Staff
DHR Executive Staff
FIA Management Staff
Constituent Services
DHR Help Desk
RESI

State of Maryland
Department of Health and Mental Hygiene
Redetermination for Medicare Beneficiaries

Only persons who receive Medicare benefits may use this redetermination form. This form may be used only by individuals and couples who are currently receiving benefits as Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), or Qualified Individuals (QI). This form must be used for continuation of any of the following benefits:

- Payment of monthly Medicare Part A and Part B premiums or partial reimbursement of Medicare premiums
- Payment of Medicare co-payments and deductibles

If you are receiving food stamps and want to continue to get them, you may also complete the food stamp application included with this form.

If you need help with old medical bills, or if you want to apply for complete Medical Assistance coverage, you should call your case manager right away and ask for an application for Medical Assistance.

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application for benefits.

The purpose of requesting this personal information is to determine your eligibility for benefits. If you do not provide this personal information, the Medical Care Program may deny your application for benefits. You have a right to inspect, amend or correct this personal information. The Medical Care and Food Stamp Programs will not permit inspection of your personal information, or make it available to others, <u>except</u> as permitted by Federal and State law.

Please answer all of the questions on this form as best you can. If more information is needed you will be contacted by telephone or mail.

KEEP THIS PAGE FOR YOUR RECORDS

Rights and Responsibilities

I agree to the release of personal and financial information from my application to agencies determining eligibility for the Medical Care or Food Stamp Program so that they can evaluate it and determine eligibility. I understand that I may be asked to provide additional information. I have the right to appeal any decision made concerning my eligibility. Officials of the Department of Human Resources and The Department of Health and Mental Hygiene may verify all information on this form. I understand that I must tell the agency that determines my eligibility about any changes in the information reported on my application within 10 days after the changes. By signing the application form, I certify under penalty of perjury that everything on the form is the truth as best I know it.

I certify that everyone requesting benefits on this application form is a U.S. citizen or lawfully admitted alien. Proof of lawful immigration status may be required.

All information and documentation gathered for determining eligibility are confidential. Disclosure of information concerning eligibility to anyone not authorized to receive it is a violation of State and Federal laws.

I understand that I am required by law to assign to the State all third party payments (hospital and medical benefits) and to cooperate with the State in securing such payments. I also understand that the State may recover from the estate of any person over 55 years old an amount not to exceed the amount of benefits paid out on behalf of that person. There will be no recovery from the estate of a deceased individual with a surviving spouse.

I understand that the programs will use social security numbers to verify information such as income and insurance and to help maintain files regarding eligibility and payments. The information may be matched with records in other agencies, such as the Social Security Administration or the Internal Revenue Service.

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Redetermination for Medicare Beneficiaries

Please print

Section 1. Information about you.

Your Name: _____
First *Middle* *Last*

Address: _____
Street Address *Apt. No.*

_____
City *State* *Zip Code*

Telephone Number: (_____) _____ - _____

Date of Birth: _____ Sex: □ Male □ Female Race:_____

Your Social Security Number: _____-_____-_____

Medicare Number: _____-_____- _____ -_____

Marital Status: □ Never Married □ Married and living with spouse
□ Divorced □ Separated □ Widowed

Are you a Maryland resident? □ Yes □ No

Are you a citizen of the U.S.? □ Yes □ No
If not a citizen, date of arrival in the U.S.: _____INS ID Number: _____

Which language do you speak the most? □ English □ Spanish □ Other: _____

Section 2. Information about your spouse.

If you are living with your spouse, please complete the following information about him or her.

** **Provide the Social Security number and citizenship information only if you are applying for QMB/SLMB or Food Stamps for him or her.**

Name: _____
First *Middle* *Last*

Date of Birth: _____Race: _____

**Social Security Number: _____-_____-_____

Medicare Number : _____ - _____ - _____ -_____

**Is this person a citizen of the U.S.? . Yes . No
If not a citizen, date of arrival in the U.S.: _____ INS ID Number _____

Section 3. Income.

Type of Income	**Amount**	**How Often** (Monthly, weekly, etc)	**Received by:** **Applicant** **Spouse**
Social Security	$		☐ ☐
Social Security (SSI)	$		☐ ☐
Veteran's Benefits	$		☐ ☐
Railroad Retirement	$		☐ ☐
Civil Service Annuity	$		☐ ☐
Pension	$		☐ ☐
Rental Income	$		☐ ☐
Mortgage Income	$		☐ ☐
Interest on account	$		☐ ☐
Job Earnings	$		☐ ☐
Alimony	$		☐ ☐
Other:	$		☐ ☐
	$		☐ ☐

Section 4. Assets.

