

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. A Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. A U.S. Citizen I.D. Card (INS Form-197), Naturalization Certificate (INS Form N-550 or N-570);

vi. A Certificate of Citizenship (INS Form N-560 or N-561);

vii. A Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. An American Indian Card with a classification code "KIC" (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos); or

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions).

2. If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, the county welfare agency shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county welfare agency shall file INS Form G-845 along with the alien registration number with the local INS district office to verify status.

3. The following sets forth acceptable documentation for eligible aliens:

i. Lawful Permanent Resident—INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

ii. Refugee—INS Form I-94 annotated with stamp showing entry as refugee under section 207 of the Immigration and Nationality Act and date of entry into the United States; INS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3," or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medicaid eligibility they are considered refugees. Refugees whose status has been adjusted will have INS Form I-551 annotated "RE-6," "RE-7," "RE-8," or "RE-9."

iii. Asylees—INS Form I-94 annotated with a stamp showing grant of asylum under section 208 of the

Immigration and Nationality Act, a grant letter from the Asylum Office of the Immigration and Naturalization Service, Forms 688B annotated "274a. 12(a)(5)," or I-766 annotated "A5."

iv. Deportation Withheld—Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or INS Form I-688B annotated "274a. 12(a)(10)" or I-766 annotated "A10."

v. Parole for at Least a Year—INS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year.

vi. Conditional Entry under Law in Effect before April 1, 1980—INS Form I-94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Forms I-688B annotated "274a. 12(a)(3)" or I-766 annotated "A3."

vii. Cuban Haitian Entrant—INS Form I-94 stamped "Cuban/Haitian Entrant under section 212(d)(5) of the INA."

viii. An American Indian born in Canada—INS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes—a membership card or other tribal document showing membership in tribe is acceptable documentation.

x. Amerasian Immigrant—INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7, or AM8.

4. For aliens subject to the five-year waiting period before eligibility for Medicaid can be established, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county welfare agency should contact the INS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the county welfare agency shall ask the alien to present Form I-94. If that form is not available, the county welfare agency shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county welfare agency shall contact the INS by submitting a Form G-845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following shall serve as documentation:

i. For discharge status, an original, or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

Amended by R.1999 d.253, effective August 2, 1999.
See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).

Rewrote the section.

Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).

See: 31 N.J.R. 2252(a).

Added a new 2 in (a) and added new (b), (c), (d) and (e).

Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.

See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).

Readopted provisions of R.1999 d.254 without change.

10:72-3.3 State residency

(a) In order to be eligible for the Medicaid program, an individual must be a resident of the State of New Jersey. The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

1. If an individual leaves New Jersey with the intent to establish permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, he or she ceases to be eligible to receive Medicaid from this State.

2. When an individual enters this State in order to receive medical care and applies for Medicaid to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making the person ineligible for the Medicaid program. It is the responsibility of the county welfare agency to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

i. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;

ii. Whether there is clear expression of intent on the part of the individual to remain permanently in this State;

iii. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he or she came;

iv. Whether the state in which the individual previously resided recognizes him or her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

3. If, after full consideration of the above factors, the county welfare agency is satisfied that the individual has become a resident of this State, Medicaid eligibility may be established.

Case Notes

Pregnant alien with student visa could not be denied Medicaid. W.W. v. DMAHS, 93 N.J.A.R.2d (DMA) 101.

10:72-3.4 Eligible persons

(a) The following persons who meet all eligibility criteria of this chapter are eligible for Medicaid benefits:

1. Pregnant women: Women of any age during the term of a medically verified pregnancy.

i. A woman who is determined eligible under the criteria of this chapter will, for purposes of eligibility, be considered to be a pregnant woman until the end of the 60-day period beginning with the last day of her pregnancy. Her eligibility as a pregnant woman shall end on the last day of the month in which the 60-day period ends.

