

State of New Jersey
Department of Institutions and Agencies
Division of Public Welfare
Bureau of Institutional Services

MEDICAL ASSISTANCE FOR THE AGED

IN

PUBLIC HOSPITALS FOR MENTAL DISEASES

AND TUBERCULOSIS

MANUAL OF ADMINISTRATION

SUPPLEMENT

NJ/KA8
IS/A26

Supplement.

DO NOT CIRCULATE

January, 1967

State of New Jersey
Department of Institutions and Agencies
Division of Public Welfare - Bureau of Institutional Services

TRANSMITTAL LETTER
MAA-S #7

MEDICAL ASSISTANCE FOR THE AGED
MANUAL OF ADMINISTRATION SUPPLEMENT

June 10, 1968

TO: DISTRIBUTION LIST

Attached is new and revised material for the Medical Assistance for the Aged Manual Supplement. This material becomes effective upon receipt.

Attached Pages (6/68)

S-3000 - Appendix I ✓
S-3100 - Appendix I ✓
S-3110. - S-3112.1 ✓
S-3122. - S-3123.2 ✓
S-3340. - S-3341. ✓

Superseded Pages

S-3000 - Appendix I (1/67) ✓
S-3100 - Appendix I (1/67) ✓
S-3110. - S-3112.1 (1/67) ✓
S-3122. - S-3123.2 (1/67) ✓
S-3340. - S-3341. (1/67) ✓

copy 4/17/69

Explanation

S-3000 - Appendix I revised to include the additional requirement of client's "consent" whenever additional and secondary sources must be used in the determination of eligibility.

S-3100 - Appendix I incorporates new Form PA-1 and instructions for use into manual supplement.

S-3111.2 incorporates revisions in the Form PA-1. General permission is no longer included for the BIS to consult other sources.

S-3123.2 - clarifies general policy regarding collateral contacts.

S-3340.1 additional section clarifies the bases upon which contacts with relatives may be made.

Instructions

Please remove superseded pages and replace with new material.

Very truly yours,

Edward D. Welsh

EDW:gp
Attachments

Edward D. Welsh, Chief
Bureau of Institutional Services
Division of Public Welfare

Approved
Irving J. Engelman, Director
Division of Public Welfare

State of New Jersey
Department of Institutions and Agencies
Division of Public Welfare - Bureau of Institutional Services

TRANSMITTAL LETTER
MAA-S #6

MEDICAL ASSISTANCE FOR THE AGED
MANUAL OF ADMINISTRATION SUPPLEMENT

TO: DISTRIBUTION LIST

December 7, 1967

Attached is new and revised material for the Medical Assistance for the Aged Manual Supplement. This material becomes effective upon receipt.

<u>Attached Pages</u>	<u>Superseded Pages</u>
S-2400. - S-2402.	S-2400. - S-2402.
S-3100. - S-3101.4	S-3100. - S-3101.3
S-3120. - S-3120.1	S-3120. - S-3120.1
S-3822. - S-3823.	S-3822. - S-3823.
S-3823. - S-3824.	S-3823. - S-3824.
S-6200.	S-6200.

Explanation

S-2400.1 clarifies method of computing current rates for hospitalization.
S-3101.2 amended to clarify the term applicant and authorized agent.
S-3101.4 specifies who may act as authorized agent for those alleged to be mentally incompetent.
S-3120.1 amended to clarify policy on visits to clients as a necessary factor in determining eligibility.
S-3822.h* supplemented to clarify emergency readmission procedures for discharged patients.
S-6200. supplemented to specify caseload and supervisory standards.

Instructions

Please remove superseded pages & replace with new material. Insert in section S-1100 the two agreements between Division of Mental Health & Hospitals - Division of Public Welfare & Essex County Overbrook Hospital - Division of Public Welfare immediately following Appendix I of S-1100.

Pen and Ink Corrections

Enter following at appropriate places in the Table of Contents:

S-2400.1 Rates
S-3101.4 Authorized Agent for Persons Alleged to be Mentally Incompetent.