Type	**Name of bank or institution, or location**	**Owner:** **Applicant** **Spouse**	**Current Value**
Savings		☐ ☐	$
Checking		☐ ☐	$
Stocks		☐ ☐	$
Bonds		☐ ☐	$
Real Estate		☐ ☐	$
Burial or Funeral Plan		☐ ☐	$
IRA		☐ ☐	$
Trust Fund		☐ ☐	$
Other:		☐ ☐	$

Section 5. Life Insurance

Insured Person	Insurance Company	Policy Number	Face Value	Cash Value
			$	$
			$	$
			$	$
			$	$

Section 6. Health Insurance

Insured Person	Insurance Company	Policy Number

Section 7. Authorized Representative. This section is optional. Complete it only if you want someone else to handle your Medical Care Program eligibility for you.

You may have another person, such as a relative, friend or attorney, to represent you in your application for benefits. If you would like that person to speak to the Department about your case and receive copies of all letters about your eligibility, please fill in the following:

Name of representative: _____
Address of representative: _____
_____
Daytime telephone: (_____)_____-_____ Evening telephone: (_____)_____- _____
Representative's relationship to you: _____
I would like the representative above to: (*check all that apply*)

☐ Receive copies of all letters about my eligibility, and to discuss my eligibility with the Department of Social Services and the Department of Health and Mental Hygiene.

☐ Receive and complete my annual applications for me.

☐ Receive my identification card for me.

I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate with the State as required. Everything in this application is true and complete to the best of my knowledge.

_____ _____
Signature of Applicant **Date**

_____ _____
Signature of any Representative **Date**

Redetermination for Food Stamp Benefits

- If you are getting food stamps and want to continue getting them, complete sections 8 through 11.
- If you are not getting food stamps and want to apply, contact your local department of social services.

Section 8. Shelter Costs

Is anyone in your household paying for any of the following? Check all those paid and answer the questions.

✓	Expenses	Amount	How Often?	Who Pays?
	Rent			
	Mortgage			
	Electric			
	Gas			
	Oil			
	Coop or Condo Association fees			
	Telephone			
	Water			
	Sewer			
	Garbage			
	Wood/Coal			
	Property Tax			
	Homeowner's Insurance			
	Other			

Is heat included in your rent? Yes No

Do you pay an electric bill for lights or cooking? Yes No

If heat is not included in the rent, what is your source of heat?_____

Do you pay for air conditioning? Yes No

Does someone help you with your utility costs? Yes No
If yes, who? _____

Are you sharing any of the shelter costs listed above? Yes No
If yes, with whom? _____ Your Share? _____

Have you received Energy Assistance at your current address within the past 12 months?
Yes No

Section 9. Dependent Care

If anyone in your household pays someone to care for a disabled adult, fill in this section:	
Name of Care Provider	Telephone
Number Street	
City State Zip code	
Household Member Receiving Care	
Who Pays?	Cost $

Section 10. Medical Expenses

Food Stamps – Does any household member pay medical expenses for any person age 60 or over, or any person receiving disability benefits? Yes No
If yes, check the appropriate box and list the monthly amount you pay.

Health/Medicare Insurance $ _____ Medical/Dental Insurance $_____

Dentures/Glasses/Hearing Aids $ _____ Transportation Costs $ _____

Hospital $ _____ Nursing $_____

Attendant Care $ _____ Pharmacy Expense $_____

Section 11. Household's Declaration

1. Has any member of your household ever been convicted of a felony offense after August 22, 1996 that involved drugs?
   Yes No If yes, who? _____
2. Is any member of your household currently violating parole or probation or fleeing from the policy of the courts?
   Yes No If yes, who?_____
3. Has any member of your household been convicted since August 22, 1996 in a Federal or State Court for misrepresenting where they lived or their identify in order to receive Food Stamp benefits or Cash Assistance from more than one place in the same month?
   Yes No
4. Has any member of your household been convicted by a court of trafficking Food Stamp benefits of $500 or more?
5. Are you or any member of your household receiving benefits under another identity or as a member of another household or in another State?
   Yes No If yes, who? _____

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About my Redetermination

I am now eligible as a Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), or Qualified Individual (QI). I understand that these benefits do not cover all of my medical expenses, but may help me to pay my Medicare premiums, deductibles and co-payments.

I understand that if I need help with other medical expenses, I must contact my case manager at the Local Department of Social Services.

I mailed my redetermination form on_____.

I mailed my redetermination form to:

_____

_____

_____

_____

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