

i. Allowances: The allowance for funeral services, exclusive of cemetery costs, is the actual amount charged or \$1,970.00 whichever is less. When ground burial is made of uncremated remains, the cemetery allowance also applies. The cemetery allowance is the sum of all cemetery charges or \$460.00, whichever is less. The maximum total of allowances for a decedent is the sum of the funeral allowance and the cemetery allowance as applicable.

ii. Payment: The payment to be made is the maximum total of allowances as reduced by all of the assets of the decedent, including cash on hand, funds in the hands of others, the value of real and personal property, and public and private death benefits; and as further reduced by the sum of all contributions from next of kin and other interested parties.

(b) Cases ineligible for purposes of State aid: It is recognized that municipal directors, who are also exercising the functions previously charged to the overseer of the poor, encounter situations where burials must be provided at public expenses for persons who do not come within the classifications specified in (a)1 above. Such burials are governed by statutes unrelated to the General Assistance Program. Payments for them are not eligible for State aid. The statutes include:

1. N.J.S.A. 44:1-157, which states: "When a person shall die in a municipality without leaving money or other means sufficient to defray his funeral expenses, the overseer of the poor of the municipality . . . shall employ some person to provide for and superintend the burial of the deceased person, and the necessary and reasonable expenses as fixed by the governing body chargeable therewith shall be paid by it upon the order of the overseer . . ."

2. N.J.S.A. 40A:9-49.1, which states: "Notwithstanding any provision of law, rule or regulation to the contrary, when an indigent person dies without a surviving spouse, parent or emancipated child and in a municipality other than his resident municipality, the resident county of the indigent decedent is responsible for the necessary and reasonable expenses for the burial. For the purposes of this act, "indigent decedent" means a person who dies without leaving an ascertainable estate sufficient to pay part or all of the person's burial expenses and whose burial expenses are not payable by the State pursuant to P.L. 1959, c.86 (N.J.S.A. 44:10-1 et seq.), P.L. 1947, c.156 (N.J.S.A. 44:8-107 et seq.) or P.L. 1973, c.256 (N.J.S.A. 44:7-85 et seq.), or by the county pursuant to N.J.S.A. 40A:9-49."

As amended, R.1980 d.436, effective October 7, 1980.

See: 12 N.J.R. 191(b), 12 N.J.R. 663(c).

(a)1i was \$500 and (a)1iii was \$350.

As amended, R.1982 d.287, effective September 7, 1982.

See: 14 N.J.R. 463(a), 14 N.J.R. 980(c).

(a)1i Ceiling of total cost increased to \$900.00, \$800.00 deleted.

Amended by R.1986 d.427, effective October 20, 1986.

See: 18 N.J.R. 1170(a), 18 N.J.R. 2125(a).

Substantially amended.

Amended by R.1988 d.39, effective January 19, 1988.

See: 19 N.J.R. 1619(b), 20 N.J.R. 194(a).

(b)1 deleted and new (b)1-2 inserted.

Petition for Rulemaking.

See: 26 N.J.R. 4104(b).

10:85-4.9 (Reserved)

R.1987 d.132, effective March 16, 1987.

See: 18 N.J.R. 2301(a), 19 N.J.R. 451(b).

Repealed by R.1990 d.33, effective January 16, 1990.

See: 21 N.J.R. 3221(b), 22 N.J.R. 218(a).

SUBCHAPTER 5. MEDICAL CARE

10:85-5.1 Medical service payment

(a) The director of welfare shall authorize payment for medical care and professional practitioner services if such care and services are deemed necessary and appropriate and, for services rendered after July 1, 1988, if the bill for each such service reaches the municipal welfare office within one year after the date of the service. For services rendered after July 1, 1991, the bill for each such service must reach the municipal welfare office within six months after the date of the service. The MWD may seek the advice of the Division of Family Development (DFD) GAP Unit in determining whether particular elements or programs of care or service are necessary and appropriate.