Very truly yours,

Edward D. Welsh
Edward D. Welsh, Director
Institutional Services Project
Division of Public Welfare

EDW:gp
Attachments

Approved
Irving J. Engelman, Director
Division of Public Welfare

me

State of New Jersey
Department of Institutions and Agencies
Division of Public Welfare - Bureau of Institutional Services

TRANSMITTAL LETTER
MAA-S #5

MEDICAL ASSISTANCE FOR THE AGED
MANUAL OF ADMINISTRATION SUPPLEMENT

September 29, 1967

TO: DISTRIBUTION LIST

Attached is new and revised material for the Medical Assistance for the Aged Manual Supplement. This material becomes effective upon receipt.

Attached Pages

S-3900 Table of Contents (p.i) (9/67)
S-3900. - S-3910. (9/67)

Superseded Pages

S-3900 Table of Contents (p.i) (1/67)
S-3900. - S-3910. (1/67)

Explanation

S-3910. recognizes that the policies and procedures concerning complaints, appeals and fair hearings shall apply to the program of MAA in the same manner and extent as to other categorical assistance programs.

Instructions

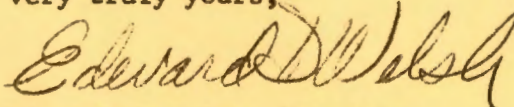
Please remove superseded pages and replace with new material.

Pen and Ink Corrections

Enter following change at appropriate place in General Table of Contents:

S-3910. Complaints, Appeals and Fair Hearings

Very truly yours,



Edward D. Welsh, Director
Institutional Services Project
Division of Public Welfare

EDW:gp
Attachments

Approved
Irving J. Engelman, Director
Division of Public Welfare

ml

NS/KAS
IS/A26

State of New Jersey
Department of Institutions and Agencies
Division of Public Welfare - Bureau of Institutional Services

TRANSMITTAL LETTER
MAA-S #4

MEDICAL ASSISTANCE FOR THE AGED
MANUAL OF ADMINISTRATION SUPPLEMENT

September 6, 1967

TO: DISTRIBUTION LIST

Attached is new and revised material for the Medical Assistance for the Aged Manual Supplement. This material becomes effective upon receipt.

Attached Pages

S-2400 - Appendix I (8/67) ✓
S-3100 - Appendix VII (8/67) ✓
S-3100 - Appendix IX (8/67) ✓
S-3200 Table of Contents (p.ii) (8/67) ✓
S-3250. - S-3251.2 (8/67) ✓
S-3322.3 - S-3322.5 (8/67) ✓
S-3342. - S-3343.2 (8/67) ✓
S-3300 - Appendix II (8/67) ✓
S-3300 - Appendix III (8/67) ✓
S-3300 - Appendix IV (8/67) ✓
S-3400 - Appendix I (p.2) (8/67) ✓

Superseded Pages

S-2400 - Appendix I (1/67) ✓

S-3200 Table of Contents (p.ii) (6/67) ✓
S-3250. - (1/67) ✓
S-3322.3 - S-3322.5 (6/67) ✓
S-3342. - S-3343.2 (1/67) ✓

S-3300 - Appendix IV (1/67) ✓
S-3400 - Appendix I (p.2) (6/67) ✓

Explanation

S-2400 - Appendix I amended to show revised per diem rates for state hospitals.

S-3100 - Appendix VIII provides instructions for use of Application Register (PA-9B).

S-3100 - Appendix IX provides instructions for use of Referral Register (PA-9C).

S-3251.1 establishes policy concerning medical eligibility in cases of release from the hospital for a temporary period.

S-3251.2 establishes policy concerning medical eligibility in cases of release from the hospital for an indefinite period without discharge.

S-3322.5 amended to clarify that a purpose of the Reserve Fund is to provide for expenses of burial; amended to confirm that exemptions to establish the Reserve Fund are allowed once only.

S-3342.1 and .2 amended for proper reference to schedules for determining financial capacity to pay for or contribute to care or service.

CJY 4/17/69

S-3300 - Appendix II establishes policy and procedure for determining financial capacity to pay for care or service.

S-3300 - Appendix III establishes policy and procedure for determining financial capacity to contribute to care or service.

S-3300 - Appendix IV amended to make numbering of sections consistent with revisions in Categorical Assistance Budget Manual.

S-3400 - Appendix I amended to establish policy concerning effective date of termination in cases of release from the hospital for an indefinite period without discharge.

Instructions

Please remove superseded pages and replace with new material.

