

CHAPTER 72

NEW JERSEY CARE ... SPECIAL MEDICAID PROGRAMS MANUAL

Authority

N.J.S.A. 30:4D-3 and 7; and Section 1902(a)(10) of Social Security Act (42 U.S.C. § 1396a(a)(1)).

Source and Effective Date

R.2002 d.241, effective July 3, 2002.
See: 34 N.J.R. 1240(a), 34 N.J.R. 2840(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 72, New Jersey Care ... Special Medicaid Programs Manual, expires on December 30, 2007. See: 39 N.J.R. 3704(a).

Chapter Historical Note

Chapter 72, New Jersey Care ... Special Medicaid Programs Manual, was adopted as Emergency New Rules by R.1987 d.312, effective June 29, 1987. See: 19 N.J.R. 1324(a). The concurrent proposal of R.1987 d.312 was adopted by R.1987 d.380, effective August 27, 1987. See: 19 N.J.R. 1324(a), 19 N.J.R. 1731(a).

Subchapter 6, Presumptive Eligibility, was adopted as R.1988 d.192, effective May 2, 1988. See: 20 N.J.R. 367(a), 20 N.J.R. 983(a).

Pursuant to Executive Order No. 66(1978), Chapter 72, New Jersey Care ... Special Medicaid Programs Manual, was readopted by R.1992 d.364, effective September 21, 1992. See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Pursuant to Executive Order No. 66(1978), Chapter 72, New Jersey Care ... Special Medicaid Programs Manual, was readopted by R.1997 d.379, effective August 15, 1997. See: 29 N.J.R. 2541(a), 29 N.J.R. 4136(a).

Chapter 72, New Jersey Care ... Special Medicaid Programs Manual, was readopted by R.2002 d.241, effective July 3, 2002. See: Source and Effective Date.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. INTRODUCTION

- 10:72-1.1 Program scope
- 10:72-1.2 Purpose
- 10:72-1.3 Administrative organization
- 10:72-1.4 Principles of administration
- 10:72-1.5 Confidentiality of information
- 10:72-1.6 Materials distributed to Medicaid applicants or eligible persons
- 10:72-1.7 Nondiscrimination
- 10:72-1.8 Assignment of medical support rights

SUBCHAPTER 2. CASE PROCESSING

- 10:72-2.1 Application
- 10:72-2.2 Interview
- 10:72-2.3 Verification requirements
- 10:72-2.4 Case transfer
- 10:72-2.5 Redetermination of eligibility
- 10:72-2.6 Post-application client responsibilities
- 10:72-2.7 Retroactive eligibility

SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

- 10:72-3.1 General provisions

- 10:72-3.2 Citizenship
- 10:72-3.3 State residency
- 10:72-3.4 Eligible persons
- 10:72-3.5 Household unit
- 10:72-3.6 Third party liability
- 10:72-3.7 Persons sanctioned under AFDC rules
- 10:72-3.8 Application for other benefits
- 10:72-3.9 Inmates of public institutions
- 10:72-3.10 Emergency services for aliens and limited prenatal care for aliens

SUBCHAPTER 4. FINANCIAL ELIGIBILITY

- 10:72-4.1 Income eligibility limits
- 10:72-4.2 Prospective budgeting of income
- 10:72-4.3 Countable income: pregnant women and infants
- 10:72-4.4 Income eligibility; aged, blind, and disabled individuals
- 10:72-4.5 Resource eligibility

SUBCHAPTER 5. ADMINISTRATIVE REQUIREMENTS

- 10:72-5.1 Notice of the county welfare agency decision
- 10:72-5.2 Fair hearings
- 10:72-5.3 Case records

SUBCHAPTER 6. PRESUMPTIVE ELIGIBILITY

- 10:72-6.1 Scope
- 10:72-6.2 Responsibilities of a qualified provider
- 10:72-6.3 Responsibility of the Division of Medical Assistance and Health Services
- 10:72-6.4 Responsibility of the county welfare agency
- 10:72-6.5 Responsibility of the applicant
- 10:72-6.6 Notification and fair hearing rights

SUBCHAPTER 7. PRESUMPTIVE ELIGIBILITY FOR CHILDREN

- 10:72-7.1 Scope
- 10:72-7.2 Period of presumptive eligibility
- 10:72-7.3 Presumptive eligibility determination entities
- 10:72-7.4 Policies governing the presumptive eligibility processing performed by the presumptive eligibility determination entity
- 10:72-7.5 Presumptive eligibility process performed by the Division of Medical Assistance and Health Services
- 10:72-7.6 Presumptive eligibility processing performed by the eligibility determination agency
- 10:72-7.7 Responsibility of the applicant
- 10:72-7.8 Notification and fair hearing rights
- 10:72-7.9 Scope of services during the presumptive eligibility period
- 10:72-7.10 Limitation on number of presumptive eligibility periods

SUBCHAPTER 8. BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT SERVICES

- 10:72-8.1 Purpose and scope
- 10:72-8.2 Definitions
- 10:72-8.3 Breast and cervical cancer-related prevention and treatment program eligibility
- 10:72-8.4 Presumptive eligibility process
- 10:72-8.5 Service restrictions
- 10:72-8.6 Redetermination of eligibility

SUBCHAPTER 9. NJ WORKABILITY

- 10:72-9.1 Purpose, scope and applicability
- 10:72-9.2 Definitions
- 10:72-9.3 Non-financial eligibility for NJ WorkAbility
- 10:72-9.4 Income eligibility for NJ WorkAbility
- 10:72-9.5 Resource eligibility for NJ WorkAbility
- 10:72-9.6 Premium payments

- 10:72-9.7 Services available through the NJ WorkAbility program
 10:72-9.8 Application process

SUBCHAPTER 1. INTRODUCTION

10:72-1.1 Program scope

(a) This chapter contains the criteria for Medicaid eligibility for certain pregnant women and infants not eligible under the provisions of N.J.A.C. 10:81 and 82, as well as, certain aged, blind, and disabled persons not eligible under the provisions of N.J.A.C. 10:71.

1. Because the eligibility criteria established by the rules contained within this chapter are more liberal than those applicable under AFDC-related Medicaid and SSI-related Medicaid, pregnant women, infants, and aged, blind or disabled individuals losing Medicaid eligibility because of financial reasons should be evaluated under the provisions of this chapter for the possibility of continuing Medicaid eligibility.

2. Except for children between the ages of one and 19, persons financially ineligible for Medicaid under the provisions of N.J.A.C. 10:71, 10:81 and 10:82 and who are income ineligible for Medicaid under the provisions of this chapter shall be evaluated for eligibility as Medically Needy under the provisions of N.J.A.C. 10:70.

i. Persons determined eligible for the Medically Needy Program may be also determined eligible as Specified Low-Income Medicare Beneficiaries.

3. Infants not eligible under the provisions of N.J.A.C. 10:71, 10:72, 10:81 or 10:82 should be evaluated for NJ KidCare under the provisions of N.J.A.C. 10:79.

(b) Medicaid eligibility under the provisions of this chapter is limited to:

1. Pregnant women; and
2. Infants under the age of one.
3. Aged, blind, and disabled individuals (as defined by Title XIX of the Social Security Act), who otherwise meet the requirements specified in this chapter. For purposes of this chapter, an aged individual is a person who is 65 years of age or older.
4. Aged, blind, and disabled individuals (as defined in (b)3 above) who qualify as Specified Low-Income Medicare Beneficiaries.
 - i. Specified low-income Medicare beneficiaries must be residents of the State, must be receiving Medicare benefits, Parts A and B, and must meet the income and resource requirements specified in N.J.A.C. 10:72-4.1(b) and 4.5(b).

ii. The enrollment and outreach process for specified low-income Medicare beneficiaries is administered by the Department of Health and Senior Services, through the Office of Pharmaceutical Assistance to the Aged and Disabled (PAAD), using the standard PAAD application form.

iii. Persons determined eligible as specified low-income Medicare beneficiaries are entitled to payment of Medicare Part B Premiums only, beginning in the month of application and up to three prior months, but no earlier than January 1, 1993.

iv. The Division of Medical Assistance and Health Services shall promptly notify any applicant for, or beneficiary of, the Specified Low-Income Medicare Beneficiary benefit, in writing, of any agency decision affecting the application disposition or the receipt of the benefit. When a decision relates to any adverse action which may entitle an individual to a fair hearing, the action may not be implemented until at least 10 days after the mailing of the notice. Such notices shall conform with provisions at N.J.A.C. 10:72-5.1(b).

(c) Retroactive Medicaid eligibility is available beginning with the third month prior to the month of application for Medicaid for any month during which the applicant meets all eligibility criteria and during which the applicant has unpaid medical expenses for covered services. In order to qualify for retroactive coverage, an individual need not be determined eligible at the time of application for Medicaid benefits. Application for retroactive Medicaid coverage may be made on behalf of a deceased person so long as the person was alive during a portion of the three-month period immediately prior to the month of application and he or she has unpaid medical expenses for Medicaid covered services.

