



Applying For Medicaid
Virginia Department of Social Services

Medical Assistance Programs in Virginia

Medicaid was established under Title XIX of the Federal Social Security Act and is financed by both state and federal funds.

Although the Department of Medical Assistance Services (*DMAS*) administers the Medicaid program, responsibility for determining eligibility and maintaining the case record is held by local agencies under the supervision of the Virginia Department of Social Services (*VDSS*).



Medical Assistance Programs in Virginia

DMAS vs DSS

Department of Medical Assistance Services (DMAS)

- Development of State Plan to cover eligibility criteria and scope of services in conformity with federal law and regulations; determination of medical care covered under the State Plan
- Oversight of **CoverVA** call center and Central Processing Unit (CPU), which handles telephonic applications for Medicaid, eligibility determinations and referrals as needed to the Health Insurance Marketplace
- Appeals
- Provider approvals
- Processing of claims and payments; recovery of expenditures in appropriate cases

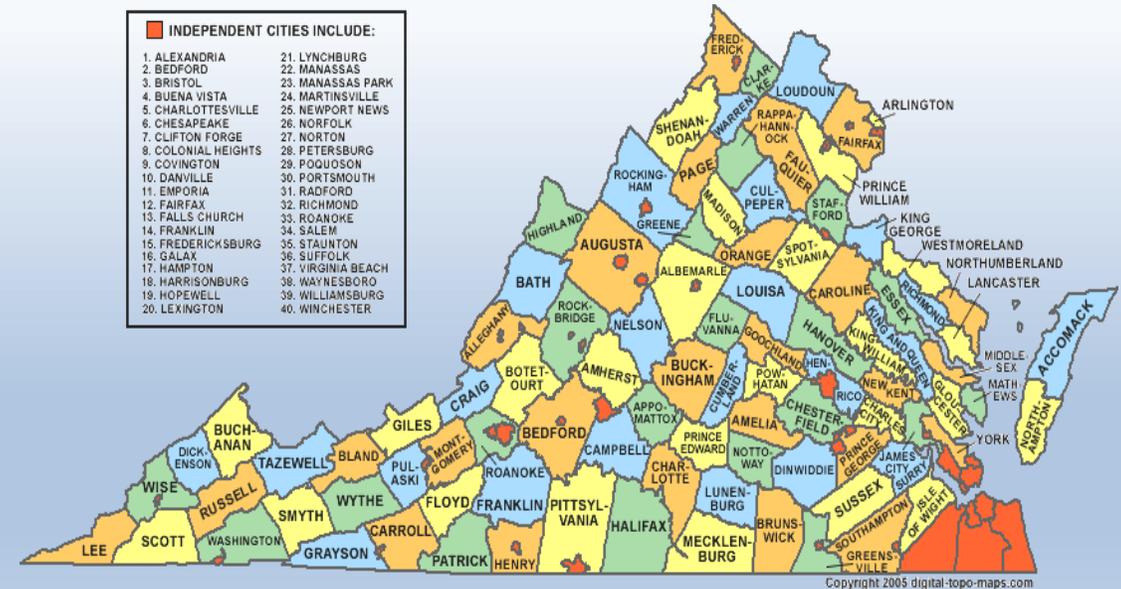
Department of Social Services (DSS)

- Determination of initial and continuing eligibility for Medicaid & FAMIS and enrollment of eligible persons
- Case maintenance
- Referral of individuals with inappropriate coverage or payments to DMAS Recipient Audit Unit (RAU)
- Referral of certain individuals to the Health Insurance Marketplace

How To Apply

- **Apply Online at:**
<https://www.commonhelp.virginia.gov/>
- Call Cover Virginia at **1-855-242-8282** to apply on the phone **Monday-Friday 8:00 AM-7:00 PM** and **Saturday 9:00 AM-12:00 PM**
- **Applications are also available Online at** http://www.dss.virginia.gov/benefit/medical_assistance/forms.cgi
- Applications can be mailed/faxed/ or dropped off to the local department of social services (**LDSS**). You can also request a **paper** Medicaid application be mailed to you.
- Applications may also be filed by calling the Virginia Department of Social Services Enterprise Call Center at **1-855-635-4370**.

- You can find the address and phone number of the local DSS at:
<http://www.dss.virginia.gov/localagency/>.
- You do not need to visit the **DSS** office to file an application.



Who Can Sign?