1. In no instance will the rate exceed that payable under the Medicaid Program. Only services covered by the Medicaid Program shall be authorized under this program for payment.

i. Payment of medical bills which is or may be paid from any benefits provided through the Medical Assistance Program (Medicaid) of the State of New Jersey or any other state shall not be authorized.

2. Medical bills, which have been paid by the client or on his or her behalf, are not subject to reimbursement by the MWD.

3. In the event that payment is obtained from a third party by or for any client for whom the MWD has made medical payments, the welfare agency shall seek recovery of such payment from the beneficiary.

4. The director of welfare may authorize payment of other medical insurance premiums.

5. Persons eligible for Medicare benefits must have health services billed to the appropriate carrier (Pennsylvania Blue Cross/Blue Shield) by the provider before submitting bills to the MWD for consideration. The amount of the Medicare deductible may be paid by the MWD.

6. Payment for medical bills which are or may be paid through no-fault insurance benefits shall not be authorized.

(b) Physicians, dentists and other health care providers: The director of welfare shall authorize payment for services provided by licensed physicians (M.D. or D.O.), dentists and other health care providers including podiatrists, optometrists, pharmacists, opticians, prosthetists and orthotists who have not been deleted for cause from the current list of approved Medicaid providers, unless such services are specifically prohibited under (b)2 below. The DFD/GAP Unit will advise all MWDs of deletions from the approved list and of any reinstatements.

1. Amount of payment: The amount of the payment which the MWD shall authorize for any medical product or service shall be the lowest amount for which the service or product or a comparable service or product can be reasonably supplied to the recipient but in no event shall total payment for each service or product be more than the rate indicated as a maximum by the DFD/GAP Unit.

i. Municipalities to which N.J.A.C. 10:85-5.8 applies will be charged for prescriptions at the Medicaid rate for the product. (See N.J.A.C. 10:85-5.8(e) and 6.8(d).)

2. Payments not authorized: Payment to physicians, dentists or other health care providers shall not be authorized for the following services:

i. Inpatient hospital care: Payment shall not be authorized for professional services (for example, physicians, dentists, podiatrists) rendered to persons receiving inpatient hospital care.

ii. Outpatient or clinic care: Payment shall not be authorized for professional services rendered in the outpatient department of a hospital.

iii. Institutional care: Payment shall not be authorized for professional services rendered to residents of public medical institutions.

iv. Municipal/county physician care: Payment shall not be authorized for services rendered by practitioners who are employed by a municipality or county for the purpose of treating recipients of general assistance or other low-income inhabitants of the community.

v. Private duty nursing: Payment shall not be authorized for private duty nursing, whether in the home, hospital or elsewhere.

vi. Pedicure service: Payment shall not be authorized for normal pedicure service.

3. Obtaining a physician and so forth: When an appropriate clinic is not available without charge, the patient shall be provided the opportunity to select a physician, dentist or podiatrist of his/her choice. In the event that a person has no such practitioner or his/her personal practitioner is not available, the director of welfare may assist in obtaining a physician, dentist or podiatrist. The MWD may consult the DMAHS District Office to learn the names of practitioners participating in the Medicaid Program. (The practitioner shall be advised that payment cannot exceed the current Medicaid rate.)

4. Consultation by a specialist: Payment shall be authorized for services provided by a medical specialist whose advice and recommendations are requested by another physician or by the municipal welfare department with respect to the non-hospital evaluation and/or treatment of a patient. (See (b)1 above regarding maximum fee.)

i. Prior authorization: Payment for consultation services shall be approved only when performed by a qualified specialist who has received prior authorization from the municipal director of welfare to perform such services.

(c) Independent clinics: The director of welfare shall authorize payment for physician services and other professional provider services, X-ray (diagnostic therapeutic, and so forth) and laboratory services, at the Medicaid rate or at a lesser rate if such has been negotiated between the clinic and the MWD.