1. Retroactive Medicaid coverage is not available under the provisions of this chapter for an infant for any period prior to the effective date of program coverage for the age of the child. Retroactive eligibility is not available to pregnant women and infants up to the age of one whose family income exceeds 133 percent of the Federal poverty guideline for any period prior to July 1, 1991.

Emergency Amendment, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a).

Substantially amended.

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Emergency Amendment, R.1991 d.223, effective March 28, 1991 (operative April 1, 1991; expires May 27, 1991).

See: 23 N.J.R. 1200(a).

Deleted obsolete language and adopted Federally required coverage pursuant to Omnibus Budget Reconciliation Act of 1989.

Adopted Concurrent Proposal, R.1991 d.302, effective May 24, 1991.

See: 23 N.J.R. 1200(a), 23 N.J.R. 1945(a).

Provisions of emergency amendment R.1991 d.223 readopted without change.

Emergency Amendment, R.1991 d.445, effective July 29, 1991 (expires September 27, 1991).

See: 23 N.J.R. 2543(a).

In (c)1: revised text to add 133 percent guideline for retroactive Medicaid coverage.

Adopted Concurrent Proposal, R.1991 d.526, effective October 21, 1991.

See: 23 N.J.R. 2453(a), 23 N.J.R. 3144(a).

Provision of emergency amendment R.1991 d.526 adopted without change.

Amended by R.1992 d.484, effective December 7, 1992.

See: 24 N.J.R. 1860(a), 24 N.J.R. 4378(a).

Eligibility expanded to include children of specified ages born after September 30, 1983.

Administrative Correction to (a).

See: 25 N.J.R. 704(a).

Amended by R.1993 d.369, effective July 19, 1993.

See: 25 N.J.R. 1042(b), 25 N.J.R. 3217(a).

Amended by R.1997 d.379, effective September 15, 1997.

See: 29 N.J.R. 2541(a), 29 N.J.R. 4136(a).

In (b)3, inserted “, who otherwise meet the requirements specified in this chapter”; and in (a)4ii, substituted “enrollment and outreach process” for “eligibility determination process” and “administered by the Department of Health and Senior Services” for “is the responsibility of the Division of Medical Assistance and Health Services”.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), added an exception at the beginning of 2, and added 3; and in (b), rewrote 2.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

Administrative correction.

See: 39 N.J.R. 4401(a).

10:72-1.2 Purpose

(a) The purpose of the rules contained within this chapter is to:

1. Set forth eligibility criteria for the Medicaid program; and
2. Specify the rights and responsibilities of program applicants and eligible persons.

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. A Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. A U.S. Citizen I.D. Card (INS Form-197), Naturalization Certificate (INS Form N-550 or N-570);

vi. A Certificate of Citizenship (INS Form N-560 or N-561);

vii. A Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. An American Indian Card with a classification code "KIC" (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos); or

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions).

2. If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, the county welfare agency shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county welfare agency shall file INS Form G-845 along with the alien registration number with the local INS district office to verify status.

3. The following sets forth acceptable documentation for eligible aliens:

i. Lawful Permanent Resident—INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

ii. Refugee—INS Form I-94 annotated with stamp showing entry as refugee under section 207 of the Immigration and Nationality Act and date of entry into the United States; INS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3," or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medicaid eligibility they are considered refugees. Refugees whose status has been adjusted will have INS Form I-551 annotated "RE-6," "RE-7," "RE-8," or "RE-9."

iii. Asylees—INS Form I-94 annotated with a stamp showing grant of asylum under section 208 of the Immigration and Nationality Act, a grant letter from

the Asylum Office of the Immigration and Naturalization Service, Forms 688B annotated "274a. 12(a)(5)," or I-766 annotated "A5."

iv. Deportation Withheld—Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or INS Form I-688B annotated "274a. 12(a)(10)" or I-766 annotated "A10."

v. Parole for at Least a Year—INS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year.

vi. Conditional Entry under Law in Effect before April 1, 1980—INS Form I-94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Forms I-688B annotated "274a. 12(a)(3)" or I-766 annotated "A3."

vii. Cuban Haitian Entrant—INS Form I-94 stamped "Cuban/Haitian Entrant under section 212(d)(5) of the INA."

viii. An American Indian born in Canada—INS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes—a membership card or other tribal document showing membership in tribe is acceptable documentation.

x. Amerasian Immigrant—INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7, or AM8.

4. For aliens subject to the five-year waiting period before eligibility for Medicaid can be established, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county welfare agency should contact the INS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the county welfare agency shall ask the alien to present Form I-94. If that form is not available, the county welfare agency shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county welfare

agency shall contact the INS by submitting a Form G-845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following shall serve as documentation:

i. For discharge status, an original, or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

Amended by R.1999 d.253, effective August 2, 1999.

See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).

Rewrote the section.

Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).

See: 31 N.J.R. 2252(a).

Added a new 2 in (a) and added new (b), (c), (d) and (e).

Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.

See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).

Readopted provisions of R.1999 d.254 without change.

10:72-3.3 State residency

(a) In order to be eligible for the Medicaid program, an individual must be a resident of the State of New Jersey. The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

1. If an individual leaves New Jersey with the intent to establish permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, he or she ceases to be eligible to receive Medicaid from this State.

2. When an individual enters this State in order to receive medical care and applies for Medicaid to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making the person ineligible for the Medicaid program. It is the responsibility of the county welfare agency to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

i. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;

ii. Whether there is clear expression of intent on the part of the individual to remain permanently in this State;

iii. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he or she came;

iv. Whether the state in which the individual previously resided recognizes him or her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

3. If, after full consideration of the above factors, the county welfare agency is satisfied that the individual has become a resident of this State, Medicaid eligibility may be established.

Case Notes

Pregnant alien with student visa could not be denied Medicaid. *W.W. v. DMAHS*, 93 N.J.A.R.2d (DMA) 101.

10:72-3.4 Eligible persons

(a) The following persons who meet all eligibility criteria of this chapter are eligible for Medicaid benefits:

1. Pregnant women: Needy women of any age during the term of a medically verified pregnancy.

i. A woman who is determined eligible under the criteria of this chapter will, for purposes of eligibility, be considered to be a pregnant woman until the end of the 60-day period beginning with the last day of her pregnancy. Her eligibility as a pregnant woman shall end on the last day of the month in which the 60-day period ends.

2. Children under the age of one.

3. A child born to a woman eligible under the provisions of this chapter (except to a presumptively eligible pregnant woman who has subsequently been found ineligible for the month the child was born) shall remain eligible for a period of not less than 60 days from his or her birth and up to one year, so long as the mother remains eligible for Medicaid, or would remain eligible if pregnant, whether or not application has been made, if the child lives with his or her mother. This also applies to an infant born to a mother whose labor and delivery were covered by Medicaid as emergency services even though the mother cannot receive Medicaid services except for emergency services.

4. Any child receiving Medicaid under the provisions of this chapter who but for the age limits in (a)2 above would be eligible for Medicaid under the provisions of this chapter and who is receiving inpatient services covered by Medicaid at the time he or she reaches the age limit, will continue to be eligible for Medicaid until the end of the stay for which the inpatient services are furnished.

5. Aged individuals: Persons who are age 65 years or older.

6. Disabled individuals: Persons who have been medically determined to meet the criteria of disability as set forth at N.J.A.C. 10:71-3.10 through 3.13.

7. Blind individuals: Persons who have been medically determined to meet the criteria of blindness as set forth at N.J.A.C. 10:71-3.10 through 3.13.

Emergency Amendment, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a).

Added (a)6-8.

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Amended by R.1989 d.397, effective August 7, 1989.

See: 21 N.J.R. 965(a), 21 N.J.R. 2383(a).

Provisions on eligibility of newborn added at (b).

Emergency Amendment, R.1991 d.223, effective March 28, 1991 (operative April 1, 1991; expires May 27, 1991).

See: 23 N.J.R. 1200(a).

Deleted obsolete language and adopted Federally required coverage pursuant to Omnibus Budget Reconciliation Act of 1989.

Adopted Concurrent Proposal, R.1991 d.302, effective May 24, 1991.

See: 23 N.J.R. 1200(a), 23 N.J.R. 1945(a).

Provisions of emergency amendment R.1991 d.223 readopted without change.

Amended by R.1991 d.483, effective October 7, 1991.

See: 23 N.J.R. 1889(a), 23 N.J.R. 3028(a).

In (a)3: revised text to clarify eligibility for newborns of Medicaid eligible women in Medicaid recipients. Added text regarding presumptively eligible pregnant women who have been found ineligible for the month the child was born.

Amended by R.1992 d.484, effective December 7, 1992.

See: 24 N.J.R. 1860(a), 24 N.J.R. 4378(a).

Eligibility expanded to include children of specified ages born after September 30, 1983.

Amended by R.1997 d.379, effective September 15, 1997.

See: 29 N.J.R. 2541(a), 29 N.J.R. 4136(a).

In (a)1i, added the last sentence.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), rewrote 2.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.1999 d.253, effective August 2, 1999.

See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).

In (a)3, added a second sentence.

