

(b) Aged, blind and disabled persons who are receiving care in an eligible medical institution and, because of in-

come or resources, do not qualify for SSI may be eligible for Medicaid Only.

10:71-1.4 Information on the manual

This manual sets forth the policies and procedures necessary for the orderly and equitable administration of the Medicaid Only program as it relates to the aged, blind and disabled. It is a statement of policy and procedures separate from all other assistance programs, and is applicable to "Medicaid Only". The criteria for determination of eligibility are based on SSI policy and procedure which do not necessarily coincide with standards for other public assistance programs and therefore require separate instructions.

10:71-1.5 Administrative organization

The Medicaid Only program is administered by the County Welfare Agency(ies) (CWA(s)) of the State of New Jersey through the Division of Medical Assistance and Health Services in the Department of Human Services. The CWAs contract with the Division of Medical Assistance and Health Services for the purpose of providing Medicaid Only benefits to eligible persons.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-1.6 Basic principles of administration

(a) The following principles of administration shall apply to the Medicaid Only program.

1. Any aged, blind or disabled person who believes he/she is eligible shall be assured an opportunity to make application (including reapplication) for Medicaid Only by completing the appropriate application form.

2. The applicants or recipients are the primary source of information. However, it is the responsibility of the agency to make the determination of eligibility and to use secondary sources when necessary, with the applicant's knowledge and consent.

3. No duplication of assistance: No recipient of Medicaid Only shall receive, during the same period, any other medical assistance from the State or any political subdivision thereof with respect to any maintenance requirements or other need for which allowance is made in the Medicaid Only program (see N.J.A.C. 10:71-3.14 regarding inmates of correctional institutions). The food stamp program is not considered a duplication of public assistance.

4. There shall be strict adherence to law and complete conformity with administrative policies. Requirements other than those established by law or regulations shall not be imposed on any person as a condition of receiving medical assistance.

5. The applicants or recipients shall have the right to request appeal on the action or inaction of the agency whenever they believe that they have not been given full consideration under the law. A fair hearing shall be conducted by an impartial official of the Department of

Human Services in accordance with prescribed procedure when:

- i. An application for Medicaid Only is denied;
- ii. An application for Medicaid Only is not acted upon by the county welfare board within 30 days for the aged and 60 for the disabled or blind; or
- iii. Medicaid Only is terminated.

6. Information about applicants and recipients and their circumstances shall not be disclosed except as required for the proper and efficient administration of the program and only to those agencies involved in the lawful administration or operation of public welfare functions or services.

7. There shall be no discrimination on grounds of race, color, religion, sex, national origin or marital, parental or birth status by state or local agencies in the administration of any public assistance program.

Amended by R.1986 d.71, effective March 17, 1986.
See: 17 N.J.R. 2522(a), 18 N.J.R. 564(b).
(a)3 amended.

10:71-1.7 Examination of review of manual

This manual is a public document. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each CWA office for examination or review during regular office hours on regular work days.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-1.8 County Welfare Agency responsibility; manual

The director of the CWA shall assign copies of this manual to staff members as appropriate and shall ensure that such persons are thoroughly familiar with its contents, apply the required policy and procedures correctly, and keep up-to-date on all policy changes.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-1.9 Providing manual material in adverse action situations

Specific policy material necessary for an applicant or recipient or his/her representative to determine whether a hearing should be requested or to prepare for a hearing shall be provided to such persons without charge.

10:71-1.10 Revisions of the manual

The Division of Medical Assistance and Health Services shall issue revisions and changes to this manual as necessary. It is the responsibility of each holder of the manual to maintain its accuracy by inserting new material and removing obsolete pages promptly.

10:71-1.11 Availability of manual

(a) A current up-to-date copy of the manual or any part of it is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing.

(b) All public and university libraries which have agreed to keep the manual up-to-date will have a copy available under their regulations.

(c) Each legal services office will be furnished with a copy of this manual free of charge.

(d) Welfare, social service and other non-profit organizations will be furnished with a copy of the manual at no cost by an official written request to the Division of Medical Assistance and Health Services.

(e) All supplementary State policy directives will routinely be sent to those who have been supplied with the manual. A mailing list will be maintained by the Division.

SUBCHAPTER 2. THE APPLICATION PROCESS
10:71-2.1 Definitions

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

“Application process” means all activity performed by the Income Maintenance Section relating to a request for medical assistance payments. The application process is primarily geared toward the determination of basic eligibility. However, since intake by its very nature involves a combination of services and income maintenance functions, a service worker shall be available as required during such process.

“Applicant,” in Medicaid Only, means the aged, disabled or blind individual or his/her authorized agent who executes the formal written application (PA-1G).