2. Children under the age of one.

3. A child born to a woman eligible under the provisions of this chapter (except to a presumptively eligible pregnant woman who has subsequently been found ineligible for the month the child was born) shall remain eligible for a period of not less than 60 days from his or her birth and up to one year, so long as the mother remains eligible for Medicaid, or would remain eligible if pregnant, whether or not application has been made, if the child lives with his or her mother. This also applies to an infant born to a mother whose labor and delivery were covered by Medicaid as emergency services even though the mother cannot receive Medicaid services except for emergency services.

4. Any child receiving Medicaid under the provisions of this chapter who but for the age limits in (a)2 above would be eligible for Medicaid under the provisions of this chapter and who is receiving inpatient services covered by

in excess of the Medicaid Only resource limit for an individual shall be deemed to the blind or disabled child. When the resources of two parents must be deemed to a child, the countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

3. For aged, blind or disabled persons, the policy concerning transfer of resources within 36 months of the date of application (see N.J.A.C. 10:71-4.7), applies equally to eligibility under this chapter for individuals seeking eligibility for institutional services through long-term care (LTC) facilities or Home- and Community-Based Waiver (HCBW) services.

(c) Effective with the first month of coverage, resource eligibility limits for participants in the NJ WorkAbility program shall be as specified in N.J.A.C. 10:72-9.5.

(d) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

Emergency Amendment, R.1988 d.96, effective February 2, 1988 (expired April 2, 1988).

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

Recodified from 10:72-4.4 and substantially amended.

Adopted Concurrent Proposal, R.1988 d.212, effective May 16, 1988.

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

Emergency Amendment, R.1991 d.223, effective March 28, 1991 (operative April 1, 1991; expires May 27, 1991).

See: 23 N.J.R. 1200(a).

Adopted Federally required coverage pursuant to Omnibus Budget Reconciliation Act of 1989.

Adopted Concurrent Proposal, R.1991 d.302, effective May 24, 1991.

See: 23 N.J.R. 1200(a), 23 N.J.R. 1945(a).

Provisions of emergency amendment R.1991 d.223 readopted without change.

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

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

Transfer of resources provision at (b)3 changed from 24 to 30 months.

Amended by R.1993 d.369, effective July 19, 1993.

See: 25 N.J.R. 1042(b), 25 N.J.R. 3217(a).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Special amendment, R.2002 d.31, effective December 26, 2001 (to expire June 26, 2002).

See: 34 N.J.R. 600(a).

Added (c).

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (d).

Amended by R.2002 d.317, effective September 16, 2002.

See: 34 N.J.R. 600(a), 34 N.J.R. 1402(a), 34 N.J.R. 3270(a).

Amended by R.2008 d.30, effective January 22, 2008.

See: 39 N.J.R. 3704(a), 40 N.J.R. 723(a).

In the introductory paragraph of (b), deleted the comma following "blind"; and rewrote (b)3.

SUBCHAPTER 5. ADMINISTRATIVE REQUIREMENTS

10:72-5.1 Notice of the county welfare agency decision

(a) The county welfare agency shall promptly notify any applicant for, or beneficiary of, the Medicaid program in writing of any agency decision affecting the applicant or beneficiary. When a decision relates to any adverse action which may entitle a beneficiary to a fair hearing, the action may not be implemented until at least 10 days after the mailing of the notice (see (e) below for exceptions to the 10-day notice requirement).

1. For notices of action adverse to a beneficiary, 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 beneficiary 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 and factual legal basis for the decision.

1. All notices of the 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) 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 beneficiary) advise of the right to reapply whenever the applicant or beneficiary believes that circumstances have changed such that the reason for program ineligibility no longer exist.

(d) 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. 10:72-2.1(d), notice shall be mailed prior to the expiration of the disposition period notifying the applicant of the delay and the reasons for it.