Pen and Ink Corrections

Enter following at appropriate places in General Table of Contents:

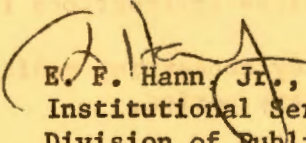
<u>S-2401.</u>	Services Provided in Public Psychiatric and Tuberculosis Hospitals
<u>S-2402.</u>	Supplementary Payment for Services Provided in Voluntary Hospitals
<u>S-3251.</u>	Release from the Hospital
<u>S-3270.</u>	Involuntary Detention
<u>S-3725.</u>	Funds Received by Representative Payees, Guardians or Legal Representatives
<u>S-3726.</u>	Benefits under Part A, Title XVIII, Federal Social Security Act
<u>S-6200.</u>	CASE LOAD AND SUPERVISORY STANDARDS

S-3100 - Appendix VII:

After Institutional Code Number 15, change to read "Essex County Overbrook Hospital".

After Institutional Code Number 16, change to read "Meadowview Hospital (Hudson County)".

Very truly yours,


E. F. Hann, Jr., Director
Institutional Services Project
Division of Public Welfare

EFH:np
Attachments

Approved
Irving J. Engelman, Director
Division of Public Welfare

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S-0000 Introduction

S-0000. FEDERAL SOCIAL SECURITY ACT

S-0001. Legal Citation

The Social Security Act Amendments of 1962 (P.L. 86-788), through what is commonly known as the "Kerr-Mills" provisions, made Federal matching funds available for State programs of Medical Assistance for the Aged (MAA). The MAA program is not assigned a new title in the Social Security Act, but is incorporated with OAA in Title I primarily to expedite the development of State plans.

The Social Security Act Amendments of 1965 (P.L. 89-97) made Federal matching funds available to states which extended their MAA programs to include persons who are patients in public hospitals for mental diseases and tuberculosis. These amendments also removed the 42 day limitation on Federal matching funds for medical assistance to persons receiving care in other medical institutions as a result of a diagnosis of tuberculosis or psychosis.

S-0002. General and Special Federal Requirements

A State Plan for MAA must conform to the same Federal requirements as are common to all assistance programs, except that in determining need an individual's income and resources may be considered according to State determined standards that are different from those applicable to the other assistance programs. There are, however, the following special plan requirements:

- a. There can be no concurrent receipt of MAA and OAA except in the month of admission to or discharge from a medical institution;
- b. There must be no required durational residence in the State;
- c. There must be no imposition of a premium, enrollment fee or similar charge; and
- d. There must be no lien for repayment of assistance imposed prior to death, and no involuntary recovery during the lifetime of the recipient and the surviving spouse of any assistance correctly paid.

S-0000

Introduction

S-0000. FEDERAL SOCIAL SECURITY ACT (Cont'd.)

S-0003. State Determination of Scope of Program

Subject to the requirements mentioned above, each state may determine the nature and scope of its own MAA program. The extent of the services to be provided, the standards of individual eligibility, and the standards and rates of payment, are all matters of state policy.

S-0000 Introduction

S-0010. NATURE OF THE PROGRAM

S-0011. Purpose and Intent

It is intended that MAA shall extend assistance to individuals who can normally maintain themselves and their families but who are unable to meet the costs of specified types of medical care. This necessarily implies a higher standard of financial eligibility for MAA, but if such individuals can be protected from depletion of their resources through heavy medical expenses their subsequent need for public assistance can be obviated. On the other hand, services are also provided through MAA to eligible needy aged persons who might otherwise be financially eligible for public assistance.

S-0012. Contrast with other Public Assistance Programs

In contrast with other public assistance programs, MAA contemplates expenditures for medical care only, and not for income maintenance. Assistance payments under MAA may include the costs of non-medical maintenance items if State policy so determines, but under present Federal legislation such costs are not matchable. In further contrast with other programs, the process of preparing a client's budget involves only the determination of available income and resources. When a person has been found eligible for MAA, the allowances are specified by the established rates of payment for the authorized services required by such person.

S-0000 Introduction

S-0020. INFORMATION ON THE MANUAL

S-0021. Organization as a Separate Manual and Supplement

The basic MAA Manual has been developed as a statement of policy and procedure separate from all other assistance programs and applicable only to MAA. The format is such that the Manual, with a minimum of reference to other materials, will serve as the State Plan for MAA. So far as possible the outline for the MAA Manual has been made consistent with the organization of the Manual of Administration for the other categorical assistance programs and the same instructions for use and maintenance will be applicable. Forms with instructions, and other reference materials, have been incorporated as appendices to the major sections where their use is prescribed.

