MEDICAL ASSISTANCE

MEDICAL ASSISTANCE PROGRAM OVERVIEW SECTION 0300

MEDICAL ASSISTANCE PROGRAM PURPOSE 0300.05

REV:06/1994

The Rhode Island Medical Assistance (MA) Program is the federal/state program to meet the medical needs of low income persons who are age 65 or over, blind, disabled, or members of families with dependent children, or qualified pregnant women and children.

The Statutory foundations of the Rhode Island MA Program are Title XIX of The Social Security Act and Rhode Island General Laws 40-8.

PROGRAM ADMINISTRATION 0300.10

REV:06/1994

The Rhode Island Department of Human Services (DHS) is the agency of state government which administers the Medical Assistance Program.

CATEGORIES OF MEDICAL ASSISTANCE 0300.15

REV:06/1994

DHS determines eligibility for and provides Medical Assistance to Rhode Island residents in two categories - Categorically Needy and Medically Needy.

Categorically Needy 0300.15.05

REV:06/1994

The Categorically Needy are those individuals or families eligible for or receiving cash assistance under the SSI or AFDC Programs, or who are deemed eligible, or are legislated under a special provision to be Categorically Needy.

SSI recipients, families eligible for and/or receiving AFDC and children for whom payments are made under Title IV-E are AUTOMATICALLY eligible for MA as Categorically Needy. A separate determination of eligibility for MA is not required for these individuals.

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0300.15.10 Medically Needy

REV:06/1994

The Medically Needy are those individuals or families whose resources and/or income exceed the standards required for eligibility as Categorically Needy, but are within the Medically Needy standards. Applicants may achieve Medically Needy eligibility with a Flexible Test of Income which applies excess income to certain allowable medical expenses, enabling individuals or families to spenddown to within Medically Needy income limits.

In addition to meeting the income and resources criteria, Medically Needy recipients must also meet all non-financial requirements for MA eligibility.

0300.20 SCOPE OF SERVICES

REV:06/1994

MA recipients eligible as Categorically Needy are entitled to the full scope of medical services provided by the MA Program. Recipients eligible as Medical Needy are entitled to a limited scope of medical services.

0300.20.05 Medical Services Provided

REV:01/2006

The medical services provided to the Categorically Needy and the Medically Needy are:

MEDICAL SERVICES PROVIDED

TYPE OF SERVICE	CATEGORICALLY NEEDY	MEDICALLY NEEDY
Inpatient Hospital Services	Yes 1,2	Yes 1,2 (see note below)
Inpatient Psychiatric Hospital Services for those age 65 and over or under age 21	Yes	Yes
Outpatient Hospital Services: (see note below)		
Clinic and Emergency Room	Yes 1,3	No
Laboratory and X-rays	Yes	Yes

Physician Services	Yes 1,2	Yes 1,2
Pharmacy Services (see note below)	Yes 8	Yes 8
Dental Services	Yes	Yes
Clinical Laboratory Services	Yes	Yes
Durable Medical Equipment, Surgical Appliances, and Prosthetic Devices	Yes	Yes 4
Certified Home Health Agency Services	Yes	Yes
Podiatry Services	Yes	No
Ambulance Services	Yes	Yes
Community Mental Health Center Services	Yes	Yes
Substance Abuse Services	Yes 5	Yes 5
Nursing Facility Services	Yes	Yes
Optometric Services	Yes 6	Yes 7
Intermediate Care Facility and Day Treatment Services for the Mentally Retarded	Yes	Yes

NOTE: Inpatient hospital services are subject to admission screening and hospital utilization review procedures. Outpatient hospital services are subject to hospital utilization review procedures.

1 The cost of abortion service is paid only when it is necessary to preserve the life of the woman or when the pregnancy is the result of an act of rape or incest.

2 Organ transplant operations as described in section 0300.20.05.25 are Medical Assistance services.

3 A $3.00 co-payment is charged to eligible individuals for non-emergency services provided in a hospital emergency room.

4 Hearing aids and molded shoes are excluded.

5 Limited to counseling and Methadone maintenance services provided by centers licensed and funded by the Division of Substance Abuse of MHRH.

6 For recipients age 21 and older, the following optometry services are limited to once every two years: one refractive eye care exam; one pair of eyeglasses (frames, lenses, dispensing fees).

7 For recipients age 21 and older, payment will be made for one refractive eyecare exam in a two year period. Payment is not made for eyeglasses (frames, lenses, dispensing fees).

8 Individuals receiving Medicare Part A, Part B, and/or Part D will receive Pharmacy services through a Medicare Prescription Drug Plan.

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0300.20.05.05 Emergency Room Co-Payment Required

REV:06/1994

With certain recipients exempted, a recipient co-payment of $3.00 will be imposed for a hospital emergency room visit WHEN THE SERVICES PROVIDED DURING THE VISIT DO NOT MEET THE DEFINITION OF EMERGENCY SERVICES. The co-payment is not imposed for children under 18, IV-E and non-IV-E foster care children, adoption assistance children, pregnant women, and institutionalized individuals.

The provider is responsible for collecting the co-payment. The collection of the co-payment is an issue between the recipient and

the provider. A provider may not deny service to a recipient who is unable to pay the co-payment at the time the service is delivered. The co-payment will not be imposed on the recipient and deducted from the hospital's claim when a claim is for an emergency service as defined below.

Emergency services are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Following is a list of examples of presenting problems/diagnoses that will not incur a co-payment:

- Chest pain
- Shortness of breath or difficulty breathing
- The sudden onset of:
  - high fever in children under five years
  - loss of vision, hearing, memory, motion or speech
  - allergic reaction with swollen tongue or fullness of throat
  - paralysis
- Suspected poisoning
- Seizures, convulsions or unconsciousness
- Drug overdose
- Suicide attempt
- Psychotic behavior
- Complications of Pregnancy:
  - sudden vaginal bleeding
  - membrane rupture
  - premature labor
  - suspected miscarriage
- Severe and unexplained bleeding

At the point of service, the hospital will determine if the visit is subject to a co-payment, and if the recipient is subject to imposition of co-payment. If both conditions are met, the hospital will charge the recipient the $3.00 co-payment, and issue a form MA-300, which advises the recipient of the co-payment, and his/her rights to appeal (see Section 0110, Complaints and Hearings, of the DHS Policy Manual).

The hospital must bill the Medical Assistance Program with the

appropriate ICD-9-CM diagnosis code(s), and a description of emergency services provided. Such services must be documented in the hospital medical record. The co-payment will be deducted from the Medical Assistance allowed payment during claims processing.

0300.20.05.10 EPSDT

REV:10/1994

Title XIX of the Social Security Act provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of eligible Medical Assistance recipients under age 21 to ascertain physical and mental defects, and requires treatment to correct or ameliorate defects and medical conditions found. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) further mandates that under EPSDT, services will be provided for such other necessary health care, diagnostic services treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services, WHETHER OR NOT SUCH SERVICES ARE NORMALLY COVERED UNDER THE MEDICAL ASSISTANCE SCOPE OF SERVICES. Eligible individuals under age 21 receive Medical Assistance services consistent with EPSDT requirements.

All services formerly provided under the Severely Disabled Children (SDC) Waiver, which was discontinued October 15, 1994, are covered in the same way under the EPSDT program.

The Severely Disabled Children Waiver provided in-home nursing services for medically fragile children. The medically fragile child is one who requires a medical device to replace or to compensate for a vital body function. This includes but is not limited to mechanical ventilation, oxygen supplementation, feeding tubes, cardiorespiratory monitoring, tracheal care and suctioning, and/or I.V./T.P.N.

Children are referred for services from a variety of sources, including pediatricians, hospital discharge staff, VNA's and parents. In order for a child to be determined eligible for in-home services there needs to be skilled nursing needs identified, that is, the child would have to be dependent on a medical device for maintenance of life.

When a child is identified as requiring in-home nursing care, the

physician makes a request to DHS/EPSDT and includes a medical history and a description of the child's current status. The request is then reviewed by OMR and EPSDT staff. If the child is an in-patient, DHS staff participate in the discharge planning activities and assist in determining level of in-home services. This process includes input from the parents, physicians, nursing staff, third party insurers and others as appropriate, e.g., DCYF. If the child is already in the community, OMR staff would meet with the parents, and determine the appropriateness of care in conjunction with the physician and others that may be involved with the child. The cost of in-home services must be less than care in a hospital or pediatric skilled nursing facility.

This process encourages a family centered approach which supports the parents in making decisions for and about the home care plan for their child. The parents are encouraged to communicate with other families who have experienced home care and to understand their options in making decisions regarding providers of care.

Nursing services are authorized by OMR staff on a monthly basis and are adjusted according to the medical/nursing needs of the child.

Abortions, Rape, or Incest 0300.20.05.15

REV:06/1994

The cost of abortion services is paid when the pregnancy is the result of an act of rape or incest or it is necessary to preserve the life of the woman.

The following policy and procedure is to be followed when the pregnancy is a result of an act of rape or incest which will qualify for reimbursement by the Rhode Island Medical Assistance Program:

- The patient must provide a signed written statement attesting to the fact that the pregnancy is the result of an act of rape or incest. This requirement shall be waived if the treating physician certifies that in his or her professional opinion, the patient was unable for physical or psychological reasons, to comply with this requirement.

- The treating physician must provide a signed statement

that she/he performed the termination of the pregnancy and that the pregnancy resulted from an act of rape or incest.

- The statements must be kept in the medical record for a period of three years to maintain an audit trail.

- The procedure must be performed by a licensed treating physician in a hospital setting or licensed out-patient facility.

0300.20.05.20 Abortions, To Save the Life of the Mother

REV:05/1995

Payment for an abortion will be rendered when a physician has found, and certified in writing to the Department of Human Services at the time payment for services is requested, that an abortion was medically necessary to save the life of the mother.

To qualify for reimbursement by the Rhode Island Medical Assistance Program for an abortion, the following policy must be followed in order to document medical necessity to save the life of a mother. (See section 0300.20.05.15 relative to payment for an abortion when the pregnancy is the result of an act of rape or incest.)

To receive Medical Assistance payment for services, the physician must:

- be a doctor of medicine or osteopathy who is licensed to practice in the State of Rhode Island;

- determine and certify in writing that in his/her professional judgement, the abortion was medically necessary to save the life of the mother;

- retain a copy of the certification in the patient's medical record for a period of three years for purposes of audit;

- submit a copy of the certification, which must contain the name and address of the patient, attached to the request for payment for services.

Organ Transplant Operations 0300.20.05.25

REV:05/1995

ORGAN TRANSPLANT OPERATIONS

The following organ transplant operations are provided as Medical Assistance services when medically necessary and when prerequisites are met:

- KIDNEY TRANSPLANTS:
  Certification from an appropriate medical specialist as to the need for the transplant.

- LIVER TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- CORNEA TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- PANCREAS TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant; evaluation at the transplant facility.

- BONE MARROW TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- LUNG TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- HEART TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- HEART/LUNG TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- OTHER ORGAN TRANSPLANT OPERATIONS

Such other organ transplant operations as may be designated by the Director of the Department of Human Services after consultation with medical advisory staff or medical consultants.

Medical Necessity

Medical necessity for an organ transplant operation is determined on a case-by-case basis using the following criteria: medical indications and contra-indications; progressive nature of the disease; existence of alternative therapies; life threatening nature of the disease; general state of health of the patient apart from the particular organ disease; any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

Prior Written Approval

Prior written approval of the Director or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are delineated in sections 200-30-1 through 200-30-5 of the Medical Assistance Program Provider Reference Manual.

0300.20.05.30 Transportation Services

REV:12/2001

The Department recognizes that Medical Assistance recipients need available and appropriate transportation in order to access medical care, and assures the provision of such transportation when required to obtain medically necessary services covered by the MA program as follows:

INFORMATION

An informational sheet about MA transportation services for elderly and individuals with disabilities is available at DHS offices or by calling the DHS Information line at 462-5300, for hearing impaired 462-3363.

EMERGENCY TRANSPORTATION

For purposes of this policy section, emergency transportation

means transportation to medical treatment when required to obtain emergency health care services for unforseen circumstances which demand immediate attention at a hospital to prevent serious impairment or loss of life. Medically necessary emergency transportation is provided by ambulance.

When medical services are obtained at a hospital participating in the MA program, appropriate transportation home, if needed, is arranged by the hospital social service or emergency department staff.

NON EMERGENCY TRANSPORTATION

Generally, non-emergency transportation means transportation needed to travel to or from necessary routine, planned medical treatment covered under the MA scope of services at a MA participating provider.

The use of friends, neighbors, and family members to provide non-emergency transportation is encouraged. In addition, free transportation, which may be available from health centers, community agencies or volunteer groups should be utilized whenever possible. Medically necessary transportation to or from medical treatment is also available as follows:

- RIDE PROGRAM

  RIDE provides door-to-door transportation to individuals over age sixty (60) and individuals with disabilities of all ages who meet certain criteria. Transportation is generally available weekdays for doctor's appointments, therapy, adult day care, medical tests and other medical treatment. Transportation may be requested by calling RIDE at 461-9760 or 1-800-479-6902 at least two (2) weeks prior to the medical appointment.

- Rhode Island Public Transit Authority (RIPTA)

  Individuals who receive MA based on age (65 or older) or disability may apply for the "no fare" program and ride free with a RIPTA Senior/Disabled ID card during all hours of operation on regularly scheduled routes.

  The Senior/Disabled ID may also be used to obtain RIPTA flex service, designed to reach areas where fixed bus routes do not go. Flex service is currently available by reservation

or at designated regular bus stops from Monday through Friday, 6:00 AM to 6:30 PM in only a few areas of the State. Information about flex service may be obtained by calling RIPTA at 1-877-906-FLEX (3539).

Applications for the Senior/Disabled "no fare" program are available at the RIPTA Identification Office, 218 Weybosset Street, Providence, RI or through the RIPTA Road Trip Community Outreach Program. Applicants must provide a copy of their RI Pharmaceutical Assistance for the Elderly (RIPAE) Card, Medical Assistance ID card, or No Fare Certification Letter from the Department of Elderly Affairs to RIPTA. Information about the Senior/Disabled "No Fare" program may be obtained by calling 784-9500.

RIPTA bus passes are also made available to RIte Care and RIte Share program participants in accordance with provisions contained in Section 0348.45.05 of the DHS Manual.

RIPTA also offers modified curb to curb Paratransit Service that is comparable to existing RIPTA bus routes for individuals with disabilities who are unable to use regular bus service. Additional information and eligibility applications are available from the RIPTA Paratransit Division Coordinator at 784-9500, ext 153, or for hearing impaired 784-3524.

From time to time, transportation services offered by RIPTA may change as new or pilot programs are developed.

When none of the above options are available or appropriate, assistance with non-emergency transportation may be obtained by calling DHS at 784-3899 during normal business hours - -Monday through Friday, 8:30am to 4:00pm. The recipient is not required to provide verification of the unavailability of alternative or free transportation. All vendors authorized to provide medical transportation must meet the standards established for MA providers by DHS. Prior authorization must be obtained before payment is made for non-emergency transportation to a provider of transportation services.

