# CHAPTER 70

# MEDICALLY NEEDY PROGRAM

**Authority**

N.J.S.A. 30:4D–3i(8), 30:4D–6g, 30:4D–7, 7a, b and c.

**Source and Effective Date**

R.1991 d.331, effective June 7, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 70, Medically Needy Program, expires on June 7, 1996.

**Chapter Historical Note**

Chapter 70, Medically Needy Program, was originally adopted as R.1986 d.237, effective June 16, 1986 (operative July 1, 1986). See: 18 N.J.R. 831(a), 18 N.J.R. 1294(a). Pursuant to Executive Order No. 66(1978), Chapter 70 was readopted as R.1991 d.331, effective June 7, 1991. See: Source and Effective Date.

See section annotations for specific rulemaking activity.

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## SUBCHAPTER 1. INTRODUCTION

### 10:70–1.1 Program scope

(a) The Medically Needy Program, enacted by P.L. 1985, Chapter 371, extends limited Medicaid program benefits to certain groups of medically needy persons whose income and/or resources exceeds the standards for the Medicaid program but are within the standards for the Medically Needy Program, or whose income exceeds the standards for the Medically Needy Program but is insufficient to meet their medical expenses as determined in this chapter.

(b) Eligibility for the Medically Needy Program is limited to the following eligibility groups within the family and adult eligibility categories:

1. AFDC-related:
   i. Pregnant women; and
   ii. Children under 21 years of age.
2. SSI-related:
   i. Persons 65 years of age or older;
   ii. Persons who are blind; and
   iii. Persons who are disabled.

(c) The medical services covered under the Medically Needy Program are limited by eligibility group and by the spend-down provisions of subchapter 6. All restrictions and limitations on services applicable to the Medicaid program apply to services for the Medically Needy. The services

covered under the Medically Needy Program (by eligibility group) are described in N.J.A.C. 10:49–1.4(b).

(d) Retroactive eligibility for the Medically Needy Program is available beginning with the third month prior to the month of application, if members of an eligibility group have incurred expenses for covered services within that period which have not yet been paid and the members would have been eligible for the Medically Needy coverage in the month in which the services were received. Members of the eligibility group need not be eligible for the program at the time of application in order to be eligible for retroactive eligibility. Application for retroactive eligibility may be made on behalf of a deceased person so long as the person was alive during a portion of the retroactive eligibility period and he or she incurred medical expenses for covered services.

1. Retroactive coverage is not available for any period prior to July 1, 1986, the effective date of the Medically Needy Program.

### 10:70–1.2 Purpose of the Medically Needy Manual

(a) Purpose of the regulations contained within this chapter is to:

1. Set forth eligibility for the Medically Needy Program;

2. Establish policy for calculating spend-down liability for persons whose income exceeds the Medically Needy Income Level; and

3. Specify the rights and responsibilities of program applicants and eligible persons.

(b) Circumstances which are neither specifically nor generally addressed in these regulations shall be referred to designated staff of the Division of Medical Assistance and Health Services for resolution.

(c) The director of the county welfare agency shall assign copies of this manual to administrative staff, all Medically Needy Program staff working with applicants and recipients, and to social services staff as appropriate and shall ensure that each staff member is thoroughly familiar with its contents in order to apply the required policy and procedures consistently.

(d) The Division of Medical Assistance and Health Services will issue revisions to the 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.

1. At least one administrative copy of all obsolete pages of the Manual must be maintained by the county welfare agency.

(e) This manual is a public document. It is important that all copies in use be absolutely accurate and up-to-date. The manual is available as follows:

1. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each county welfare agency office for examination or review during regular office hours.

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

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

4. Each legal services office will be furnished with a copy of this manual.

5. Welfare, social service, and other nonprofit organizations will be furnished with a copy of this manual at no cost upon an official written request on agency letterhead to the Division of Medical Assistance and Health Services.

6. 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.

### 10:70–1.3 Administrative organization

The Medically Needy Program is administered by the county welfare agencies under the supervision of the Division of Medical Assistance and Health Services of the Department of Human Services.

### 10:70–1.4 Principles of administration

(a) The following principles of administration apply in the Medically Needy Program.

1. Any individual who believes he or she is eligible shall be afforded an opportunity to make application (or reapplication) for the Medically Needy Program without delay.

2. Program applicants or eligible persons are the primary source of information concerning program eligibility and spend-down liability. The county welfare agency shall, when necessary, in the process of determining eligibility and spend-down liability, use secondary sources of information with the knowledge and consent of the applicant or eligible person.

3. There shall be strict adherence to law and complete conformity with regulations and administrative policy. Requirements other than those established by law or regulation shall not be imposed as a condition of receiving assistance under the Medically Needy Program.

### 10:70–1.5 Confidentiality of information

(a) No member, officer, or employee of the county welfare agency shall produce or disclose any confidential information to any person, except as authorized below.

1. Information considered confidential includes, but is not limited to, the following:

i. Names and addresses;

ii. Medical services provided;

iii. Social and economic conditions or circumstances;

iv. County welfare agency evaluation of personal information; and

v. Medical data, including diagnosis and past history of disease or disability.

2. The county welfare agency may disclose information concerning an applicant or eligible person to persons and agencies directly related to the administration of Medicaid, including the Medically Needy Program. Persons and agencies directly related to program administration are those that are properly authorized to be involved in the:

i. Establishment of eligibility;

ii. Determination of the amount and scope of medical assistance;

iii. Provision of services for recipients; and

iv. Conduct or assisting in the conduct of an investigation, prosecution, or civil or criminal proceeding related to the Medically Needy Program.

3. The county welfare agency may release information whenever the applicant or eligible person waives confidentiality, but only to the extent authorized by the waiver.

4. If a court issues a subpoena for a case record or any other confidential information or for any agency representative to testify concerning an applicant or eligible person, the county welfare agency, personally or through counsel, shall make a statement substantially as follows:

i. "Under provisions of the Social Security Act, information concerning applicants and recipients of Medical Assistance must be restricted to persons directly connected with the administration of such assistance. The authorities of the Federal government have advised that this includes a requirement of nondisclosure of such information in response to a subpoena. If a disclosure is made of this information, either by personal testimony or by production of records, this is considered nonconformance with Federal requirements and may subject the State to loss of Federal financial participation in the Medical Assistance program."