This Manual Supplement has been developed for use in administering that segment of the MAA program which provides medical assistance to persons in public hospitals for mental diseases and tuberculosis. The format and outline of the basic MAA Manual have been retained, but certain sections have been omitted, condensed or modified as consistent with the specific use.

S-0022. Referrals to other Manual Material

Certain factors such as determination of age, determination of county responsibility in respect to customary place of abode, and identification of eligible institutions are the same for MAA as for OAA or DA. In addition, the policies concerning fair hearings, safeguarding information and merit system administration have equal application to all categorical assistance programs.

In order to avoid unjustified duplication, the basic MAA Manual contains a limited number of references to other published materials which already set forth the policies and procedures applicable to these factors. However, those references which apply to assistance for persons in public hospitals have been included as appendices in this Supplement.

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T A B L E O F C O N T E N T S

CHAPTER S-1000

STATUTORY AUTHORITY

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Part I	State Law and Administrative Organization
S-1000	Statutory Authority

S-1000. STATUTORY AUTHORITY

S-1001. Legal Citation

The New Jersey program of Medical Assistance for the Aged was established by Chapter 222, P.L. 1962, approved January 14, 1963 with effective date of July 1, 1963. By its title this legislation supplements Title 44 of the Revised Statutes.

S-1002. Reference to R.S. Title 44, Chapter 7

Section 4 of the MAA law specifically provides that this program "shall be administered in accordance with the provisions of Chapter 7 of Title 44 of the Revised Statutes . . .," excepting certain sections.

.1 Purport of Included Provisions

Subject to the excepted sections of R.S. Title 44, Chapter 7, the program of MAA is to be administered in the same manner as other categorical assistance programs. In further clarification of this fact, an amendment to R.S. 44:7-1 provides that wherever the term "old age assistance" is used in Chapter 7 of Title 44 it shall, unless otherwise indicated, be taken to include "all programs of assistance . . . authorized to be administered by or through the county welfare boards." This Manual Supplement provides certain adaptations to deal with the specific administrative problems incident to medical assistance for persons receiving in-patient care in public hospitals for mental diseases and tuberculosis.

.2 Purport of Excluded Provisions

Those sections of R.S. Title 44, Chapter 7, which do not apply to MAA, and the results of these exclusions, are as follows:

44:7-3 and 44:7-5 - The specific and more limited eligibility requirements for OAA are not relevant to MAA.

44:7-14 through 44:7-16 - All of the incidents of the agreement to reimburse, and the liens resulting therefrom, have no application to MAA.

44:7-25 - The Formula for sharing of costs of OAA between state and county governments has no application to MAA.

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APPENDIX

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Part I	State Law and Administrative Organization
S-1100	Statutory Authority - Administrative Organization

S-1100. ADMINISTRATIVE ORGANIZATION

S-1101. Department of Institutions and Agencies

The Department of Institutions and Agencies is the administrative unit of state government which has general cognizance over the administration of MAA. In the terminology of Federal law and regulations this Department is the "single state agency." Under the terms of the MAA law, this Department is responsible for the general policies governing administration of MAA, and for effecting the issuance of rules, regulations and administrative orders implementing the statutory provisions.

.1 Division of Public Welfare

The Division of Public Welfare is the administrative unit of the Department of Institutions and Agencies responsible for coordinating the administration of MAA with other public welfare and public assistance programs. This Division also provides administrative liaison with the other departmental divisions.

a. Bureau of Medical Affairs

The Bureau of Medical Affairs was created by the MAA statute as a unit of the Division of Public Welfare. It provides a professional medical and para-medical staff which is advisory to the Division in all matters of health care relevant to public welfare and public assistance programs. This Bureau is specifically responsible by law to survey and maintain a roster of facilities for health services; develop plans, standards and rates of payments for health services; and provide professional and technical consultation to other units of the Division and the local public welfare agencies.

b. Bureau of Institutional Services (BIS)

Administration of MAA for persons in public hospitals for mental diseases and tuberculosis requires liaison with such hospitals and community contacts in all counties of the State. This activity is administered through area offices of the Bureau of Institutional Services, a unit of the Division of Public Welfare having state-wide jurisdiction. In providing assistance and services to such persons this Bureau exercises or participates in certain administrative activities and functional tasks which would otherwise devolve upon a county welfare board. (See S-1100, Appendix I)

Part I	State Law and Administrative Organization
S-1100	Statutory Authority - Administrative Organization

S-1101. Department of Institutions and Agencies (Cont'd.)