Transportation is authorized by the most economical means, unless there are compelling medical reasons for using more expensive means. Payment is not authorized for any of the following reasons:

1. For transportation which is ordinarily made available to other persons in the community without charge;
2. For care or services that are not covered under the MA program;
3. To non-participating service providers; or,
4. When the MA recipient is not actually transported in the vehicle.

0300.20.05.35 PHARMACY SERVICES

EFF:01/2006

Under the Medicare Part D Program, in accordance with the Medicare Modernization Act of 2003, Medicaid beneficiaries who also receive Medicare Part A and or Part B, qualify for Part D and must receive their pharmacy services through a Prescription Drug Plan. Therefore, Medicaid beneficiaries who also receive Medicare benefits do not receive pharmacy benefits under the State Medicaid Program. There are, however, five (5) classes of drugs that are exempted from these drug plans and for which Medicaid will provide coverage under Medicaid Pharmacy Services to those receiving Medicare. The five (5) classes of drugs are: barbiturates, benzodiazepines, vitamins, over the counter medications, and cough and cold medications.

0300.20.05.35.05 PHARMACY SERVICES COST SHARING REQUIREMENTS

EFF:01.2006

Individuals who receive both Medicaid and Medicare benefits may be subject to cost sharing requirements under Medicare Part D in the form of premiums and/or co-payments.

PREMIUMS:

Individuals who select a Part D plan with enhanced benefits will be responsible for that plan’s premiums.

CO-Payments:

Individuals will be required to pay a co-payment for each prescription that they purchase.

Income Level	Amount of Co-Payment

Income below 100% FPL	$1.00 Per Generic Prescription $3.00 Per Brand Name Prescription
Income above 100% FPL	$2.00 Per Generic Prescription $5.00 Per Brand Name Prescription

Individuals who are participants in both waiver and assisted living programs and who receive both Medicaid and Medicare benefits will be required to pay a co-payment for their prescriptions.

EXCEPTION TO CO-PAYMENT REQUIREMENT:

Institutionalized individuals residing in nursing facilities will not be required to pay a co-payment for their prescriptions.

No co-payments are required for those five (5) classes of medications listed in DHS Policy Section 0300.20.05.35 that are not covered by Medicare Part D Prescription Plans.

Waiver Programs 0300.20.20

REV:06/1994

Section 1915(c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Waiver services are in addition to the services otherwise provided under the Medical Assistance Program. Waiver services may include case management, personal care, adult day care, homemaker services, respite care and similar home-based services.

The Rhode Island Department of Human Services operates several programs under Home and Community-Based Services Waivers. To be eligible, a recipient must require the level of care provided in an institutional setting, be in one of the target groups of an established waiver program and meet the requirements of the particular waiver program. Waiver recipients must be eligible as Categorically Needy or Medically Needy, as required by the specific waiver program.

MA Payment Policy 0300.20.25

REV:03/2002

Medical Assistance is the payor of last resort. Community, public and private resources such as Federal Medicare, Blue Cross/Blue Shield, VA benefits, accident settlements or other health insurance plans must be fully utilized before payment from the Medical Assistance Program can be authorized.

Payments to physicians and other providers of medical services and supplies are made on a fee for service basis in accordance with applicable federal and state rules and regulations, and established rates of reimbursement governing the Rhode Island

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Medical Assistance Program. Payments to physicians and other providers of medical services and supplies represent full and total payment. No supplementary payments are allowed. Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

Payments for enrollment in a Rite Care Health Plan or a Rite Share approved employer based group health plan are made in accordance with policy contained in Section 0348.75.15 and 0349.30 respectively.

0300.20.30 Provider Deficiencies/Plan of Correction

REV:06/1994

The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities/Mental Retardation (ICF/MR) for compliance with the federal participation requirements of the Federal Medicare and State Medical Assistance Programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

Statements of provider deficiencies must be made available to the public through the Social Security Offices and Public Assistance Agencies.

The Health Standards and Quality Bureau of the Regional Office transmits these reports in the following manner:

- Nursing Facilities (NF) - Reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located, and the Central Office of the Department of Human Services (DHS).

- Intermediate Care Facilities/Mental Retardation (ICF/MR) - Reports are sent to the Central Office of DHS.

The agency is required to send the reports for both Nursing and Intermediate Care Facilities/Mental Retardation to the appropriate Long Term Care (LTC) Unit covering the district in which the

facility is located. The agency must also send the ICF reports to the SSA office covering the catchment area in which the facility is located.

These files are available to the public upon request. If an individual has questions about the reports, or requests additional data, the Supervisor will be informed and will contact the Chief Medical Care Specialist in the Long Term Care (LTC) Unit at Central Office.

Material from each survey will be held in the District Office for three (3) years and then destroyed.

Medicare Buy-in 0300.20.35

REV:05/1995

Medicare Buy-in is a provision of the Medical Assistance program which allows Medical Assistance to pay for the Medicare Part A and/or Part B premiums of certain categories of MA eligibles.

Pharmacy Lock-In Program 0300.20.40

REV:01/2002

The Code of Federal Regulations at 42CFR440.230(d) allows DHS to place appropriate limits on a medical service based on such criteria as medical necessity or on utilization control procedures. The Medical Assistance Pharmacy Lock-In Program has been established by the Division of Health Care Quality, Financing and Purchasing to restrict recipients whose utilization of Medical Services is documented as being excessive. Recipients are "Locked-In" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medical Assistance recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

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0300.20.40.05 Enrollment in Pharmacy Lock-In Program

REV:01/2002

Whenever Medical Assistance records indicate that recipient utilization is excessive or inappropriate with reference to medical need, the Division of Health Care Quality, Financing and Purchasing may require an individual to designate a physician and pharmacy of choice for exclusive service in order to:

- Protect the individual's health and safety;
- Provide continuity of medical care;
- Avoid duplication of service by providers;
- Avoid inappropriate or unnecessary utilization of Medical Assistance as defined by community practices and standards; and,
- Avoid excessive utilization of prescription medications.

Excessive utilization of prescription medications will be determined from published current medical and pharmacological references.

The Department selects for enrollment in the Medical Assistance Pharmacy Lock-In Program recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medical Assistance Program.

Recipients will be given a written notice (MA/DUR-1) of his/her excessive or inappropriate utilization thirty days prior to the implementation of the restriction and will be requested to choose a primary pharmacy/physician as a single source of medical care.

The notification will also advise the individual that failure to cooperate in this program will necessitate the Department's designating a physician/pharmacy for the individual based on the recipient's previous use and geographical location.

The notification will include the individual's right to request a fair hearing within 30 days if he/she disagrees with the findings and the Department action.

REVS Identification of Lock-In Recipients 0300.20.40.10

REV:05/1995

Recipients who are in the Medical Assistance Pharmacy Lock-In Program are identified through the Recipient Eligibility Verification System (REVS).

Primary Pharmacy of Choice 0300.20.40.15

REV:05/1995

The Primary Pharmacy of Choice must monitor the drug utilization of each restricted recipient and must exercise sound professional judgement when dispensing drugs in order to prevent inappropriate drug utilization by the recipient. When the pharmacist reasonably believes that the recipient is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist must contact the providing physician to verify the authenticity and accuracy of the prescription presented. Primary pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative action by the Department, including the recovery of payments.

Primary Care Physician 0300.20.40.20

REV:05/1995

The Primary Care Physician is delegated the responsibility of overseeing the health care needs of the restricted recipient and providing all medically necessary care for which the recipient is eligible. The provider should be knowledgeable about the recipient's health care problems and aware of the care and services the recipient is receiving.

Change in Primary Pharmacy/Physician 0300.20.40.25

REV:05/1995

A recipient may change his/her primary pharmacy/physician for reasonable cause by notifying the Medical Assistance Pharmacy Lock-In Program and choosing a new primary pharmacy/physician.

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0300.20.40.30 Change in Recipient Status

REV:05/1995

If, after review of the recipient's drug-usage profile, it is determined by the Medical Assistance Pharmacy Lock-In Program that restriction is no longer appropriate, the restriction will be removed. Such review will not take place prior to 15 months from the date of enrollment.

0300.25 OVERVIEW OF MA ELIGIBILITY REQUIREMENTS

REV:06/1994

The eligibility requirements of the MA Program are categorized as technical requirements, characteristic requirements, cooperation requirements, cost effectiveness and financial requirements.

0300.25.05 Technical Eligibility Requirements

REV:06/1994

Technical eligibility requirements for the Rhode Island MA Program are citizenship, residence and possession of, or application for, a social security number.

0300.25.10 Characteristic Eligibility Requirements

REV:01/2002

Characteristics are non-financial eligibility factors. The required characteristics for an individual applying for MA are those of the SSI program - age (65 or older), blindness or disability. The required characteristics for families are generally those of the FIP program - age, relationship and deprivation factor (absence, death, unemployment, or incapacity of a parent or caretaker relative).

Pregnant women, certain children and parent(s) (or caretaker relative) of eligible children may be eligible for MA without having one or more of the usual characteristics of the AFDC program prior to 5/97. For example, pregnant women, poverty level children and Section 1931 parents or caretaker relatives are not required to meet a deprivation factor. All children are required to meet an age requirement.

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**CV

Cooperation Requirements 0300.25.15

REV:06/1994

As a condition of eligibility, the MA applicant/recipient must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

Financial Eligibility Requirements 0300.25.20

REV:06/1994

Financial eligibility is based on the applicant/recipient's income and resources. Certain income and resources are COUNTABLE and thus included in the calculation of the individual's total income and resources to determine if financial eligibility exists. Other income and resources may be EXCLUDED from the calculation and not count toward the individual's allowable limit.

Income Flex-Test and Spenddown 0300.25.20.05

REV:06/1994

Medical Assistance policy provides that an otherwise eligible applicant with income in excess of the allowable income limits may be eligible for MA if the excess income is insufficient to meet the cost of certain medical expenses. An individual's unpaid medical bills and current receipts for incurred medical expenses may be subject to an Income Flex-Test. The applicant may qualify for an income spenddown in which allowable medical expenses absorb his excess income, enabling him to qualify for MA as Medically Needy.

METHODOLOGY FOR DETERMINING COVERAGE GROUP 0300.30

REV:11/1998

A Coverage Group is a classification of individuals eligible to receive Medical Assistance benefits. There are numerous coverage groups distinguishable by income and resource standards and other non-financial criteria. An individual must satisfy all the

requirements of at least one coverage group to be eligible for Medical Assistance.

Medical Assistance coverage groups are categorized as SSI-related, family-related or special treatment coverage groups.

The term "SSI-related" refers to the methodologies used for evaluating the individual's income and resources, and the non-financial criteria to be met for MA eligibility. Thus, an individual may be eligible for one of the SSI-related coverage groups if he/she is blind, disabled or age 65 or over, and has income and resources within the limits required for MA eligibility. Some coverage groups in this category are referred to as "special treatment" coverage groups (e.g., QMBs, SLMBs, QIs, etc.).

Similarly, the term "family-related" refers to the methodologies for evaluating income, resources, and the non-financial criteria to be met for determining eligibility under family MA coverage groups. Thus, if family members meet the required characteristics of MA for families, then the countable income and resources are evaluated using the family-related methodologies.

Pregnant women, certain children and parent(s) of eligible children may qualify for MA without possessing an SSI characteristic or a family characteristic of deprivation through the absence, death, incapacity or unemployment of a parent or caretaker relative. For example, a pregnant woman may be eligible for MA without a deprivation characteristic or a resource test. For families, only Medically Needy eligibility, including Medically Needy eligibility based on spending down excess income, requires a deprivation characteristic.

Early in the application process an initial determination is made regarding the potential coverage group to which the MA applicant may belong, usually based on the non-financial criteria of the coverage groups. MA eligibility is then determined based on the applicable income/resource standards of the individual's particular coverage group.

If an applicant is a potential candidate for more than one coverage group, then the determination of MA eligibility is made considering all possible coverage groups. The agency must allow an individual who would be eligible under more than one category to have his/her eligibility determined for the category he/she selects.

ORGANIZATION OF THE MANUAL 0300.35

REV:01/2002

The Medical Assistance Policy Manual is comprised of four major topics of which COMMON PROVISIONS is the first. The three remaining topics are as follows:

- Sections 0326 through 0349 of this Manual set forth the policies and procedures which govern Medical Assistance eligibility for families with dependent children, poverty level children, pregnant women, and children in foster care.

- Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility for Aged, Blind, or Disabled individuals or couples living in community settings (SSI-Related cases)are set forth in Sections 0350 through 0374.

- Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility and Medical Assistance payment for services to institutionalized individuals. Institutionalized persons in this context refers to individuals who reside in institutional settings, or who receive home and community based services under a Waiver.

MEDICAL ASSISTANCE

THE APPLICATION PROCESS SECTION 0302

THE REQUEST FOR MEDICAL ASSISTANCE 0302.05

REV:01/2002

The application process begins when an individual or his/her representative contacts the agency to request Medical Assistance and ends with:

- a decision by the Department of Human Services to approve or to deny assistance; or,
- a decision by the applicant to withdraw his/her request for assistance.

The purpose of the application process is to ensure that the application is fully considered and acted upon in a timely manner. It provides the individual an opportunity to state his/her needs and to learn what the agency can do in response. It also provides the agency an opportunity to explain the individual's responsibilities in relation to the agency and the need to inform the agency of changes in circumstances which may affect eligibility for Medical Assistance.

A request for assistance may be received in a DHS office in person, by phone or by mail. When a request is received, a DHS staff member gives or mails the individual an application packet.

A request for Medical Assistance on behalf of a pregnant woman or family with a child under the age of nineteen (19) years may be received in locations other than district offices through outreach workers known as Family Resource Counselors (FRC's). Currently FRC's are located in twelve participating community health centers and three hospital clinics statewide. The Family Resource Counselors screen pregnant women and young children for potential eligibility for Medical Assistance (and the RIte-Care, WIC, and Food Stamp programs) and assist those thought to be eligible in the application process. The goal is to help non-cash assistance eligibles to obtain early pre-natal and pediatric health services.

SECTION 0302 THE APPLICATION PROCESS

0302.05.05 THE REQUEST FOR A MEDICARE PART D APPLICATION

EFF:01/2006

An individual who does not qualify for Medicaid or his/her representative has the option to contact either a Social Security Administration Office or a Department of Human Services Office to request an application for the Medicare Part D Program. This request may be received at a DHS office in person, by phone or by mail. When a request is received at a DHS Office, a DHS staff member gives or mails the individual an application for the Medicare Part D Program. At this time the DHS staff member should also provide the individual with an MPP-1 Application Form so that the individual may be reviewed for QMB or SLMB eligibility.

Completed applications may be submitted to either a Social Security Administration Office or a Department of Human Services Office. If a Medicare beneficiary insists that DHS process the application, the DHS representative is required to do so. If the beneficiary insists that the DHS representative process the application, the DHS representative must complete the process within sixty (60) days from the date the application is received.