(d) Mental health services: For all mental health services, the payment shall be deemed to cover all services of the provider. It does not cover prescription costs. If the MWD has negotiated a rate with the mental health agency or provider which is no higher than the rate which would otherwise be payable and which takes into account any funding by the municipality or county, that rate shall be used for all participants receiving services from that provider. In all other instances, payment to other providers shall be at the Medicaid rate.

1. Partial Care Program (see N.J.A.C. 10:37-5.46 through 5.51): Partial Care is a program serving people who need more than hourly outpatient services and less than inpatient hospitalization. Some clients are served to avoid inpatient hospitalization; for others the program serves as a transition from institutional to community living. Clients usually receive services five days per week. This level of service is reduced as the client becomes more independent. Minimum attendance is one-half day per week. Services offered usually include case management, medication supervision, group therapy, activities of daily living (ADL), socialization, skill development, and prevocational activities. Program participants are divided into two Target Groups:

i. Target Group I (see N.J.A.C. 10:37-5.2) consists of:

(1) Individuals currently in a State/County/Local psychiatric hospital who could live in the community with appropriate services.

(2) Individuals in the community with a history of psychiatric hospitalization, who are in serious risk of rehospitalization.

(2) Individuals in the community who are mentally, emotionally, and functionally impaired and in serious risk of psychiatric hospitalization.

ii. Target Group II (see N.J.A.C. 10:37-5.2) consists of individuals in the community who are mentally, emotionally, and functionally impaired and are not in serious risk of psychiatric hospitalization.

iii. Referral procedures: Proper referral is the responsibility of the mental health agency which seeks payment. It is in two parts:

(1) The agency will, within five working days of the acceptance of an individual for partial care, so notify the MWD in writing. Form PA-14, Referral for Services, or any substantially similar document may be used for this purpose.

(2) The agency will, within 30 calendar days of the acceptance of an individual for Partial Care, submit Medicaid Form FD-07 to the MWD. The Target Group classification shall appear on the form. The MWD will record receipt of the form and send it promptly to the DFD/GAP Unit for approval.

iv. Service periods are as follows:

(1) The MWD will not authorize payment for any services rendered more than five days prior to notice (see (d)1iii(a) above) nor more than 30 days prior to submittal of Form FD-07 (see (d)1iii(2) above).

(2) For Target Group I clients the expected term of service is two years from the date of acceptance into this program. For Target Group II clients the expected term of service is one year from the date of acceptance into the program. The MWD will authorize no payments beyond these periods without the specific written authorization of the DFD/GAP Unit.

2. Payment for other mental health services is as follows:

i. Mental health clinics: Payment shall be authorized as described in (d) above for an initial period of 30 days or until receipt by the MWD of a completed Medicaid Form FD-07, whichever occurs first. The MWD will record receipt of the form and forward it promptly to the DFD/GAP Unit. The DFD/GAP Unit will return the form indicating any further services which are approved. For services beyond the initial period, payment shall be authorized only for services approved by the DFD/GAP Unit.

ii. Private practitioners: If no local clinic offers services which are necessary, the MWD shall authorize payment to a private psychologist or psychiatrist in accordance with the provisions and limitations specified in (d)2i above.

(1) Payments are not to be authorized for services provided by psychiatric social workers, unlicensed psychologists, or psychiatric assistants in private practice.

(e) Visiting nurse or home health agency services: The municipal director of welfare shall authorize payment for services rendered by a Visiting Nurses Association or Home Health Agency provided that the client is not entitled to such services without cost.

