Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	FIA ACTION TRANSMITTAL
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TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND CASE MANAGERS

FROM: ROBERT J. EVERHARD, EXECUTIVE DIRECTOR, FIA

JOSEPH MILLSTONE, DIRECTOR, DHMH/MCPA

RE: MEDICAL ASSISTANCE RETROSPECTIVE RELIEF

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICE: OFFICE OF POLICY, RESEARCH AND SYSTEMS

SUMMARY

Federal welfare reform legislation signed into law in August 1996 required that we determine eligibility for Medicaid separately from welfare. Unfortunately, as an unintended consequence of welfare reform, Medicaid eligibility was not always considered when denying or closing a TCA case. As a result, some families may not have received Medicaid benefits to which they were entitled. DHR and the Department of Health and Mental Hygiene (DHMH) developed strategies to ensure that families who may have been incorrectly denied or closed have eligibility for Medicaid continued.

In mid October, DHR will mail a notice and two short applications to all families who were denied or closed for TCA between January 1, 1997 and April 30, 1999. Closed TCA/MA cases will receive notice TCA/MA 1, TCA/MA Application A and TCA/MA Application B (attached). Denied TCA/MA applicants will receive notice TCA/MA 2 (attached), TCA/MA Application A and TCA/MA Application B. The mailing will also contain an envelope for the customer to return completed applications to DHMH.

Before the end of October, DHMH will mail to the people whose TCA/MA cases were closed TCA and who did not subsequently receive MA, red and white Medical Assistance cards valid from **November 1, 1999** through **December 31, 1999**.

Retrospective Relief

DHMH and DHR wish to provide appropriate relief to those families who may have been adversely affected. This is referred to as "retrospective relief". To provide this retrospective relief, the following steps are being taken:

- Families whose TCA eligibility was denied or canceled since January 1, 1997, and who did not subsequently receive an MA determination are being given the opportunity to request coverage of medical expenses incurred back to the month of their denial or closure. These families will receive a packet which includes a one-page yellow application form and a return envelope. The yellow applications will be returned to DHMH and will be processed by DHMH staff. Eligibility for the coverage of prior bills will not appear on the CARES system, but will be determined off-line. The certifications will appear on MMIS in the Administration coverage group (S13).

- Families whose TCA was canceled since January 1, 1997, and who subsequently did not receive MA, will receive a Medical Assistance card valid for the months of November and December 1999. Recipients of the two-month cards will not be enrolled in HealthChoice. The two-month eligibility will be certified by MMIS in coverage group S13 and this eligibility will not appear on CARES.

- DHMH will make an eligibility determination for any bills received as long as they are outside the regular three-month retroactive period.

Current Eligibility

In addition to the retrospective relief noted above, all families whose TCA eligibility was denied or canceled since January 1, 1997 and who did not receive a subsequent determination of MA eligibility will receive a short application form for current benefits. This short form will be included in the same mailing that includes the notices regarding retrospective relief and the yellow application. If the families want current MA they are asked to use the return envelope to send the short form to DHMH. DHMH will maintain a log on the application forms received and will forward them immediately to the appropriate LDSS for processing of current eligibility.

It is important to understand that the short form application is a step taken to compensate for the fact that the automatic determinations of MA eligibility, which should have occurred at the time of denial or closure, may not have taken place. In the automatic determination that is made when a case sprouts and trickles the applicant/recipient is not required to file a new application, attend an interview, and generally does not have to submit any additional information. When a determination is made without the participation of the client, it is called an "ex parte" determination.

The law requires that an ex parte determination occur when TCA is closed or denied. In certain instances, an ex parte determination may not have occurred, such determinations need to be conducted at this time. The short form application is required

to update information such as address and income, and to provide sufficient identifying information on each AU member to process the case though CARES and MMIS. However, other standard application requirements, such as a face to face interview, are not required if they would not have been required when the case ideally should have sprouted or trickled. Due to the fact that the CARES system most likely will have outdated information, it is necessary to update such information in order to determine current eligibility. However, this should be done with the least amount of involvement of the client as possible.

Local Department Action

When the short forms are received from DHMH these applications should be pended immediately. The date of the application is the date received at DHMH. All standards of timeliness are applicable to these cases. The following principles should be applied when determining eligibility for these cases:

- A face to face interview is not required. Case managers may determine that a face to face interview is necessary on a case by case basis if information cannot be ascertained through systems interfaces, telephone calls or correspondence, and such information is critical to the eligibility determination.

