

5. The county welfare agency shall afford full cooperation in the investigation of complaints of discrimination as may be requested by the Federal Department of Health and Human Services, the State Division of Medical Assistance and Health Services, or the State Division of Civil Rights.

Amended by R.1992 d.364, effective September 21, 1992.
See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Reference to Americans with Disabilities Act added.

10:72-1.8 Assignment of medical support rights

(a) Any person who applies for Medicaid, by virtue of the application for benefits, is deemed to have assigned to the Commissioner of the Department of Human Services any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for care from any third party. Program applicants and recipients are required to cooperate in the identification of and the obtainment of any such rights.

1. The county welfare agency shall advise program applicants and recipients of the terms of the assignment and the consequences thereto.

SUBCHAPTER 2. CASE PROCESSING

10:72-2.1 Application

(a) Application for Medicaid benefits for pregnant women and children shall be accomplished by the completion and signing of Form FD-335 for pregnant women and children as well as any addenda to that form as prescribed by the Division of Medical Assistance and Health Services. Application for Medicaid benefits for aged, blind, or disabled individuals shall be accomplished by the completion and signing of Form PA-1G as well as any addenda to that form as prescribed by the Division of Medical Assistance and Health Services.

1. The application for the program shall be executed by:

- i. The pregnant woman (regardless of age);
- ii. The parent, guardian, or caretaker relative of a child (including a blind or disabled child) for whom Medicaid is sought; or
- iii. The aged, blind or disabled individual.

2. For cases in which, because of confinement, illness, incapacity, disability, or lack of competence of a person specified in (a)1 above, the application may be executed on behalf of such person by:

- i. A relative by blood or marriage;
- ii. A staff member of a public or private welfare or social service agency of which the person seeking assis-

tance is a client and who has been designated by the agency to so act;

iii. An attorney or physician of the person seeking Medicaid benefits; or

iv. A staff member of an institution or facility in which the individual is receiving care and who has been designated by the institution or facility to so act.

3. A legal guardian shall be recognized as an authorized agent to execute an application on behalf of any individual.

(b) The county welfare agency, under policies and procedures established by the Division of Medical Assistance and Health Services, has the direct responsibility in the application process to:

1. Inform applicants of the purpose of and the eligibility requirements for the Medicaid program, including their rights to a fair hearing;

2. Receive applications and review them for completeness, consistency, and reasonableness;

3. Assist program applicants in exploring their eligibility for program benefits;

4. Make known to program applicants the appropriate resources and services both within the agency and in the community; and

5. Assure the prompt and accurate submission of eligibility data to the Medicaid Eligibility File for eligible persons and prompt notification to ineligible persons of the reason for their ineligibility.

(c) As part of the application process, an applicant for Medicaid has the responsibility to:

1. Complete, with the assistance of the county welfare agency as required, any forms required as part of the application process;

2. Assist the county welfare agency in securing evidence that verifies his or her statements regarding eligibility;

3. Provide medical confirmation of pregnancy when Medicaid benefits are sought on that basis; and

4. Submit to necessary medical tests and examinations to determine disability or blindness and provide the county welfare agency with evidence relating to that determination.

(d) For any application for Medicaid benefits under the provisions of this chapter, the county welfare agency must accomplish disposition of the application as soon as all factors of eligibility are met and verified but not later than 30 days from the date of application (or from the date of the inquiry form PA-1C, if applicable) for pregnant women, children, and aged individuals. For disabled and blind

individuals, the standard for application disposition is 60 days. Exceptions to the timeliness standard appear in (d)2 below.

1. "Disposition of the application" means the official determination by the county welfare agency of eligibility or ineligibility of the applicant(s) for Medicaid.

2. Disposition of the application may exceed the applicable processing standard when substantially reliable evidence of eligibility or entitlement for benefits is lacking at the end of the processing period. In such circumstances, the application may be continued in pending status. The county welfare agency shall fully document in the case record the circumstances of the delayed application processing. The processing standard may be exceeded for any of the following:

- i. Circumstances wholly within the control of the applicant;
- ii. A determination by the county welfare agency, when evidence of eligibility or entitlement is incomplete or inconclusive, to afford the applicant additional time to provide evidence of eligibility before final action on the application;
- iii. An administrative or other emergency that could not reasonably have been avoided;
- iv. Circumstances wholly beyond the control of both the applicant and the county welfare agency.