0302.10 CONTENTS OF THE APPLICATION PACKET

REV:12/2001

The application packet consists of the following documents:

INDIVIDUALS/COUPLES/QMB'S/QDWI'S	FAMILIES
DHS-1 Application Form/ DHS-2 Statement of Need	DHS-1 Application Form/ DHS-2 Statement of Need Or, MARC-1 Application Packet
MA Booklet	DHS-14 Office Locations
DHS-14 Office Locations	R-11 EPSDT Information
QMB-2 Information for QMB's	
Transportation Information	
Return Addressed Stamped Envelope	Return Addressed Stamped Envelope

This packet provides information about the agency, the conditions

under which Medical Assistance is provided and an applicant's rights and responsibilities under the law. The family packet also provides an informational brochure on the Department of Health's WIC Program (women, infants and children's supplemental food program in Rhode Island) and the locations of participating WIC facilities.

The DHS-1 and the DHS-2 are the application documents for individuals, (including a blind or disabled child), couples and families which serve as the basis of the MA eligibility determination. These forms and other supplementary forms, as appropriate, constitute an application for Medical Assistance.

0302.10.05 Assistance in Completing the Application

REV:06/1994

An applicant is informed that a friend, relative, attorney, guardian or legal representative may assist in completing the application forms and that, if needed, an Eligibility Technician is also available for assistance.

Occasionally a completed application form is received in the district or regional office through the mail without any prior request for assistance. This occurs when credit departments of hospitals provide patients with the forms, and when Central Office mails an application form to an individual being terminated on SSI. In such instances, there must be the usual response to the application for Medical Assistance:

- The date of receipt must be noted on the application form;
- The applicant must be contacted, where appropriate, for information relative to eligibility;
- The application must be acted upon within the applicable time frame; and
- A notice of action must be provided to the applicant.

Who Must Sign the Application 0302.10.10

REV:11/2000

The following individuals must sign the application:

- When two spouses are living together, both spouses must sign the application form;
- When two parents of a dependent child are living together, both parents must sign the application form.

The following individuals may sign the application form:

- A relative or non-relative caretaker may file an application form for a child under the age of (19);
- An individual under the age of nineteen (19) who is living independently (and not merely "temporarily absent" from home as defined in Section 0328.10.10) may file an application;
- A relative may file an application on behalf of a deceased individual for retroactive coverage.

MEDICAL ASSISTANCE

SECTION 0302 THE APPLICATION PROCESS

0302.15 DECISION ON ELIGIBILITY

REV:08/1999

A decision on a Medical Assistance application for families and for aged and blind individuals is made within THIRTY (30) DAYS of the receipt of the application by the department. An eligibility decision for disabled individuals is made within NINETY (90) DAYS of the receipt of the application by the department.

An eligibility decision must be made within the above standards except in unusual circumstances when good cause for delay exists. Good cause exists: 1) when the agency representative cannot reach a decision because the applicant or examining physician delays or fails to take a required action, provided that the agency promptly reviews submitted medical and social data and requests any necessary additional medical documentation from the treating provider within two weeks from the date the completed forms MA-63 (Physician's Report), AP-70 (Information for Determination of Disability) and DHS-25M (Release) are received by the agency, or within two weeks of learning of the existence of a treating provider or of the need to obtain supplementary treating provider information; or 2) when there is an administrative or other emergency beyond the agency's control. The reason for the delay must be documented in the case record. In addition, the applicant must be provided with written notification stating: 1)the reason for delay; and 2)the opportunity for an expedited hearing to contest the delay.

The agency representative makes the decision on eligibility on the basis of information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application which is questionable must be confirmed before eligibility can be certified.

For applications which require a determination of resources (i.e., all SSI related applications and some family-related applications), at least ONE (1) AP-91 FORM is sent to determine the amount of money in, or existence of, a bank account. The form is sent to the bank where the individual has or had an account. If no account is declared, the AP-91 is sent to the banking institution most likely to have been used by the individual considering the location of home and/or employment. At redetermination, at least ONE (1) AP-91 form is sent, but to an institution, such as a bank or credit union, not selected at the time of the application.

If a decision cannot be made because of omissions or inconsistencies, the agency representative must contact the applicant by mail, phone or in person for clarification, additional information or verification. If it is necessary for the agency to obtain or confirm any information, the applicant is advised of the necessary steps s/he or the agency must take. If other collateral sources of information must be contacted, the applicant should be informed of why the information is necessary and how it will be used by the agency. The applicant must sign AP-25, Release of Information Authorization, and permit DHS to use public records and contact collateral sources for purposes of the eligibility determination.

If an applicant/recipient refuses to present information or verification required to reach a decision on an initial or continuing determination of eligibility and requests the agency not to obtain it, the agency would be unable to determine eligibility and would have no recourse but to deny or discontinue assistance.

In those instances where eligibility is based on the existence of the conditions of blindness or disability, additional medical information verifying these conditions is necessary. Appropriate forms and instructions are provided applicants for submitting this information.

PERIOD OF ELIGIBILITY 0302.20

REV:05/1999

When an individual is determined eligible for Medical Assistance, eligibility exists for the entire first month. Therefore, eligibility BEGINS on the first day of the month in which the individual is determined eligible. Medical Assistance ENDS when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given. Medical Assistance benefits cease on the last day of the 10-day notice period when eligibility is determined to no longer exist.

However, in cases where the Flexible Test of Income policy is applied, eligibility is established on the day the excess income is absorbed; i.e., the day the medical service was provided. Eligibility is for the balance of the six (6) month period.

MEDICAL ASSISTANCE

SECTION 0302 THE APPLICATION PROCESS

The certification periods for MA beneficiaries are as follows:

- Family,individual, and couple cases, with the exception of flexible test of income cases, are certified for MA up to a maximum of TWELVE (12) MONTHS. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

- Flexible Test of Income cases are certified for MA for the full SIX (6) MONTH (if eligible) or the BALANCE of the SIX (6) month period.

- Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary(SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

Time limits for certification are established on the InRhodes Statement of Need Panel.

0302.25 CERTIFICATION OF ELIGIBILITY

REV:01/2002

Written notice is sent to each applicant who files an application regarding his/her eligibility or ineligibility. When the applicant is found eligible, a NOTICE OF ELIGIBILITY is sent via InRhodes by the agency representative to notify the applicant of eligibility and the length of MA certification.

Eligible homeless individuals and families who are unable to provide a mailing address are advised to pick up computer-generated eligibility notices and MA cards at the District Office. the next business day. Homeless individuals and families who cannot provide mailing addresses are further advised of the need to come to the District Office one month prior to the certification end date to re-apply for MA. If a homeless recipient without a mailing address does not contact the District Office by the end of the certification period, staff must close the case on the end date of the certification period. Homeless individuals and families are certified for a maximum of three months.

PAYMENT PROCESS 0302.30

REV:03/2002

Payment for medical care provided within the MA scope of services is made by the department's fiscal agent based on claims submitted by the provider of the medical service and supplies. The fiscal agent utilizes the Medicaid Management Information System (MMIS) to review the claim and make payment.

Payment for services can also be made for unpaid medical services received in the three months prior to the month of application, provided the individual was eligible in that period. All bills are cleared for eligibility through the Division of Health Care Quality Financing and Purchasing, Center for Adult Health. Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

Payments for enrollment in a RIte Care Health Plans or a RIte Share approved employer based group health plan are made in accordance with policy contained in Section 0348.75.15 and 0349.30 respectively.

MA as Payor of Last Resort 0302.30.05

REV:06/1994

Medical insurance is not a bar to eligibility. However, all benefits for which the recipient is eligible must be paid before the Medical Assistance Program assumes responsibility for payment. State law makes it illegal for insurance companies to exclude MA recipients from benefits, reinforcing the requirement of third-party liability (TPL) and that MA is the last payer.

The most common medical resources are Blue Cross/Blue Shield, Major Medical, Plan 100, Delta Dental, Harvard Community Health Plan of New England and Ocean State. Most employed people in Rhode Island are covered by one or a combination of these resources. Even in cases of separation, the family frequently continues to be covered by the absent parent's family coverage. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) now pays claims for dependents of service personnel who are also MA recipients.

Older applicants, or those who are blind or disabled, are usually

eligible for Federal Medicare. This is frequently supplemented by "Blue Cross 65" and/or a commercial accident and health insurance policy.

If, in the clearance of a claim, the Division of Medical Services discovers the possibility of a resource, a notice is sent to the Eligibility Technician requesting this be followed up with the recipient. A follow-up report regarding the results of the contact is submitted to the Division of Medical Services at Central Office.

IT IS MOST IMPORTANT THAT THE POSSIBILITY OF EVERY MEDICAL RESOURCE BE EXPLORED AND THAT ANY RESOURCE AVAILABLE BE NOTED ON THE INRHODES STATEMENT OF NEEDS FUNCTION. THE APPLICANT IS INSTRUCTED TO REPORT ANY NEWLY ACQUIRED RESOURCE.

0302.30.10 Direct Reimbursement to Recipients

REV:03/2002

Some individuals, while appealing a determination of Medical Assistance (MA) ineligibility, incur and pay for covered services. To correct the inequitable situation which results from an erroneous determination made by the Department, direct reimbursement is available to recipients in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of MA coverage is received by the Department within the time frame specified in Section 0110.20.

2. The original decision to deny or discontinue MA coverage is determined to be incorrect and, as such, is reversed on appeal by the Appeals Officer (hearing decision) or by the Regional Manager or Chief Supervisor/Supervisor (adjustment conference decision).

   Reimbursement is only available if the original decision was incorrect. Reimbursement is not made, for example, if the original decision is reversed because information or documentation, not provided during the application period, is provided at the time of the appeal.

3. The recipient submits the following:

- o a completed Application for Reimbursement form (MA 1R);
- o a copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;
- o proof of the date and amount of payment made to the provider by the recipient or a person legally responsible for the recipient. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the recipient or a person legally responsible for the recipient.

4. Payment for the medical service was made during the period between a denial of MA eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date of MA termination, if later) and before the date of the written decision issued by the DHS Appeal Office, or decision by the Regional Manager/Chief Casework Supervisor after adjustment conference, reversing such denial is implemented (or the date MA eligibility is approved, if earlier).

Example 1: An MA application is filed 9/1. A written notice of denial is issued on 10/1. On 10/15, a written request for appeal is received by the Department. The Appeal Office's decision, dated 12/1, finds that the original decision was incorrect and the individual is eligible for MA beginning in September. The agency representative approves MA eligibility on 12/2.

To be considered for reimbursement, a medical expense must have been incurred and paid on or after 10/1 (date of denial) and before 12/2 (date appeal decision was implemented.)

Example 2: Application is filed 9/1. A notice is issued on 9/15 denying MA for September due to excess income and approving MA beginning 10/1. The individual sends in a written request for an adjustment conference on 10/10. Upon review, the Chief Casework Supervisor

finds that the original decision to deny MA was incorrect; the individual is eligible beginning September 1. MA eligibility is approved on 10/20.

To be considered for reimbursement, a medical expense must have been incurred and paid on or after 9/15 and on or before 9/30.

Example 3: A redetermination of continuing eligibility is completed and a notice of MA discontinuance is issued on 9/15. MA is discontinued effective 9/30. A written request for appeal is received on 10/12. In her written decision on 12/2, the Appeals Officer finds that the Department's original decision to discontinue MA was incorrect; MA must be reinstated beginning 10/1. MA is approved on 12/11.

To be considered for reimbursement, a medical expense must have been incurred and paid on or after 10/1 and before 12/11.

5. At the time the service was provided, the individual was eligible for MA and the service was within the covered scope of services, categorically needy or medically needy, allowed for the recipient.

6. A MA vendor payment would otherwise have been made at the time the service was provided, except that the provider does not have to be participating in the MA program.

6. The service was medically necessary when provided. However, prior approval requirements do not apply to such services.

7. Third party reimbursement is not available for the service.

8. Direct reimbursement may only be provided within the MA fee schedule in effect at the time the service in question was provided, even if the individual paid more than that amount.

PROCEDURE AND NOTIFICATION

The Department's notices of MA ineligibility provide applicants and recipients with information about their rights to appeal the agency's decision. These notices also contains specific

information about the availability of direct reimbursement if a written appeal is filed and the Department's initial decision is overturned as incorrect.

The written request for appeal is completed by the applicant or recipient and returned to the local DHS office. The agency representative, responsible for the case, completes the Department response. If upon receiving the request for hearing, the original decision is reversed and MA is reinstated, that information and the reason for reinstatement is noted in the Department response section of the hearing request form. The completed form is forwarded to the Appeals Office in accordance with policy in Section 0110.

If the original decision is reversed and MA is reinstated at any other time prior to the hearing, the Department representative sends written notification of the date of and reason for reinstatement to the Appeals Office.

The Appeals Office provides individuals who may qualify with an Application for Reimbursement form to request repayment for medical expenses which they incurred and paid while their appeal was pending. The form contains instruction for completion and return to the local DHS office.

The individual must complete and sign the Application for Reimbursement form and include: a) a copy of the provider's bill showing date and type of service; and b) proof that payment was made by the recipient or a person legally responsible for the recipient between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

If either the bill or proof of payment is not included with the Application form, the Department representative offers to assist the recipient in obtaining the required documentation, and sends an InRhodes SPEC reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the MA-1R. If all documents are not received within thirty (30) days, or if the documentation provided indicates that medical service or payment was not made between the date of MA denial (or termination) and the date of MA acceptance (or reinstatement), the agency representative denies the request for reimbursement. A DHS 167A is completed and mailed, along with DHS form 121, to the recipient.

Otherwise, the agency representative forwards a referral form (DHS-48R), attaching the recipient's written request for reimbursement and all supporting documentation to the DHS Administrator in the Center for Adult Health, or his/her designee, for a decision on payment. The Center for Adult Health is responsible for providing the individual with written notification (DHS 40A or DHS 167A) of the agency's decision and rights to appeal.

MEDICAL ASSISTANCE

TECHNICAL ELIGIBILITY REQUIREMENTS SECTION 0304

REQUIREMENTS OF CITIZENSHIP/ALIENAGE 0304.05

REV:02/1999

To be eligible for the Medical Assistance Program, an otherwise eligible applicant must be a member of one of the following categories:

- A United States Citizen;
- A Repatriate;
- An Amerasian;
- An American Indian Born in Canada;
- A Resident Alien;
- An Alien Residing in U.S. Under Color of Law;
- A Legal Temporary Resident (LTR). (Note: Program authorizing LTRs expired in May, 1991)
- A member of a state-funded coverage group as defined in Section 0304.05.45

Medical Assistance for emergency services is accessible to all persons regardless of citizenship status, provided such persons are residents of Rhode Island and meet the categorical and financial criteria for the Medical Assistance Program. This includes persons who, but for citizenship status, meet the criteria for MA under SSI-related, family-related, or Rite Care rules. In addition, each applicant must have a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that inpatient hospital or hospital emergency room treatment is required.

The SAVE Program 0304.05.05

REV:06/1994

The Immigration Reform and Control Act of 1986 mandated the establishment of the Systematic Alien Verification for Entitlements (SAVE) Program. SAVE enables states and federal assistance programs to exchange information regarding the immigration status

of aliens applying for benefits under certain programs, including Medical Assistance.

Applicants for Medical Assistance programs must declare in writing that they are United States citizens or nationals, or that they are in "satisfactory immigration status." The DHS/SAV-1 is used for the declaration of citizenship or alienage.