1. Maximum fee: Payment shall not exceed the applicable Medicaid rate.

(f) Care of individuals in long term care facilities: The director of welfare shall authorize payments for patient care and allow for a personal needs allowance (PNA) for those clients who were residing in a non-Medicaid nursing facility on or prior to June 30, 1995 when a physician certifies that the client has a defect, disease, or impairment (other than psychosis) which necessitates such care, the client is not eligible for Medicaid, or for nursing facility services under the Medically Needy Program, and there is no person available who will provide such care without cost to the client. Those GA recipients shall continue to receive GA nursing facility benefits until such time as the GA nursing facility benefits are no longer required or when the client is no longer eligible to receive such GA benefits as long as the client remains in the same non-Medicaid nursing facility.

1. Physician certification (completion of GA-18): Physician certification shall be accomplished by means of Form GA-18, Certification of Need for Patient Care in Facility Other than Public or Private General Hospital.

This form shall be completed in duplicate, by the attending, or staff physician and the operator or superintendent of the appropriate facility. One copy shall be submitted to the DFD/GAP Unit for determination of nursing facility care and subsequently, filed in the case record and the other copy shall be retained by the nursing facility or institution.

2. Maximum fees: payment to the non-Medicaid facility shall not exceed the rates established by the DFD/GAP Unit for that facility. The MWD shall contact the DFD/GAP Unit to obtain the per diem rate for room, board, and nursing care. A personal needs allowance of \$35.00 per month shall be allowed to the patient.

i. To determine the all inclusive rate the MWD will be authorized to pay the non-Medicaid nursing facility, the MWD shall calculate the non-Medicaid facility rate established by the GAP Unit times the number of days of care for the month less the payment by or on behalf of the client. Each month the MWD will obtain a current bill for all services rendered during the previous month.

(1) The MWD shall authorize per diem payments for periods of up to 10 days during which the client is temporarily absent from the facility for hospitalization or for periods of up to 25 days in a calendar year for therapeutic visits.

ii. Prescription drugs, laboratory, X-ray, physician, dental, podiatry services and supplies are not included

in the nursing facility per diem rate. Such services shall be paid directly to the provider. An order for lab, X-ray, pharmacy services, and so forth must be based on a written prescription from the attending physician (see N.J.A.C. 10:85-8.4(g)1i regarding the Pharmaceutical Assistance to the Aged and Disabled program).

(g) The director of welfare shall authorize payment for physical, occupational, or speech therapy under the conditions and in the amounts indicated in (g)1 through 2 below.

1. Conditions:

i. The therapy must have been recommended in writing by a physician.

ii. The therapy must be a part of a planned physical restoration program.

iii. The therapy must be performed by an appropriately qualified therapist under the direction and supervision of a physician.

iv. The therapy has been approved in advance by the DFD/GAP Unit. Request for the DFD/GAP Unit approval shall be submitted via Form GA-18A with any other documentation which is appropriate and available or is requested by the DFD/GAP Unit. Approvals by DFD/GAP Unit will be made for a maximum of three months. Requests for approval for an additional three-month period shall be made prior to the commencement of the additional period. Such a request shall include a new Form GA-18A if appropriate or a written statement by the supervising physician describing all changes since the previous submittal.

2. Amount of payment: The MWD will authorize no payment for therapy which is available or could have been provided to the client without cost. The amount of payment shall be at the rate established for the service by the Medicaid program. The DFD/GAP Unit will ascertain the rate and indicate it in the notice of approval. Welfare directors in need of rate information before submitting an approval request may communicate with the DFD/GAP Unit.

(h) Miscellaneous services: The director of welfare shall authorize payment for drugs, blood, blood plasma, infusions, hearing aids, prosthetics, oxygen, dental services or dentures, eyeglasses and other visual prosthesis, braces and appliances, if recommended in writing by an appropriately licensed practitioner and if not otherwise available without cost to the patient.

1. Maximum fee: The DFD/GAP Unit will determine an appropriate fee for the services provided as stated in (b)1 above.

2. Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program: See N.J.A.C. 10:85-8.4(f)1i regarding referral to the PAAD program.