10:72-3.5 Household unit

(a) The term "household unit" means those persons whose income is counted in the determination of eligibility under the provisions of this chapter. The following persons, if they reside with the program applicant or beneficiary, shall be considered members of the household unit:

1. In the case of a pregnant woman:

i. The pregnant woman and the unborn child (or children, when it is medically verified that there is more than one fetus);

ii. The pregnant woman's spouse;

iii. The pregnant woman's natural or adoptive children under the age of 21;

iv. The blood-related siblings (including those of half-blood) of the pregnant woman's children who are under the age of 21; and

v. The natural or adoptive father of any children in the household unit.

2. In the case of an infant:

i. The child;

ii. The child's natural or adoptive parents;

iii. The child's blood-related (including half-blood) and adoptive siblings under the age of 21; and

iv. At the option of the applicant, the child's stepparent. If the applicant elects not to include the stepparent in the household unit, his or her income will not be included in the determination of eligibility except to the extent that he or she makes it available to the eligible members.

3. In the case of an aged, blind, or disabled individual, the household unit will consist of that individual and his or her spouse if the spouse resides with the aged, blind, or disabled individual. In the case of a blind or disabled child, the household unit will consist of only that child; however, the income and resources of the child's parents will be deemed to that child in accordance with N.J.A.C. 10:72-4.4(d).

4. Any person who is in receipt of Work First New Jersey/TANF or SSI or who has applied for and been found eligible for Medicaid based on eligibility for those cash assistance programs will not be included in the household unit. Any person whose income and resources have been deemed to an eligible SSI beneficiary shall likewise not be included in the household unit unless that person is applying for benefits under this chapter.

5. Any person in (a)1 and 2 above shall be included in the household unit even though he or she is in an AFDC-related Medically Needy budget unit in accordance with N.J.A.C. 10:70-3.5. Likewise, any person in (a)1 and 2 above required by N.J.A.C. 10:70-3.5 to be included in an AFDC-related Medically Needy budget unit, shall be included in that budget unit even if he or she is included in a household unit under the provisions of this section. Any aged, blind, or disabled person eligible under the provisions of this chapter or who is eligible for Medically Needy (or pending spend-down) will not be included in the household unit of a pregnant woman or child.

6. A spouse shall not be included in the household unit of an aged, blind, or disabled individual if the spouse is himself or herself in the household unit of an eligible pregnant woman or infant under the provisions of this chapter, or is in the budget unit of an eligible AFDC-related Medically Needy case (including eligible pending spend-down). Note: Resources of a spouse of an aged, blind, or disabled individual will be deemed to that indi-

vidual in accordance with N.J.A.C. 10:72-4.5 even though the spouse is not in the household unit.

Emergency Amendment. R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a).

Substantially amended.

Adopted Concurrent Proposal. R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Amended by R.1995 d. 539, effective October 16, 1995.

See: 27 N.J.R. 2527(a), 27 N.J.R. 3956(a).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), substituted a reference to Work First New Jersey/TANF for a reference to AFDC in the first sentence of 4.

Adopted concurrent proposal. R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

10:72-3.6 Third party liability

Program applicants and beneficiaries are required to identify to the county welfare agency any third party (individual, entity, or program) that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or beneficiary.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

10:72-3.7 Persons sanctioned under AFDC rules

Persons who would be ineligible for AFDC using the rules in existence as of July 16, 1996 or due to the imposition of a sanction of ineligibility for a factor of AFDC eligibility that does not apply in Medicaid (such as noncooperation with work registration or WIN requirements) shall have eligibility determined under this chapter without regard to the sanction. (For persons ineligible for AFDC due to a period of ineligibility imposed as a result of the receipt of lump sum income, see N.J.A.C. 10:72-4.3(c)).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Substituted "would be ineligible for AFDC using the rules in existence as of July 16, 1996 or" for "are ineligible for AFDC" in the first sentence.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

10:72-3.8 Application for other benefits

(a) As a condition of eligibility for the Medicaid program, applicants and beneficiaries are required to take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, unless they can show good cause for not doing so. Applicants and beneficiaries must avail themselves of any health insurance coverage available to the household unit at no cost, such as coverage provided by an employer at no cost.

1. Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, Social Security benefits, and unemployment compensation. They do not include AFDC, Supplemental Security Income (SSI), or General Assistance.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Case Notes

Petitioner's income caused ineligibility for Medicaid benefits. L.H. v. DMAHS, 93 N.J.A.R.2d (DMA) 107.

10:72-3.9 Inmates of public institutions

(a) Any person who is an inmate of a public institution is ineligible for the Medicaid program.

(b) Any person who is incarcerated in a Federal, State, or local correction facility (prison, jail, detention center, reformatory, etc.) is not eligible for the Medicaid program.

10:72-3.10 Emergency services for aliens and limited prenatal care for aliens

(a) Any alien who is not an eligible alien as specified in N.J.A.C. 10:72-3.2(c) and (d), shall be ineligible for Medicaid benefits. Any such alien shall be, if a resident of New Jersey and if he or she meets all other Medicaid eligibility requirements, entitled to Medicaid coverage for the treatment of an emergency medical condition only.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- i. Placing the patient's health in serious jeopardy;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition shall include all labor and delivery for a pregnant woman. It does not include routine prenatal or post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(b) Limited prenatal care shall be provided by the Division to alien pregnant women who would be eligible for New Jersey Care ... Special Medicaid Programs or NJ FamilyCare services but for their immigration status. Services available through NJSPCP shall be limited to pregnancy-related services provided at a clinic or at a hospital, and shall include primary care, radiology, and clinical laboratory services or, in the case of radiology and clinical laboratory services, ordered by a clinic. In addition, pregnancy-related pharmaceuticals dispensed at a clinic or a hospital are covered. No other services shall be provided.

1. Services available through NJSPCP shall be limited to pregnancy-related services provided at a clinic or at a hospital, including primary care, radiology, and clinical laboratory services, or, in the case of radiology and clinical laboratory services, ordered by a clinic. In addition, pregnancy-related pharmaceuticals dispensed at a clinic or a hospital shall be covered. No other services shall be provided. Services eligible for reimbursement shall be directly related to the beneficiary's primary diagnosis. The eligible beneficiary's primary diagnosis shall be one or more of the pregnancy-related diagnostic codes 640 through 648.9 or V22 through V23.89, as found in the ICD-9-CM (International Classification of Diseases).

i. Labor and delivery services shall not be covered by the NJSPC program, but may be provided through the Medical Emergency Payment Program for Aliens, in accordance with the provisions of N.J.A.C. 10:49-5.4.

2. Eligible services, as described in (b)1 above, shall be reimbursed if the services were rendered to an eligible individual on or after July 1, 2001 and before the termination of the NJSPC program.

3. When the appropriated funds have been expended, the program will terminate.

Emergency New Rule, R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).

See: 31 N.J.R. 2252(a).

Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.

See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).

Readopted provisions of R.1999 d.245, with changes to (b) effective October 4, 1999.

Amended by R.2002 d.297, effective September 16, 2002.

See: 34 N.J.R. 1400(a), 34 N.J.R. 3269(a).

Rewrote (b).

Administrative correction.

See: 34 N.J.R. 3524(b).

(b) Effective with the first month of coverage, January 1, 1993, income limits for specified low-income Medicare beneficiaries shall be based on 110 percent of the poverty income guidelines as defined by the U.S. Department of Health and Human Services in accordance with Sections 1902(a)(10)(E)iii of the Social Security Act, 42 U.S.C. 1396a. Effective January 1, 1995, the income limits will be set at 120 percent of the Federal poverty level.

(c) Income limits for pregnant women and children under the age of one year covered under the provisions of this chapter shall be based on 185 percent of the poverty income guideline as defined by the Department of Health and Human Services in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub.L. 97-35). The monthly income standard will be one-twelfth of 185 percent of the annual poverty income guideline rounded down to the next whole dollar amount for each household size. The annual revision to the Federal poverty income guideline will be effective for the purposes of this section with the first day of the year for which the poverty guideline is promulgated.

(d) In order to be eligible for Medicaid benefits under the provisions of this chapter, monthly household income (as determined by this chapter) must be equal to or less than the income limit established in (a), (b) or (c) above as applicable.

1. If a pregnant woman is determined to be income eligible during any month prior to the end of her pregnancy, she, if otherwise eligible, will continue eligible without regard to changes in the household unit's income for the term of her pregnancy, including the 60-day period beginning with the last day of the pregnancy whether or not the pregnancy results in a live birth. If the income change results from the addition of a new household member, the new income is not considered through the 60-day period beginning with the last day of the pregnancy.

i. The child resulting from the pregnancy will be eligible for Medicaid without regard to changes in the household unit's income for a period of not less than 60 days and up to a period of one year, so long as the mother remains eligible for Medicaid, or would remain eligible if pregnant, and the child remains in the mother's custody.

ii. A pregnant woman who, during the course of the pregnancy, was receiving or would have been eligible to receive AFDC benefits using the eligibility rules in existence as of July 16, 1996. Medicaid Special, or Medicaid for the Unborn is deemed to have met the income requirements of this chapter.