Verification of U.S. citizenship or naturalized citizen status is accomplished by the applicant providing a valid birth certificate, U.S. passport or other acceptable documentation (see sections 304.05.10 - 304.05.20).

To be considered in "satisfactory immigration status," an applicant must provide either:

- Alien registration documentation of proof of immigration registration from the INS containing the alien's admission or file number; or
- Such other documents as constitute reasonable evidence of satisfactory immigration status (see sections 0304.05.25 - 0304.05.35).

For SAVE participation and procedural requirements, see 0104.40 through 0104.75.

0304.05.10 Eligibility as a United States Citizen

REV:06/1994

A United States citizen is defined in the Immigration and Nationality Act as any person born in any of the 50 States, the District of Columbia, Puerto Rico, Guam or the United States Virgin Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens, as are those persons who are naturalized U.S. Citizens.

Verification of Citizen Status 0304.05.10.05

REV:06/1994

The following constitute documentation of United States citizenship:

- Birth Certificate;
- Religious document such as a baptismal record, recorded within three months of birth showing that the birth took place in the United States;
- United States passport;
- Report of Birth Abroad of a Citizen of the United States (Form FS-240)
- Certification of Birth (Form FS-545);
- United States Citizen I.D. Card (I-97);
- Naturalization Certification (N-550); or
- Certificate of Citizenship (N-560).

Various "documents" issued by an organization called the World Council of Washington, D.C. are considered bogus and unacceptable as evidence of identity, citizenship, age, etc., for enumeration or other official purposes. These "documents" include: World Birth Certificates, World Citizen Cards, World Identity Cards, and World Marriage Certificates.

Eligibility as a Repatriate 0304.05.15

REV:06/1994

A repatriate is a citizen or dependent of a citizen, identified by the United States Department of State as having returned or been brought from a foreign country because of destitution or illness of the citizen or any of his/her dependents, or because of war, threat of war, invasion, or similar crisis and who is without available resources. Such a person would be referred by a Central Office contact.

MEDICAL ASSISTANCE

SECTION 0304 TECHNICAL ELIGIBILITY REQUIREMENTS

0304.05.15.05 Verification of Repatriate Status

REV:06/1994

Verification of repatriate status is made by documenting United States citizenship with one of the following:

- Birth Certificate;
- Religious document such as a baptismal record, recorded within three months of birth showing that the birth took place in the United States;
- United States passport;
- Report of Birth Abroad of a Citizen of the United States (Form FS-240)
- Certification of Birth (Form FS-545);
- United States Citizen I.D. Card (I-97);
- Naturalization Certification (N-550); or
- Certificate of Citizenship (N-560).

0304.05.20 Eligibility as an Amerasian

REV:06/1994

Certain Amerasians may have a claim to United States citizenship under Section 301(g) of the Immigration and Nationality Act, as made applicable by Section 309(a) (amended November 14, 1986), if such Amerasian was:

- A resident of Vietnam as of the date (December, 1987), of the Amerasian Homecoming Act, Section 584 of the Continuing Resolution for Fiscal Year 1987 (P.L. 100-200);
- Born in Vietnam after January 1, 1962 and before January 1, 1976; and,
- Fathered by an identified United States citizen.

Verification of Amerasian Status 0304.05.20.05

REV:06/1994

In order to establish United States citizenship for such Amerasian, an identified American father must meet several requirements under the law, which may include:

- Establishment of both blood and legal relationship to the child;
- Acknowledgement of paternity in writing under oath; and
- Agreement to provide financial support until the child's eighteenth birthday.

Amerasian Refugees 0304.05.20.10

REV:06/1994

An Amerasian not entering the United States as an American citizen or as a beneficiary of an immediate relative or preference visa petition, filed on her/his behalf by relatives in the United States, may be eligible for refugee benefits. (See Section 901, III, A., B., C., and D.)

Elig as an American Indian Born in Canada 0304.05.25

REV:06/1994

An American Indian born in Canada who has maintained residence in the United States since entry is considered lawfully admitted for permanent residence if s/he is at least one-half American Indian blood. This does not include the non-citizen spouse or child of such Indian, or a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is at least 50 percent or more American Indian blood.

MEDICAL ASSISTANCE

SECTION 0304 TECHNICAL ELIGIBILITY REQUIREMENTS

0304.05.25.05 Verif of Stat as Amer Indian Born in Canada

REV:06/1994

Documents which may verify status as an American Indian born in Canada are:

- Birth or baptismal certificate issued on a reservation;
- Tribal records;
- Letter from the Canadian Department of Indian Affairs; or
- School records.

0304.05.30 Eligibility as a Resident Alien

REV:06/1994

A resident alien is one who was lawfully admitted for permanent residence in accordance with the immigration laws, such status not having changed since admission.

A resident alien, sponsored by an individual or organization and applying for AFDC within three years following entry into the United States, shall, as a condition of eligibility, provide information and documentation from the sponsor in support of his/her immigration application.

0304.05.30.05 Verification of Status as a Resident Alien

REV:06/1994

The following INS forms may be used as evidence to determine whether an alien is lawfully admitted for permanent residence:

- Form I-181, Memorandum of Creation of Record of Lawful Permanent Residence, is a temporary identification document issued by an INS field office pending issuance of an Alien Registration Receipt Card;
- Forms AR-3 and AR-3a, Alien Registration Receipt Card. This document was issued between 1941 and 1949 and

pertains to lawful permanent resident alien;

- o Form I-151, Alien Registration Receipt Card. This document was issued prior to June 1978 and remains valid indefinitely;

- o Form I-551, Resident Alien Card. This is the current document given to a lawful permanent resident alien and is valid indefinitely. This form is commonly referred to as a "green card";

  Lawful temporary resident aliens who become lawful permanent residents will be issued Form I-551 with a registration number in the 90-million series. In addition, the date such aliens are granted LTR status is indicated as the fourth line on the reverse of the form. The fourth line will read: "TEMP RES ADJ DATE - MM/DD/YY." Eligibility for AFDC, full Medical Assistance and Food Stamp benefits will exist five (5) years from the date that appear on the reverse of the I-551.

- o Form I-551, Resident Alien Card (Conditional Resident Alien). This form is issued to a conditional permanent resident, such as an alien spouse of a U.S. citizen. It is the same form as issued to a permanent resident alien but is valid for a limited period of time and has an expiration date stamped on the back; or

- o Form I-327, Re-entry Permit, is issued to a lawful permanent resident alien before s/he leaves the U.S. for a one-to-two-year period. This document contains an expiration date.

Elig as Alien Resid in US Under Color of Law 0304.05.35

REV:06/1994

The definitions of an alien residing in the U.S. under color of law (PRUCOL) are:

- o An alien who entered the United States prior to January 1, 1972 is considered "permanently residing under color of law" (PRUCOL) and may be eligible for lawful permanent

resident (LPR) status in accordance with Section 249 of the Immigration and Nationality Act;

- A conditional entrant lawfully present in the United States under the provisions of Section 203 (a) (7) (prior to 4/1/80);

- A refugee under Section 207(c) (after 3/31/81) (Refer to the Refugee Assistance Program, Section 900, for specific eligibility and verification procedures.);

- An asylee under Section 208 or a parolee under Section 212 (d) (5). Asylum or parole into the United States may be provided at the discretion of the U.S. Attorney

  General, for an indefinite temporary for emergency reasons or for reasons in the public interest;

- An alien granted "voluntary departure." A Cuban refugee or any other alien who was not legally paroled into the United States may be granted "voluntary departure" for an indefinite period or may be granted an indefinite stay of deportation because of: humanitarian considerations or technical difficulties which cannot be overcome and which prevent the Immigration and Naturalization Service (INS) from deporting them;

- A Western Hemisphere alien. An alien from a Western Hemisphere country who applied for a residency visa between July 1, 1968 and December 31, 1976, but entered the United States before their visa was granted and whose last entry was before March 11, 1977, is allowed to remain in the United States until further notice without threat of expulsion or deportation under a temporary restraining order granted in the United States District Court, Northern District, Illinois (Silva v. Levi).

MEDICAL ASSISTANCE

TECHNICAL ELIGIBILITY REQUIREMENTS SECTION 0304

Alien Status Verification Under Color of Law 0304.05.35.05

REV:06/1994

For an alien in the United States prior to 1972, records showing the alien to have been in the United States prior to 1972, such as school, marriage, medical, insurance applications, or driver's license, are used as verification of residence. In lieu of such documents, a statement from two persons attesting to the fact that the claimant was in the United States prior to 1972 and the basis of their knowledge may be used.

A Western Hemisphere Alien should have the following court ordered notice: "Due to a Court Order in Silva v. Levi, 76- C4268, entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized."

All persons admitted "under the color of law" should have one of the following documents:

- Form AR-3a, Alien Registration Receipt card--issued during 1941-1949 for permanent resident aliens;
- Form I-94, Arrival-Departure Record--annotated either "Section 207" or "Refugee," or "Section 208" or "Asylum";
- Form I-94, Arrival-Departure Record-Parole Edition--annotated either "Section 212(d)(5)", or "Conditional Entry" or "Section 203(a)(7)";
- Form I-94, Arrival-Departure Record--annotated "Section 243(h)";
- Form I-94, Arrival-Departure Record--annotated "Cuban-Haitian Entrant".

MEDICAL ASSISTANCE

SECTION 0304 TECHNICAL ELIGIBILITY REQUIREMENTS

0304.05.40 Legal Temporary Resident (LTR) Defined

REV:06/1994

The Immigration Reform and Control Act of 1986 (IRCA) established a legalization program in which certain aliens living in the United States in an unlawful status could apply for legalization during the twelve month period beginning May 5, 1987. To participate in the legalization program, an alien must have entered the U.S. before January, 1982 either unlawfully or on a non-immigrant visa which expired before January 1, 1982, and must have lived in the U.S. continuously since January 1, 1982. Persons whose application for legalization was approved by the Immigration and Naturalization Service (INS) were granted Legal Temporary Resident (LTR) status. To adjust their status from Legal Temporary Resident to Legal Permanent Resident (LPR), such aliens must have applied for legal resident status during the permitted 12-month period.

Certain alien groups had special exemptions from the entry date and date of application (see section 104.20.05).

The Immigration Reform and Control Act expired in May, 1991.

0304.05.45 State-Funded Coverage Group Defined

REV:02/1999

The state-funded alien group is comprised of lawfully residing non-citizens who do not meet the citizenship/alienage criteria under Title XIX.

This group includes:

- Persons with a pending application for political asylum or withholding of deportation who have employment authorization or if under age 14 have an application pending for at least 180 days;
- Deportable aliens residing in the US pursuant to an indefinite stay of deportation;
- Aliens granted suspense of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the INS does not contemplate enforcing;
- Aliens residing in the U.S. pursuant to an Order of

Supervision;

- o Other aliens who are permitted to remain in the U.S. for humanitarian or other public policy reasons including:
  - * Aliens in Temporary Protected Status;
  - * Family Unity Beneficiaries;
  - * Aliens granted Deferred Action Status;
  - * Aliens under Deferred Enforced Departure; and
  - * Aliens who are the spouses or children of citizens with approved visa petitions pending adjustment of status applications.

Eligility as a State Funded Alien 0304.05.45.05

REV:10/1999

R.I.G.L. 40-8-1, 42-12.3-4 and 42-12.3-15 provide the legal authority for state-funded Medical Assistance for aliens.

Members of the state-funded alien group may establish eligibility for State-funded MA under SSI-related, family-related, or RIte Care rules.

Non-citizen children are eligible for MA if they possess a lawfully residing alien status, as indicated in section 0304.05.45, and they meet the all MA requirements. This group includes minor heads of household.

Otherwise eligible adults must possess a lawfully residing alien status (See 0304.05.45) AND show that they were:

(1) lawfully residing in the US prior to 8/22/96; and,

(2) a RI resident prior to 7/1/97.

Pregnant women and children (including minor heads of household) who do not qualify for Title XIX due to their alien status may establish eligibility for MA under RIte Care provisions contained in section 0348. This includes individuals who are undocumented.

MEDICAL ASSISTANCE

SECTION 0304 TECHNICAL ELIGIBILITY REQUIREMENTS

0304.05.45.10 Verification of Lawfully Residing Status

REV:02/1999

Documents which may be used to verify alien status include:

In general,

* INS form I-94 with date of admission and annotated with unexpired status as listed in Section 0304.05.45.05;

* Dated INS letter or court order indicating a lawfully residing status listed in section 0304.05.45.05; and/or

* An unexpired INS employment authorization document (I-688-B) annotated with status code.

More specifically,

* Applicants for asylum: I-94, I-589 on file, I-688B coded 274a.12(c)(8).

* Applicants for suspension of deportation: I-94, I-256A on file, I-688B coded 274a.12(c)(10);

* Aliens granted stays of deportation by court order statute or regulation or by individual determination of INS whose departure the INS does not contemplate enforcing: letter or copy of court order showing that the alien has been granted a stay of deportation, I-688B coded 274.12(c)(12);

* Aliens granted suspension of deportation pursuant to section 244 of INA (8 USC 1254) whose departure the INS does not contemplate enforcing: letter/order from the immigration judge and a Form I-94 showing suspension of deportation granted;

* Aliens residing in the U.S. pursuant to an Order of Supervision: INS Form I-220B, I-688B coded 274a.12(c)(18);

* Temporary Protected Status: I-94 "Temporary Protected Status" and/or I-688B employment authorization coded 274a.12(a)(12);

* Deferred Enforced Departure: Letter from INS; I-688B coded 274a.12(a)(11);

* Family Unity: INS approval notice, I-797, and/or I-688B coded 274a.13;

* Aliens granted deferred action status: Letter indicating that the alien's departure has been deferred and/or I-688B coded 274a.12(c)(14).

* Aliens who have filed applications for adjustment of status whose departure the INS does not contemplate enforcing: Form I-94 or I-181 or passport stamped with either of the following : "adjustment application" or " employment authorized during status as adjustment applicant"; and/or I-688B coded 274a.12(c)(9).

To determine if the applicant was lawfully residing in the US prior to 8/22/96 use the following:

* Form I-94, date of admission;

* If an applicant presents an INS grant letter or court order, derive date status was granted from the date of the letter or court order. If missing, contact INS to verify date of grant by filing Form G-845, attaching copy of document.

* If employment authorization documents are presented, ask for I-94 or other INS documentation showing effective date of status. If not available contact INS by submitting Form G-845, attaching a copy of the document presented.

Expired or absent documentation:

If an applicant presents an expired INS document, a receipt indicating the s/he applied to INS for a replacement document, or is unable to present any document demonstrating his or her immigration status, further verification of current alien status

must be obtained before eligibility can be established. The DHS worker offers to assist the applicant in obtaining the required documentation from INS. The applicant may decline this assistance, in which case eligibility is denied. Otherwise, the worker completes and files INS Form G-845 (secondary verification) along with the alien registration number, a copy of the expired document and a copy of photo I.D. (if available) with the INS office to verify status.

Note: Pregnant women may qualify for Medical Assistance under the RIte Care waiver even when undocumented.