5. In no instance is it intended that any officer or employee of the agency place him or herself in contempt of court through refusal to follow the orders of a court. However, the above action as appropriate shall be taken in all instances, and a report of the results shall be entered in the case record.

6. Pertinent information and records may be released in conjunction with an administrative hearing conducted by the Office of Administrative Law regarding action or inaction by the county welfare agency affecting an applicant's or eligible person's eligibility or entitlement under the Medically Needy Program.

### 10:70–1.6 Materials distributed to program applicants or eligible persons

(a) All materials distributed to applicants or eligible persons must:

1. Directly relate to the administration of the Medicaid program;

2. Have no political implications;

3. Contain names only of individuals directly connected with the administration of the Medicaid program; and

4. Identify those individuals only in their official capacity with the State or the county welfare agency.

(b) The county welfare agency must not distribute materials such as "holiday" greetings, general public announcements, voting information, or alien registration notices.

(c) The county welfare agency may distribute materials directly related to the health and welfare of program applicants and eligible persons, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

### 10:70–1.7 Nondiscrimination

(a) Title VI of the Federal Civil Rights Act of 1964 (Public Law 88–352) and Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the ground of race, color, national origin, or handicap in the administration of any program for which Federal funds are received. Strict compliance with the provisions of this Act and any regulations based thereon is required as a condition of eligibility to receive Federal funds for assistance programs administered through the county welfare agencies. These principles apply to the Medically Needy Program in New Jersey.

1. The county welfare agency shall inform all staff members of their obligations in regard to Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

2. All persons seeking medical assistance shall be informed of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

3. All persons seeking or receiving medical assistance shall be afforded an opportunity to file a complaint alleging discrimination on the ground of race, color, national origin, or handicap. Such complaints may be filed directly with the Regional Manager, U.S. Department of Health and Human Services, Office of Civil Rights, Federal Plaza, New York, New York 10007, or with the Director, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625.

4. In any instance in which a complaint of alleged discrimination is filed with a State or county agency, the complaint shall be forwarded immediately to the Director, Division of Medical Assistance and Health Services. The Director, upon receipt of any such complaint, will take whatever action he or she deems appropriate to the situation. This action may include, but is not limited to, the securing of reports from whatever sources may have knowledge pertinent to the situation and referral to the Division of Civil Rights of the New Jersey Department of Law and Public Safety, for investigation, evaluation, and recommendation by that agency.

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 Division of Medical Assistance and Health Services, or the Division of Civil Rights.

6. The Director, Division of Medical Assistance and Health Services, will be responsible for all final determinations as to whether or not the fact of discrimination has been established and for all decisions as to the disposition of the complaint. In arriving at such determinations, the Director will take into consideration relevant decisions or actions on the part of a court or governmental agency.

7. Each county welfare agency shall comply with the decision of the Director of the Division of Medical Assistance and Health Services on any complaint of discrimination, including the imposition of disciplinary action as found necessary and reasonable in the case of discrimination by a staff member.

**10:70–1.8 Assignment of medical support rights**

(a) Any person who applies for the Medically Needy Program, 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. It is required that program applicants and recipients cooperate in the identification of and the obtainment of any such rights.

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

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## SUBCHAPTER 2. CASE PROCESSING

**10:70–2.1 Application**

(a) Application for the Medically Needy Program shall be accomplished by the completion and signing of Form PA–1G for SSI-related cases and Form PA–1J for AFDC-related cases, as well as, any addenda to those forms as prescribed by the Division of Medical Assistance and Health Services.

1. Application for the Program shall be executed by:

i. A parent, caretaker relative, or guardian for cases with children under the age of 21 residing with a parent or caretaker relative;

ii. A child age 18 or older when not residing with a parent or caretaker relative;

iii. A pregnant woman age 18 or older;

iv. The parent or caretaker relative of a disabled or blind child;

v. The adult seeking benefits as aged, blind, or disabled.

2. For cases which, because of confinement, illness, incapacity, disability, or lack of competence of the person(s) required to execute the application, and for children who not yet attained the age of 18, the application may be executed on such person's behalf by:

i. A relative by blood or marriage;

ii. A staff member of a public or private welfare agency of which the person seeking program benefits is a client, who has been designated by the agency to so act;

iii. The attorney or physician of the person seeking program benefits;

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

3. A legal guardian shall be recognized as an authorized agent to initiate an application for the Medically Needy Program.

(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 and the eligibility requirements for the Medically Needy Program, their rights and responsibilities under the Program, and of their right 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 the community;

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

(c) As part of the application process, the program applicant has the responsibility to:

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

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

3. Report any change in circumstances that may affect program eligibility or amount of benefits;

4. Provide the county welfare agency evidence, as requested, of incurred medical expenses and liability for payment;

5. If applicable, submit to examinations or tests and provide such medical and other evidence as may be necessary to determine disability or blindness.

(d) With the exceptions noted below, disposition of an application for the Medically Needy Program must be accomplished within 30 days of the date of application (or the date of the inquiry form PA–1C, if applicable) for AFDC-related cases and for persons applying on the basis of being aged. The disposition standard for the disabled and blind is 60 days from the date of application (or the date of the inquiry form PA–1C, if applicable).

1. "Disposition of the application" means the official determination by the county welfare agency of application approval or rejection.

2. Disposition of the application may exceed the processing standards when substantially reliable evidence of eligibility or entitlement 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 document that the delay in application processing resulted from one of the following:

i. Circumstances wholly within the applicant's control;

ii. A determination to afford the applicant, whose evidence of eligibility or entitlement is inconclusive, additional time to provide sufficient evidence of eligibility before final action on his or her application;

iii. An administrative or other emergency that could not reasonably be avoided; or

iv. Circumstances wholly outside the control of both the applicant and the county welfare agency.