- Screen the applications in the FAC track, but if the case is denied FAC due to resources, technical factors or lack of verification, or if the FAC case is preserved for spenddown, be sure to test the children for MCHP.

- Other than the face to face interview and the application form, there are no differences in determining eligibility for those families who apply via the short form.

INQUIRIES

Please direct questions on current procedures to Cynthia Davis at (410) 767-7495. Refer retroactive eligibility questions to DHMH Division of Eligibility at (410) 767-1463. Customer inquiries about these applications may be referred to 1(800) 332-6347.

cc: DHR Executive Staff
DHMH Executive Staff
FIA Management Staff

Constituent Services

STATE OF MARYLAND

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

IMPORTANT
MEDICAL CARE FOR YOUR FAMILY

Members of your family **will** be getting **Maryland Medical Assistance** cards very soon. People who got Temporary Cash Assistance at any time after January 1, 1997 also got Maryland Medical Assistance. Some people who stopped getting Temporary Cash Assistance also stopped getting Medical Assistance. Our files show that members of your family got Temporary Cash Assistance during this time and that their Medical Assistance was stopped. To help your family get medical coverage we are doing three things:

- We are mailing red and white Medical Assistance cards to each family member who got Temporary Cash Assistance and whose Medical Assistance stopped when their Temporary Cash Assistance was stopped. The cards will be mailed to you before November 1, 1999. These cards will be valid from **November 1, 1999** through **December 31, 1999** only. You may use the cards to get medical care from any doctor, pharmacy or other medical care provider who accepts Maryland Medical Assistance. You will not have to pay any part of the cost. **Use these cards in November and December to get the medical care you need.** *Call the number below if you do not receive the cards by October 25 ,1999.*

- We are sending you an application form with this letter. If you want to apply **to continue** to get Medical Assistance **after December 31, 1999**, you should fill out the form and return it to us **by December 1, 1999.** We will send it to the local department of social services nearest to you, and they will decide if you can continue to get Medical Assistance. They will send you a letter to let you know. *You may mail the form after December 1, 1999, but there may be a break in your coverage even if you are found to be eligible.*

- We are also sending you a yellow application form to fill out if you have any **old medical bills** for medical care that you or anyone in your family received **after January 1, 1997.** It doesn't matter if you paid these bills, or if you still owe them. Fill out the yellow form and mail the form **and the bills** to us. We will send you a letter to let you know if Medical Assistance can pay the bills for you. *If you want help with old medical bills, you must send the application and the bills **no later than April 30, 2000.***

We are sending you a stamped envelope with this letter. Use this envelope to mail back the applications and your old medical bills. Call the number below if you need help filling out the forms or if you need extra forms or envelopes.

If you have any questions about this letter call 1 (800) 332-6347.

STATE OF MARYLAND

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

IMPORTANT

MEDICAL CARE FOR YOUR FAMILY

You and your family may be able to get benefits under the **Maryland Medical Assistance** Program. Our files show that you applied for Temporary Cash Assistance. You did not qualify for Temporary Cash Assistance but you may still have your case reviewed to find out if you or anyone in your family can get Medical Assistance. To see if your family can get medical coverage we are doing two things:

- We are sending you an application form with this letter. **If you want to apply for Medical Assistance now**, you should fill out the form and return it to us. We will send it to the local department of social services nearest to you, and they will decide if you can get Medical Assistance. They will send you a letter to let you know. *Fill out the form and mail it as soon as you can to make sure you get the benefits you may be eligible for.*

- We are sending you a yellow application form to fill out if you have any **old medical bills** for medical care that you or anyone in your family received **after December 31, 1996.** It does not matter if you paid these bills or if you still owe them. Fill out the yellow form and mail the form **and the bills** to us. We will send you a letter to let you know if Medical Assistance can pay the bills for you. If you want help with old medical bills, you must send the yellow application and the bills ***no later than April 30, 2000.***

We are sending you a stamped envelope with this letter. Use this envelope to mail back the applications and your old medical bills. Call the number below if you need help filling out the forms or if you need extra forms or envelopes.

☎If you have any questions about this letter call 1 (800) 332-6347.

Application for Medical Assistance

Please Read Before Filling Out the Application Form

If you have any questions about how to fill out this form, or if you need extra forms or extra envelopes, please call **1(800)332-6347.**

Please make sure that your address is correct, and if possible, please list a telephone number where we can call you during daytime hours. If any additional information is needed to determine Medical Assistance eligibility you will be contacted by mail or telephone. You may need to appear for an interview. If so, you will be contacted to arrange for an appointment.