“Approved” means that the applicant has been determined to be eligible for Medicaid Only.

“Disposition of the application” means the official determination of the CWA that one of the following actions is appropriate: approval or rejection as defined in the section.

“New application” means a written request for assistance from an individual or his/her agent who has never previously requested assistance in any county in the State under the Medicaid Only program.

“Pending application” means the general term for application, reapplication, reopened application or transfer application prior to official disposition.

“Reapplication” means a written request for assistance by the individual whose previous application was rejected in any county in the State and who requests reconsideration of his/her current eligibility for Medicaid Only.

“Registration” means the action of the CWA in assigning a control number to an application.

“Rejected” is an inclusive term (for statistical purposes) for the following actions:

1. Denied means that the applicant has been determined to be ineligible for assistance for a specific reason.
2. Dismissed means official recognition that eligibility need not be considered further because:
 - i. The applicant died (however, if there were unpaid medical bills incurred subsequent to inquiry or application, whichever occurred first, the application process is to be completed); or
 - ii. The applicant cannot be located; or
 - iii. The application was registered in error; or
 - iv. The applicant moved to another county in New Jersey during the application process.
3. Withdrawn means that the applicant decided not to pursue the application further.

“Reopened application” means a written request by a former recipient in any county in the State for reconsideration of his/her current eligibility for the program.

“Transfer application” means a written request for assistance by the individual who at the time of registration is still receiving assistance through the CWA of another county from which he/she moved.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Case Notes

Medicaid-only applicant entitled to funeral expenses. *B.F. v. Monmouth County Board of Social Services*, 92 N.J.A.R.2d (DMA) 45.

10:71-2.2 Responsibilities in the application process

(a) The Division of Medical Assistance and Health Services is the administrative unit of the Department of Human Services responsible for coordinating the administration of Medicaid Only with the Supplemental Security Income program. This Division provides for payment of claims for, and evaluation of health services rendered under Medicaid Only; maintains administrative liaison with other departmental divisions and provides professional, medical and paramedical staff which is advisory to this Division in all matters of health care relevant to the administration of Medicaid Only. This Division contracts with CWAs for reimbursement of costs of administering the Medicaid Only program.

(b) 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 this person ineligible for the medical assistance program. It is the responsibility of the county welfare board to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

1. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;
2. Whether the move is part of a carefully conceived social service plan which would serve to meet other requirements of the individual in addition to purely physical needs, for example, a person moves to a nursing home in order to be closer to relatives who are interested in the person's welfare;
3. Whether there is a clear expression of intent on the part of the individual to remain permanently in this State;
4. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he/she came;
5. Whether the State in which the individual previously resided recognizes him/her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

(c) If, after full consideration of these factors, the CWA is satisfied that the individual has become a resident of this State, then eligibility for medical assistance is established if the person is otherwise eligible.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-3.9 Age

- (a) Age requirements are:
1. The applicant must be 65 years of age or older to be eligible based on age alone.
 2. A disabled or blind child must be under 18 years of age, or under 22 years of age and a student regularly attending school and neither married nor the head of the household.
 3. A disabled or blind adult must be over 21 years of age and under 65 years of age or between 18 years of age and 22 years of age if not a full-time student.

(b) The applicant must present acceptable proof of age. Among acceptable sources of verification of age are:

1. Birth certificate;
2. Marriage certificate;

3. Church records—baptismal, confirmation membership;
4. Immigration or naturalization papers;
5. Census records;
6. School records;
7. Military service records;
8. Court records;
9. Employment records;
10. Records of public or private welfare agencies;
11. Voting records;
12. Medical records;
13. Affidavit from disinterested persons;
14. Driver's licenses; or
15. Insurance policies.

(c) CWAs shall maintain administrative controls to assure:

1. That a disabled or blind recipient who becomes 65 years of age continues to have his or her eligibility determined on the basis of disability or blindness if it appears more advantageous to the recipient;
2. That a disabled child recipient is processed as a disabled adult when reaching 18 years of age, or 22 years of age and a student regularly attending school and neither married nor the head of the household;
3. That a disabled child recipient is processed as a disabled adult when reaching 18 years of age and a student regularly attending school and either married or the head of a household.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-3.10 Disability and blindness factors

For purposes of determining medical eligibility for the Medicaid Only program, the disability and blindness standards shall be the same as for the Supplemental Security Income program under Title XVI of the Social Security Act, as amended by Public Law 92-603.

Case Notes

Medicaid Only applicant failed to demonstrate disability which prevented her from working. *E.N. v. Division of Medical Assistance and Health Services*, 96 N.J.A.R.2d (DMA) 89.