(e) The 10-day notice requirement for actions adverse to a program beneficiary need not be adhered to when:

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

2. The county welfare agency receives a clear written statement, signed by the beneficiary, 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 beneficiary has indicated in writing that he or she understands that this must be the consequence of supplying such information;

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

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

5. A beneficiary 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.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

10:72-5.2 Fair hearings

(a) It is the right of every applicant for, or beneficiary of, the Medicaid program to be afforded the opportunity for a fair hearing in the manner set forth in N.J.A.C. 10:49, 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, Office of the Legal and Regulatory Liaison, PO Box 712, Trenton, New Jersey 08625-0712.

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

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

Address changed.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.2008 d.30, effective January 22, 2008.

See: 39 N.J.R. 3704(a), 40 N.J.R. 723(a).

In (a), inserted commas following the first occurrences of "for" and "of" and updated the N.J.A.C. reference.

10:72-5.3 Case records

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

(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 forms relating to financial eligibility.

3. 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.

SUBCHAPTER 6. PRESUMPTIVE ELIGIBILITY

10:72-6.1 Scope

(a) The presumptive eligibility determination makes it possible for a pregnant woman to receive ambulatory prenatal care from a Medicaid participating provider for a temporary period prior to application for Medicaid benefits and while a Medicaid application is being processed by the county welfare agency. Presumptive eligibility continues until the county welfare agency reaches its formal eligibility determination as follows:

1. The period of presumptive eligibility begins on the date a qualified provider determines that, based on information provided by the pregnant woman, the woman meets the requirements and standards of this chapter applicable to pregnant women.

2. The period of presumptive eligibility will terminate:

i. If the woman has filed an application with the county welfare agency, on or before the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the date a determination of eligibility or ineligibility for Medicaid is made by the county welfare agency; or

ii. If the pregnant woman fails to file an application with the county welfare agency, on the last day of the month subsequent to the month in which she was determined presumptively eligible.

(b) A qualified provider shall be:

1. A participating Medicaid provider;

2. Currently certified by the New Jersey Department of Health as a provider of HealthStart Comprehensive Maternity Care Services (see N.J.A.C. 10:49-3). A provider certified only for Medical Maternity Care Services, Health Support Services, or Pediatric Preventive Services shall not be a qualified provider for purposes of this subchapter;

3. A provider of the following services:

- i. Outpatient hospital services; or
- ii. Clinic services furnished by or under the direction of a physician, without regard to whether or not the clinic itself is administered by a physician; and

4. Trained and approved by the Division of Medical Assistance and Health Services for the purposes of making presumptive eligibility determinations.

- i. The Division of Medical Assistance and Health Services will monitor the presumptive eligibility determinations made by qualified providers. In the event the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to procedural requirements, appropriate staff of the Division will initiate corrective action. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements will result in the Division revoking approval for that provider to make presumptive eligibility determinations.

Amended by R.1989 d.498, effective September 18, 1989.

See: 21 N.J.R. 1791(a), 21 N.J.R. 2998(a).

Clarification of process for presumptive eligibility.

Amended by R.1992 d.10, effective January 6, 1992.

See: 23 N.J.R. 2827(a), 24 N.J.R. 100(a).

Added new text to (a) and (a)2i. and ii. regarding presumptive eligibility.

In (b)4.i.: technical revisions.

10:72-6.2 Responsibilities of a qualified provider

(a) From preliminary information provided by a woman whose pregnancy has been medically verified, the qualified provider shall determine if the pregnant woman meets the eligibility criteria of this chapter as it applies to pregnant women. The qualified provider must obtain sufficient information from the pregnant women to complete the Certification of Presumptive Eligibility (FD-334) by having the pregnant women complete, sign and date a referral for Medicaid benefits as designated and provided by the Division of Medical Assistance and Health Services. For purposes of the presumptive eligibility determination, the qualified provider shall request from the pregnant woman only that information necessary to determine her presumptive eligibility or ineligibility. The qualified provider shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the pregnant woman's statements.