Not all of the information on the form affects Medical Assistance eligibility. Some of the information helps us to keep your records, and some of it is used to verify the information you give us. Some information might not be used at all since different rules apply to different people. The rules that apply to each person are based on things like age, whether or not the person wants Medical Assistance or just lives in the household, and how the person is related to the people who need Medical Assistance. Usually, if the application is filled out completely eligibility can be determined more quickly.

A Social Security Number **is required** for each person who wants Medical Assistance. A Social Security Number **is not required** for other members of the household, but it is helpful to us to have a social security number for everyone listed on the application. The Program uses the social security numbers to maintain files, to verify income, and to confirm insurance coverage. The social security number may be matched with files in other agencies such as the Social Security Administration and the Internal Revenue Service. If you decide not to give the social security number for a person who does not want Medical Assistance, this will not affect the eligibility of those who do want Medical Assistance.

PLEASE PRINT ALL ANSWERS. Use the last page for any information you cannot fit in the spaces below.

Last Name | First Name | M.I.

Address

City | State | Zip Code

Home Telephone # ( ) | Daytime Telephone # ( )

HOUSEHOLD MEMBERS

Please list everyone in your household (including yourself) and complete each space by their name.

Are You Applying For This Person	Name	Social Security #	Relationship to You	Date of Birth	Sex	Race	Does this person have Health Insurance?	If pregnant, due date
Yes No			SELF					
Yes No								
Yes No								
Yes No								
Yes No								

Has anyone above dropped health insurance coverage in the past six months?

☐ Yes ☐ No If yes, who? _____

INCOME INFORMATION

List wages, earnings, or money from a job or money from self-employment that you, your spouse or others listed above receive.

Name of Employed Person	Name of Employer	Address of Employer	Telephone #	Gross Amount (before deductions)	How Often (weekly, bi-weekly)	Begin Date	Student Status: Full Time/ Part Time

List any alimony, child support, pension, social security, rental income, retirement, strike benefits, unemployment, veterans, workers compensation benefits that you, your spouse or others in your household receive.

Person Receiving Benefit	Type of Benefit	Amount Received	How Often?

CHILD CARE EXPENSES

Fill in this section if you or anyone in your household pays for child care.

Name of Child Care Provider or Day Care Center	Telephone #	Child's Name	Cost
			$ Per
			$ Per

CHILD SUPPORT/ALIMONY

List anyone in the household who pays child support or alimony to anyone outside the household.

Name of person paying child support or alimony	Name of person to whom child support or alimony is paid	Amount paid	How often?

Fill in the following information about an absent or deceased parent of child applicant, or check the box below.

☐ I am afraid that my family or myself will be harmed by giving this information. I understand that I will be interviewed to confirm this.

Child's Name	Name of Absent or Deceased Parent	Parent's Social Security #	Last Known Address	Race	Sex	Date of Birth

Check Yes or No for each ASSET TYPE.
If you check YES, fill in the other boxes. Include all assets on which a household member's name appears.

ASSET TYPE	CHECK ONE	OWNER	AMOUNT
Cash on Hand	☐ YES ☐ NO		$
Checking and/or Savings Account	☐ YES ☐ NO		$
Trust Funds	☐ YES ☐ NO		$
Stocks, Bonds, Certificates, Money Market Funds, Treasury or Other Notes	☐ YES ☐ NO		$
Other, List:	☐ YES ☐ NO		$
			$

If you or anyone in your household has a car, truck, motorcycle, boat, camper, trailer, and/or recreational vehicle, fill in this section. Complete for tagged and untagged vehicles.

TYPE OF VEHICLE	YEAR	MAKE/MODEL	HOW USED?	AMOUNT OWED
				$
				$
				$

LIFE INSURANCE. If you or anyone in your household has any life insurance, fill in this section.

NAME OF PERSON INSURED	FACE VALUE	CASH VALUE	POLICY NUMBER	COMPANY

REAL PROPERTY. If you or anyone in your household owns property such as a house, land or buildings, fill in this section.

Number	Street	City	State	Zip +4

Owner	How Used?	Fair Market Amount $	Amount Owed

Number	Street	City	State	Zip +4

Owner	How Used?	Fair Market Amount	Amount Owed

Please read before signing

→ I understand that a social security number must be given for each person who wants Medical Assistance, and that this number will be used to obtain and verify information that affects eligibility. It will also be used to help maintain files.

