

**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.

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**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.2001 d.465, effective November 14, 2001 (to expire May 13, 2002).  
See: 33 N.J.R. 4390(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: 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 over 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 native-born 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 authorized 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. TICKET TO WORK****Authority**

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