Applicants Age 18 or Older

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Applicants Age 18 or Older

Applicants must sign the application, even if it is filed by another person, unless the application is filed and signed by the following: legal guardian, conservator, power of attorney, or authorized representative. A spouse, aged 18 or older, can sign an application for an individual only if they are living together. A parent can sign an application if the child is <21 and living with the parent. (The parent does not need to be authorized by the child to conduct business on their behalf.)

- **Authorized Representative**—A person aged 18 or older that the applicant has designated in writing to conduct business on their behalf. (The authorized representative of an incompetent or incapacitated individual is their spouse, parent, power of attorney, guardian, conservator, or family substitute representative.)
- **Family Substitute Representative**—When an applicant can't sign the application and doesn't have an authorized representative, an individual aged 18 or older who is willing to take responsibility for the MA application will be considered the applicant's "family substitute representative". The preferred **relationship** order for the "family substitute representative" is in this order: spouse, child, parent, sibling, grandchild, niece/nephew, and aunt/uncle.



Who Can Sign?

Applicants Age 18 or Older

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No individual authorized to sign

If it has been verified in writing by the applicant's doctor that they are unable to sign due to their condition, and they do not have someone that can apply on their behalf per policy requirements, there are specific procedures that must be followed to determine whether or not anyone has been legally appointed as a guardian or conservator.

Deceased Applicant

Applications may be made on behalf of a deceased individual within a three month period prior to the month of his death if they received a Medicaid covered service on or before the date of death, and it was within a month covered by the MA application.

- Applications may be filed by guardians or conservators, power of attorneys, executor of his estate, surviving spouse, or family representative.



Applicants Under Age 18

- ***Child Applicant***—A child under age 18 years old is not legally able to sign their own application unless they are legally emancipated from their parents. If they are not emancipated, someone who is age 18 or older must sign the application: parent, legal guardian, authorized representative, an adult related by blood or marriage with whom the child lives, or a spouse aged 18 or older with whom the child lives. If there is no one who meets these criteria, whomever the child is living with is responsible for seeking custody or guardianship.
- ***Minor Parent Applying for His Child***—A parent under age 18 years old may apply for **his** child because **he** is the parent.



What Happens Next?

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- Once a local agency receives an application, it is reviewed to see if the individual currently has an open case or current coverage.
 - **If there is current coverage, the application is denied as a duplicate and a Notice of Action should be generated.**
- If a case has been closed within the past 90 days for failure to complete a renewal, that application may be treated as a late renewal.



Medicaid requires that individuals meet a covered group to be evaluated for **full or limited coverage**.

There are two covered groups:

- Adults, Families & Children (F&C)
- Aged, Blind, and Disabled (ABD)



Each covered group has its own subset of eligible individuals and programs.



Adults, Families & Children (F & C) Covered Groups

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Adults, Families & Children Medicaid is primarily full coverage . *There is no resource evaluation.*

- Pregnant woman (Newborn child)
- Children < 19
- Foster Care & Adoption Assistance
- Low Income Families & Children (**LIFC**)—Parent/Caretaker of dependent child < 18 years old
- Former Foster Care Children under age 26 (Must have been in Foster Care at the age of 18)
- Adults age 19 to 64
- Plan First—Limited coverage that only pays for Family Planning services



Aged, Blind, Disabled (ABD) Covered Groups

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To qualify for adult Medicaid, the individual must be either aged (65), blind, or disabled per Social Security criteria. (If a Hospice agreement has been signed and in effect for 30 days, the individual is deemed disabled for Medicaid purposes.)

Coverage can be either full or limited depending on the individuals income and resources.

- **Full coverage**
 - SSI, Auxiliary Grant recipients
 - Individuals with income \leq 80% Federal Poverty Limit
 - Long Term Services and Support Recipients (Nursing home, personal care, hospice, etc.)
- **Limited Coverage (Medicare Savings Programs)**
 - Qualified Medicare Beneficiary (QMB)—
Pays the Medicare deductible and the monthly Medicare premium
 - Special Low Income Medicare Beneficiary (SLMB), Qualified Individual (QI)—
Only pays the monthly Medicare premium



Evaluation of Eligibility

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To qualify for Medicaid, an individual must meet specific non-financial and financial criteria.

Verifications may be required before an evaluation of eligibility can be determined.