2. With the exception in (d)1 above, income eligibility exists for each month in which the household unit's income is equal to or less than the income limits.

SUBCHAPTER 4. FINANCIAL ELIGIBILITY

10:72-4.1 Income eligibility limits

(a) Income limits for Medicaid for aged, blind, and disabled persons (except for specified low-income Medicare beneficiaries), covered under the provisions of this chapter will be based on 100 percent of the poverty income guidelines as defined by the U.S. Department of Health and Human Services in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub.L. 97-35). The monthly income standard will be $\frac{1}{2}$ of the annual poverty income guideline rounded down to the next whole dollar amount for household unit sizes of one and two for aged, blind, and disabled individuals. The annual revision to the Federal poverty income guideline will be effective for purposes of this section with the first day of the year for which the poverty income guideline is promulgated.

(e) Effective with the first month of coverage, earned income eligibility limits for participants in the NJ WorkAbility program shall be 250 percent or less of the Federal poverty level and unearned income 100 percent or less of the Federal poverty level (see 42 U.S.C. § 9902(2)), and as specified in N.J.A.C. 10:72-9.4.

Emergency Amendment, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a).

Added (b)iii.

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Emergency Amendment, R.1991 d.223, effective March 28, 1991 (operative April 1, 1991; expires May 27, 1991).

See: 23 N.J.R. 1200(a).

Adopted Federally required coverage pursuant to Omnibus Budget Reconciliation Act of 1989.

Adopted Concurrent Proposal, R.1991 d.302, effective May 24, 1991.

See: 23 N.J.R. 1200(a), 23 N.J.R. 1945(a).

Provisions of emergency amendment R.1991 d.223 readopted without change.

Emergency Amendment, R.1991 d.445, effective July 29, 1991 (expires September 27, 1991).

See: 23 N.J.R. 2543(a).

In (b): added "aged one through five years" regarding children covered; added new (c), recodifying existing (c) as new (d).

Adopted Concurrent Proposal, R.1991 d.526, effective October 21, 1991.

See: 23 N.J.R. 2453(a), 23 N.J.R. 3144(a).

Provisions of emergency amendment R.1991 d.445 adopted without change.

Administrative Correction to (b).

See: 24 N.J.R. 851(a).

Added "133 percent of" to text regarding the poverty income guideline.

Amended by R.1992 d.364, effective September 21, 1992.

See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Child's eligibility for Medicaid extended.

Amended by R.1992 d.484, effective December 7, 1992.

See: 24 N.J.R. 1860(a), 24 N.J.R. 4378(a).

Revised (a).

Amended by R.1993 d.369, effective July 19, 1993.

See: 25 N.J.R. 1042(b), 25 N.J.R. 3217(a).

Public Notice: Increase in eligibility limits.

See: 29 N.J.R. 3088(a).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), deleted "as well as children six years of age or older" following "beneficiaries," in the first sentence, and deleted "and for the appropriate family size for children aged six years or over" at the end of the second sentence; deleted former (c); recodified former (d) as (c); and recodified former (e) as (d), deleted a reference to (d) in the introductory paragraph, rewrote iii, and substituted a reference to (d)1 for a reference to (e)1 in 2.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Special amendment, R.2002 d.31, effective December 26, 2001 (to expire June 26, 2002).

See: 34 N.J.R. 600(a).

Added (e).

Amended by R.2002 d.317, effective September 16, 2002.

See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

Public Notice: Annual Federal Poverty Level Revisions.

See: 36 N.J.R. 2564(a).

Case Notes

Reasonable basis existed for use of income multiplier to determine eligibility under Medical Assistance and Health Service Act. P.P. v. New Jersey Dept. of Human Services, Div. of Medical Assistance and Health Services, 280 N.J.Super. 1, 654 A.2d 471 (A.D.1994), certification denied 142 N.J. 452, 663 A.2d 1359.

10:72-4.2 Prospective budgeting of income

(a) The county welfare agency shall establish the best estimate of income that will be available to the household unit.

1. The best estimate of income shall be based on an average of the household unit's income for the full two-month period preceding the date of application or redetermination. Adjustments shall be made to the estimated income to reflect changes in income that either have occurred or which are reasonably anticipated to occur which would affect the household unit's income during a period of eligibility.

10:72-4.3 Countable income: pregnant women and infants

(a) Except as specified below, countable income for pregnant women and infants under the provisions of this chapter shall include the income of all members of the household unit as determined at N.J.A.C. 10:72-3.5(a)1 and 2, and shall be determined in accordance with regulations applicable to income in the AFDC-C program in effect as of July 16, 1996 (see N.J.A.C. 10:82).

1. The maximum income limits as provided for at N.J.A.C. 10:82-1.2(d) do not apply.

2. Neither the \$30.00 nor the one-third disregard of earned income at N.J.A.C. 10:82-2.8(a)3 and 10:82-4.4(c) apply.

3. The deeming of stepparent income at N.J.A.C. 10:82-2.9(d) does not apply. (See N.J.A.C. 10:72-3.5(a)2 regarding the inclusion or exclusion of the stepparent in the household unit.)

4. The deeming of an alien sponsor's income at N.J.A.C. 10:82-3.13 does not apply.

(b) Nonrecurring lump sum income received by a household unit of a pregnant woman or infant shall be added to any other income received by the household unit in that month. The total shall be divided by the income eligibility limit applicable to the household. The result will be the number of months the eligible members of the household unit shall be ineligible to receive Medicaid under the provisions of this chapter. Any remaining income from this calculation is treated as if it were unearned income in the first month following the period of ineligibility. No period of ineligibility shall apply to a pregnant women eligible under the provisions of this chapter.

1. The period of ineligibility shall begin the first month subsequent to the month the nonrecurring income is received or, if there is insufficient time to provide timely adverse action notice, the following month.

2. Once established, the period of ineligibility may be reduced only in accordance with the AFDC provisions for shortening a period of ineligibility as found at N.J.A.C. 10:82-4.15(a)5. The basis for a determination to shorten the period of ineligibility shall be fully documented in the case record.

(c) Any person who received AFDC or Medicaid based on AFDC rules and became ineligible for such assistance because of a period of ineligibility imposed as a result of the provisions of N.J.A.C. 10:82-4.15 may establish eligibility under the provisions of this chapter. The amount of the lump sum used to determine the original period of ineligibility shall be divided by the applicable income eligibility limit to determine the period of ineligibility for Medicaid under this chapter. If that period has already expired, eligibility for benefits under this chapter may be established so long as all other eligibility criteria are met.

(d) The parents of an infant and the spouse of a pregnant woman are legally responsible relatives to pregnant women and infants applying for or eligible for benefits under the provisions of this chapter. When a legally responsible relative resides in the same household, his or her income is considered in the determination of eligibility and no further action is required. When a legally responsible relative does not reside in the same household, the county welfare agency shall pursue support from that relative in accordance with the provisions of N.J.A.C. 10:82-3.8 et seq.

1. Except when the legally responsible relative resides in the same household, income of the relative shall be counted only to the extent that the income is actually made available to the household unit.

(e) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

Amended by R.1987 d.380, effective August 27, 1987.
See: 19 N.J.R. 1324(a), 19 N.J.R. 1731(a).

(c): missing text inserted.

Emergency Amendment, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a)

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Emergency Amendment, R.1991 d.223, effective March 28, 1991 (operative April 1, 1991; expires May 27, 1991).

See: 23 N.J.R. 1200(a).

Adopted Federally required coverage pursuant to Omnibus Budget Reconciliation Act of 1989.

Adopted Concurrent Proposal, R.1991 d.302, effective May 24, 1991.

See: 23 N.J.R. 1200(a), 23 N.J.R. 1945(a).

Provisions of emergency amendment R.1991 d.223 readopted without change.

Amended by R.1992 d.364, effective September 21, 1992.

See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Stylistic change.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted "in effect as of July 16, 1996" following "program".

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (e).

10:72-4.4 Income eligibility; aged, blind, and disabled individuals

(a) Except as specified below, countable income for aged, blind, and disabled individuals shall be determined in accordance with rules applicable to income in Medicaid Only—Aged, Blind, and Disabled (see N.J.A.C. 10:71-5).

1. The disregard of cost-of-living increases in Social Security benefits provided for in N.J.A.C. 10:71-5.3(a)7x and xi do not apply.

2. The deeming of the income of an alien's sponsor as provided for at N.J.A.C. 10:71-5.7 does not apply.

(b) Nonrecurring lump sum income received by the household unit of an aged, blind, or disabled individual shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months, except as follows:

1. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes;

(c) An aged, blind, or disabled individual will have the value of in-kind support and maintenance counted as unearned income in the following circumstances.

1. An aged, blind, or disabled adult, who would in accordance with rules at N.J.A.C. 10:71-5.6(c) be determined to be "living in the household of another," shall be considered to have unearned income in the amount specified at N.J.A.C. 10:71-5.4(a)12 less \$20.00. The amount of income so assigned is not rebuttable by the applicant or beneficiary.