.2 Division of Mental Health and Hospitals

The Division of Mental Health and Hospitals is the administrative unit of the Department of Institutions and Agencies responsible for planning, developing and coordinating a comprehensive mental health program for the State, including those services provided through the State mental hospitals. This Division cooperates with the Division of Public Welfare in the administration of MAA for persons in public hospitals as provided in S-1100, Appendix II.

S-1102. County Welfare Board

.1 Basic Administrative Responsibilities

Each county welfare board, individually or in cooperation with BIS as to persons in public hospitals for mental diseases and tuberculosis, is responsible for the administration of the MAA program within its own geographical area of jurisdiction. In the terminology of Federal law and regulations the county welfare board is the "single local agency." Responsibility for administration includes receipt and processing of applications for medical assistance; investigation and determination as to all factors affecting eligibility, with consequent notice to essential parties of the decision reached; authorization and processing of payments for services on behalf of eligible individuals; reinvestigation and re-determination of continuing eligibility; provision of supportive social services which will enhance cure and rehabilitation; and termination of medical assistance upon cessation of eligibility or need.

.2 Conformance to State Law and Regulations

In carrying out its assigned responsibilities for administration of the MAA program each county welfare board is charged with assuring conformance with State law and official regulations and directives issued pursuant thereto, submitting prescribed reports, and making its files and records available for review by authorized representatives of the Division of Public Welfare.

Part I	State Law and Administrative Organization
S-1100	Statutory Authority - Administrative Organization

S-1103. County Court and County Adjuster

.1 Responsibilities

Under the New Jersey laws with respect to commitment and admission to public hospitals (R.S. Title 30, Chapter 4, Article 3), persons may be admitted by voluntary application or involuntarily for a temporary period. However, continuance of care on an involuntary basis requires an order of commitment by the County Court. Such order may also determine county settlement and direct payments toward the cost of care by the patient and/or legally responsible relatives, but this is not required where acceptable provision is made for paying the costs of care and maintenance. (R.S. 30:4-63)

The County Adjuster is responsible for supervision of the papers relating to commitment, and is normally designated by the court to act as referee in taking testimony on questions of county settlement and financial ability of the patient or legally responsible relatives.

.2 Records

The County Adjuster maintains official records of testimony, findings and recommendations as to county settlement and financial ability of the patient and legally responsible relatives. Copies of orders of commitment are also maintained in the files of the County Adjuster.

BUREAU OF INSTITUTIONAL SERVICES

Area Organization

<u>Area</u>	<u>Hospitals Served</u>	<u>Counties Served</u>	
No. 1	Greystone Park Overbrook (Essex County) Essex County Sanatorium	Bergen Essex Morris	Passaic Sussex
No. 2	Marlboro	Middlesex Monmouth	Ocean Union
No. 3	Trenton Neuro-Psychiatric Institute Glen Gardner	Hudson Hunterdon Mercer	Somerset Warren
No. 4	Ancora	Atlantic Burlington Camden Cape May	Cumberland Gloucester Salem

Area Office Responsibility

1. In receiving and processing applications, and during time client is an in-patient, area office of responsibility is determined by the hospital served.
2. When client is released from the hospital to an alternative plan of care, area office of responsibility is determined by the county served.
3. Liaison relationships with a county welfare board, and visits and contacts in any county as required for eligibility determination or provision of services, are the responsibility of the area office serving that county. For these purposes referrals will be made by and between area offices as required, with the referring office providing information adequate to identify and support the action requested.

State of New Jersey
Department of Institutions and Agencies
Division of Mental Health and Hospitals - Division of Public Welfare

AGREEMENT

In order to provide an effective program of care, treatment, assistance and services for patients 65 years of age and older in the state mental hospitals, the Division of Mental Health and Hospitals and the Division of Public Welfare jointly promulgate this agreement.

A. This agreement is applicable to, and is intended for the benefit of patients 65 years of age and older in, the State Hospital at Trenton, the State Hospital at Greystone Park, the State Hospital at Marlboro, the State Hospital at Ancora and the Neuro-Psychiatric Institute, hereinafter referred to collectively as "the Hospital."