3. When disposition of the application is delayed beyond the processing standard, the county welfare agency shall provide the applicant written notification prior to the expiration of the processing period setting forth the specific reasons for the delay.

4. Each county welfare agency director shall establish appropriate operational controls to expedite the processing of applications and to assure maximum compliance with the processing standard.

i. The county welfare agency shall maintain control records which identify all pending applications which have exceeded the processing standard and the reason therefor. The record shall be adequate to make possible the preparation of reports of such information as may be requested by the Division of Medical Assistance and Health Services.

(e) The following actions on an application qualify as disposition of an application for purposes of the processing standard:

1. Approved: The applicant has been determined eligible for Medicaid;
2. Denied: The applicant has been determined ineligible for Medicaid;

3. Dismissed: A decision by the county welfare agency that the application process need not be completed because:

- i. The applicant has died (the application process must be completed if there are unpaid medical bills for covered services in the retroactive coverage period or subsequent to program application);
- ii. The applicant cannot be located;
- iii. The application was registered in error;
- iv. The applicant has moved out of the State during the application process and there are no unpaid bills for the time period beginning with the retroactive eligibility period up to the date of relocation.

4. Withdrawn: The applicant requests that eligibility for the Medicaid program be no longer considered.

Amended by R.1987 d.380, effective August 27, 1987.

See: 19 N.J.R. 1324(a), 19 N.J.R. 1731(a).

(b)5: missing text inserted.

Emergency Adoption, R.1988 d.96, effective March 7, 1988.

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

Substantially amended.

Readoption of 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.1992 d.364, effective September 21, 1992.

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

New form numbers added; unpaid bill provision added at (e)3iv.

Cross References

Delays in application process, notice required, see N.J.A.C. 10:72-5.1.

10:72-2.2 Interview

The county welfare agency is required to conduct a personal face-to-face interview with the program applicant or the authorized agents as part of the process of determining program eligibility.

10:72-2.3 Verification requirements

(a) The county welfare agency is required to verify all factors related to eligibility for the Medicaid program. Factors subject to verification include:

1. Pregnancy: For women seeking benefits under the provisions of this chapter, pregnancy must be medically verified. The medical verification must include the estimated dates of conception and delivery.

2. Disability and blindness: For individuals seeking Medicaid benefits because of disability or blindness, the condition must be established in accordance with the definitions, verification requirements, and processes set forth at N.J.A.C. 10:71-3.10 through 3.13.

3. Birth date: The birth date of any person for whom benefits are sought must be verified.

4. Alien status: The status of any alien seeking benefits must be verified to establish entitlement for Medicaid benefits.

5. Citizenship: When an applicant's or recipient's statements of U.S. citizenship are questionable, citizenship must be verified.

6. Household composition: The county welfare agency must verify the household composition in order to ascertain which persons will be included in the determination of eligibility for Medicaid benefits.

7. Social Security number: The Social Security number of any person seeking Medicaid benefits must be verified.

8. The county welfare agency must verify all sources of income of any person whose income must be counted in the determination of program eligibility. While resources are not a factor of eligibility for benefits for pregnant women and children under this chapter, resources must be identified and verified to determine if income is derived from the resources. For the aged, blind, and disabled, resources must be verified.

(b) The county welfare agency shall use documentary evidence as the primary source of verification. Documentary evidence is written confirmation of the family's circumstances. It is the responsibility of the applicant to obtain or to assist the county welfare agency in obtaining any required documentation.

(c) In circumstances in which the documentary evidence is questionable or is not available, the county welfare agency may use collateral contact to confirm the family's circumstances. A collateral contact is a verbal confirmation of a family's circumstances by a person outside the family. In order to be acceptable as verification, a collateral contact must be in a position to provide accurate information about the family and the circumstance in question.

(d) Subsequent to the initial application, verification is required for only those factors of eligibility which are subject to change or for those factors for which the original verification has become questionable.

(e) In the absence of credible verification of all eligibility factors, eligibility for the Medicaid program may not be established.

Emergency Adoption, R.1988 d.96, effective March 20, 1988.
See: 20 N.J.R. 548(a).

Added (a)2; renumbered all (a)2-7. as 3.-8. and added text to (a)8. "pregnant women and children", "for the aged, blind and disabled, resources must be verified".

Readoption of Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

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

10:72-2.4 Case transfer

(a) When individuals move permanently to another county within the State, responsibility for the case shall be transferred in accordance with the provisions of this section. The case transfer shall be accomplished in a manner so as not to adversely affect the rights of any individual to program entitlement.