2. Any aged, blind, or disabled person other than those addressed in (c)1 above, to whom food, clothing, or shelter is given or paid for by someone other than a spouse, parent, or minor child residing in the same household, shall be presumed to receive in-kind support and maintenance. The presumed value of the support and maintenance will be the values specified at N.J.A.C. 10:71-5.4(a)12. The presumed value so assigned may be rebutted in accordance with the provisions of that subsection.

(d) In accordance with the rules at N.J.A.C. 10:71-5.5, the income of the spouse of an aged, blind, or disabled individual shall be deemed to the aged, blind, or disabled individual if they are residing in the same household. Income of the parent(s) of a blind or disabled child under the age of 18 residing in the same household shall be deemed available to the child in determining income eligibility for benefits under this chapter. No income shall be deemed to an aged, blind, or disabled individual from a person who is a member of a household unit of an eligible pregnant woman or child under the provisions of this chapter or who is in the budget

unit of eligible AFDC-related Medically Needy cases (including a case that is eligible pending spend-down.)

1. If the countable income (before income deeming) of the aged, blind, or disabled individual exceeds the poverty income guideline for one person he or she is ineligible for benefits and income deeming does not apply.

2. When income of a spouse is deemed to an aged, blind, or disabled individual, the total countable income after deeming is compared to the poverty income guideline for two persons.

3. In determining income eligibility of a child, the child's income after deeming is compared to the poverty income guideline for one person.

4. When the income of a spouse must be deemed to both an aged, blind, or disabled individual and a blind or disabled child, the income is first deemed to the aged, blind, or disabled spouse. If the income (after deeming) of the aged, blind, or disabled spouse does not exceed the poverty income guideline, he or she is income eligible and there is no income to be deemed to the blind or disabled child. If the poverty income guideline is exceeded, the aged, blind, or disabled adult is income ineligible and the excess income is deemed to the blind or disabled child.

5. When parental income must be deemed to more than one blind or disabled child, the deemable income shall be divided equally among such children.

Emergency New Rule, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a).

This section was originally "resource eligibility" which was recodified to 4.5.

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

In (b), added ", except as follows:" at the end of the introductory paragraph and added i.

Case Notes

Reinstatement of severely disabled man's New Jersey Care benefits in spite of income in excess of maximum allowable amount was appropriate. *L.E. v. Camden County Board of Social Services*, 94 N.J.A.R.2d (DMA) 11.

Prospective-only application of regulation did not violate equal protection. *J.B. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 89.

10:72-4.5 Resource eligibility

(a) Pregnant women and infants seeking Medicaid benefits under the provisions of this chapter are eligible without regard to the value of the household unit's resources. The county welfare agency shall inquire about the household unit's resources only in order to establish income that may result from the household unit's resources.

(b) Aged, blind or disabled persons (including specified low-income Medicare beneficiaries) must meet resource eligibility criteria as specified below in order to be eligible for benefits under this chapter. Eligibility for benefits does not exist in any month in which the countable resources of an aged, blind, or disabled person exceeds the limits of \$4,000 for an individual and \$6,000 for a couple.

1. The resource provisions of the Medicaid Only Manual apply in the determination of countable resources for aged, blind, or disabled individuals except that, the provisions requiring the deeming of the resources of an alien's sponsor (N.J.A.C. 10:71-4.6(f)) do not apply in this chapter.

2. The spouse-to-spouse and parent-to-child deeming of resources found at N.J.A.C. 10:71-4.6 apply to eligibility under this chapter. In the deeming of resources from one parent to a child, the countable parental resources in excess of the Medicaid Only resource limit for an individual shall be deemed to the blind or disabled child. When the resources of two parents must be deemed to a child, the countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

3. For aged, blind, or disabled persons, the policy concerning transfer of resources within 30 months of the date of application (see N.J.A.C. 10:71-4.7), applies equally to eligibility under this chapter.

(c) Effective with the first month of coverage, resource eligibility limits for participants in the NJ WorkAbility program shall be as specified in N.J.A.C. 10:72-9.5.

(d) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

Emergency Amendment, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

See: 20 N.J.R. 548(a).

Recodified from 10:72-4.4 and substantially amended.

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Emergency Amendment, R.1991 d.223, effective March 28, 1991 (operative April 1, 1991; expires May 27, 1991).

See: 23 N.J.R. 1200(a).

Adopted Federally required coverage pursuant to Omnibus Budget Reconciliation Act of 1989.

Adopted Concurrent Proposal, R.1991 d.302, effective May 24, 1991.

See: 23 N.J.R. 1200(a), 23 N.J.R. 1945(a).

Provisions of emergency amendment R.1991 d.223 readopted without change.

Amended by R.1992 d.364, effective September 21, 1992.

See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Transfer of resources provision at (b)3 changed from 24 to 30 months.

Amended by R.1993 d.369, effective July 19, 1993.

See: 25 N.J.R. 1042(b), 25 N.J.R. 3217(a).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Special amendment, R.2002 d.31, effective December 26, 2001 (to expire June 26, 2002).

See: 34 N.J.R. 600(a).

Added (c).

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (d).

Amended by R.2002 d.317, effective September 16, 2002.

See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

(d) When the processing of an application will be delayed beyond the standards for disposition of an application as set forth in N.J.A.C. 10:72-2.1(d), notice shall be mailed prior to the expiration of the disposition period notifying the applicant of the delay and the reasons for it.

(e) The 10-day notice requirement for actions adverse to a program beneficiary need not be adhered to when:

1. The county welfare agency has factual information confirming the death of a beneficiary;
2. The county welfare agency receives a clear written statement, signed by the beneficiary, that he or she no longer wishes to receive program benefits, or which gives information indicating a change in circumstances which requires a termination or reduction in benefits, and the beneficiary has indicated in writing that he or she understands that this must be the consequence of supplying such information;
3. The beneficiary's whereabouts are unknown and agency mail directed to him or her has been returned by the postal service indicating no forwarding address;
4. The beneficiary has been accepted for public or medical assistance in another state and that fact has been confirmed by the county welfare agency; or
5. A beneficiary child has been removed from the home as a result of a judicial determination or voluntarily placed in foster care by his or her legal guardian.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

SUBCHAPTER 5. ADMINISTRATIVE REQUIREMENTS

10:72-5.1 Notice of the county welfare agency decision

(a) The county welfare agency shall promptly notify any applicant for, or beneficiary of, the Medicaid program in writing of any agency decision affecting the applicant or beneficiary. When a decision relates to any adverse action which may entitle a beneficiary to a fair hearing, the action may not be implemented until at least 10 days after the mailing of the notice (see (e) below for exceptions to the 10-day notice requirement).

1. For notices of action adverse to a beneficiary, the date of mailing of the notice must appear on the notice.
2. Notices of any county welfare agency action must contain the name, address, and telephone number of the legal services agency serving that county.
3. In the case of an applicant or beneficiary who cannot be located, the notice shall be mailed to his or her last known address.

(b) All notices of agency decision shall state in clear and simple language, the nature of the agency decision and an accurate and factual legal basis for the decision.

1. All notices of the agency decision shall include an explanation of the right to a fair hearing.
2. Notices of agency decisions adverse to the applicant or recipient shall include the citation and title of the regulations upon which the agency decision is based.

(c) All notices of denial or termination shall include an explicit statement of the reason for program ineligibility and (except in the case of the death of an applicant or beneficiary) advise of the right to reapply whenever the applicant or beneficiary believes that circumstances have changed such that the reason for program ineligibility no longer exist.

10:72-5.2 Fair hearings

(a) It is the right of every applicant for or beneficiary of the Medicaid program to be afforded the opportunity for a fair hearing in the manner set forth in N.J.A.C. 10:49-51 et seq., including, when applicable, continuation of program benefits pending the results of the fair hearing.

(b) Any request for a fair hearing shall be forwarded to the Division of Medical Assistance and Health Services, Office of the Legal and Regulatory Liaison, PO Box 712, Trenton, New Jersey 08625-0712.

Amended by R.1992 d.364, effective September 21, 1992.

See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Address changed.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

10:72-5.3 Case records

(a) The purpose of the case record is to provide a complete documentary record of county welfare agency actions and the reasons therefor.

(b) The case record shall include:

1. A record of all county welfare agency actions and decisions relating to the case, as well as documentary evidence relating to such actions and decisions, including application forms.
2. All forms relating to financial eligibility.
3. All case-related correspondence, memorandum, and documents except those required by law or regulation to be maintained elsewhere.

(c) No case record, or part thereof, shall be removed from its file location without a record identifying the person who has custody of it.

(d) No case record, or part thereof, shall be removed from the county welfare agency offices except upon the specific authorization of the agency director, deputy director, or other person specifically designated by the agency director to authorize such removal.

(e) All case records shall be filed in a secure and fire-resistant location.