The Medicaid non-financial eligibility requirements are:

- Legal presence in the U.S., effective January 1, 2006
- Citizenship/alien status
- Virginia residency
- Social Security Number (SSN) provision/application requirements
- Assignment of rights to medical benefits and pursuit of support from the absent parent requirements
- Application for other benefits
- Institutional status requirements
- **Covered group requirements**



The Medicaid Financial Eligibility requirements are:

Income within appropriate income limits relative to the individual's **covered group**

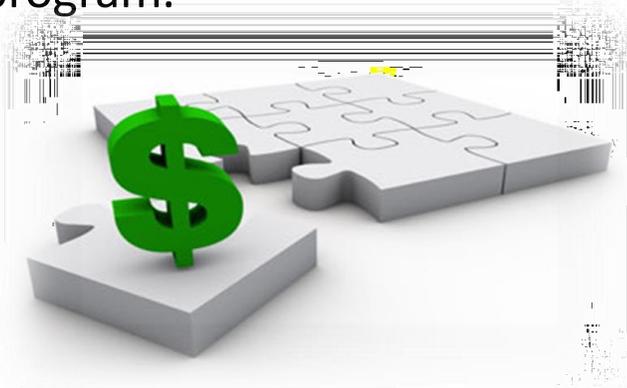
Resources within appropriate resource limits relative to the individual's **covered group**

Asset transfer evaluation for individuals who need **Long-Term Services and Support**



To qualify for assistance, an individual's income must meet the income requirements appropriate to the individual's **covered group**.

- **Types of income:** Earned income, Self-Employment, Social Security, Worker's Compensation, Veteran's benefits, Unemployment, Spousal support/Child Support, Retirement/Pensions, etc.
- After income has been verified, the **gross** income is reviewed, and program specific disregards are allowed to determine the countable income. This amount is then compared to the maximum income limit for each program.



As a program based on need, Medicaid uses the value of a person's **countable resources** as one of two financial criteria in determining eligibility. The other criterion is income.

Note: Resources are exempt for Family's and Children Medicaid

The **resource limit** is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an adult Medicaid category.

These amounts are established by law.

- **The resource limit for full Medicaid coverage is \$2000 for one person, \$3000 for two.**

Not everything a person owns (i.e., not every asset) is a resource, and not all resources count against the resource limit. Resources are things such as bank accounts (checking, savings, certificates of deposit, Christmas club, etc.), stocks, bonds, the cash value of some life insurance policies, property that does not adjoin the home. The home and adjoining property, one automobile, burial plots, home furnishings, property in which there is only a life interest, and personal jewelry are not counted.



The Verification Checklist

- After reviewing the application, the agency may need verification of specific eligibility requirements when they cannot be verified through other means. (Income, resources, etc.)
- Before taking action on the application, the applicant must be notified in writing of the required information. The verification request (checklist) must be sent to the authorized representative, if one has been designated.
- **The eligibility worker must allow at least 10 calendar days for receipt of the necessary verifications**

Processing Time-frame

- **Medicaid policy allows for a 45 day processing timeframe.**
 - If a disability determination is required, that timeframe may be extended to 90 days. (However, any non-financial requirements must be verified by the 45th day or the application will be denied.)
 - Pregnant woman applications must be processed within 7 calendar days if all necessary verifications have been provided.



- **Once a decision has been made on the application, a Notice of Action is generated** and mailed. (If there is an authorized representative, a Notice of Action may be mailed to them.)
- At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and *enrollee* of medical assistance shall be informed in writing of his right to appeal.
- A Medicaid card is issued to an **individual that has** been found eligible for Medicaid and enrolled with the Department of Medical Assistance Services (DMAS).
 - **Exception:** The following recipients do not receive a Medicaid card:
 - Individuals eligible for Medicare premium payment only,
 - Individuals enrolled in a closed period of coverage in the past with no ongoing coverage



Medicaid coverage is provided through two delivery systems: **fee-for-service (FFS)** and a managed care organization (**MCO**). **FFS** benefits are administered by DMAS through participating providers within the traditional Medicaid program rules.

However, most Virginia Medicaid enrollees are required to receive medical care through a managed care organization (**MCO**). After the individual is approved, they will receive information from DMAS regarding selecting a managed care provider.

- **Note:** There are some exemptions to participating in Managed Care:

Inpatients in state mental hospitals, long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled, individuals who meet a spenddown and are enrolled for a closed period of coverage, Enrollees under age 21 in Level C residential facilities, those with other health insurance coverage, and enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.



- Contact:
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QUESTIONS



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