3. Prosthetics and orthotics (for example, artificial limb, eye or brace): Clients who have a job disability which may be reduced or diminished if provided with an appliance (that is, prosthesis or brace) should be referred to the Division of Vocational Rehabilitation Services (DVRS) (see N.J.A.C. 10:85-8.4(g)). If accepted for service by that agency, the cost of the appliance is the responsibility of DVRS. Only if the client is rejected as not feasible for the services furnished by DVRS should the municipal welfare agency consider authorizing payment for such an appliance, and then only after consulting with the DFD/GAP Unit.

(i) Persons eligible for Medicare Part B (medical insurance) benefits must have health care services billed to the appropriate carrier (for New Jersey Medicare, the carrier is Medicare/Pennsylvania Blue Shield, Harrisburg, Pennsylvania) by the practitioner or other provider before submitting bills to the MWD for consideration. Recipients eligible for Medicare Part B benefits shall submit the statement, "Explanation of Benefits", from the Medicare carrier before the MWD determines if additional payment may be allowed.

(j) Residential treatment for drug or alcohol abuse: When the director of welfare authorizes the GA grant, payments for room and board shall be made by the client, and a PNA in amounts as specified in N.J.A.C. 10:85-3.3(f)4iv shall be retained by the client. The payment for room and board by the GA client shall be considered as inclusive of all goods and services.

1. When laboratory tests necessary for admission to drug treatment programs are performed by independent laboratories, payment procedures are as follows:

i. For costs incident to admission to methadone maintenance outpatient drug treatment facilities, laboratories will submit their charges on the appropriate Medicaid form and send that form to the MWD for submittal to the DFD/GAP Unit for costing.

ii. For costs incident to admissions to residential drug treatment facilities, laboratories will submit charges on the appropriate Medicaid form to the MWD for submittal to the DFD/GAP Unit for costing and processing in customary manner.

As amended, R.1977 d.168, effective May 12, 1977.

See: 9 N.J.R. 174(c), 9 N.J.R. 278(a).

As amended, R.1978 d.77, effective April 1, 1978.

See: 10 N.J.R. 13(b), 10 N.J.R. 153(d).

As amended, R.1979 d.141, effective May 1, 1979.

See: 10 N.J.R. 488(a), 11 N.J.R. 249(c).

As amended, R.1979 d.495, effective December 14, 1979.

See: 11 N.J.R. 516(c), 12 N.J.R. 43(a).

(b), (b)5, (c)1, (c)2, (c)3, (c)3i through iii, (d), (e), (g), (g)1, and (h): "shall" was "may."

As amended, R.1979 d. 496, effective December 14, 1979.

See: 11 N.J.R. 507(b), 12 N.J.R. 43(b).

(b)1: Added "a center ... alcohol abuse." (b)2: Substantially amended. Added (c)4 and (j).

As amended, R.1980 d.11, effective February 1, 1980.

See: 11 N.J.R. 506(b), 12 N.J.R. 86(c).

(f)1: Added "facility" (g)4i: Added comma after "therapy."

As amended, R.1980 d.252, effective July 1, 1980.

See: 12 N.J.R. 275(c), 12 N.J.R. 419(a).

(b)2i added.

As amended, R.1980 d.311, effective August 1, 1980.

See: 12 N.J.R. 123(a), 12 N.J.R. 483(b).

(f)1i added.

As amended, R.1980 d.531, effective January 1, 1981.

See: 2 N.J.R. 586(a), 13 N.J.R. 18(c).

(f)1 amended to require submission of Form GA-18 to DPW/BMA; (f)1i amended to require annual recertification by Form GA-18 and to delete previous requirement.

As amended, R.1980 d.547, effective February 1, 1981.

See: 12 N.J.R. 662(c), 13 N.J.R. 100(a).

(b)1 "Residential Health Care Facility" was "licensed boarding home for sheltered care."

As amended, R.1981 d.263, effective July 9, 1981.

See: 13 N.J.R. 225(a), 13 N.J.R. 433(a).