Applicant with injury to right leg and polio in left leg was not disabled in sense necessary for Medicaid benefits. *A.G. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 9.

10:71-3.11 Determination of disability and blindness eligibility; a State function

(a) The determination of disability and blindness eligibility for the Medicaid Only program is a direct responsibility of the medical review team in the Division of Medical Assistance and Health Services, Disability Review Unit. Determination of all other factors of eligibility is the responsibility of the CWAs. The medical review team is composed of a medical consultant; and a medical social work consultant; it reviews Medicaid Only applications submitted by the CWA.

(b) In situations where an applicant's disability or blindness appears to meet the definition in section 12 of this subchapter, presumptive eligibility for either of these factors can be granted with the approval of the Medical Review Team (MRT) in the Disability Review Unit.

(c) If an individual has been determined disabled for Social Security purposes (that is, he or she is currently receiving Disability Insurance Benefits), the CWA shall not refer the individual to the Disability Review Unit for a determination of medical eligibility. The individual shall be considered automatically eligible, in this respect, for Medicaid Only benefits.

1. In the event the Social Security Administration determined within the 12 months prior to the application for Medicaid Only that the individual was not disabled, the Disability Review Unit will not make an independent determination of the applicant's disability but will be bound by the determination of the Social Security Administration. If an individual whose Social Security or SSI disability claim was denied within the last 12 months presents new or additional evidence to support that claim, the CWA should refer the applicant to the Social Security Administration for a reevaluation of its determination.

2. When the denial by the Social Security Administration occurred more than 12 months prior to the application for Medicaid Only, the Disability Review Unit will make an independent determination of disability.

As amended, R.1979 d.364, effective November 1, 1979.
See: 11 N.J.R. 379(b), 11 N.J.R. 519(e).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Cross References

Redetermination of medical eligibility, see N.J.A.C. 10:71-8.2.

10:71-3.12 Disability; definitions

(a) An individual is disabled for purposes of this part if he/she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity).

(b) A physical or mental impairment is an impairment which results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinic and laboratory diagnostic techniques. Statements of the applicant including his/her own description of his/her impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

(c) An individual is "blind" for purposes of this part if he/she has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central visual acuity of 20/200 or less.

(d) The presence of a condition diagnosed as addiction to alcohol or drugs will not itself be the basis for a finding that the individual is or is not under a disability.

Case Notes

Insufficient finding of disability defeats Medicaid benefits application for blindness. *BP. v. Division of Medical Assistance and Health Services and Middlesex County Board of Social Services*, 97 N.J.A.R.2d (DMA) 1.

10:71-3.13 County welfare agency responsibility and procedures

(a) The CWA shall furnish the Medical Review Team with current, pertinent social and medical information, and to obtain any special or additional reports on request.

(b) When it appears that an applicant meets the income and resources requirements for Medicaid Only, arrangements for obtaining medical evidence should be initiated immediately by whichever of the following procedures is applicable to the applicant's situation.

1. When the applicant is currently (within three months) under the care of a private physician, he or she shall be furnished with a copy of Form PA-5 (Examining Physician's Report) to take to the physician for completion.

2. If the applicant is currently receiving treatment in a hospital clinic, public health facility (that is, tuberculosis clinic, mental health clinic or other outpatient facility) on a regular basis for the medical condition related to his or her application for Medicaid Only, a copy or abstract of the clinic record may be submitted in lieu of the PA-5.

3. If the applicant has been hospitalized within three months for a condition related to the impairment for which he or she is applying for Medicaid Only, an abstract of the hospital record may be submitted for patients in long-term care facilities.

4. In the event none of the above are applicable, the CWA should assist the applicant in choosing a physician to complete the PA-5, who is competent to determine the nature and extent or degree of disability.

5. When the applicant states that he/she is blind or that visual impairment is his/her primary disability, the CWA shall, prior to submission of the record to the Medical Review Team, obtain a Report of Eye Examination (Form PA-5A) from a qualified medical specialist in diseases of the eye (for example, ophthalmologist), or an optometrist, or from an eye clinic of a general hospital,

whichever the individual may select. (The membership directory of the Medical Society of New Jersey is suggested as reference for identification of, in each municipality, physicians specializing in diseases of the eye). Optometrists are listed in the yellow pages of local telephone directories under the heading "Optometrists—Doctors of Optometry." The Form PA-5A should be transmitted in duplicate to the MRT with any other pertinent medical evidence as outlined above. When appropriate, the Certification of Need for Patient Care in Facility Other Than Public or Private General Hospital (Form PA-4) will be submitted to the Disability Review Unit.