(b) A qualified provider shall be:

1. A participating Medicaid provider;
2. Currently certified by the New Jersey Department of Health as a provider of HealthStart Comprehensive Maternity Care Services (see N.J.A.C. 10:49-3). A provider certified only for Medical Maternity Care Services, Health Support Services, or Pediatric Preventive Services shall not be a qualified provider for purposes of this subchapter;
3. A provider of the following services:
 - i. Outpatient hospital services; or
 - ii. Clinic services furnished by or under the direction of a physician, without regard to whether or not the clinic itself is administered by a physician; and
4. Trained and approved by the Division of Medical Assistance and Health Services for the purposes of making presumptive eligibility determinations.
 - i. The Division of Medical Assistance and Health Services will monitor the presumptive eligibility determinations made by qualified providers. In the event the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to procedural requirements, appropriate staff of the Division will initiate corrective action. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements will result in the Division revoking approval for that provider to make presumptive eligibility determinations.

SUBCHAPTER 6. PRESUMPTIVE ELIGIBILITY**10:72-6.1 Scope**

(a) The presumptive eligibility determination makes it possible for a pregnant woman to receive ambulatory prenatal care from a Medicaid participating provider for a temporary period prior to application for Medicaid benefits and while a Medicaid application is being processed by the county welfare agency. Presumptive eligibility continues until the county welfare agency reaches its formal eligibility determination as follows:

1. The period of presumptive eligibility begins on the date a qualified provider determines that, based on information provided by the pregnant woman, the woman meets the requirements and standards of this chapter applicable to pregnant women.
2. The period of presumptive eligibility will terminate:
 - i. If the woman has filed an application with the county welfare agency, on or before the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the date a determination of eligibility or ineligibility for Medicaid is made by the county welfare agency; or
 - ii. If the pregnant woman fails to file an application with the county welfare agency, on the last day of the month subsequent to the month in which she was determined presumptively eligible.

Amended by R.1989 d.498, effective September 18, 1989.

See: 21 N.J.R. 1791(a), 21 N.J.R. 2998(a).

Clarification of process for presumptive eligibility.

Amended by R.1992 d.10, effective January 6, 1992.

See: 23 N.J.R. 2827(a), 24 N.J.R. 100(a).

Added new text to (a) and (a)2i. and ii. regarding presumptive eligibility.

In (b)4.i.: technical revisions.

10:72-6.2 Responsibilities of a qualified provider

(a) From preliminary information provided by a woman whose pregnancy has been medically verified, the qualified provider shall determine if the pregnant woman meets the eligibility criteria of this chapter as it applies to pregnant women. The qualified provider must obtain sufficient information from the pregnant woman to complete the Certification of Presumptive Eligibility (FD-334) by having the pregnant woman complete, sign and date a referral for Medicaid benefits as designated and provided by the Division of Medical Assistance and Health Services. For purposes of the presumptive eligibility determination, the qualified provider shall request from the pregnant woman only that information necessary to determine her presumptive eligibility or ineligibility. The qualified provider shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the pregnant woman's statements.

ii. In the event the processing of the application is delayed beyond the presumptive eligibility period, the county welfare agency shall provide the applicant with written notification prior to its expiration setting forth the specific reasons for the delay.

3. In the case of a presumptively eligible pregnant woman who is determined ineligible for Medicaid within the presumptive eligibility period, the woman's eligibility shall terminate as of the day of the ineligibility determination.

New Rule, R.1992 d.10, effective January 6, 1992.

See: 23 N.J.R. 2827(a), 24 N.J.R. 100(a).

Existing 6.4 recodified to 6.5.

Amended by R.1992 d.364, effective September 21, 1992.

See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Stylistic change.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

10:72-6.5 Responsibility of the applicant

A presumptively eligible pregnant woman must contact the county welfare agency during the presumptive eligibility period so that a face-to-face interview can be scheduled. As part of the eligibility determination process for Medicaid, the pregnant woman must be interviewed by county welfare agency staff, complete any forms required as a part of the application process, and assist the county welfare agency in securing evidence that verifies her statements regarding eligibility.

Amended by R.1992 d.10, effective January 6, 1992.

See: 23 N.J.R. 2827(a), 24 N.J.R. 100(a).

Recodified from 6.4.

Added phrase regarding presumptive eligibility.

10:72-6.6 Notification and fair hearing rights

(a) For a presumptively eligible pregnant woman who is subsequently determined ineligible for Medicaid benefits:

1. The county welfare agency is not required to provide either timely or adequate notice for the end of the presumptive eligibility. The pregnant woman has no right to a fair hearing based on the termination of her presumptive eligibility.

2. The county welfare agency shall provide the applicant notice of denial of her Medicaid application in accordance with N.J.A.C. 10:72-5.1. The pregnant woman has the right to apply for a fair hearing based on the denial of her Medicaid application.

(b) For a presumptively eligible pregnant woman whose eligibility for Medicaid has not yet been determined within the presumptive eligibility period:

1. The county welfare agency is not required to provide either adequate or timely notice for the termination

of her period of presumptive eligibility. The pregnant woman has no right to a fair hearing based on the termination of presumptive eligibility.

2. In accordance with N.J.A.C. 10:72-2.1(d)3, the county welfare agency shall provide the pregnant woman with written notification prior to the expiration of the presumptive eligibility period, setting forth the specific reasons for the delay in the Medicaid application processing. The pregnant woman is entitled to a fair hearing based on the county welfare agency's failure to determine her Medicaid eligibility or ineligibility within the application processing period.

(c) A woman denied presumptive eligibility by a qualified provider is neither entitled to adequate notice of that determination nor entitled to a fair hearing on that action. The denial of presumptive eligibility shall not affect the woman's right to apply for Medicaid at the county welfare agency and to receive a formal determination of eligibility or ineligibility.

Amended by R.1992 d.10, effective January 6, 1991.

See: 23 N.J.R. 2827(a), 24 N.J.R. 100(a).

Recodified from 6.5.

In (a): revised "eligible" to "ineligible for Medicaid benefits . . .".

In subsection (b) and (b)2: revised text to "presumptive eligibility period" from "45-day period."

SUBCHAPTER 7. PRESUMPTIVE ELIGIBILITY FOR CHILDREN

Authority

Sections 1902(a)(47), 1903(u)(1)(D)(v) and 1920A of the Social Security Act (42 U.S.C. §§ 1396a(a)(47), 1396(a)(8), 1396(b)(u)(1)(D)(v) and 1396r-1a) and P.L. 1999 d.170.

Source and Effective Date

R.2000 d.266, effective July 3, 2000.

See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

10:72-7.1 Scope

This subchapter describes the presumptive eligibility process for children, up to the age of one year, who may meet the eligibility requirements for New Jersey Care . . . Special Medicaid Programs. The presumptive eligibility determination makes it possible for a child or the children in a family to receive fee-for-services care from a Medicaid participating provider for a temporary period prior to the application for New Jersey Care . . . Special Medicaid Programs benefits, and while an application for these benefits is being processed by the eligibility determination agency.

10:72-7.2 Period of presumptive eligibility

(a) The period of presumptive eligibility shall begin on the date an approved presumptive eligibility entity determines that, based on information provided by the family of

the presumptive eligibility beneficiary, the child(ren) meets the requirements and standards of this chapter.

(b) The period of presumptive eligibility shall terminate:

1. On the date a determination of eligibility or ineligibility for New Jersey Care . . . Special Medicaid Programs is made; or
2. If the child's parent, guardian, or caretaker relative fails to file an application with the applicable eligibility determination agency, on the last day of the month subsequent to the month in which the child(ren) was (were) determined presumptively eligible.

10:72-7.3 Presumptive eligibility determination entities

(a) A qualified presumptive eligibility entity shall be a New Jersey Medicaid provider and:

1. An acute care hospital;
2. A local health department; or
3. A Federally Qualified Health Center (FQHC).

(b) An eligible entity shall apply to the Division of Medical Assistance and Health Services and shall be approved as a presumptive eligibility determination agency upon training of the entity by the Division of Medical Assistance and Health Services.

(c) The Division of Medical Assistance and Health Services shall monitor the presumptive eligibility determinations made by approved presumptive eligibility determination entities. If the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to requirements, the Division shall initiate corrective action, including, but not limited to, consultation and training. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements shall result in the Division revoking approval for that entity to make presumptive eligibility determinations.

10:72-7.4 Policies governing the presumptive eligibility processing performed by the presumptive eligibility determination entity

(a) From preliminary information provided by a parent, guardian, or caretaker relative, the approved presumptive eligibility entity shall determine if the child meets the eligibility criteria of this subchapter as it applies to children. The approving presumptive eligibility entity shall obtain sufficient information from the parent, guardian, or caretaker relative to complete the certificate of presumptive eligibility. For purposes of the presumptive eligibility determination, the approved presumptive eligibility determination entity shall request from the parent, guardian, or caretaker relative only that information necessary to determine the child's presumptive eligibility or ineligibility. The approved presumptive eligibility determination entity shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the presumptive eligibility beneficiary's statements.