3. When application processing is delayed beyond the processing standards, the county welfare agency shall provide to the program 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 assure maximum compliance with the processing standards.

i. The county welfare agency will maintain control records which will identify all pending applications which did not meet the processing standards and the reason therefor. That 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 standards:

1. Approved: The applicant(s) has been determined eligible for participation in the Medically Needy Program;

2. Denied: The applicant(s) has been determined ineligible for participation in the Medically Needy Program;

3. Eligible pending spend-down: The applicant(s) is eligible for participation in the Medically Needy Program in all respects except that the countable income of the budget unit exceeds the medically needy income levels. Eligibility for program benefits may be established through medical spend-downs (see subchapter 6);

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

i. The death of the applicant(s) (the application process must be completed if there are unpaid medical bills for covered services incurred in either the retroactive coverage period or subsequent to program application or inquiry);

ii. The applicant(s) cannot be located;

iii. The application was registered in error;

iv. The applicant(s) moved out of the State during the application process (see N.J.A.C. 10:70–2.4 for a move to another county within the State during the application process).

5. Withdrawn: The applicant(s) request that eligibility for the Medically Needy Program not be considered further.

(f) The county welfare agency is required by law (N.J.S.A. 30:6–1) to report to the Department of Human Services, Commission for the Blind and Visually Impaired, every individual coming to its attention who is known to be, or is believed likely to become, permanently blind. Such information shall be reported on a form prescribed by the Commission.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Word "collaborates" deleted in (c)2.

### 10:70–2.2 Interview

A personal face-to-face interview with the program applicant(s) or the authorized agent is required as part of the process of determining program eligibility.

### 10:70–2.3 Collateral verification

(a) Collateral verification is the use of third-party information (both documentary and nondocumentary) from agencies or individuals other than members of the applicant's household to substantiate the accuracy of statements made on the application and during the interview.

1. Program applicants have the primary responsibility for providing verification of factors of eligibility. If it would be difficult or impossible for the applicants to provide necessary verification in a timely manner, the county welfare agency shall provide assistance in obtaining the evidence.

2. In the absence of credible verification of all eligibility factors, eligibility for the Medically Needy Program may not be established.

### 10:70–2.4 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 not to adversely affect the rights of any individual to program entitlement. In a case transfer, the existing eligibility period, as established by the county of origin, does not change.

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) For persons who move from the county in which application for the Medically Needy Program is made prior to a 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 Program, add the eligible persons to the Medicaid Status File (MSF) with the correct effective date of Medically Needy eligibility and the new address (in the receiving county); and

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

2. The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized agent upon receipt of the case material to advise of continued program entitlement or when the case has been determined eligible pending spend-down, to advise that the client should report to the receiving county upon achieving spend-down liability; and

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

(d) For cases which are eligible for the Medically Needy Program and those which have been determined eligible pending spend-down:

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 numbers, the new address in the receiving county, and, if applicable, all necessary spend-down information.

ii. Send with the above case material, a cover letter specifying that the case is being transferred and requesting written acknowledgment 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 case material described in i. or iii. above.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative when case material is received;

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 for 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 Status File (MSF), as necessary. If the case is determined eligible for Medically Needy in the receiving county, there shall be no interruption of entitlement. If the case is determined ineligible for Medically Needy in the receiving county, eligibility shall be terminated, subject to timely and adequate notice, and the previously eligible persons deleted from the MSF; and

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

(e) Any case for which the transfer procedures in (b) through (d) above are not begun within 30 days of the date of original referral, shall be promptly reported by the county of origin to the Division of Medical Assistance and Health Services by letter, setting forth the pertinent available facts.

**10:70–2.5 Redetermination of eligibility**

(a) Eligibility for the Medically Needy Program shall be redetermined as follows:

1. When required, on the basis of information the county welfare agency has obtained previously about anticipated changes in the case situation, or when additional information is necessary to adjust the best estimate of income when such income is subject to significant fluctuation;

2. Promptly, after information is obtained by the county welfare agency which indicates changes in the case circumstances that may affect program eligibility or the amount of benefits received under the Program;

3. For cases not subject to medical spend-down, a full redetermination of program eligibility, no later than six months from the date eligibility was first established or from the date of the last full redetermination;

4. For cases subject to spend-down, a full redetermination of program eligibility, by the completion of the current prospective six-month budget period.

(b) For redeterminations of eligibility required by (a)1 and 2 above, the completion of a new application form and a face-to-face interview are required only if, on the basis of the information obtained, in conjunction with existing case information, the county welfare agency is unable to arrive at a decision regarding eligibility or ineligibility.

(c) Full redeterminations of eligibility ((a)3 and 4 above) require the completion of a new application form and a face-to-face interview. All factors of eligibility subject to change (with the exception of disability and blindness factors; see N.J.A.C. 10:70–2.6) must be verified or reverified.

(d) The responsibilities of the client(s) in the process of eligibility redetermination are the same as those delineated for program applicants at N.J.A.C. 10:70–2.1(c).

**10:70–2.6 Redetermination of medical factors**

(a) Except for persons receiving Social Security benefits as a result of disability or blindness, the factors of disability and blindness will be redetermined at intervals established by the Division of Medical Assistance and Health Services, Disability Review Section.

(b) Any person whose eligibility for the Program is based on a determination of disability or blindness is required to submit to examinations or tests and provide medical and other evidence necessary for the purpose of determining continued disability or blindness.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Disability determinations shifted from Division of Public Welfare, Bureau of Medical Affairs to Division of Medical Assistance and Health Services, Disability Review Section.

**10:70–2.7 Post-application client responsibilities**

(a) Upon a determination of eligibility for the Medically Needy Program, members of the eligibility group (or their authorized agent) have on-going responsibility for the reporting of changes in circumstances and the provision of information as delineated at N.J.A.C. 10:70–2.1(c). Further, as requested by the county welfare agency during the eligibility period, additional or updated information must be provided. At any time the county agency lacks sufficient information to confirm continuing program eligibility because of the unwillingness of the eligibility group to provide necessary information, the agency shall commence action to terminate the case.

## SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

**10:70–3.1 General provisions**

(a) Eligibility must be established in relation to each legal requirement of the Medically Needy Program to provide a valid basis for granting or denying medical assistance.

(b) The applicant's statements regarding his or her eligibility, as set forth in 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, either documentary or nondocumentary.

1. Documentary sources of evidence present factual information recorded at some previous date by a disinterested party and filed as part of a record. Examples: certificates, legal papers, insurance policies, licenses, bills, receipts, notices of RSDI benefits, and so forth.

2. Nondocumentary sources of evidence are factual oral statements, which appear to be reliable, made by individuals based on their observation and personal knowledge of applicant's circumstances.

**10:70–3.2 Citizenship**

(a) In order to be eligible for the Medically Needy Program, an individual must be a citizen of the United States or an alien lawfully admitted for permanent residence or permanently residing in the United States under color of law.

1. The term "citizen of the United States" includes person 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 Medically Needy Program:

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

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

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

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

vi. 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 reasons deemed strictly 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; and

vii. An alien living within 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 judgment of the United States Attorney General that the alien would otherwise be subject to persecution on account of race, religion, or political opinion.

**10:70–3.3 Residency**

(a) In order to be eligible for the Medically Needy Program, an individual must be a resident of the State of New Jersey. State residence shall be determined in accordance with the regulations at N.J.A.C. 10:71–3.5, 3.7, and 3.8.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Changed internal N.J.A.C. cites.

**10:70–3.4 Eligibility group criteria**

(a) Eligibility for the Medically Needy Program is limited to groups of persons within two specified eligibility categories. An individual must meet the definition of one of the categories below to be eligible for the Medically Needy Program.

(b) AFDC-related: The following eligibility groups are within the AFDC-related eligibility category:

1. Pregnant women: Needy women of any age during the term of a medically verified pregnancy, through the end of the month during which the 60th day from delivery occurs.

i. A child born to a woman eligible as a pregnant woman under the provisions of this chapter shall remain eligible for a period 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.

2. Children under the age of 21: Needy children under the age of 21.

i. Children under the age of 21 may be eligible regardless of: Parental deprivation; school attendance; emancipation; residence with parent(s) or other caretaker relative(s); or Work Incentive program (WIN) or other AFDC employment or training requirements.

ii. A child may be eligible for program benefits when temporarily absent from his or her family in accordance with the provisions of N.J.A.C. 10:81–3.32 through 3.34.

(c) SSI-related: The following eligibility groups are within the SSI-related eligibility category:

1. Aged: Needy persons aged 65 years of age or older.

2. Blind: Needy persons who are statutorily blind. Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends at an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

i. Persons who are receiving Social Security disability benefits as a result of blindness are presumed to be blind for purposes of this program.

ii. Except for persons described in (c)2i above, the determination of statutory blindness is the responsibility of the Division of Medical Assistance and Health Services, Disability Review Section.

3. Disabled: Needy persons who are disabled. Disability is the inability to do any substantial gainful activity by reason of any 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. The severity of impairment must be such that the individual is unable to do his or her previous work or any other substantial gainful activity which exists in the national economy. In the determination of a person's ability to do any other work, residual functional capacity, age, education, and work experience are considered.

i. Disability for children under the age of 18 is any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult disabled.

ii. Persons who are receiving Social Security disability benefits are presumed to be disabled for purposes of this program.

iii. Except for persons described in (c)3ii above, the determination of disability is the responsibility of the Division of Medical Assistance and Health Services, Disability Review Section.

(d) Under certain circumstances, an individual may be considered for eligibility under both the SSI-related and AFDC-related categories (for example, a blind child under the age of 21). Such an individual may select the category under which he or she wishes to be considered for program eligibility upon being advised by the county welfare agency of the option and the consequences thereof.

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 and specification of time limit of eligibility of mother after delivery added at (b).
Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Shift in administrative functions from Division of Public Welfare, Bureau of Medical Affairs, Medical Review Team to Division of Medical Assistance and Health Services, Disability Review Section.

**10:70–3.5 Budget unit**

(a) The term "budget unit" means those persons whose income and resources are counted in the determination of eligibility for persons applying for or eligible for the Medically Needy Program. Incurred medical expenses of all members of the budget unit are applied in meeting spend-down liability when applicable (see N.J.A.C. 10:70–6). Only those members of the budget unit who are either SSI-related or AFDC-related (see N.J.A.C. 10:70–3.4) may qualify for coverage under the Medically Needy Program.

(b) For AFDC-related persons (pregnant women and children under the age of 21), the budget unit shall be constituted as follows:

1. A pregnant woman shall comprise a budget unit of two (except in medically verified cases of multiple pregnancy, where the budget unit shall consist of the pregnant woman and the confirmed number of fetuses). If the pregnant woman is married and living with her husband, the budget unit shall consist of one additional person. The woman's natural or adoptive children under the age of 21, living in the same household, shall be included in the budget unit. If the pregnant woman is under the age of 21 and resides in the same household as her natural or adoptive parents, the parents shall be included in the budget unit.

2. For children under the age of 21, the budget unit shall be composed of all blood-related or adoptive brothers and sisters under the age of 21 living in the same household, as well as the natural or adoptive parent(s) of the children when living in the same household.

i. In the event the children under the age of 21 reside with a stepparent, the stepparent may be included in the budget unit. If the stepparent is included in the budget unit, his or her income and resources will be included in the determination of Medically Needy eligibility and his or her medical expenses will apply in the determination of spend-down liability, if applicable. If the stepparent is not to be included in the budget unit, his or her income, resources, and medical expenses will not be included in the determination of Medically Needy eligibility.

ii. The option of including or not including the stepparent in the budget unit, and the consequences thereof, shall be fully explained to program applicants so that an informed decision may be made.

3. Any person who is in receipt of AFDC or SSI or who has applied for and been found eligible for regular Medicaid benefits related to those programs shall not be included in the budget unit of an AFDC-related case. Any person whose income and resources have been deemed to an eligible SSI recipient shall likewise not be included in the budget unit.