1. A temporary visit out-of-county shall not be considered to be a change of county residence until the visit has continued for longer than three calendar months.

(b) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (c) and (d) below.

(c) Applicant cases: For persons who move from the county in which application for Medicaid is made prior to the determination of eligibility or ineligibility:

1. The county in which the application was made has the responsibility to:

i. Complete the eligibility determination process;

ii. If determined eligible for the Medicaid program, accrete the eligible person(s) to the Medicaid Eligibility File with the correct effective date of Medicaid eligibility and the new address in the receiving county; and

iii. If the case is determined eligible, within five working days of that determination, transfer the case record material to the receiving county in accordance with (d)1i through iv below.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client upon the receipt of the case material to advise of continued program entitlement; and

ii. Immediately notify the county of origin, in writing, of the date the case material was received.

(d) Eligible cases: For cases which are determined eligible for the Medicaid program:

1. The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent application form (including all verification), Social Security number(s), and the new address in the receiving county;

ii. Send with the above case material, a cover letter specifying that the case is being transferred and requesting written acknowledgement of receipt;

iii. Forward promptly to the receiving county, copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any of the case material.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client upon receipt of the case material;

ii. Immediately notify the county of origin, in writing, of the date the initial case material was received;

iii. Review eligibility for the case. If questions regarding case eligibility exist because of information provided by the county of origin, that county shall be consulted for resolution of the issues;

iv. Accept responsibility for the case (provided application to transfer has been made) effective with the next month if the initial case material has been received before the 10th of the month;

v. Accept responsibility for the case (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such material is received on or after the 10th of the month;

vi. Update the Medicaid Eligibility File as necessary including entry of a new case number. If the case is determined eligible for Medicaid in the receiving county, there shall be no interruption of entitlement. If the case is determined ineligible for Medicaid in the receiving county, eligibility shall be terminated, subject to timely and adequate notice, and the previously eligible person terminated on the Medicaid Eligibility File; and

vii. Notify the county of origin of the date eligibility for Medicaid will begin or will be terminated in the receiving county.

Amended by R.1992 d.364, effective September 21, 1992.
See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).
Stylistic changes.

10:72-2.5 Redetermination of eligibility

(a) Eligibility for Medicaid under this chapter shall be redetermined, including a face-to-face interview and the completion of a new application form, as follows:

1. For a pregnant woman, eligibility need not be redetermined until the birth of her child. Upon the birth of the child, the newborn 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, or would remain eligible if pregnant, and the child resides with her, whether or not application has been made.

2. For the eligibility of children, other than newborns, eligibility must be redetermined no later than six months following the month of initial eligibility or the last redetermination.

3. For an aged, blind, or disabled individual, eligibility must be redetermined no later than 12 months following the month of initial eligibility or the last redetermination.

(b) The county welfare agency shall reassess program eligibility as follows:

1. When required on the basis of information the county welfare agency has obtained previously about anticipated change in the case situation or when additional information is needed to ascertain income eligibility for the program.

2. Promptly after information is obtained by the county welfare agency which indicates changes in the case circumstances that may affect program eligibility or past eligibility treatment of income.

Emergency Adoption, R.1988 d.96, effective March 7, 1988.
See: 20 N.J.R. 548(a).

Added (a)3.
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)1: revised text to conform with Federal requirements to expand eligibility for newborn children of Medicaid eligible women.
Amended by R.1992 d.364, effective September 21, 1992.
See: 24 N.J.R. 2145(a), 24 N.J.R. 3343(a).

Clarification added to (b)2 to include treatment of income after determination of eligibility.

10:72-2.6 Post-application client responsibilities

(a) Upon a determination of eligibility for the Medicaid program, eligible persons have the on-going responsibility for the reporting of changes in family circumstances and for the provision of information as delineated at N.J.A.C. 10:72-2.1(c). Further, as requested by the county welfare agency, additional information must be provided. At any time that the county welfare agency lacks sufficient information to confirm continuing program eligibility because of the unwillingness of an eligible person to provide necessary information, the agency shall commence action to terminate the case.