0304.05.45.15 Documentation of RI Residency Before 7/1/97

REV:02/1999

Any one of the following documents which are dated prior to 7/1/97 and contain the applicant's address at that time will meet the verification requirement:

* Utility/telephone bills;
* Rent receipt, lease, mortgage bill/receipt;
* Tax receipts or tax records;
* Insurance policy or insurance records;
* Employment records/pay stubs;
* INS documents;
* Court records;
* State agency records;
* Medical dental records;
* State-issued I.D. or license (drivers, professional, or recreational) showing issuance date;
* School records; and
* Other legal document; such as marriage license, will, etc.

Also acceptable as verification are contemporary documents attesting to the alien's residency prior to 7/1/97 signed by an authorized person.
(Two collateral sources are necessary to meet verification requirement.) For example:

* Employer letter on company letterhead;
* Agency (government or private) letter on agency letterhead;
* Doctor/health care provider on appropriate letterhead;

* Religious institution letter from authorized person;
* Third party affidavit attesting to alien's residency prior to 7/1/97 and the basis for that knowledge.

Verification of RI residence at any time prior to 7/1/97 is sufficient; residence in RI need not be continuous.

RESIDENCY REQUIREMENT 0304.10

REV:06/1994

The Medical Assistance Program exists primarily to meet the needs of residents of the Rhode Island. Therefore, as a factor of eligibility, an individual who is applying for eligibility must be a resident of the state. Any person living in the state voluntarily and intending to make Rhode Island his/her home, for whatever reason, is a resident of the state.

MA Residency Requirements 0304.10.05

REV:01/2002

The residency definitions apply to SSI individuals, MA families, MA individuals age 21 and over, MA individuals under twenty one (21), and institutionalized MA individuals.

SSI Individual 0304.10.05.05

REV:06/1994

For an individual eligible for SSI and receiving a State Supplementary Payment (SSP), the State of Residence is the state paying the SSP. (In some instances, a person may have sufficient income to receive only the State Supplement.)

MEDICAL ASSISTANCE

SECTION 0304 TECHNICAL ELIGIBILITY REQUIREMENTS

0304.10.05.10 MA Families

REV:01/2002

For individuals and families applying for MA based on family-related (formerly AFDC-related) rules, a resident of the state is a person:

- Who is living in Rhode Island voluntarily with the intention of making his/her home there, and not for a temporary purpose. A child is a resident of the state in which (s)he is living other than on a temporary basis. (Residence may not depend on the reason for which the individual entered the state except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose); or,

- Who, at the time of application, is living in the state, is not receiving assistance from another state, and entered the state with a job commitment or seeking employment in the state (whether or not currently employed). Under this definition, the child is a resident of the state in which the caretaker relative is a resident.

0304.10.05.15 MA Individual Over 21

REV:06/1994

For an individual over age 21 applying for MA, not living in an institution, the State of Residence is the state where the individual is:

- Living voluntarily with the intention to remain permanently or for an indefinite period (or if incapable of stating intent, where (s)he is living); or,

- Living voluntarily, is not receiving assistance from another state, and which (s)he entered with a job commitment or seeking employment (whether or not currently employed).

MA Individual Under 21 0304.10.05.20

REV:06/1994

For an individual under 21 applying for MA, not living in an institution, the State of Residence is the state in which the caretaker relative is a resident unless Medicaid eligibility is based on blindness or disability, then the State of Residence is the state in which (s)he is living.

Institutionalized MA Individual 0304.10.05.25

REV:06/1994

For MA individuals living in institutions, applying for MA (Public, Medical or Group Care Facilities), the State of Residence is as fol

- If a state places an individual in an institution in another state, the state making the placement is the State of Residence, irrespective of the individual's indicated intent or ability to indicate intent; otherwise,
- If over 21, the State of Residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period; however,
- If the individual is under 21 (or is age 21 or older and became incapable of indicating intent before age 21), the State of Residence is:
  - that in which his/her parent(s) or legal guardian, if one had been appointed, resides; or,
  - that of the parent applying on the individual's behalf if the parents reside in separate states and no legal guardian has been appointed.
- If the individual became incapable of indicating intent at, or after age 21, the State of Residence is the state in which the individual was living when (s)he became incapable of indicating intent. If this cannot be determined, the State of Residence is the state in which the individual was living when (s)he was first determined to be incapable of declaring intent.

SECTION 0304 TECHNICAL ELIGIBILITY REQUIREMENTS

In any case, the state in which the institution is located is the State of Residence unless that state determines that the individual is a resident of another state according to the above rules.

0304.15 REQUIREMENT FOR SOCIAL SECURITY NUMBER

REV:06/1994

Section 2651 of the Deficit Reduction Act (DEFRA) of 1984 (P.L. 98-369) requires that each individual (including children) requesting Medical Assistance furnish his or her own Social Security Number (SSN) as a CONDITION OF ELIGIBILITY for the program. Since many MA applicants/recipients are receiving Social Security benefits through claim numbers, which may be the Social Security number of a parent or spouse, with a letter(s) suffix, they must now procure their OWN SSNs.

The applicant or recipient must be notified that the furnishing of the SSN is a condition of eligibility and that the number will be utilized only in the administration of the MA Program, including its use in verifying income and eligibility.

CHARACTERISTIC REQS FOR INDS & COUPLES 0306.05

REV:01/2002

Characteristic requirements are either SSI-related of AFDC (prior to 5/97)- related. The term "SSI-related" refers to the methodology to be used for evaluating the individual's or the couple's income and resources, and the standards to be met for MA eligibility. Thus, an individual or couple who applies for MA may be eligible for one of the SSI-related coverage groups if s/he possesses a SSI- related characteristic and has limits and resources within the limits required for MA eligibility.

The SSI-related characteristics are:

- Age (65 years old and older);
- Blindness; or
- Disability.

SSI-Related Age Requirement 0306.05.05

REV:06/1994

An individual applying for MA on the basis of the SSI-related characteristic of age must be 65 years of age or older. The age as stated on the application must be verified. Appropriate sources of verification are:

- Birth certificate;
- Birth record of a child over 50 as evidence that the parent is over 65;
- Birth record of child where age of parent is recorded;
- Marriage certificate; or
- Other documents such as insurance policies, passport or naturalization papers, employment, school, military or alien registration records.

MEDICAL ASSISTANCE

SECTION 0306 CHARACTERISTIC REQUIREMENTS

0306.05.10 Eligibility Based on Blindness

REV:06/1994

To be eligible on the basis of blindness, the individual's (adult or child) vision must meet the policy definition: in terms of ophthalmic measurement, central vision acuity of 20/200 or less in the better eye with corrective lenses, or a field defect in which the peripheral field is contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees.

0306.05.15 Eligibility Based on Disability

REV:06/1994

To be eligible for Medical Assistance because of permanent or total disability, a person (adult or child) must have a permanent physical or mental impairment, disease or loss, other than blindness, that substantially precludes engagement in useful occupations within his/her competence.

A physical or mental impairment is an impairment which results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable, clinical and laboratory diagnostic techniques.

For purposes of eligibility, an individual is disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted, or can be expected to last for a continuous period of not less than twelve (12) months or, in the case of a child, if s/he suffers from any medically determinable physical or mental impairment of comparable severity.

Statements of the applicant, including the individual's own description of the impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

MEDICAL ASSISTANCE

CHARACTERISTIC REQUIREMENTS SECTION 0306

CHARACT REQS FOR FAMILIES (AFDC-RELATED) 0306.10

REV:01/2002

The characteristic requirements for families (AFDC prior to 5/97-related) who are applying for Medical Assistance are age, relationship (a child living with at least one parent or caretaker relative) and deprivation of parental support.

Age Requirement 0306.10.05

REV:07/1999

To be eligible for MA, a parent (or other caretaker relative) must maintain a home for a needy child under the age of eighteen (18) without regard to whether the child is attending school or making passing grades, or for an eighteen-year-old child qualifying for an "in-school extension".

> In-school Extension: If the child is eighteen (18), s/he must be a full time student in secondary school, or in the equivalent level of technical or vocational training. The student must reasonably be expected to complete the program before reaching age nineteen (19).

Children who are under the age of nineteen (19) may be eligible under the provisions of section 0348, but their eligibility does not extend to a parent or caretaker relative.

Medical Assistance coverage is also available to certain groups of children up to age 21. These groups are:

- Children receiving foster care services, whether through DCYF or private, non-profit agencies;
- Children for whom there is a State adoption subsidy agreement (hard to place children with special needs who are not eligible under the criteria of the IV-E program);
- Children in Nursing Facilities and ICFs/MR.

MEDICAL ASSISTANCE

SECTION 0306 CHARACTERISTIC REQUIREMENTS

0306.10.10 Relationship Requirement

REV:06/1994

To satisfy the MA requirement of relationship, a child meeting the age requirement must be living with a relative in a home maintained by such relative. When the relative is not the natural or adoptive parent of a child, the term loco parentis ("in place of the parent") is used. A child meets this eligibility factor if his/her home is with any of the following relatives:

- father, adoptive father, mother or adoptive mother;
- stepfather or stepmother (but not the parent of either);
- grandfather, great grandfather, great-great grandfather, great-great-great grandfather;
- grandmother, great grandmother, great-great grandmother, great-great-great grandmother;
- adoptive grandparent, if the grandchild is the natural child of a parent who was adoptive, or if the grandchild is the adopted child of a parent who was the natural child of the grandparent;
- brother, half brother, adoptive brother, stepbrother, sister, half sister, adoptive sister, stepsister;
- uncle, great uncle, great-great uncle, aunt, great aunt, great-great aunt (including uncle or aunt of whole or half blood);
- Nephew, great nephew, great-great nephew, niece, great niece, great-great niece (including nephew or niece of whole or half blood).
- First cousin (including first cousin of whole or half blood), first cousin once removed.

Spouses of any of the persons in the above groups meet the relationship requirement and continue to meet it even after the marriage is terminated by death or divorce.

Deprivation of Parental Support 0306.10.15

REV:06/1994

To satisfy the eligibility factor of deprivation, a child must be deprived of support or care by the natural or adoptive parents due to:

- The continued absence of parent from the home; or
- The death of a parent; or
- The physical or mental incapacity of one natural (or adoptive) parent; or
- The unemployment of the natural (or adoptive) father or mother.

In situations where a parent(s) is separated from the child because a parent has placed him/her with a relative (or agreed to placement with a relative), it is necessary to determine that the child and the child's primary family is eligible based on one of the deprivation factors.

Also, when a child is living with both his/her natural or adoptive parents, whether or not they are married to each other, the child is not eligible, except if one of the parents meets the definition of incapacity or unemployment.

Exceptions to the Req of an AFDC Charact 0306.10.20

REV:06/1994

Legislative mandate has created several MA coverage groups whose eligibility is based on rules which depart from the requirement of an AFDC characteristic. These coverage groups include children and pregnant women.

MEDICAL ASSISTANCE

COOPERATION REQUIREMENTS SECTION 0308

APPLICANT REQUIRED TO COOPERATE 0308.05

REV:04/2001

As a condition of eligibility, the MA applicant must meet certain cooperation requirements. These requirements include:

- Providing the information needed for an eligibility determination;
- Assignment of rights to medical support or other third party payments for medical care to the Department;
- Cooperating in establishing paternity and obtaining support (an exception exists for pregnant women with no other children, pregnant women are not required to cooperate with Child Support Enforcement until the birth of the child);
- Cooperating in identifying and providing third party liability information;
- Making resources available and utilizing resources;
- Cooperating in Quality Control procedures;
- Enrollment in cost effective employer-sponsored health insurance through the RIte Share Premium Assistance Program (Section 0349).

ASSIGNMENT OF RIGHTS 0308.10

REV:06/1994

By applying for Medical Assistance, the applicant makes an assignment of his/her rights to any medical support available under an order of a court or an administrative agency to the Rhode Island Department of Human Services. He/she also assigns to the Department of Human Services any third party payments for medical care and payments for any other individual eligible under the Medicaid State plan for whom he/she has the legal authority under State law to make an assignment. This assignment is automatic under State law upon an applicant's filing for Medical Assistance.

MEDICAL ASSISTANCE

SECTION 0308 COOPERATION REQUIREMENTS

0308.10.05 Coop in Est Paternity & Obtaining Support

REV:06/1994

Except for poverty level pregnant women, the applicant must cooperate in establishing the paternity of a child born out of wedlock for whom the applicant can legally assign rights and in obtaining medical care support and medical care payments for himself/herself, as well as for any other person for whom the individual can legally assign rights.

0308.10.10 Coop in Identifying & Providing TPL Info

REV:06/1994

The applicant must cooperate in identifying and providing information to assist the Department of Human Services in pursuing any third party which may be liable to pay for care and services available under the plan. Individuals are not required to pursue collections themselves; pursuit is the responsibility of the provider or the State.

As part of a cooperation, the agency may require an individual to:

- Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;
- Appear as a witness at a court or other proceeding;
- Provide information, or attest to lack of information, under penalty of perjury;
- Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and
- Take any other reasonable steps to assist in establishing paternity and securing medical support and payments, and in identifying and providing information to assist the State in pursuing any liable third party.

MEDICAL ASSISTANCE

COOPERATION REQUIREMENTS SECTION 0308

REQUIREMENT TO UTILIZE RESOURCES 0308.15

REV:06/1994

Clients are required, as a condition of eligibility, to take all reasonable actions to make income/resources available to meet needs. A reasonable action is one that will likely result in more financial benefit accruing to a household than the cost of obtaining the benefit. Reasonable actions also include the requirement to file applications for other benefits to which the individual is entitled. The individual must make a good faith effort to bring the resources or income into a state of availability.

The actions which may be required of clients to make income/resources available include, but are not limited to:

- Formal written requests to other joint owners to sell otherwise liquidate jointly held property;
- Formal written requests to guardians, trustees, etc. to make resources or income available from estates, trusts, settlements, etc.;
- Retention of counsel to petition a court to adjudicate any monetary or property claim which the client may have against any person;
- Periodically (at least quarterly) report to the agency on the progress being made toward making the resource or income available for use. For eligibility to continue to exist, the client must continue to show a good faith effort to obtain resources or income.

Dist Office Procedures When Unavailable 0308.15.05

REV:01/2002

District Office staff must identify sources of income or resources which are not currently available to the client. If the income or resource would, in addition to other income or resources, render the case ineligible, further action is needed. Staff must obtain all available documentation regarding the item, and refer the case to the Chief Supervisor or Regional Manager (or the Administrator of Long Term Care or his/her designee) for determination as to the availability of the resource or income.

SECTION 0308 COOPERATION REQUIREMENTS

Copies of all relevant documents relating to the resource, such as trust documents, settlement agreements, account agreements and statements, deeds, etc. should accompany the referral memo.

The Office of Legal Counsel is available to assist the Regional Manager in the determination of the current availability of the income or resource. The Regional Manager or LTC Administrator, in consultation with the Office of Legal Counsel, determines the action(s) that the client must take to make the income or resources available, and the time frame for taking the action(s).