(c) For SSI-related persons (aged, blind, and disabled individuals), the budget unit shall be constituted as follows:

1. An aged, blind, or disabled adult not living with his or her spouse is a budget unit of one regardless of the number of other persons (related or unrelated) living in the same household.

2. An aged, blind, or disabled adult living with his or her spouse (whether or not the spouse is program eligible) is a budget unit of two regardless of other persons (related or unrelated) living in the same household (see N.J.A.C. 10:70–4.6(d)1 for an exception to this rule in circumstances involving an SSI-related child).

3. For a blind or disabled child (under the age of 21), the budget unit shall consist of the child. Parental income is deemed to any such child under the age of 18 in accordance with provisions at N.J.A.C. 10:70–4.6(d).

4. For circumstances in which more than one sibling residing in the same household with their parent(s) apply as SSI-related, each such child will be a budget unit of one person and parental income deemed in accordance with provisions at N.J.A.C. 10:70–4.6(d).

5. Any person who is in receipt of AFDC or SSI or who has applied for and been found eligible for regular Medicaid benefits related to those programs shall not be included in the budget unit of an SSI-related case.

6. When one or more siblings of a Medically Needy SSI-related child apply for and are found eligible for the Medically Needy Program as AFDC-related, the SSI-related child will be considered in a budget unit of one. (Parental income and resources will be considered toward the AFDC-related children only.)

(d) In family groups living in the same household, some of the members may qualify as SSI-related and others as AFDC-related. The family's choice of persons for whom Medically Needy benefits are sought will vary the composition of the budget unit and affect eligibility for the program. Available options shall be fully explained to the family by the county welfare agency so that the family may make an informed decision regarding application options.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Change to consider pregnant mother and medically verified number of fetuses in budget unit.

**Cross References**
Special medicaid programs, household units, see N.J.A.C. 10:72–3.5.

### 10:70–3.6 Third party liability

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

### 10:70–3.7 Eligibility under other Medicaid categories

Eligibility for the Medically Needy Program will not be established for any individual who is eligible for Medicaid Only, Medicaid Special, Medicaid for the Unborn, or extended Medicaid benefits resulting from the previous receipt of AFDC. Such individuals are eligible for payment of covered medical services under the categorically needy Medicaid program.

### 10:70–3.8 Persons sanctioned under AFDC rules

(a) Persons who are ineligible for AFDC due to the imposition of a sanction of ineligibility in that program may be eligible for the Medically Needy Program (with the exception below) without regard to the sanction.

1. Any person ineligible for AFDC solely as a result of being on strike is likewise ineligible for the Medically Needy Program. Because caretaker relatives are not eligible for the Medically Needy Program, participation in a strike by the caretaker relative will not affect the eligibility of children applying for the Medically Needy Program.

2. See N.J.A.C. 10:70–4.5(c) for persons ineligible for AFDC due to a period of ineligibility imposed as a result of the receipt of lump sum income.

### 10:70–3.9 Application for other benefits

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

1. Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, Social Security benefits, unemployment compensation.

### 10:70–3.10 Inmates of public institutions

(a) Any person who is an inmate of a public institution is ineligible for the Medically Needy Program.

(b) Any person who is incarcerated in a Federal, State, or local correctional facility (prison, jail, detention center, reformatory, etc.) is not eligible for Medically Needy Program benefits.

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## SUBCHAPTER 4. INCOME ELIGIBILITY

### 10:70–4.1 Medically Needy Income Levels

(a) Income eligibility for the Medically Needy Program may be established by two methods. If the countable income of the budget unit (as determined in this subchapter) is equal to or less than the Medically Needy Income Level (MNIL) appropriate for the budget unit size, income eligibility is established and the eligible persons are entitled to Medically Needy Program payment for covered services. For cases in which the countable income of the budget unit exceeds the appropriate MNIL, income eligibility may only be established through medical spend-down (see N.J.A.C. 10:70–6).

1. The monthly MNIL for budget units consisting of two to ten persons shall be based on the AFDC–C and -F allowance standards (as set forth at N.J.A.C. 10:82–1.2(c)). The allowance standard for the eligible unit size corresponding to the budget unit size will be multiplied by 1.333. The result of this computation shall be multiplied by 12 and the result rounded up to the next nearest $100.00. After rounding, the amount shall be divided by 12. Any cents resulting from this calculation are dropped and the remainder is the monthly MNIL.

2. To establish the monthly MNIL for budget units of more than 12 persons, the calculation in 1. above shall be applied to the AFDC–C and -F increment applicable for each additional person in eligible units of more than 10 persons (see N.J.A.C. 10:82–1.2(c)). The resulting amount for each additional budget unit member shall be added to the monthly MNIL for ten persons.

3. For budget units of one person, the AFDC–C and -F allowance standard for two persons shall be reduced by the increment for each additional person applicable to eligible units of more than ten persons (see N.J.A.C. 10:82–1.2(c)). The result of this computation shall be calculated as in 1. above. The resulting amount is the monthly MNIL for one person.

### 10:70–4.2 Eligibility periods

(a) The retroactive eligibility period is the three calendar months immediately preceding the month in which application for benefits is made.

(b) The prospective eligibility period is the six calendar months beginning with the month of application. Once established, the prospective eligibility period will not be changed unless the case becomes ineligible for the Medically Needy Program during the eligibility period. Upon reapplication for the program, a new prospective eligibility period will be established.

1. Except for certain pregnant women, eligibility does not extend beyond the end of the eligibility period. A pregnant woman, who delivers her child near the end of the six-month eligibility period, may be eligible for a period exceeding six months if her post-partum extended eligibility exceeds the last day of the prospective eligibility period (see N.J.A.C. 10:70–3.4(b)1). In all other cases, continuation of program benefits is contingent upon a redetermination of all factors of eligibility (see N.J.A.C. 10:70–2.5). Any period of eligibility for a pregnant woman which exceeds the prospective eligibility period under the provisions of N.J.A.C. 10:70–3.4(b)1 shall be without regard to income or resources for such additional period of time.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Change in continued eligibility for pregnant women and newborns based on amendments to the Social Security Act (42 U.S.C. 1396a).