10:72-2.7 Retroactive eligibility

(a) Persons may be eligible under the provisions of this chapter for retroactive Medicaid eligibility for the three months preceding the month of application. Retroactive Medicaid coverage is available for any of the three months prior to application so long as eligibility existed and there are unpaid medical bills for services in that month. In the case of a pregnant woman, in order to be eligible for a retroactive month, the medical verification of pregnancy must have occurred in the retroactive month or in a previous month. In the case of a disabled or blind individual, the disability or blindness must be confirmed to have begun in a retroactive month or earlier.

(b) Determination of retroactive eligibility is the responsibility of the Division of Medical Assistance and Health Services. If the applicant has unpaid medical bills from the retroactive eligibility period, the county welfare agency shall provide the applicant with an Application for Payment of Unpaid Medical Bills (FD-74) and instruct the applicant to forward it to the Division of Medical Assistance and Health Services, Retroactive Eligibility Unit, CN-712, Trenton, New Jersey 08625-0712. An application for retroactive eligibility must be received by the Retroactive Eligibility Unit within six months of the date of application for Medicaid at the county welfare agency.

Emergency Adoption, R.1988 d.96, effective March 7, 1988.

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

Substantially amended (a).

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

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

Form specified at (b).

SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

10:72-3.1 General provisions

(a) Eligibility for the Medicaid program must be established in relation to each requirement of the Medicaid program to provide a valid basis for the granting or denying of Medicaid assistance.

(b) The applicant's statements regarding his or her eligibility, as set forth in the application form, are evidence. The statements must be consistent and meet prudent tests of credibility. Incomplete or questionable statements shall be supplemented and substantiated by corroborative evidence from other pertinent sources.

10:72-3.2 Citizenship

(a) In order to be eligible for the Medicaid program, an individual must be a citizen of the United States, an alien lawfully admitted for permanent residence, or an alien approved for temporary residence.

1. The term "citizen of the United States" includes persons born in Puerto Rico, Guam, the Virgin Islands, Swains Island, American Samoa, and the Northern Mariana Islands.

2. The following aliens shall be considered lawfully admitted for permanent residence for purposes of establishing eligibility for the Medicaid program:

i. Immigrant: An alien lawfully admitted for permanent residence pursuant to sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act;

ii. Continuous residence: An alien who entered the United States prior to June 30, 1948, or some later date as required by law, and has continuously maintained

residency in the United States since then, and is not ineligible for citizenship but is considered to be lawfully admitted for permanent residence as a result of an exercise of discretion by the United States Attorney General pursuant to section 249 of the Immigration and Nationality Act;

iii. Conditional entry after March 31, 1980: An alien qualified for conditional entry after March 31, 1980 because of persecution or fear of persecution on account of race, religion, or political belief pursuant to section 207 (formerly section 203(a)(7)) of the Immigration and Nationality Act;

iv. Conditional entry prior to April 1, 1980: An alien who qualifies for conditional entry prior to April 1, 1980 pursuant to former section 203(l)(7) of the Immigration and Nationality Act;

v. Granted asylum: An alien granted asylum through an exercise of discretion by the United States Attorney General pursuant to section 208 of the Immigration and Nationality Act;

vi. Emergent reasons: An alien lawfully present in the United States as a result of an exercise of discretion by the United States Attorney General for emergent reasons or for reasons deemed strictly to be in the public interest pursuant to section 212(d)(5) of the Immigration and Nationality Act, or as a grant of parole by the United States Attorney General;

vii. Deportation withheld: An alien living in the United States to whom the United States Attorney General has withheld deportation pursuant to section 243 of the Immigration and Nationality Act because of the judgement of the United States Attorney General that the alien would otherwise be subject to persecution on account of race, religion, or political opinion.

3. Aliens granted the status of lawfully admitted for temporary residence by the Immigration and Naturalization Service are, if otherwise eligible, entitled to Medicaid under the provisions of this chapter.

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 women 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.

2. Children under the age six years, and children born after September 30, 1983 who have:

i. Effective December 1, 1991, attained the age of six, seven, or eight;

ii. Effective October 1, 1992, attained the age of nine;

iii. Effective October 1, 1993, attained the age of 10;

iv. Effective October 1, 1994, attained the age of 11;

v. Effective October 1, 1995, attained the age of 12;

vi. Effective October 1, 1996, attained the age of 13;

vii. Effective October 1, 1997, attained the age of 14;

viii. Effective October 1, 1998, attained the age of 15;

ix. Effective October 1, 1999, attained the age of 16;

x. Effective October 1, 2000, attained the age of 17; and

xi. Effective October 1, 2001, attained the age of 18.

3. The 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.

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.