(b)2: added "shall total . . . or product be."

As amended, R.1983 d.328, effective July 25, 1983.

See: 15 N.J.R. 938(a), 15 N.J.R. 1378(a).

Originally adopted as an Emergency Readoption as R.1983 d.209 effective May 23, 1983, operative June 1, 1983.

Subsection (f) added, regarding authorizing payments for physical, occupational and speech therapies; (h) recorded as (g).

Amended by R.1984 d.593, effective January 7, 1985.

See: 16 N.J.R. 2488(a), 17 N.J.R. 90(a).

(c): Substantially amended.

Amended by R.1985 d.565, effective November 4, 1985.

See: 17 N.J.R. 1836(a), 17 N.J.R. 2665(a).

Amended by R.1986 d.70, effective March 17, 1986.

See: 17 N.J.R. 2953(a), 18 N.J.R. 564(a).

Payments for periods up to 14 days amended to 10 days.

Amended by R.1987 d.176, effective April 20, 1987.

See: 19 N.J.R. 33(a), 19 N.J.R. 646(a).

(a)1 added.

Amended by R.1987 d.322, effective August 3, 1987.

See: 19 N.J.R. 619(b), 19 N.J.R. 1454(b).

Personal incidental allowance increased from \$25.00 to \$35.00 per month.

Amended by R.1988 d.169, effective April 18, 1988.

See: 20 N.J.R. 162(a), 20 N.J.R. 902(b).

Added text to (a) "and, for services . . .".

Amended by R.1990 d.33, effective January 16, 1990.

See: 21 N.J.R. 3221(b), 22 N.J.R. 21(a).

Allowed costs for drug or alcohol programs added to (i).

Amended by R.1991 d.521, effective October 21, 1992 (operative November 1, 1991).

See: 23 N.J.R. 1741(a), 23 N.J.R. 3155(a).

Medical care providers to bill within six months; labs to use Medicaid forms.

Amended by R.1992 d.503, effective December 21, 1992.

See: 24 N.J.R. 3075(a), 24 N.J.R. 4538(a).

Text on general provisions deleted; text on other medical payments recodified from 5.3, with amendments deleting references to inpatient and outpatient services and physician recertification.

Prior annotations on general provisions

As amended, R.1983 d.328, effective July 25, 1983.

See: 15 N.J.R. 938(a), 15 N.J.R. 1378(a).

Originally adopted as an Emergency Readoption as R.1983 d.209, effective May 23, 1983, operative June 1, 1983.

Explanation of payments expanded.

Amended by R.1990 d.33, effective January 16, 1990.

See: 21 N.J.R. 3221(b), 22 N.J.R. 218(a).

Stylistic changes.

Amended by R.1994 d.591, effective December 5, 1994.

See: 26 N.J.R. 2757(b), 26 N.J.R. 4765(b).

Amended by R.1995 d.663, effective January 2, 1996.

See: 27 N.J.R. 3553(a), 28 N.J.R. 186(a).

Amended (f).

10:85-5.2 Procedure for payment of medical bills

(a) This section does not apply to prescription bills except for medical supplies and equipment in those municipalities which pay prescription charges through Medicaid.

(b) Rules concerning determination of Medicaid rate are as follows:

1. MWD responsibility: The MWD shall submit bills received from providers of health services, or requests for authorized fee levels, to the DDF/GAP Unit. Such bills and/or requests should be submitted on official Medicaid vendor voucher forms which all providers servicing Medicaid recipients utilize. The forms shall contain the following: signature of the vendor and client, date, and description of the commodity delivered or service rendered with full Medicaid product and procedure codes. Exception: The signature of the client/designee is not required on bills for residential services such as Long Term Care Facilities (see (b)4 below for requirement of client/designee signature).