### 10:70–4.3 Computing income for six-month prospective period

(a) The county welfare agency shall establish the best estimate of income that will be available in the six-month prospective eligibility period.

1. The best estimate of income shall be based on an average of the budget unit's income for the full two-month period prior to the date of application. Adjustments shall be made in the estimated income to reflect changes in income that either have occurred or are reasonably anticipated to occur which would affect countable income for the prospective budget period. Once established, the best estimate of monthly income shall be applied to each of the six months of the budget period. If the income for the full six-month period is less than or equal to the MNIL for the six-month period, eligibility for program benefits has been established. If the income for the period exceeds the six-month MNIL, eligibility for program benefits may be established through the medical spend-down process.

2. Income changes during the six-month eligibility period require an adjustment to the countable income for the month of the income change and a new best estimate of income must be established for the remaining months of the eligibility period if the change in income will continue.

i. For a case not subject to medical spend-down, an increase in countable income for the remaining months of the eligibility period, will result in the establishment of a spend-down liability if the income for those months exceeds the MNIL for the remaining months.

ii. For a case which has been determined eligible pending spend-down, changes in income during the eligibility period require a recomputation of spend-down liability for the eligibility period which may increase or decrease the liability of the budget unit. If a decrease in income is sufficient to reduce the budget unit's income below the six-month MNIL, eligibility is established without a spend-down liability for the remaining months of the eligibility period.

iii. For a case which has met the spend-down liability during the eligibility period, the recomputation of income for the remaining months of the eligibility period will result in the establishment of an additional spend-down liability if the countable income for the remaining months exceeds the MNIL for those months. Eligibility for the months in which the previously computed liability was met will not be retroactively affected by the new liability established for the remaining months of the eligibility period.

### 10:70–4.4 Computing income for retroactive period

(a) In determining income eligibility for the retroactive eligibility period, countable income actually received in each month of the three-month period shall be compared to the

budget unit's monthly MNIL for the same month. If the countable income for a month is less than or equal to the MNIL, eligibility for program benefits for that month has been established. If the income for a month exceeds the MNIL for that month, eligibility for program benefits may be established through the spend-down process (see N.J.A.C. 10:70–6).

**10:70–4.5 Countable income: AFDC-related cases**

(a) Except as specified below, countable income for AFDC-related cases shall be determined in accordance with regulations applicable to income in the AFDC–C program (see N.J.A.C. 10:82).

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

2. The $30.00 and the one-third disregard of earned income at N.J.A.C. 10:82–2.8(a)3 and 10:82–4.4(c) do not apply.

3. The deeming of stepparent income at N.J.A.C. 10:82–2.9(d) does not apply. See N.J.A.C. 10:70–3.5(b)2 regarding inclusion or exclusion of the stepparent from the budget unit.

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

(b) Nonrecurring lump sum income received by an AFDC-related budget unit shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months. The receipt of such income will require a recomputation of income eligibility for the remaining months of the eligibility period.

(c) Any person who received AFDC or Medicaid based on AFDC rules and became ineligible for such assistance because of a period of ineligibility imposed as a result of the provisions of N.J.A.C. 10:82–4.15 shall likewise be ineligible for the Medically Needy Program for the same period as determined in AFDC. Once imposed, the period of ineligibility may only be reduced in accordance with the provisions of N.J.A.C. 10:82–4.15(a)5.

(d) For AFDC-related cases the following persons are legally responsible relatives to members of the AFDC-related eligibility group: parents of a child under the age of 18; parents of a child aged 18 to 21 unless the child is him or herself a parent; and the spouse of any member of the eligibility group. When a legally responsible relative resides in the same household as the member of the eligibility group, income of the legally responsible relative is counted in accordance with the structure of the budget unit and no additional evaluation of the relative is required. When the eligible group member does not reside in the same household as the legally responsible relative, the county welfare agency shall pursue support from such relative in accordance with the provisions of N.J.A.C. 10:82–3.8 et seq.

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

**10:70–4.6 Countable income: SSI-related cases**

(a) Except as specified below, countable income for SSI-related cases shall be determined in accordance with regulations applicable to income in Medicaid Only—Aged, Blind, and Disabled (see N.J.A.C. 10:71–5).

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

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

(b) Nonrecurring lump sum income received by an SSI-related budget unit shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months. The receipt of such income will require a recomputation of eligibility for the remaining months of the eligibility period.

(c) In the following circumstances, an SSI-related case will have the value of in-kind support and maintenance counted as unearned income.

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

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

(d) In accordance with the rules at N.J.A.C. 10:71–5.5, the income of an ineligible spouse shall be deemed to the eligible spouse when they are residing in the same household. Income of the parent(s) of an SSI-related child under the age of 18 residing in the same household shall be deemed available to the child in the determination of eligibility for Medically Needy benefits. Income shall not be deemed from any person whose income is counted in determining income eligibility for an AFDC-related case which is eligible for the Medically Needy Program.

1. When an ineligible spouse's income must be deemed to both an SSI-related spouse and an SSI-related child, the income of the ineligible spouse is deemed to the SSI-related spouse to the extent that the total income of the SSI-related spouse equals the MNIL for two persons. The excess income of the ineligible spouse is deemed to the SSI-related child. The eligibility of the SSI-related child is based on a budget unit of one person. Allowable incurred medical expenses of the ineligible spouse shall be applied to the spend-down liability, if any, of the SSI-related child.

2. When parental income must be deemed to more than one SSI-related child, income shall be deemed in accordance with the following model based on two SSI-related children. Income to child A is deemed to the extent that the child's total income equals the MNIL for a budget unit of one person. The remaining deemed income shall be deemed to child B. Child A's eligibility will be based on a budget unit of one person (with no spend-down liability) and child B's eligibility will be based on a budget unit of one and the allowable incurred medical expenses of the parents applied to child B's spend-down liability if any. For additional SSI-related children, deeming of income would be to the MNIL for one person for each additional child.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Internal N.J.A.C. cites changed.