(b) For any child determined presumptively eligible, the approved presumptive eligibility determination entity shall:

1. Complete and sign the certificate of presumptive eligibility and forward the original of the certificate of presumptive eligibility to the Division of Medical Assistance and Health Services within two working days of the date the presumptive eligibility determination was made;
2. Forward a copy of the completed certificate and the referral, if appropriate, to the eligibility determination agency of the applicant's choice;
3. Inform the parent, guardian, or caretaker relative that they must contact the eligibility determination either by mailing an application to the Statewide eligibility determination agency or by arranging for a face-to-face interview with the county board of social services in order to complete the application process;
4. Give the parent, guardian, or caretaker relative of the presumptively eligible child a copy of both the certificate and the referral, if completed; and
5. Advise the parent, guardian, or caretaker relative of the presumptively eligible child, in writing, of the address and telephone number of the eligibility determination agency that the parent, guardian, caretaker relative or sponsoring adult chose.

(c) For any child for whom the approved presumptive eligibility determination entity is unable to determine presumptive eligibility, or who is ineligible under the criteria and standards of this subchapter or any other Division rules applicable to children, the approved presumptive eligibility determination entity shall refer the child to the appropriate eligibility determination agency for evaluation of potential eligibility for any other Medicaid or NJ KidCare programs. The address and telephone number of the appropriate eligibility determination agency shall be provided, in writing, to the parent, guardian, or caretaker relative of the child.

10:72-7.5 Presumptive eligibility process performed by the Division of Medical Assistance and Health Services

(a) Upon receipt of a properly completed certificate from the approved presumptive eligibility determination entity, Division staff shall:

1. Assign a presumptive eligibility number;
2. Create an eligibility record;
3. Issue a Medicaid eligibility identification card; and
4. Notify the approved presumptive eligibility determination agency and the appropriate county board of social services of the presumptive eligibility identification number assigned to the beneficiary.

10:72-7.6 Presumptive eligibility processing performed by the eligibility determination agency

(a) Upon receipt of the certificate of presumptive eligibility and a referral, if completed, from the approved presumptive eligibility determination entity, the eligibility determination agency shall check the Medicaid, Medically Needy, and NJ KidCare Eligibility database for existing Medicaid or NJ KidCare eligibility. If the child is receiving Medicaid benefits, Medically Needy benefits, or NJ KidCare benefits, no further action shall be required by eligibility determination agency.

(b) If the child is not currently receiving Medicaid or NJ KidCare benefits, the eligibility determination entities shall, notwithstanding the application disposition standards in N.J.A.C. 10:72-2.1(d), arrive at a case disposition within the presumptive eligibility period.

1. If the time period specified in N.J.A.C. 10:72-7.2(b)2 is exceeded, the eligibility determination agency shall notify the Division of Medical Assistance and Health Services of any such delay. The Division shall continue the child's presumptive eligibility until a final determination is made.

2. The eligibility determination agency shall also provide the applicant written notification of the specific reason(s) for the delay, prior to the expiration of the presumptive eligibility period in accordance with N.J.A.C. 10:72-7.8(b).

(c) In the case of a presumptively eligible beneficiary who is determined ineligible for New Jersey Care ... Special Medicaid Programs within the presumptive eligibility period, the child's eligibility shall terminate on the date of the eligibility determination. If the child is determined ineligible for any other Medicaid program, Medically Needy, or NJ KidCare, the eligibility determination agency shall provide a written notice of such denial and the reasons why, as set forth in N.J.A.C. 10:72-7.8.

10:72-7.7 Responsibility of the applicant

The parent, guardian, or caretaker relative of a presumptively eligible child shall contact the eligibility determination agency during the presumptive eligibility period by mailing an application to either the Statewide eligibility determination agency or arranging for a face-to-face interview with the county board of social services to complete the application process. As part of the eligibility determination process for Medicaid, the parent, guardian, or caretaker relative of a presumptively eligible child shall assist the eligibility determination agency in securing evidence that verifies eligibility.

10:72-7.8 Notification and fair hearing rights

(a) For a presumptively eligible child who is subsequently determined ineligible for Medicaid or NJ KidCare benefits:

1. The eligibility determination agency shall not be required to provide either timely or adequate notice for the end of the presumptive eligibility period. The pre-

sumptively eligible beneficiary shall not have any right to a fair hearing based on the termination of presumptive eligibility; and

2. The eligibility determination agency shall provide the child's parent, guardian or caretaker relative a notice of denial of the child's Medicaid application in accordance with N.J.A.C. 10:72-5.1. The presumptively eligible beneficiary shall have the right to apply for a fair hearing in accordance with N.J.A.C. 10:72-5.1 based on the denial of the application.

(b) For a presumptively eligible child whose eligibility for Medicaid or NJ KidCare has not yet been determined within the presumptive eligibility period, in accordance with N.J.A.C. 10:72-2.1(d)3, the eligibility determination agency shall provide the parent, guardian, or caretaker relative of the presumptively eligible child with written notification prior to the expiration of the presumptive eligibility period, setting forth the specific reasons for the delay in the application processing. The presumptively eligible beneficiary shall be entitled to a fair hearing based on the eligibility determination agency's failure to determine the child's Medicaid eligibility or ineligibility within the application processing period.

(c) A child denied presumptive eligibility by an approved presumptive eligibility determination entity shall not be entitled to adequate notice of that determination and shall not be entitled to a fair hearing on that action. The denial of presumptive eligibility shall not affect the parent's, guardian's or caretaker relative's right to apply for Medicaid or NJ KidCare on behalf of the child and to receive a formal determination of eligibility or ineligibility.

10:72-7.9 Scope of services during the presumptive eligibility period

All presumptively eligible New Jersey Care ... Special Medicaid Programs children under the age of one year shall be eligible during the presumptive eligibility period to receive on a fee-for-service basis all the Medicaid services defined at N.J.A.C. 10:49-5.2.

10:72-7.10 Limitation on number of presumptive eligibility periods

All beneficiaries of presumptive eligibility for children who make an application for presumptive eligibility benefits for any Medicaid or NJ KidCare program shall be limited to one continuous presumptive eligibility period during the year, which shall be counted from the first day the applicant initially received presumptive eligibility.

**SUBCHAPTER 8. BREAST AND CERVICAL
CANCER PREVENTION AND TREATMENT
ACT SERVICES**

Authority
N.J.S.A. 30:4D-6, 7 and 12; P.L. 1997, c.272,
as amended by P.L. 2001, c.186.

Source and Effective Date

R.2002 d.138, effective April 15, 2002.
See: 33 N.J.R. 4390(a), 34 N.J.R. 1716(a).

Subchapter Historical Note

Subchapter 8, Breast and Cervical Cancer Prevention and Treatment Act Services, was adopted as special new rules by R.2001 d.465, effective November 14, 2001 (to expire May 13, 2002). See: 33 N.J.R. 4390(a).

The provisions of R.2001, d.465 were reapopted as R.2002 d.138, effective April 15, 2002. See: Source and effective date.

10:72-8.1 Purpose and scope

The purpose of this subchapter is to provide the coverage stipulated in P.L. 2001, c.186, effective July 27, 2001, for women who are New Jersey residents who are under the age of 65 and who have been screened for breast and cervical cancer in accordance with the Breast and Cervical Cancer Prevention and Treatment Act, 42 U.S.C. § 1396a(aa), and who would not otherwise be eligible for the Medicaid program.

10:72-8.2 Definitions

The words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Creditable coverage” means, with respect to an individual, in accordance with Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, coverage of that individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than benefits solely under section 1928 of the Act;
5. Title 10, Chapter 55 of the United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5, chapter 89 of the United States Code;
9. A public health plan;
10. A health benefit plan under 22 U.S.C. § 2504(e);
or
11. Coverage of excepted benefits as defined in 29 U.S.C. § 1186(c).

10:72-8.3 Breast and cervical cancer-related prevention and treatment program eligibility

(a) An eligible individual shall:

1. Be a citizen or eligible qualified alien as defined in N.J.A.C. 10:72-3.2;
2. Be under 65 years of age;
3. Have been screened for breast or cervical cancer under the Federal Centers for Disease Control (CDC) Breast and Cervical Cancer Early Detection program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);
4. Not have creditable coverage; and
5. Meet all other Medicaid non-financial eligibility requirements as defined in N.J.A.C. 10:49-2, unless otherwise specified in this subchapter.

10:72-8.4 Presumptive eligibility process

In accordance with Pub.L. 106-354 and 42 U.S.C. § 1396a(aa), an individual referred to the Division by a CDC funded screening center shall be determined to be presumptively eligible for medical assistance in accordance with N.J.A.C. 10:72-7.5.

10:72-8.5 Service restrictions

In the case of an individual qualified for services in accordance with this subchapter, the only medical assistance provided shall be payment for services provided during the period in which the individual requires treatment for breast or cervical cancer.

10:72-8.6 Redetermination of eligibility

(a) A redetermination of medical eligibility shall be made every six months, and shall be based upon the need for continuing treatment for breast or cervical cancer, as determined by the individual's treating physician. Continuing treatment shall not include routine monitoring services. The treating physician shall complete a form provided for the purpose of certifying the continuing need for treatment and shall send the form to the county board of social services in the beneficiary's county of residence.