If the income or resource in question is determined to be unavailable and the client agrees to take the action prescribed by the Office of Legal Counsel, the resource is not countable. Eligibility exists if the case is otherwise eligible. It is the responsibility of the District Office staff to track and review such cases to assure that the client takes the required actions in a timely manner, and that any periodic reporting requirement is met.

Periodic reports, if required, are forwarded to the Office of Legal Counsel for review to assure that continuing eligibility exists.

0308.20 APPLICANT'S PURSUIT OF OTHER BENEFITS

REV:06/1994

It is important to assess the other benefit programs available to help those in need. These may be programs for which an individual is eligible based on his or her own activities or based on indirect qualification through family circumstances.

0308.20.05 Availability of Other Program Benefits

REV:01/2002

Other program benefits for which an individual must file, upon written notification, include annuities, pensions, RSDI benefits (e.g., retirement, disability, widows, parents' benefits), and payments similar to those discussed below. These benefits have the following characteristics in common:

- They require an application or similar action;

- They have conditions for eligibility;
- They make payments on an ongoing or one-time basis; and
- They are sources of income that increase countable income.

The client must file for benefits which will increase his/her countable resources or income. Such benefits include:

- RSDI Benefits;
- Veterans' Pension and Compensation Payments;
- Workers' Compensation Payments;
- Pensions;
- Unemployment Insurance Benefits;
- Temporary Disability Benefits; and
- Earned Income Tax Credits (EITC).

The client is not required to file for benefits that are welfare payments based on need, or for benefits that will not increase his/her countable income or resources. Such benefits are:

- Family Independence Program (FIP);
- General Public Assistance;
- Bureau of Indian Affairs General Assistance; and
- Other Federal, State, local or private programs whose payments are disregarded in the determination of eligibility.

MEDICAL ASSISTANCE

SECTION 0308 COOPERATION REQUIREMENTS

0308.20.10 Requirement to Pursue Other Benefits

REV:06/1994

A client cannot be eligible for Medical Assistance benefits if (s)he is advised in a written, dated notice, of potential eligibility for other benefits; and (s)he does not take all appropriate steps to file for and, if eligible, obtain any such payments within 30 days of receipt of such notice.

A client must take all appropriate steps to pursue eligibility for other benefits. If the type of benefit for which a claimant/recipient must file offers a choice about the method of payment, the client must file for all benefits payable in the highest amount available.

Taking appropriate steps includes:

- Applying for the benefit; and
- Providing the other benefit source with necessary information to determine eligibility for the benefit.

Where a client files for the other benefit but does not pursue the claim, he/she is not eligible for Medical Assistance.

A client is not required to pursue a claim for other program benefits through the appeals process.

0308.20.15 Good Cause for Not Pursuing Other Benefits

REV:06/1994

An individual is eligible for Medical Assistance despite failure to apply for other benefits within the 30-day period or take other necessary steps to obtain them if there is good cause for not doing so. For example, there is good cause if:

- The individual is unable to file for other benefits because of illness; or
- It would be useless to apply because the other program has already turned down the individual for reasons that have not changed.

MEDICAL ASSISTANCE

RETROACTIVE COVERAGE SECTION 0310

RETROACTIVE COVERAGE DEFINED 0310.05

REV:07/2002

Categorically Needy and Medically Needy individuals who meet the SSI-related eligibility criteria may request retroactive eligibility for UP TO THREE (3) MONTHS PRIOR TO THE MONTH OF APPLICATION. To obtain retroactive coverage, applicants must meet all eligibility criteria during the retroactive period.

Retroactive coverage is also available to IV-E and non IV-E foster children and adoption subsidy family-related coverage groups.

Retroactive coverage for the three (3) months prior to the month of applicantion is not available to members of all other family-related coverage groups, including Section 1931 families, Waiver Familes, Medically Needy Families (including flex test cases), RIte Care or RIte Share pregnant women and children, all RIte Care State-funded coverage groups, and all Extended Family Planning coverage groups.

The following chart details the family-related coverage groups who are eligible/ineligible for retroactive services:

COVERAGE GROUP	ELIGIBLE FOR RETRO
Section 1931 MA (including FIP)	N
Family Waiver MA income greater than 110% FPL	N
Pregnant Women income less than or equal to 250% FPL	N
Children up to age 19 income less than or equal to 250% FPL	N
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
Medically Needy (includes Flex Test) Family-related groups	N
SSI-related coverage groups Categorically or Medically needy	Y

SECTION 0310

Non-citizens who are ineligible for ongoing medical assistance due to immigration status - All coverage groups Y

At the time of application for Medical Assistance, if the applicant indicates that an unpaid medical bill was incurred in the three month period preceding the application, eligibility for retroactive coverage must be determined.

Current eligibility for SSI, FIP or Medical Assistance does NOT affect retroactive eligibility. Individuals who are denied SSI, FIP, or MA in the month of application may be eligible for retroactive coverage.

An applicant need not be alive when an application for retroactive coverage is filed.

Retroactive eligibility is not available to persons who were not residents of Rhode Island in the retroactive period and at the time the service was provided.

0310.10 ELIGIBILITY REQUIREMENTS

REV:01/2001

Retroactive coverage applies only to unpaid medical bills for services provided within the scope of the Medical Assistance (MA) Program. The medical bills must have been incurred during the three month retroactive period. The applicant must meet MA eligibility requirements for each month in which an unpaid medical bill was incurred. Thus, retroactive eligibility may be determined for one, two or three months of the retroactive period.

ONLY THE INCOME AND RESOURCES AVAILABLE TO THE APPLICANT IN THE RETROACTIVE PERIOD ARE USED TO DETERMINE ELIGIBILITY.

All services are subject to the same Title XIX utilization review standards as all other medical services of the Medical Assistance Program.

PROCEDURES FOR DETERMINING RETRO ELIGIBILITY 0310.15

REV:07/2002

In determining retroactive eligibility, the applicant's net income (after allowable deductions and disregards) and resources are compared to Medically Needy limits UNLESS the unpaid medical bill is for Categorically Needy service only. In this case, eligibility must be based on the applicable Categorically Needy limits.

To determine retroactive eligibility, complete the following:

- Verify that the bill is unpaid and is for a covered service provided within the three (3) months prior to the first of the month of application for SSI,FIP or MA.

- Establish eligibility based on:

  - Residence
  - Characteristic (if required)
  - Relationship (if required)
  - Citizenship or alienage; and,

  at the time of application, the applicant must fulfill cooperation and enumeration requirements.

- Compare the resources and net income (after allowable deductions and disregards) to the appropriate income limit for the month(s) in which there is a verified, unpaid bill(s) (income limits refer to Categorically Needy income limits, Medically Needy income limits and Low Income Aged and Disabled income limits). Resources must be within the applicable resource limit as of the first day of each month for which eligibility is being determined.

- Determine whether retroactive coverage is available to individual's coverage group.

- If eligible, certify the case for the month or months of eligibility. Retroactive eligibility is for one (1), two (2), or all of the three (3) months immediately preceding the month of application.

- If the income exceeds the Medically Needy Income Limits

apply the Flexible Test of Income. If the Flexible Test of Income results in achieving MA retroactive eligibility, only those bills not applied to excess income are authorized for retroactive coverage.

If the bill is for a service not provided under the Medically Needy scope of services, the application must be determined for eligibility as Categorically Needy.

- If an unpaid bill is for a Categorically Needy service and the applicant's income exceeds the Categorically Needy Income Limits, the application for retroactive eligibility is denied. There is no Flexible Test of Income for income in excess of the Categorically Needy Income Limits.

- If unpaid bills for both Medically Needy and Categorically Needy services are submitted, the applicant must be found eligible as Categorically Needy or the bill(s) for the Categorically Needy service(s) must be denied. If the individual is eligible as Medically Needy, only the bill(s) for Medically Needy services can be authorized for retroactive coverage.

0310.20 AUTHORIZATION OF RETROACTIVE ELIGIBILITY

REV:01/2001

Retroactive eligibility is determined on a month by month basis, with the eligibility technician or social caseworker using the InRHODES Eligibility (ELIG) function to review and approve results.

No bill can be paid unless it is submitted by the provider and received by the Center for Adult Health WITHIN TWELVE (12) MONTHS OF THE DATE THE SERVICE AS PROVIDED.

A copy of each medical bill or other verification that a medical expense exists during the retroactive period must be included in the case record to support the decision on the application.

MEDICAL ASSISTANCE

LIENS & RECOVERY OF MA PAYMENTS SECTION 0312

LEGAL BASIS 0312.05

REV:04/1998

To conform with federal mandates enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and Rhode Island law (section 40-8-15 as amended June 30, 1995), lien and recovery policy is modified to apply to the estates of recipients, whether categorically or medically needy, fifty-five (55) years of age or older at the time of receipt of Medical Assistance.

Under previous provisions of state law and the Department of Human Services (DHS) Manual, liens had applied to medically needy recipients, 65 years of age and older, as of May 18, 1982 and to categorically needy recipients, 65 years of age and older, as of June 1, 1994.

APPLICATION OF THE LIEN 0312.10

REV:04/1998

The lien shall apply to the individual's estate which includes all real and personal property and other assets includable within the individual's probate estate. Consequently, an individual's probate estate may be comprised of liquid assets as well as real property, including any resources remaining at the time of death which were allowable in the individual's Medical Assistance eligibility determination. For example, the lien would apply to the previously allowable $4,000 resource (medically needy resource standard).

A lien cannot attach to assets which are not the subject of a probate estate initiated within the State of Rhode Island, or in any other state in which the individual was a domiciliary. For example, real or personal property which passes by operation of law, (e.g., passes to a surviving joint tenant(s) or the surviving tenant by the entirety) or passes to beneficiaries under a contract, deed, or other instruments such as trust agreements or insurance policies, or any other property which does not require the initiation of a probate process to convey title or beneficial interests or ownership to others, is excluded from the lien process. For other forms of investment or when an asset is in question, the Legal Unit at Central Office may be consulted.

The lien for the recovery of Medical Assistance expenditures:

SECTION 0312 LIENS & RECOVERY OF MA PAYMENTS

- Does not attach during the recipient's lifetime;
- Does not attach to any real or personal property that is not included or includable in the deceased Medicaid recipient's probate estate.

The lien for the recovery of Medical Assistance expenditures:

- Does cover all periods of receipt of Medical Assistance from and after age 55. The recipient does not have to be receiving Medical Assistance at the time of death.
- Does attach at death to all assets included or includable within the individual's probate estate. That is, any and all assets that are subject to probate or to assets where there is no probate due to the use of the Rhode Island "small estates" statute (R.I.G.L. Chapter 33-24-1, et seq.).
- Does attach to and remain a lien upon the estate property, whether or not the property is transferred, and upon all property acquired by the executor or administrator in substitution therefore while that property remains in his or her hands until the Medical Assistance is paid, but the lien shall not affect any tangible personal property or intangible personal property after it has passed to a bona fide purchaser for value.

0312.15 EXCEPTIONS TO THE LIEN

REV:01/2002

A lien SHALL NOT apply:

1. For periods of receipt of Medical Assistance before the recipient reached the age of 55.
2. If the recipient is survived by:
   - A spouse; or,
   - A child who is under the age of twenty-one (21); or,
   - A child who is blind or permanently and totally

disabled as defined in Title XVI (SSI) of the Social Security Act.

An individual who is a survivor of the deceased recipient need not be residing in property of the estate or be a beneficiary of the estate.

Receipt of SSI, RSDI or Railroad Retirement (RR) benefits is acceptable evidence of disability. However, if the child is not in receipt of such benefits, the characteristic of disability must be determined by the Office of Medical Review located at Central Office. Staff is to specify on the AP-65 that the purpose of the referral is to determine whether the child qualifies as a disabled child, thus exempting the parent from the lien provision.

CLIENT NOTIFICATION 0312.20

REV:04/1998

During application for Medical Assistance for the individual who is fifty-five or older at the time of application or who will turn fifty-five before recertification, the individual, or his/her representative, must be advised that, under Rhode Island law, receipt of Medical Assistance may constitute a lien upon his/her estate. Similarly, at recertification for Medical Assistance for an individual who is fifty-five years of age or older or who will become fifty-five before the next recertification, it must be explained to such individual that the lien is an attachment against the individual's estate, taking effect at death, which allows the Department of Human Services to recover from the individual's estate any Medical Assistance paid on behalf of the individual from the time s/he became fifty-five years of age (and after the effective date of the law). The exceptions in Section 0312.15 relative to certain survivors must be explained to the applicant.

PROCEDURES 0312.25

REV:01/2002

When an individual aged 55 or older is found eligible for Medical Assistance, the Eligibility Technician/LTC social caseworker completes the sections on the MA-89M pertaining to the recipient's resources and family information.

SECTION 0312 LIENS & RECOVERY OF MA PAYMENTS

The MA-89M is filed in the case record. At each recertification, the MA-89M is reviewed with the recipient and the information is revised as needed. The MA-89M remains filed in the case record and used only in event of the individual's death.

0312.30 RECOVERY

REV:04/1998

Recovery of Medical Assistance expenditures by the Department of Human Services is a function of the Division of Health Care Quality, Financing and Purchasing, TPL Unit. However, it is the responsibility of the Eligibility Technician or LTC worker closing a Medical Assistance case due to the death of an individual aged fifty-five years or older to complete the remaining sections of the MA-89M which has been filed in the case record. The MA-89M is forwarded to the TPL Unit at Central Office.

Based on the information regarding the deceased's resources and the assistance which would by law be recovered, a decision regarding recovery is made by the TPL Unit.

DHS Recovery Practices

A. The TPL Unit initiates estate recoveries upon receipt of information (from internal or external sources) relative to the death of a Medical Assistance recipient who was at least 55 years of age, and responds to requests from estate representatives to release and/or discharge liens upon payment of reimbursable amounts or upon determination by the TPL Unit that a lien is inapplicable.

B. The TPL Unit does not automatically file an encumbrance in the land evidence records. It is DHS' policy not to encumber the chain of title to real estate until the DHS claim is contested by the legal representatives of the estate, or until it appears that the legal representatives of the estate are unresponsive to the TPL Unit's inquiries or claims.

C. Usually, the recovery process begins with a letter to the next of kin or legal representatives requesting estate asset information. In most cases, there are no assets left after payment of funeral expenses and other

preferred debts (R.I.G.L. 33-12-11), and no recovery is pursued by DHS. If requested, the TPL Unit will issue a discharge of lien. If there are any assets remaining to pay the DHS claim, in whole or in part, the TPL Unit will request reimbursement by letter which provides an accounting of the Medical Assistance expenditures. Upon receipt of payment, the TPL Unit will issue a discharge of lien.

D. If DHS is notified of the pendency of a probate estate either in response to a written notice from the executor/administrator, (see In Re: Estate of Santoro, 572 A. 2d 298, R.I. (1990) and R.I.G.L. 33-11-5.1 for notice to creditor requirements), the TPL Unit will file a formal claim in the estate. Land evidence lien notices are not normally filed at this time (see B. above). Lien notices are filed in the land evidence records if the claim is contested.