## SUBCHAPTER 5. RESOURCE ELIGIBILITY

### 10:70–5.1 Resource eligibility limits

(a) Eligibility for the Medically Needy Program does not exist for any month in which the total value of a budget unit's countable resources exceeds the limits below:

| Budget Unit Size | 1 | 2 | 3 | 4 | 5 | Each Additional |
|---|---|---|---|---|---|---|
| Before 1/1/87 | $3,400 | $5,100 | $5,200 | $5,300 | $5,400 | $100 |
| 1/1/87–12/31/87 | 3,600 | 5,400 | 5,500 | 5,600 | 5,700 | 100 |
| 1/1/88–12/31/88 | 3,800 | 5,700 | 5,800 | 5,900 | 6,000 | 100 |
| 1/1/89 and after | 4,000 | 6,000 | 6,100 | 6,200 | 6,300 | 100 |

### 10:70–5.2 AFDC-related cases

For AFDC-related cases, the resource provisions of AFDC (see N.J.A.C. 10:82) apply in determining countable resources.

1. AFDC provisions requiring the deeming of the resources of an alien's sponsor do not apply in the determination of resource eligibility for the Medically Needy Program.

2. AFDC provisions allowing the establishment of eligibility pending the liquidation of nonexempt resources (N.J.A.C. 10:82–3.6) do not apply in the determination of resource eligibility for the Medically Needy Program. All nonexempt property shall be counted in the determination of resource eligibility.

### 10:70–5.3 SSI-related cases

(a) For SSI-related cases, the resource provisions of the Medicaid Only (Aged, Blind, and Disabled) program shall apply in determining countable resources for the Medically Needy Program.

1. Medicaid Only provisions requiring the deeming of the resources of an alien's sponsor (N.J.A.C. 10:71–4.6(f)) do not apply in the Medically Needy Program.

(b) The provisions relating to deeming of resources found at N.J.A.C. 10:71–4.6 apply in SSI-related cases. In the deeming of resources from one parent to a child, the countable parental resource in excess of the Medicaid Only resource limit for an individual shall be deemed to the child. When the resources of two parents must be deemed to the child, countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Internal N.J.A.C. cites changed.

### 10:70–5.4 Transfer of resources

(a) For AFDC-related cases, the AFDC policy regarding the transfer of resources to qualify for benefits (N.J.A.C. 10:81–3.38(c)) shall apply to all members of the budget unit.

(b) For SSI-related cases, the Medicaid Only Program policy regarding the transfer of resources (N.J.A.C. 10:71–4.7) shall apply to all members of the budget unit.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Internal N.J.A.C. cite changed.

## SUBCHAPTER 6. MEDICAL SPEND–DOWN

### 10:70–6.1 Eligibility under medical spend-down

(a) Persons who are eligible in all respects for the Medically Needy Program, except that the countable income of the budget unit as determined in subchapter 4 exceeds the medically needy income level, may establish eligibility for payment of covered services benefits through medical spend-down.

1. Medical spend-down is a process whereby the excess countable income of a budget unit is offset by the allowable incurred medical expenses of the budget unit.

2. Spend-down liability is the amount by which the countable income of the budget unit exceeds the medical-

ly needy income level as determined under the provisions of this subchapter.

(b) The retroactive eligibility period is the three calendar months immediately preceding the month in which application for benefits is made. For each of the three months, a monthly spend-down liability is established. The monthly spend-down liability shall be the amount by which actual countable income of the budget unit for that month exceeds the medically needy income level for that month.

1. Within the retroactive eligibility period, income eligibility is established for any month in which the allowable incurred medical expenses of the budget unit exceed the spend-down liability established for that month.

2. Eligibility for payment of covered services is established effective with the first day of each or any month in which the allowable incurred medical expenses of the budget unit exceed the spend-down liability only for those claims for services that are not covered under the Medically Needy Program and were not used to meet spend-down liability. (Note: The effective date to be entered in the Medicaid Status File is the day after the day that spend-down liability is met.)

(c) Except for retroactive eligibility, income eligibility for the Medically Needy Program is determined using a six-month prospective eligibility period. The six-month period begins with the month in which application for benefits is made. For the full six-month period, a six-month spend-down liability is established. The six-month spend-down liability shall be the amount by which the countable income of the budget unit, as determined at N.J.A.C. 10:70–4.2, exceeds the budget unit's medically needy income level for the full six-month period.

1. Eligibility for medically needy benefits is established effective with the first day of the month in which the allowable incurred medical expenses of the budget unit exceed the six-month spend-down liability only for those claims for services that are covered under the Medically Needy Program and were not used to meet spend-down liability. (Note: The effective date to be entered on the Medicaid Status File is the day after the day spend-down liability is met.)

2. Changes in the countable income of the budget unit and/or the size of the budget unit during the six-month prospective period require a recalculation of the six-month spend-down liability.

3. In order to receive program benefits, upon meeting the spend-down liability, all other factors of program eligibility must also be met.

### 10:70–6.2 Allowable incurred medical expenses

(a) Allowable incurred medical expenses which may be applied against spend-down liability are those which are:

1. Incurred by a member of the budget unit and for which a member of the budget unit has an express obligation for payment;

2. For necessary medical or remedial services recognized under state law, provided, prescribed, or recommended by a qualified and appropriately licensed medical practitioner; and

3. Submitted with sufficiently detailed information and documentation to determine the allowableness of the expense. Minimum necessary information includes: the date of the service, name of the provider, the nature of the service, the name of the individual to whom the service was provided, and the total amount of the bill, as well as the remaining balance outstanding.

(b) Medical expenses which have been paid in full prior to the retroactive budget period, shall not be applied against spend-down liability. However, medical expenses paid by a member of the budget unit during an eligibility period may be used in meeting spend-down liability so long as the expense met the criteria specified in (a) above.

(c) The county welfare agency shall refer the submission of expenses for questionable medical services to designated staff of the Division of Medical Assistance and Health Services for a determination of allowableness.