(b) The individual beneficiary shall provide, or shall assist in providing, information as requested by the county board of social services in order to determine continuing medical eligibility. Medical eligibility will be evaluated every six months.

(c) The county board of social services will assess non-financial eligibility factors every 12 months.

SUBCHAPTER 9. NJ WORKABILITY

Authority

N.J.S.A. 30:4D-1 et seq., as amended by P.L. 2000, c.116.

Source and Effective Date

R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 3270(a).

Subchapter Historical Notes

Subchapter 9, Ticket to Work, was adopted as special new rules by R.2002 d.31, effective December 26, 2001 (to expire June 26, 2002). See: 34 N.J.R. 600(a).

Subchapter 9, Ticket to Work, expired on June 26, 2002.

Subchapter 9, NJ WorkAbility, was adopted as new rules by R.2002 d.317, effective September 16, 2002. See: Source and Effective Date. See, also, section annotations

10:72-9.1 Purpose, scope and applicability

(a) The purpose of this subchapter is to establish requirements to implement the NJ WorkAbility program in accordance with N.J.S.A. 30:4D-1 et seq., as amended by P.L. 2000, c.116, and in accordance with the Federal Ticket to Work and Work Incentives Improvement Act, Public Law 106-170 (113 Stat. 1860), and 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV). The purpose of the NJ WorkAbility program is to provide an opportunity for disabled individuals who are employed to purchase Medicaid coverage when their earnings would otherwise disqualify them for Medicaid.

(b) The rules apply to employed permanently disabled individuals residing in New Jersey who are between the ages of 16 and 64 whose earned incomes are below 250 percent, and unearned incomes below 100 percent, of the Federal poverty level for an individual or a couple. These individuals may apply to purchase Medicaid coverage (Medicaid buy-in) from the State of New Jersey, and shall pay for such coverage based on the standards contained in this subchapter.

(c) Unless specifically excepted, all other requirements of this chapter shall apply to the NJ WorkAbility program.

Amended by R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

10:72-9.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Applicant” means any person who has made application for purposes of becoming a “qualified applicant.”

“Commissioner” means the Commissioner of the Department of Human Services.

“Department” means the Department of Human Services.

“Director” means the Director of the Division of Medical Assistance and Health Services.

“Division” means the Division of Medical Assistance and Health Services.

“Medicaid” means the New Jersey Medical Assistance and Health Services program.

“Medical assistance” means payments made on behalf of beneficiaries to providers for medical care and services.

“Net income” means both earned and unearned income after disregards are taken in accordance with this subchapter.

“Provider” means any person, public or private institution, agency or business concern approved by the Division in accordance with N.J.A.C. 10:49, lawfully providing medical care, services, goods and supplies which are specified in this subchapter and holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

“Qualified applicant” means a person who is a resident of this State who meets the requirements contained in this subchapter.

10:72-9.3 Non-financial eligibility for NJ WorkAbility

(a) Permanently disabled employed individuals who are 16 years of age or over, but under 65 years of age, shall be eligible to participate in the NJ WorkAbility program.

(b) Either the Social Security Administration or the Division’s Disability Review Team may make the determination of permanent disability.

(c) The test of disability shall be identical to the SSI/SSDI disability test, except that employment activity, earnings and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.

Amended by R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

10:72-9.4 Income eligibility for NJ WorkAbility

(a) The earned income of a qualified applicant, after disregards, shall not exceed 250 percent of the Federal poverty level for a family unit of one or two, as applicable.

(b) The unearned income of a qualified applicant, after disregards, shall not exceed 100 percent of the Federal poverty level for a family unit of one or two, as applicable.

(c) Countable income for NJ WorkAbility individuals shall be determined in accordance with the income rules found at N.J.A.C. 10:71-5. All rules at N.J.A.C. 10:71-5 shall apply, with the following exceptions:

1. The disregard of cost-of-living increases in Social Security benefits provided for in N.J.A.C. 10:71-5.3(a)7x and xi shall not apply.

2. The deeming of the income of an alien's sponsor as provided for at N.J.A.C. 10:71-5.7 shall not apply.

3. Wages paid by the U.S. Census Bureau for temporary employment related to Census 2000 activities shall not be counted as income.

4. Social Security Disability benefits and Railroad Disability benefits received by the individual on his or her own account shall not be counted as income.

5. Nonrecurring lump sum income received by the household unit of a disabled individual shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months.

(d) A disabled individual shall have the value of in-kind support and maintenance counted as unearned income in the following circumstances:

1. A disabled adult, who would, in accordance with rules at N.J.A.C. 10:71-5.6(c)4, be determined to be "living in the household of another," shall be considered to have unearned income in the amount specified at N.J.A.C. 10:71-5.4(a)12, less \$20.00. The amount of income so assigned shall not be rebuttable by the applicant or beneficiary.

2. Any disabled person other than those addressed in (d)1 above, to whom food, clothing, or shelter is given or paid for by someone other than a spouse, parent, or minor child residing in the same household, shall be presumed to receive in-kind support and maintenance. The presumed value of the support and maintenance shall be the values specified at N.J.A.C. 10:71-5.4(a)12. The presumed value so assigned may be rebutted in accordance with the provisions of N.J.A.C. 10:71-5.4(a)12i.

(e) In accordance with N.J.A.C. 10:71-5.5, the income of the spouse of a disabled individual shall be deemed to the disabled individual if they are residing in the same household. Income of the parent(s) of a disabled child under the age of 18 residing in the same household shall be deemed available to the child in determining income eligibility for benefits under this chapter. No income shall be deemed to a disabled individual from a person who is a member of a household unit of an eligible pregnant woman or child under the provisions of this chapter or a person who is in the budget unit of an eligible AFDC-related Medically Needy case (including a case that is eligible pending spend-down).

1. If the countable income (before income deeming) of the disabled individual exceeds the Federal poverty level for one person, he or she shall be ineligible for benefits and income deeming shall not apply.

2. When income of a spouse is deemed to a disabled individual, the total countable income after deeming shall be compared to the Federal poverty level for two persons.

3. In determining income eligibility of a child, the child's income after deeming shall be compared to the Federal poverty level for one person.

4. When the income of a spouse shall be deemed to both a disabled individual and a blind or disabled child, the income shall be first deemed to the disabled spouse. If the income (after deeming) of the disabled spouse does not exceed the Federal poverty level, he or she shall be income-eligible and there shall be no income to be deemed to the blind or disabled child. If the Federal poverty level is exceeded, the disabled adult shall be income ineligible and the excess income shall be deemed to the blind or disabled child.

5. When parental income shall be deemed to more than one blind or disabled child, the deemable income shall be divided equally among such children.

Amended by R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

10:72-9.5 Resource eligibility for NJ WorkAbility

(a) Qualified applicants for NJ WorkAbility shall meet resources eligibility standards as defined in N.J.A.C. 10:71-4 in order to be eligible for benefits under this chapter.

(b) In the determination of countable resources, N.J.A.C. 10:71-4.2 shall apply.

(c) Eligibility shall not exist in any month in which the countable resources of a NJ WorkAbility person exceeds the limits of \$20,000 for an individual and \$30,000 for a couple.

(d) The spouse-to-spouse and parent-to-child deeming of resources found at N.J.A.C. 10:71-4.6 shall apply to eligibility for NJ WorkAbility. In the deeming of resources from one parent to a child, the countable parental resources in excess of the Medicaid Only resource limit for an individual shall be deemed to the blind or disabled child. When the resources of two parents shall be deemed to a child, the countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

(e) In addition to those resources excluded under N.J.A.C. 10:71-4.4, funds in an IRA, 401K or other retirement accounts shall also be excluded.

(f) The provisions at N.J.A.C. 10:71-4.6(f) requiring the deeming of resources of an alien's sponsor shall not apply.

Amended by R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

10:72-9.6 Premium payments

(a) An eligible individual with net income in excess of 150 percent of the Federal poverty level shall pay a premium of \$25.00 per month to the Division.

(b) An eligible couple with net income in excess of 150 percent of the Federal poverty level shall pay a premium of \$50.00 per month to the Division.

(c) Premium payments required shall be submitted each month to:

Division of Medical Assistance and Health Services
NJ WorkAbility—Premiums
PO Box 712, Mail Code #27
Trenton, New Jersey 08625-0712

(d) Participants shall be billed in advance of the coverage month. Failure to submit the full contribution shall result in termination of coverage for the month following the coverage month where the premium has not been received by the NJ WorkAbility program.

Amended by R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

10:72-9.7 Services available through the NJ WorkAbility program

Services available through the NJ WorkAbility program shall be provided by the Division through its existing contracts with health maintenance organizations and fee-for-service providers.

Amended by R.2002 d.317, effective September 16, 2002.
See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

10:72-9.8 Application process

(a) Applications shall be obtained from, and returned to, the county board of social services in the applicant's county of residence.

(b) Information can be obtained from the Division of Disability Services by calling toll free 1-888-285-3036 or at the address below.

Division on Disability Services
DHS—Capital Place I
PO Box 700, 1st Floor
Trenton, NJ 08625-0700