i. Bills/requests shall include age of the patient, diagnosis, and whether or not he or she is receiving disability insurance benefits. The signature of the MWD director, preceded by the words "approved by" is required on the bottom or on the reverse side of the Medicaid vendor form. This signature may be affixed either before or after submission to the DDF/GAP Unit for rate approval but prior to payment.

ii. Medicaid vendor forms not completed in accordance with the above instructions must be accompanied by a Form GA-11, General Assistance Order, properly completed.

iii. In instances of repeated submission of a Medicaid vendor form showing the same client, same vendor, same commodity or service and same price, the MWD may, for audit purposes, attach a photocopy of the previous rate-approved form to each resubmittal in lieu of submission to the DDF/GAP Unit as required above.

2. State responsibility: It is the responsibility of the DDF/GAP Unit to authorize appropriate rates in accordance with those established by the State Medicaid Program insofar as feasible. The DDF/GAP Unit will return disapproved, any voucher submitted from a provider who has been deleted for cause from the current list of approved Medicaid providers. Such disapproval will prevent States, matching on the payment, but will not eliminate any responsibility for payment which the MWD may have incurred by prior authorization.

i. The DDF/GAP Unit will enter the appropriate fee for each service listed, mark the bill or voucher as approved for amount of payment and return it to the MWD. The MWD shall retain this form in file for audit purposes.

3. Notification of provider: The MWD shall promptly notify the provider of the authorized fee and shall make payment accordingly.

4. Client/designee signature requirements: The following procedures may be used when the patient's signature is unobtainable.

i. Illiterate patient: The patient may sign by mark (X), and the signature must be witnessed by another person and also the provider of the service must sign his/her name and address on the same line.

ii. Client designee: If the patient is physically or mentally incapable of signing, a minor child, deceased, or for other reasons the patient's signature is not obtainable, through reasonable effort, the form may be signed on the patient's behalf by:

- (1) A parent; or
- (2) A legal guardian; or
- (3) A relative; or
- (4) A friend; or
- (5) An individual provider; or
- (6) A representative of the institution/agency providing care and/or support; or
- (7) A representative of a governmental agency providing assistance.

iii. A brief explanation of the reason the patient was not personally able to sign voucher form must be written directly on the form or recorded on an attachment should additional space be required. The explanation must include a statement as to how the designee and the patient are related.

As amended, R.1977 d.168, effective May 12, 1977.

See: 9 N.J.R. 174(c), 9 N.J.R. 278(a).

As amended, R.1979 d.141, effective May 1, 1979.

See: 10 N.J.R. 488(a), 11 N.J.R. 249(c).

As amended, R.1980 d.252, effective July 1, 1980.

See: 12 N.J.R. 275(c), 12 N.J.R. 419(a).

"Note" added before (a).

As amended, R.1981 d.417, effective November 2, 1981.

See: 13 N.J.R. 499(c), 13 N.J.R. 768(b).

(a)1: Last sentence added; (a)4 added.

As amended, R.1983 d.328, effective July 25, 1983.

See: 15 N.J.R. 938(a), 15 N.J.R. 1378(a).

Originally adopted as an Emergency Readoption as R.1983 d.209, effective May 23, 1983, operative June 1, 1983.

Exception added at (a)1, and (b) and (c) deleted and replaced by text regarding retroactive medical eligibility.

Amended by R.1990 d.33, effective January 16, 1990.

See: 21 N.J.R. 3221(b), 22 N.J.R. 218(a).

Stylistic changes.

Amended by R.1992 d.503, effective December 21, 1992.

See: 24 N.J.R. 3075(a), 24 N.J.R. 4538(a).

Text on inpatient hospital care deleted; text on procedures for a payment of medical bills recodified from 5.4, with amendment deleting subsection (c).

Prior annotations on inpatient hospital care (including case note):

As amended, R.1977 d.134, effective June 1, 1977.

See: 9 N.J.R. 123(c), 9 N.J.R. 238(b).