E. In accordance with R.I.G.L. 40-8-15(b), and R.I.G.L. 33-11-5.1, legal representatives and/or the heirs-at-law of the decedent are required to provide to the DHS, TPL Unit, within sixty (60) days of the date of death, written notice identifying the decedent, the assets included in the individual's probate estate, the social security number and date of birth of the decedent, and the names and addresses of all persons interested in, or entitled to take any share of the individual's probate estate.

DISCHARGE OF LIEN 0312.35

REV:04/1998

DHS will issue a discharge of its lien in each of the following situations:

1. Upon payment in full of its claim;

2. Upon payment of its claim in part by payment to DHS of all remaining estate assets after allowance for the preferences outlined in R.I.G.L. 33-12-11 and any court approved expenses relating to any pre-existing guardianship or conservatorship of the decedent.

   a. DHS does not "compromise" or reduce its claim

except as provided above;

b. DHS will require the sale or liquidation of non-liquid assets;

c. DHS does not accept deferred or installment payments.

3. Upon a determination by DHS that the lien is inapplicable due to:

a. A statutory exception listed above; or,

b. The decedent was never a recipient of Medical Assistance, was not age 55, or was receiving Medical Assistance but was not "Medically Needy" or "Categorically Needy" during the relevant time periods; or,

c. DHS received reimbursement from another third party source or insurer; or,

d. No assets are included or includable in the decedent's probate estate.

0312.35.05 Request for Discharge Due to Inapplicability

REV:04/1998

There is no required form to request a discharge of a lien due to inapplicability. A written request should be sent to the Division of Health Care Quality, Financing and Purchasing, TPL Unit, 600 New London Avenue, Cranston, RI, 02920, and should contain, at a minimum:

1. A copy of the Death Certificate;

2. The decedent's social security number;

3. A detailed explanation of the basis for a finding of inapplicability (for example, no assets of the deceased individual were included or were includable within the individual's probate estate), with appropriate documentation for the finding. Acceptable documentation may include affidavits;

4. A description of the real estate (tax assessor's plat/lot numbers and street address).

The TPL Unit will review and verify the information and will compare with information previously disclosed on Medical Assistance applications on file with DHS. If approved, the TPL Unit will issue a discharge of lien.

UNDUE HARDSHIP CONSIDERATION 0312.40

REV:04/1998

The Department of Human Services (DHS) may make adjustments to and settle estate liens to obtain the fullest amount practicable. A lien may be postponed in whole or in part when the Department determines execution of the lien would work an undue hardship.

An undue hardship may be found to exist and execution of the lien may be postponed if a sale of real property, in the case of an individual's home, would be required to satisfy a claim, if all of the following conditions are met.

An heir or beneficiary may request that the Department of Human Services delay the execution of its lien if:

1) an individual was using the property as a principal place of residence on the date of the recipient's death; and,

2) that individual resided in the decedent's home on a continual basis for at least twenty-four (24) months immediately prior to the date of the deceased recipient's death; and,

3) that individual has, from the time the Department first presented its claim for recovery against the deceased recipient's estate and after, annual gross income in an amount not to exceed 250 percent of the then applicable federal poverty level (FPL) income standard based on the same family size, and assets not to exceed the then applicable Medically Needy resource standards (see section 0338.05).

If an individual meets the above criteria, the heir(s) or beneficiary(ies) may submit a request to the Department of Human

Services, TPL Unit for consideration of undue hardship and the delay of the execution of the Department's lien against the property if it appears that the individual is able to continue to reside in the property.

Requests for consideration of undue hardship will be reviewed by a team of three members therein designated by the Director of the Department of Human Services, of which one member will be from the DHS Office of Legal Services. The review team will render decisions by giving due consideration to the equities involved as well as the obligations of the parties involved.

In addition to the foregoing criteria, undue hardship will be determined by the Department on a case-by-case basis and will include, but will not be limited to, the following examples, e.g., the individual or self, on whose behalf the heir(s) or beneficiary(ies) is requesting a consideration of undue hardship, would:

A. be rendered homeless without the resources to find suitable housing; or,

B. lose his/her means of livelihood; or,

C. be deprived of food, clothing, shelter, or medical care such that life would be endangered should a finding of undue hardship be denied.

0312.40.05 Application for Undue Hardship Consideration

REV:04/1998

A requestor shall mail his or her application for an undue hardship consideration in writing to the Department within 45 days after the date the Department has filed its claim with probate court. The application shall include the following information:

1. the relationship of the undue hardship applicant to the decedent and copies of documents establishing that relationship; and,

2. the basis for the application and documentation supporting the undue hardship applicant's position; and,

3. supporting documentation that the requestor has the legal

standing and will be allowed to continue to reside in the property indefinitely should the undue hardship request be approved.

The Department may require additional documentation, such as a current title examination, a list of existing creditors, etc. as adequate proof that its decision to defer its lien will not otherwise adversely affect its claim.

The Department shall review each application and issue a written decision within 90 days after the application was received by the Department. The Department shall consider and base its decision on all information received with the application and any independent investigation it may undertake.

The decision shall be the final decision of the Department.

Undue Hardship Granted 0312.40.10

REV:04/1998

If the Department finds that an undue hardship exists, the execution of the lien is delayed for as long as:

- the undue hardship grantee is alive and residing in the property; and has income and assets not to exceed the amounts specified in Section 0312.40.

- the undue hardship circumstances upon which the decision is based continue to exist; and,

- as long as the property is adequately maintained and continues to exist in its then current state, (e.g., if the structure is destroyed by fire, the lien will be executed against the real estate if it appears that the home will not be rebuilt).

The circumstances of the hardship will be subject to review by the Department at least every two years provided, however, that the grantee must notify the Department of any material change in circumstances, income and/or assets.

MEDICAL ASSISTANCE

SECTION 0312 LIENS & RECOVERY OF MA PAYMENTS

0312.40.15 Transfer/Sale of Property

REV:04/1998

If the owner of the property sells or transfers ownership of the home, the Department of Human Services will execute the lien.

MEDICAL ASSISTANCE

MA PAYMENT FOR OUT OF STATE CARE SECTION 0314

REQUIREMENT OF PRIOR AUTHORIZATION 0314.05

REV:01/2002

Payment for out-of-state medical services that are provided to eligible MA recipients living within Rhode Island requires PRIOR AUTHORIZATION from the Division of Medical Services.

The following conditions must be met to obtain prior authorization for out-of-state medical services:

- If a patient requires services from an out-of-state hospital or physician, the patient's attending physician must submit written medical justification to the Division of Health Care Quality, Financing and Purchasing;

- The service which is required and being requested must not be available within Rhode Island.

Recipients who inquire about out-of-state medical services are informed that prior authorization is required, and that only those services within Rhode Island MA scope of services will be recognized.

Exceptions to the Requirement of Prior Auth 0314.05.05

REV:06/1994

The following provisions are exceptions to the requirement for prior authorization:

- Emergency medical treatment and hospital services were needed because the recipient's health would have been endangered if required to travel back to Rhode Island;

- Treatment was provided by hospitals and practitioners located in close proximity to the Rhode Island state line (e.g., Attleboro, Seekonk, Fall River, New London, etc.) where it is the general practice for residents to use medical resources outside the State;

- Medical and hospital treatment were provided to foster children residing with families located outside Rhode Island or in out-of-state residential treatment centers.

MEDICAL ASSISTANCE

SECTION 0314 MA PAYMENT FOR OUT OF STATE CARE

0314.05.10 Services Rendered to Temp Absent Recipients

REV:06/1994

Payment for medical care provided to eligible residents of Rhode Island who are temporarily absent from the state is made under certain circumstances. Temporarily absent includes visiting, traveling or residing temporarily in another state without intending to become a permanent resident of the other state. MA payment is authorized only in one of the following circumstances:

- An emergency arises from accident or illness; or
- The health of the individual would be endangered if the care and services were postponed until the individual returned to Rhode Island; or
- The health of the individual would be endangered if s/he undertook travel to return to Rhode Island.

0314.05.15 Follow-up Procedures

REV:01/2002

When bills are received over a continuing period of time for out-of-state medical care not previously authorized, and which was rendered to MA recipients temporarily absent from the state, the following occurs:

- The Division of Health Care Quality, Financing and Purchasing notifies the district office that follow-up is needed;
- The district office mails form AP-719 to the recipient at the out-of-state address;
- If the recipient indicates s/he is planning to return to the state, written notification of this effect is sent to the Division of Medical Services;
- If the recipient indicates s/he plans to reside permanently outside the state, the case is closed at

the end of the month following the month of notification of intent to reside outside Rhode

MEDICAL ASSISTANCE

MEDICAL ASSISTANCE FOR ALIENS SECTION 0316

IMPACT OF ALIEN STATUS ON SCOPE OF SERVICES 0316.05

REV:10/1999

An Alien who meets all other requirements of the Medical Assistance Program is either eligible for the full scope of Medical Assistance benefits or eligible for restricted services, depending on alien status.

Aliens who are potentially eligible for the full scope of Medical Assistance benefits as Categorically Needy or Medically Needy are:

- Aliens admitted for permanent residence;
- Certain American Indians born in Canada and some Amerasians;
- Refugees, Amerasian Immigrants or Cuban/Haitian entrants;
- Aliens Permanently Residing in the U.S. Under Color of Law (PRUCOL);
- Parolees;
- Asylees.
- Lawfully residing aliens who are members of the state-funded coverage group as defined in 0304.05.45.

Aliens who are potentially eligible for RESTRICTED SERVICES are:

- Undocumented Aliens who are in the U.S. without permission from the Immigration and Naturalization Service and who are not otherwise defined as PRUCOL;
- Aliens with temporary status who are admitted to the U.S. for a temporary period, usually for travel, visits, study or diplomatic service. Included in this group are foreign government representatives, crewman on shore leave, foreign students, temporary workers, members of the foreign media and film crews.

Undocumented pregnant women and children are potentially eligible for benefits under RIte Care. (See Manual Section 0348.10 through 0348.10.15 for state-funded RIte Care Coverage Group benefits.)

MEDICAL ASSISTANCE

SECTION 0316 MEDICAL ASSISTANCE FOR ALIENS

0316.05.05 SAVE Requirement

REV:06/1994

Aliens who are potentially eligible for MA as either Categorically Needy or Medically Needy must:

- Provide documentation of alien status;
- Sign a statement attesting to their satisfactory alien status; and
- Permit DHS to verify their documentation and alien status directly with the Immigration and Naturalization Service.

Once the documentation and verification requirements are met, eligibility determination proceeds in the same manner as eligibility determination for applicants who are U.S. citizens.

0316.05.10 Refugee Medical Assistance

REV:01/2002

Refugees who have resided in the United States for eight (8) months or less, and who have been determined ineligible for one of the categorical programs due to lack of a characteristic may be eligible for Refugee Medical Assistance (RMA). Family cases will have eligibility determined according to family-related (RIte Care) rules. Individuals and couples will have RMA eligibility determined according to SSI-related rules.

0316.10 INELIG ALIENS RECEIVING RESTRICTED SERVICES

REV:06/1994

Aliens whose status renders them ineligible for Medical Assistance as Categorically or Medically Needy may be eligible for restricted services only. Restricted services are emergency in-patient hospital services and hospital emergency room services, including labor and delivery services. No other services are covered for this group.

MEDICAL ASSISTANCE

MEDICAL ASSISTANCE FOR ALIENS SECTION 0316

Restricted Services Eligibility Requirements 0316.10.05

REV:06/1994

Normally, eligibility for persons in restricted services is determined retroactively. The alien must have received and incurred expenses for the services in the month of application, or in one of the three months prior to the month of application. However, a pregnant woman in the third trimester of pregnancy may be certified for restricted services until the end of the month in which her estimated date of confinement falls.

To be eligible under this restricted services provision, an alien must meet all eligibility requirements of the Medical Assistance Program except for citizenship, enumeration and SAVE requirements. Eligibility for Medical Assistance must exist at the time the services are rendered.

Restricted Services Eligibility Requirement 0316.10.05.05

REV:06/1994

The alien must be a resident of Rhode Island. Residency is an eligibility condition for all individuals and families. The determination of residency is largely based on the intent of the applicant to reside in Rhode Island, with no retrospective or prospective durational requirement.

Exception to SAVE Requirement 0316.10.05.10

REV:06/1994

Aliens who are admitted to the U.S. for a temporary purpose, or as Legal Temporary Residents or Legal Permanent Residents must provide documentation of their legal status. However, signing the DHS/SAV-1 to certify that s/he is in satisfactory alien status is NOT a requirement for aliens eligible only for restricted services. Aliens who can not receive INS documentation need not declare themselves to be in satisfactory alien status.

MEDICAL ASSISTANCE

SECTION 0316 MEDICAL ASSISTANCE FOR ALIENS

0316.10.05.15 Exception to Enumeration Requirement

REV:06/1994

Ineligible aliens eligible for restricted services only are exempt from the enumeration requirement and are not required to file for or provide a Social Security number. However, an alien must provide his/her social security number if one has been issued by the Social Security Administration.

MEDICAL ASSISTANCE

MEDICAL ASSISTANCE REDETERMINATION SECTION 0318

REDETERMINATION OF MA ELIGIBILITY 0318.05

REV:05/1999

The redetermination of MA eligibility is based on a new application (DHS-2 or MARC-1) and supporting documents, as needed, from which a determination is made that the recipient continues to meet all eligibility requirements.

A redetermination results in a recertification at the existing scope of services, recertification for a reduced scope of services or case closure. Redetermination precedes a case closure. A case is not closed without a positive finding of ineligibility.

For Categorically Needy and Medically Needy INDIVIDUALS and FAMILIES, a full redetermination is completed every twelve (12) months. In addition, eligibility must be redetermined whenever a change in circumstances occurs, or is expected to occur that may affect eligibility.

Although the newborn is deemed eligible at birth, the birth itself is a change in household composition that always requires redetermination of continuing eligibility for the mother, the newborn and the rest of the family, either for FIP or Medical Assistance only.

REDETERMINATION PROCESS 0318.10

REV:12/2001

Two months prior to the end of a certification period, InRHODES identifies cases due for redetermination and sends to the Management Information Systems (MIS) Unit at the DHS Central Office a list of the cases and a name and address label for each case.

The MIS Unit sends the cards, labels and list of cases due for redetermination to the appropriate district office from which redetermination packets are mailed. The list provided to the district office identifies cases as family or adult and also indicates whether the case was previously certified using the DHS-2 or MARC-1 application form.

MEDICAL ASSISTANCE

SECTION 0318 MEDICAL ASSISTANCE REDETERMINATION

The redetermination packet consists of the following materials, (plus other forms, and documents as they relate to the individual situation; e.g., the MA-1 Supplement when a spenddown is indicated).

INDIVIDUALS/COUPLES	FAMILIES
DHS-2 Statement of Need	DHS-2 Statement of Need OR, as appropriate, MARC-1 Mail-In Application
Transportation Information	EPSDT Information
Pre-addressed return envelope	Pre-addressed return envelope

When the application form is returned within the required time period (prior to expiration of the certification period), the eligibility worker compares the information on the new application to the InRHODES record, entering changes once necessary verification has been provided. If the information is the same and the client remains eligible, the recipient's next redetermination date is advanced up to twelve months, as appropriate. If new information results in ineligibility or a change in the level of coverage, the worker must approve the results.