→ I agree to the release of any necessary personal or financial information to the agencies determining eligibility for Medical Assistance.

→ I understand that the Medical Assistance program has the right to all medical support and third party payments for medical expenses, and I agree to cooperate in securing these.

→ I certify under penalty of perjury that every person for whom Medical Assistance is being requested is a U.S. citizen or a lawfully admitted alien.

→ I understand that the information on this form will be verified and I certify under penalty of perjury that everything on this form is the truth as best I know it.

Signature: _____ Date: _____

Relationship to Applicant:
- ❑ Self
- ❑ Head of Household, Parent or Caretaker Relative
- ❑ Power of Attorney (enclose P.O.A. document)
- ❑ Legal Guardian (enclose a copy of the guardianship document)

WRITE ADDITIONAL INFORMATION HERE

APPLICATION FOR MEDICAL ASSISTANCE COVERAGE OF MEDICAL SERVICES RECEIVED 1/1/97 through 5/31/99

Please make sure you fill in your current address and, if possible, a telephone number where you may be reached during daytime hours. Additional information may be required. If so, you will be contacted by telephone or mail.

You must include the medical bills you need help with. You may send the original bills or copies. If you send originals, we will return them to you. If you do not have the bills, call the medical care provider and ask them to send you a copy.

If you have any questions about how to fill out this application form, or if you need extra forms or envelopes, call 1(800)332-6347.

PLEASE PRINT ALL ANSWERS

Use the other side of this page for any information you cannot fit in the spaces below

Last Name	**First Name**	**M.I.**
Address		
City	**State**	**Zip Code**
Home Telephone # ( )	**Daytime Telephone # ( )**	

I am requesting Medical Assistance coverage of past medical bills. The oldest bill was received in _____ (Month) _____ (Year)

The latest bill was received _____ (Month) _____ (Year)

HOUSEHOLD MEMBERS

Please list everyone in your household (including yourself) during the months in which you received medical bills and complete each space by their name.

Are You Applying For This Person?	Name	Social Security #	Relationship to You	Date of Birth	Sex	Race	Does this person have medical bills?
Yes No			SELF				
Yes No							
Yes No							
Yes No							
Yes No							

When did you apply for Temporary Cash Assistance? _____ (Month) _____ (Year)

Where did you apply? _____ (Baltimore City or Name of County)

Did you receive temporary cash assistance? ☐ Yes ☐ No

Continued on the other side

Please read before signing

→ I understand that a social security number must be given for each person who wants Medical Assistance, and that this number will be used to obtain and verify information that affects eligibility. It will also be used to help maintain files. A social security number is **not required** for a person who does not want coverage.

→ I agree to the release of any necessary personal or financial information to the agencies determining eligibility for Medical Assistance.

→ I understand that the Medical Assistance program has the right to all medical support and third party payments for medical expenses, and I agree to cooperate in securing these.

→ I certify under penalty of perjury that every person for whom Medical Assistance is being requested is a U.S. citizen or a lawfully admitted alien.

→ I understand that the information on this form will be verified and I certify under penalty of perjury that everything on this form is the truth as best I know it.

Signature: _____ Date: _____

Relationship to Applicant:

- ❑ Self
- ❑ Head of Household, Parent or Caretaker Relative
- ❑ Power of Attorney (enclose P.O.A. document)
- ❑ Legal Guardian (enclose a copy of the guardianship document)

Make sure you have included the medical bills you need help with.

WRITE ADDITIONAL INFORMATION BELOW

MARYLAND MEDICAL ASSISTANCE

A short time ago you received a letter to let you know that you would receive Medical Assistance for the months of **November and December, 1999.** This is your Medical Assistance Identification Card. You may use this card to pay for medical services you receive from November 1, 1999 through December 31, 1999. This card is only good for **two months**, so you should make plans to get any medical care you need as soon as possible. You can receive care from any doctor, pharmacy or medical care provider who accepts Maryland Medical Assistance. You will not have to pay any part of the cost.

You were also mailed forms to fill out and mail in if you have old medical bills you need help with or if you want Medical Assistance after December 31, 1999. Fill these out and send them in as soon as you can. If you do not have these applications, or if you have any questions about this card, please call this number: ☎ 1 (800) 332-6347