B. This agreement is applicable to the Bureau of Institutional Services and other administrative units of the Division of Public Welfare, and the county welfare boards as appropriate, hereinafter referred to collectively as "the agency."

C. The Division of Mental Health and Hospitals agrees:

1. The hospital in addition to providing adequate medical treatment will provide for an initial medical, psychiatric and social evaluation of patients within 30 days of admission, and will provide for such evaluation periodically thereafter, all of which will be recorded together with plans and assessments of the treatment and progress of each patient.
2. The hospital will cooperate with the agency in screening and referral of patients who appear eligible for public assistance in order that the agency may make a prompt determination of eligibility and need for assistance and services.
3. The hospital, with appropriate consultation, and in a manner appropriate to the patient's condition and the hospital's normal functioning, will provide for access by the agency to the hospital, the patient and the patient's records as necessary for the agency to carry out its responsibilities.
4. The hospital will maintain a medical and social history for each patient found eligible to receive public assistance as a basis for developing and implementing an appropriate plan of care and service.
5. The hospital through its social service staff, with appropriate cooperation of the agency staff as specific service responsibilities may be delegated, will provide psychiatric and medical social services consistent with the plan of care and service for each recipient-patient:
 - a. to maintain or restore the greatest possible degree of health and independent functioning;
 - b. to assist effective use of the hospital treatment and rehabilitative resources;
 - c. to encourage the continuation or development and maintenance of family and community interests and relationships; and

d. to plan for and effectuate release from the hospital to an alternative method of care.

6. The hospital will give constant attention to plans for alternative methods of care for recipient-patients and will initiate such planning at the time of admission. There will be special and particular attention given to the feasibility of an alternative method of care for each recipient-patient who had been hospitalized prior to the execution of this agreement and whose hospital stay has continued for over twelve months.

7. The hospital will release recipient-patients to alternative methods of care only on the basis of joint planning with the agency.

8. The hospital will provide methods for handling, protecting and accounting for the funds of each recipient-patient, including those funds made available through public assistance for personal incidental expenses.

9. The hospital will provide to the agency such information as may be necessary for completing reports required by the Federal government.

D. The Division of Public Welfare Agrees:

1. The agency will receive and promptly process applications for public assistance filed by or on behalf of patients, and will notify the hospital and the patient of the decision on each application.

2. When a patient is determined eligible to receive public assistance, the agency will provide for periodic payments to the hospital for the costs of care and treatment received by the recipient-patient on and after 30 days preceding the date of application for public assistance, but not earlier than January 1, 1967. Such payments will be based on the number of days of care received during the period, times the currently effective per diem rate approved for payment through public assistance.

3. The agency will provide for each recipient-patient a money payment to cover personal incidental expenses when such is not available from personal income or other sources.

4. The agency will determine and redetermine the financial capacity of the patient and/or legally liable relatives to make payments or contributions toward the costs of hospital care, and will take appropriate action as may be necessary for collection of such payments or contributions.

5. The agency will cooperate with the hospital in providing social services for recipient-patients:

a. within the hospital as specific service responsibilities may be delegated; and

b. outside the hospital as may be appropriate in planning, effecting and supporting release to an alternative method of care.

6. The agency will maintain a case record for each recipient-patient, including a social study showing current personal and social needs and a plan of service, and an evaluation of the patient's financial resources and a plan for use of such resources in meeting needs. Information from such records will be made available to the hospital as necessary to carry out the plan of service.

E. The Division of Mental Health and Hospitals and the Division of Public Welfare jointly agree:

1. Guides and instructions will be provided to the hospital and the agency as required to discharge their respective responsibilities.
2. Medical and social information will be exchanged by the hospital and the agency on a professional and confidential basis as necessary to carry out the plan of service for each recipient-patient.
3. The hospital and the agency will jointly review the care, treatment and progress of each recipient-patient, at intervals not to exceed three months, in order to evaluate the plan of service and continued need for hospital care.
4. The effectiveness of operations under this agreement and the benefits attained for recipient-patients will be evaluated periodically; and the provisions of the agreement will be revised, at least annually, as necessary to achieve its purposes.
5. The Divisions, through staff designated for such purpose, will maintain continuing assessment of and, where appropriate, cooperatively develop and implement procedures necessary to improve or correct deficiencies related to:
 - a. the mental health problems and needs of all age groups, in terms of prevention, treatment, care and services;
 - b. the current resources to meet these needs available through mental health and public welfare resources;
 - c. the new resources that are needed and the current resources requiring extension or upgrading in quality and effectiveness; and
 - d. priorities for emphasis in achieving progress, giving immediate attention to gaps or inadequacies in mental health and public welfare resources that are essential to the proper and effective implementation of the legal provisions concerning aged persons in mental hospitals, including the utilization of community mental health centers and other alternatives to care in such institutions.
6. The Divisions will cooperate in preparing an annual report to the Department of Institutions and Agencies of progress in the development of mental health and related public welfare resources, including recommendations for assuring maintenance of State effort in providing mental health services as contemplated by the Federal Social Security Act.