If the application is not received by the 20th of the month or ten days prior to the end of the certification period, the worker enters a non-cooperation code on the InRHODES STAT/STAT panel causing a TEN-DAY NOTICE of discontinuance to be sent.

The case closes at the end of the old certification period if the recipient has not responded by the end of the 10-day notice period.

0318.15 REDETERMINATION IN SHORT TERM FLEX TEST CASE

REV:01/2002

Medically Needy Individuals/Couples and Families who are eligible under the flexible test of income are certified for the full six (6) month period of flex test eligibility or the balance remaining on the six (6) month period once spenddown of excess

income is achieved.

A flexible test case accepted for two months or less requires an expedited redetermination process. Since the time between the notice of acceptance and the notice of impending discontinuance is shortened, redetermination activity should begin at the time of approval. For cases accepted for less than two (2) months, the time between sending of the application and sending of the notice of eligibility will be shortened. For instance, when a case is accepted during the last two weeks of the flexible test period, the redetermination packet, and the Notification of Eligibility are sent at about the same time.

Many cases accepted using the flexible test of income will have a period of ineligibility between the expiration date of one period and the date of eligibility for a subsequent flex test period.

Redetermination of Disability Determination 0318.20

REV:09/2005

When the MART determines after review that a recipient's disability continues, it must also determine whether medical improvement is expected; and if so, when this review should be conducted. This information must be recorded in the case file. The active case should contain the review date of the disability on the InRhodes STAT/DISA panel. The next disabi review date is set in accordance with the review date established by the Mart unless one of the factors set out below requires an earlier redetermination of the disability.

Cases are reviewed in order to determine whether or not an individual's disability has improved medically to the point where he/she is able to work. When determining whether a medical condition has improved, DHS uses a point of comparison to compare the current severity of the impairment(s) to the most recent favorable disability determination that the individual has received.

When the MART has decided that a case must be reviewed in the future, all medical documentation, must be sent to the MART for review at the specified time period.

MEDICAL ASSISTANCE

SECTION 0318 MEDICAL ASSISTANCE REDETERMINATION

The Department of Human Services (DHS) conducts continuing disability reviews when one or more of the following in accordance with 20 CFR, Section 416.990(b) apply:

- The date the MART has rescheduled for the expected medical improvement review,
- A recipient has been scheduled for a periodic review by the MART in accordance with Paragraph 1.
- Current medical or other reports are necessary to determine if a recipient's disability has continued (for example, where medical technology has changed),
- A recipient returns to work and successfully completes a trial period of work,
- A recipient informs DHS that s/he has recovered from disability or that they have returned to work, or Vocational Rehabilitation reports recipient is working or is able to work,
- Someone in a position to know of recipient's physical or mental condition informs DHS that the recipient is not disabled, has not been following prescribed treatment, or has returned to work, and it appears that the report could be substantially correct, or
- DHS receives evidence that raises a question as to whether or not an individual's disability continues,
- A recipient has earned substantial wages during the eligibility period, unless otherwise eligible under the Sherlock Act, R.I.G.L. 40-8.7.
- By his/her first birthday, for a child whose low birth weight was a contributing factor material to the disability determination, or

- After his/her first birthday for a child who has an impairment(s) that is not expected to improve by his/her first birthday.

There are several definitions that are important to know in order to understand why an individual's disability determination would be reviewed.

Definitions:

MEDICAL IMPROVEMENT: Any decrease in the medical severity of an individual's impairment(s) which was present at the time of the most recent favorable medical decision that they were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be made on improvement in the symptoms, signs and/or laboratory findings associated with the individual's impairment(s).

POINT OF COMPARISON: When determining whether medical improvement has occurred, compare the current medical severity of the impairment(s) to the medical severity of the impairment(s) which was present at the time the most recent favorable medical decision of disability was made.

MEDICAL SEVERITY: Medical evidence that establishes a physical or mental impairment or combination of impairments of sufficient severity as to be the basis of a finding of

inability to engage in any substantial gainful activity.

DHS, upon initiating a continuing disability determination review, will notify the individual by a written notice advising that:

- DHS will be reviewing the individual's disability,
- The reason why the disability is being reviewed,
- There are medical improvement standards as listed in 20 CFR, Section416.994(b)(1)(ii),(iii),(iv) and DHS Policy Section 0318.20 that apply,
- The individual has a right to submit medical and/or other evidence to be considered in the review process,
- That the review could result in a later decision to discontinue the individual's Medical Assistance benefits.

During the continuing disability determination review, DHS uses reasonable efforts to obtain the individual's medical reports and develop a complete medical history consisting of at minimum the preceding twelve (12) months. The MART has the right to request and obtain a consultative examination from the recipient.

An individual's Medical Assistance benefits will not be terminated for lack of disability until DHS has completed the review, determined that the individual has improved medically, or that under standards set out in 20 CFR Section 416.994(b)(3) or (4) has determined that an exception applies, and sent a timely and adequate written advance notice to the individual.

An individual's Medical Assistance benefits will be discontinued if the individual refuses to:

1. Obtain a consultative examination, or
2. Cooperate in obtaining the required documentation.

Evaluation

To assure that disability reviews are conducted with uniformity, objectivity, and expeditiously, the following steps as referenced in 20 CFR Section 416.994(b)(5) will be followed when determining whether or not an individual's disability continues:

Step 1: An individual has an impairment or combination of impairments that meets or equals the severity of an impairment as listed in 20 CFR Section 416.994, Appendix 1, Subpart P of Part 404. If the individual does, the disability will be found to continue.

Step 2: If an individual does not meet Step 1, has there been medical improvement in the individual's condition as shown by a decrease in medical severity (as defined). If not, there has been no medical Improvement and the individual's disability will be found to continue.

Step 3: If there has been medical improvement, determine whether it is related to the individual's ability to work, i.e. whether there has been an increase in the residual functional capacity based on the impairment(s) present at the time of the most recent favorable disability determination.

Step 4: If there is no medical improvement or the Medical improvement is not related to the individual's ability to work, the individual's disability is found to continue.

Step 5: If there is medical improvement and it is shown to be related to an individual's ability to work, all of the individual's current impairments are reviewed to determine whether they are severe as defined in 20 CFR Section 416.921, and

whether the impairments in combination significantly limit basic work activities.

Step 6: If an individual's impairment(s) is severe, s/he will be assessed to determine his/her ability to do substantial gainful activity in accordance with 20 CFR Section 416.961. The individual's residual functional capacity based on all of their current impairment(s) is assessed to determine whether s/he can still do the work that was done in the past. If s/he can do such work, the individual's disability will be found to have ended.

Step 7: If an individual cannot perform the work that s/he has done in the past, one final step must be considered. Given the individual's residual functioning capacity assessment and considering his/her age, education, and past work experience, are reviewed to determine if other work can be performed. If the individual can perform other work, the disability will be considered to have ended. If the individual cannot perform other work, the disability will be considered to have continued.

All individuals are tested to evaluate the possibility of another eligibility category of medical assistance before Medical Assistance benefits are discontinued.

MEDICAL ASSISTANCE

REFERRAL TO OTHER RESOURCES FOR MED CARE SECTION 0320

AVAILABILITY OF OTHER RESOURCES 0320.05

REV:01/2002

In addition to the Medical Assistance Program, there are other resources within the State for individuals with medical needs. Some individuals may be concurrently eligible for more than one of these resources, such as Office of Rehabilitation Services and Medical Assistance. Veterans' benefits may also be received instead of, or in addition to, Medical Assistance or other assistance programs.

Applicants who do not meet the eligibility requirements for Medical Assistance may be eligible for one or more of the following programs:

- Veterans' Benefits (VA);
- Office of Rehabilitation Services (ORS);
- Rhode Island Pharmaceutical Assistance for the Elderly.

REHABILITATION (ORS) SERVICES 0320.10

REV:01/2002

When a recipient of MA is eligible for Office of Rehabilitation Services (ORS), or a recipient of ORS is eligible for MA, the medical expenses are shared by the two agencies.

ORS has the responsibility for the administration of all services needed to preserve or develop to the maximum the self-sufficiency of the individual toward a vocational goal.

VR Responsibilities 0320.10.05

REV:01/2002

In order to fully utilize the services of both agencies, ORS assumes responsibility for the following services:

- A complete general medical examination providing an appraisal of the current medical status of the individual;
- Examination by specialists in all fields as needed, including psychiatric and/or psychological examinations

in all cases of suspected mental or emotional illness;

- Such laboratory tests, x-ray services and other indicated studies as are necessary to establish the diagnosis(es), to determine the extent to which disability limits the individual's daily living and work activities, and to estimate the potential results of physical restoration services;
- The initial purchase of durable medical equipment and surgical and prosthetic appliances required as part of a vocational rehabilitation plan;
- Inpatient and outpatient services provided by rehabilitation facilities not covered within the scope of services of the Rhode Island Medical Assistance Program;
- Private psychiatric services within the normal limitations of the ORS program;
- All other medical services and supplies which are required as part of an overall ORS plan that are not covered by the Rhode Island Medical Assistance Program.

0320.10.10 MA Responsibilities

REV:06/1994

The Medical Assistance Program assumes responsibility for payment of the following services:

- Hospital services in licensed general hospitals certified for participation in the Title XVIII and Title XIX Programs when provided in accordance with applicable Federal and State rules and regulations;
- Durable medical equipment and surgical and prosthetic appliances utilized on an ongoing basis;
- Hemodialysis treatments provided in a hospital or a hemodialysis facility;
- All other medical services and supplies which are

medically justifiable and included within the scope of services of the Rhode Island Medical Assistance Program, but not covered by Vocational Rehabilitation.

Prior Authorization Required 0320.10.15

REV:06/1994

All medical services and supplies paid for by the Medical Assistance Program will be provided in accordance with established methods of reimbursement, fee schedules and other applicable rules and regulations. Since certain hospital and outpatient department services provided in out-of-state hospitals require prior authorization, consultation between the two agencies will be required before authorization is granted for such services. All rehabilitative services will be provided within the scope of services of VR. Referrals between the two agencies will be administered as agreed upon by both agencies.

VR will take the initiative to evaluate and determine those services needed to return an individual to a remunerative occupation. Those medical services not directly connected with the individual's major disabling condition and vocational rehabilitation process will be included.

MA will be responsible for the ongoing medical needs not directly related to the vocational rehabilitation process.

VR will provide ongoing counseling and guidance and other non-medical services required to achieve the individual's vocational objective.

Referral of MA Ineligible Indiv w/Disability 0320.10.20

REV:01/2002

When an individual who is ineligible for MA has a disability, s/he may be referred to:

Office of Rehabilitative Services (ORS)
40 Fountain Street
Providence, RI 02903
Telephone: 421-7005

MEDICAL ASSISTANCE

SECTION 0320 REFERRAL TO OTHER RESOURCES FOR MED CARE

0320.15 VETERANS BENEFITS

REV:06/1994

Veterans Benefits are a resource for which increasing numbers of individuals may be eligible. These benefits and services are available to veterans and their dependents or survivors. They may be received instead of, or in addition to, Medical Assistance.

0320.15.05 Who is a Veteran

REV:01/2002

Service in any branch of the armed forces during the following periods designated for the various wars and specific periods of qualifying peacetime service qualifies an individual as a Veteran.

Mexican Border Period	May 9, 1916 to April 5, 1917
World War I	April 6, 1917 to November 11, 1918 Service in Russia, ending date: April 1, 1920
World War II	December 7, 1941 to December 31, 1946
Korean Campaign	June 27, 1950 to January 31, 1955
Vietnam	February 28,1961 to May 7, 1975

Verification by discharge papers (Form DD-214) is required upon application for benefits.

0320.15.10 Who is Eligible

REV:01/2002

Veterans Benefits are a possible source to any disabled veteran whether the disability is service-connected or not. Dependents and survivors may also be entitled to benefits. All applicants who are veterans (served during the specified periods) and who have a disability must apply for Veterans Benefits through the US Department of Veterans Offices. All widows of a veteran, or caretaker relative of the child(ren) of a deceased or disabled veteran must investigate the possible eligibility for Veterans

Benefits. There are also benefits and services available to non-disabled veterans.

Benefits Available 0320.15.15

REV:06/1994

In addition to the regular Compensation (for service connected disabilities) or Pension (for non-service connected disabilities) that a veteran (and his/her dependents) or a widow pensioner receives, additional amounts are allowed when the individual:

- Is housebound;
- Has unusual medical expense (reimbursed expenditures above 5% of income which could reduce countable income below VA income limitation, thereby creating entitlement); or
- When the individual is in need of aid or attendance (this will be construed to include public or private nursing care facilities, foster homes and non-profit organizations).

Death Benefits 0320.15.15.05

REV:01/2002

Death benefits (gratuity) are available only to veterans who receive compensation or had active duty during wartime.

Medical Benefits 0320.15.15.10

REV:01/2002

Information about medical benefits available through the Veterans Administration Medical Centers for veterans whose benefits are service connected or non-service connected may be obtained from :

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VA Medical Center
Davis Park
Providence, Rhode Island

0320.15.15.15 Cost of Living Increases

REV:06/1994

Whenever there is a cost of living increase in Social Security benefits the VA shall, effective the date the increase becomes effective, increase by the same percentage the maximum annual rates of the VA pension.

0320.15.20 How to Receive VA Benefits

REV:01/2002

All benefits must be applied for and substantiating data must be provided by the veteran or survivor.

Individuals potentially eligible may be referred directly to:

Veterans Administration Regional Office
380 Westminster Street
Providence, RI 02903
Telephone: 1-800-827-1000

If the individual questions whether there is eligibility for a specific program or benefit or needs help in making the application, referral may be made to:

Office of Veterans Affairs
600 New London Avenue
Cranston, RI 02920
Telephone: 462-0350

0320.20 RI PHARMACEUTICAL ASSIST FOR ELDERLY (RIPAE)

REV:01/2002

RIPAE is operated by the Rhode Island Department of Elderly Affairs. The program provides assistance to low and middle income individuals or couples, 65 years of age or older, to help pay for prescription medication for certain medical conditions.

MEDICAL ASSISTANCE

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Eligibility for Coverage 0320.20.05

REV:01/2002

To be eligible, an individual must:

- Be a resident of Rhode Island;
- Be sixty-five (65) years of age or older;
- Have income within program guidelines established by the Department of Elderly Affairs; and
- Have no coverage for prescription medication.

Covered Medications 0320.20.10

REV:01/2002

Current information about medications covered by RIPAE may be obtained from the Rhode Island Department of Elderly Affairs. In 2001, RIPAE covered a portion of the cost of prescriptions used to treat Alzheimer's disease, arthritis, diabetes, heart problems, depression, anti-infectives, Parkinson's disease, high blood pressure, cancer, urinary incontinence, circulatory insufficiency, high cholesterol, asthma and chronic respiratory conditions, glaucoma, and prescriptive vitamins and mineral supplements for renal patients.

Application Process 0320.20.15

REV:01/2002

Elderly individuals, ineligible for MA, should contact the Department of Elderly Affairs at 222-2880 for information concerning RIPAE and other programs for which s/he may be eligible.