(d) To the extent that payment of any bill for medical service is the responsibility of a third party (for example, a health insurer), the expense shall not be applied against spend-down liability. An exception would be made for any medical expense paid by a State or territory, or a subdivision of a State or territory (except for a Medicaid program), if the program is financed by a State or territory.

(e) Any bill for medical services rendered more than six months prior to the bill's submission to the county welfare agency for application against spend-down liability must be accompanied by a statement from the provider that the expense remains an express obligation of a member of the budget unit and has not been forgiven by the provider or otherwise determined uncollectible.

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
Modification of spend-down requirement at (d) based on federal Department of Health and Human Services, (HCFA) in the State Medicaid Manual, Part 3—Eligibility, Transmittal 48, Nov. 1990.

### 10:70–6.3 Application of medical expenses toward spend-down

(a) In determining eligibility under medical spend-down, expenses are applied in the following order against the spend-down liability:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges incurred by a member of the budget unit;

2. Expenses incurred by the members of the budget unit for allowable medical expenses for services not covered under the Medically Needy Program (including covered services provided to members of the budget unit who are not members of a medically needy eligibility category);

3. Expenses incurred by budget unit members, who are also members of a medically needy eligibility category, for services covered by the Medically Needy Program.

(b) Health insurance premiums billed less often than monthly, shall be averaged over the period of coverage that the premium is intended to purchase and applied incrementally against spend-down liability. The client is required to report to the county welfare agency the cancellation of any such insurance.

(c) If a member of a budget unit has arranged to make monthly payments toward a previously incurred medical expense thereby modifying the terms of the liability for the expense, the amount of the monthly obligation rather than the outstanding balance shall be applied against spend-down liability.

(d) Any medical expenses may be applied against spend-down liability only once. However, incurred medical expenses in excess of those required to meet the spend-down liability for a budget period (which have not been applied against spend-down liability), may be applied against spend-down liability in future budget period so long as a member of the budget unit continues to have an express obligation for payment of the expense.

1. If, in any eligibility period, the budget unit does not meet its spend-down liability, the incurred medical expenses that were compared to that spend-down liability are not considered to have been used in meeting spend-down liability. Any such expenses may be applied to subsequent eligibility periods so long as the expenses remain allowable in accordance with N.J.A.C. 10:70–6.2.

(e) In certain circumstances, it may be beneficial to program applicants or recipients to delay the application of incurred medical expenses against spend-down liability. For example: An individual has sufficient incurred medical expenses to establish eligibility under medical spend-down in each of the three months of the retroactive eligibility period. However, during that period, he has no or few incurred expenses for services covered under the Medically Needy Program. The individual may elect to forego eligibility for the months of retroactive coverage and apply the incurred medical expenses against spend-down liability for the prospective eligibility period. In any such circumstances, the county welfare agency shall fully explain the options available and the ramifications thereto.

## SUBCHAPTER 7. OTHER ADMINISTRATIVE REQUIREMENTS

### 10:70–7.1 Notice of county welfare agency decision

(a) The county welfare agency shall promptly notify any applicant for, or recipient of, the Medically Needy Program in writing of any agency decision affecting the applicant or recipient. When a decision relates to any adverse action which may entitle a recipient to a fair hearing, the action may not be implemented until at least ten days after the mailing of the notice (see (f) of this section for exceptions to the ten-day notice).

1. For notices of action adverse to a recipient, the date of mailing of the notice must appear on the notice.

2. Notices of any county welfare agency action must contain the name, address, and telephone number of the legal services agency serving that county.

3. In the case of an applicant or recipient who cannot be located, the notice shall be mailed to his or her last known address.

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

1. All notices of agency decision shall include an explanation of the right to a fair hearing.

2. Notices of agency decisions adverse to the applicant or recipient shall include the citation and title of the regulations upon which the agency decision is based.

(c) For cases which are determined eligible pending spend-down, the notice shall include a statement of the amount of spend-down liability and shall advise the applicant to notify the county welfare agency when that liability is met. The notice shall also advise that the established spend-down liability is subject to a change based on changes in countable income or budget unit size or composition. Further, the notice must specify that eligibility under medical spend-down is contingent on all other factors of eligibility being met at the time that the spend-down liability is met.

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

(e) When the processing of an application will be delayed beyond the standards for disposition of an application as set forth in N.J.A.C. 10:70–2.1(d), notice shall be mailed prior

to the expiration of the disposition period notifying the applicant of the delay and the reasons for it.

(f) The ten-day notice requirement for actions adverse to a program recipient need not be adhered to when:

1. The county welfare agency has factual information confirming the death of a recipient;

2. The county welfare agency receives a clear written statement, signed by a recipient, that he or she no longer wishes to receive program benefits, or which gives information indicating a change in circumstances which requires a termination or reduction in benefits, and the recipient has indicated in writing, that he or she understands that this must be the consequence of supplying such information;

3. The recipient's whereabouts are unknown and agency mail directed to him or her has been returned by the post office indicating no forwarding address;

4. The recipient has been accepted for public or medical assistance in another state and that fact has been established by the county welfare agency; or

5. A recipient child has been removed from the home as a result of a judicial determination, or voluntarily placed in foster care by his or her legal guardian.

**10:70–7.2 Fair hearings**

(a) It is the right of every applicant for or recipient of the Medically Needy Program to be afforded the opportunity for a fair hearing in the manner set forth in N.J.A.C. 10:49–5, including when applicable, continuation of program benefits pending the results of the fair hearing.

(b) Any request for a fair hearing shall be forwarded to the Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625.

**10:70–7.3 Case records**

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

(b) The case record shall include:

1. A record of all county welfare agency actions and decisions relating to the case, as well as, documentary evidence relating to such actions and decisions, including application forms;

2. All medical reports and a record of action of the Disability Review Section as appropriate;

3. All forms relating to financial eligibility including, when appropriate, spend-down liability; and

4. All case-related correspondence, memorandum, and documents except those required by law or regulation to be maintained elsewhere.

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

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

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

Amended by R.1991 d.331, effective July 1, 1991.
See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).
In (b)2, "Medical Review Team" changed to "Disability Review Section."