As amended, R.1978 d.217, effective June 30, 1978.

See: 10 N.J.R. 345(b).

As amended, R.1979 d.197, effective July 1, 1979.

See: 11 N.J.R. 184(a), 11 N.J.R. 283(c).

As amended, R.1980 d.92, effective April 1, 1980.

See: 12 N.J.R. 29(c), 12 N.J.R. 193(d).

(a): Added Bergen County.

(c): "are included per diem" was "quality for State aid".

As amended, R.1980 d.311, effective August 1, 1980.

See: 12 N.J.R. 123(a), 12 N.J.R. 483(b).

(a) Amended to require eligible hospitalized persons in first class counties to receive payment authorization from the director of welfare of their municipality of residence.

As amended, R.1980 d.466, effective December 1, 1980.

See: 12 N.J.R. 534(c), 12 N.J.R. 704(a).

(d)7iii added.

As amended, R.1980 d.515, effective January 1, 1981.

See: 12 N.J.R. 585(b), 13 N.J.R. 18(b).

(g) Add "which shall . . . (c) above," delete "per diem" rate.

(g)2 delete existing text and replace with current text.

As amended, R.1981 d.394, effective November 2, 1981.

See: 13 N.J.R. 433(b), 13 N.J.R. 768(a).

(a): "Hudson" and "Essex" deleted from list of counties of the first class.

As amended, R.1983 d.328, effective July 25, 1983.

See: 15 N.J.R. 938(a), 15 N.J.R. 1378(a).

Originally adopted as an Emergency Readoption as R.1983 d.209, effective May 23, 1983, operative June 1, 1983.

Lead-ins and descriptive language added at many subsections.

Correction: Deleted Hudson from the counties of the first class.

See: 17 N.J.R. 1339(b).

Amended by R.1986 d.7, effective February 3, 1986.

See: 17 N.J.R. 252(a), 18 N.J.R. 274(b).

Old text in (a) deleted and new text substituted.

Amended by R.1986 d.47, effective March 3, 1986.

See: 17 N.J.R. 2519(a), 18 N.J.R. 483(a).

Old (f) deleted; (g) recodified to (f).

Amended by R.1988 d.251, effective June 6, 1988.

See: 20 N.J.R. 521(a), 20 N.J.R. 1222(a).

Added text to (f)1. "Starting July 8, 1988, State Aid . . .".

Amended by R.1990 d.33, effective January 16, 1990.

See: 21 N.J.R. 3221(b), 22 N.J.R. 218(a).

Stylistic changes.

Case Notes

Former regulation mandated payment for in-patient hospitalization only for residents of municipalities in first class counties. R.S. v. Gloucester Cty. Welfare Dept., 1 N.J.A.R. 448 (1980).

Statutorily mandated hospital costs payments are limited to counties of the first class; limitation does not amount to denial of equal protection. Sharp v. Dept. of Human Services, 178 N.J.Super. 70 (App.Div.1982).

Director of welfare has discretion in authorization of payments. In re R.S., OAL Dkt. HPW 2369-7 (Dec. 6, 1979), rejected, DPW (Feb. 29, 1980), App. Div., Dkt. No. A-2315-79T1.

10:85-5.3 Travel costs for health care

(a) The director of welfare shall authorize payment for travel costs necessary for the receipt of health services, provided that such transportation is not otherwise available without cost.

1. Method of payment: To the extent possible, such services shall be purchased directly from the vendor.

i. Payment to the recipient: Payment may be made directly to the recipient when prior authorization for the expenditure has been obtained from the MWD.

2. Maximum rate: Payment shall not exceed the Medicaid rate, when appropriate, or the most reasonable rate for which service may be obtained.

As amended, R.1979 d.495, effective December 14, 1979.

See: 11 N.J.R. 516(c), 12 N.J.R. 43(a).

(a): "shall" was "may".

Recodified by R.1992 d.503, effective December 21, 1992.