Dated: November 30, 1967

Division of Mental Health and Hospitals

Approved:

By: /s/ V. Terrell Davis

V. Terrell Davis, Director

/s/ Lloyd W. McCorkle

Lloyd W. McCorkle, Commissioner

Department of Institutions and Agencies

Division of Public Welfare

/s/ Lloyd B. Wescott

Lloyd B. Wescott, President

State Board of Control of

Institutions and Agencies

By: /s/ Irving J. Engelman

Irving J. Engelman, Director

State of New Jersey
Department of Institutions and Agencies
Essex County Overbrook Hospital - Division of Public Welfare

AGREEMENT

In order to provide an effective program of care, treatment, assistance and services for patients 65 years of age and older, the Essex County Overbrook Hospital and the Division of Public Welfare jointly promulgate this agreement.

A. This agreement is applicable to, and is intended for the benefit of patients 65 years of age and older in, the Essex County Overbrook Hospital, hereinafter referred to as "the Hospital."

B. This agreement is applicable to the Bureau of Institutional Services and other administrative units of the Division of Public Welfare, and the county welfare boards as appropriate, hereinafter referred to collectively as "the agency."

C. The Essex County Overbrook Hospital Agrees:

1. The hospital in addition to providing adequate medical treatment will provide for an initial medical, psychiatric and social evaluation of patients within 30 days of admission, and will provide for such evaluation periodically thereafter, all of which will be recorded together with plans and assessments of the treatment and progress of each patient.
2. The hospital will cooperate with the agency in screening and referral of patients who appear eligible for public assistance in order that the agency may make a prompt determination of eligibility and need for assistance and services.
3. The hospital, with appropriate consultation, and in a manner appropriate to the patient's condition and the hospital's normal functioning, will provide for access by the agency to the hospital, the patient and the patient's records as necessary for the agency to carry out its responsibilities.
4. The hospital will maintain a medical and social history for each patient found eligible to receive public assistance as a basis for developing and implementing an appropriate plan of care and service.
5. The hospital through its social service staff, with appropriate cooperation of the agency staff as specific service responsibilities may be delegated, will provide psychiatric and medical social services consistent with the plan of care and service for each recipient-patient:
 - a. to maintain or restore the greatest possible degree of health and independent functioning;
 - b. to assist effective use of the hospital treatment and rehabilitative resources;
 - c. to encourage the continuation or development and maintenance of family and community interests and relationships; and
 - d. to plan for and effectuate release from the hospital to an alternative method of care.

6. The hospital will give constant attention to plans for alternative methods of care for recipient-patients and will initiate such planning at the time of admission. There will be special and particular attention given to the feasibility of an alternative method of care for each recipient-patient who had been hospitalized prior to the execution of this agreement and whose hospital stay has continued for over twelve months.
7. The hospital will release recipient-patients to alternative methods of care only on the basis of joint planning with the agency.
8. The hospital will provide methods for handling, protecting and accounting for the funds of each recipient-patient, including those funds made available through public assistance for personal incidental expenses.
9. The hospital will provide to the agency such information as may be necessary for completing reports required by the Federal government.

D. The Division of Public Welfare agrees:

1. The agency will receive and promptly process applications for public assistance filed by or on behalf of patients, and will notify the hospital and the patient of the decision on each application.
2. When a patient is determined eligible to receive public assistance, the agency will provide for periodic payments to the hospital for the costs of care and treatment received by the recipient-patient on and after 30 days preceding the date of application for public assistance, but not earlier than January 1, 1967. Such payments will be based on the number of days of care received during the period, times the currently effective per diem rate approved for payment through public assistance.
3. The agency will provide for each recipient-patient a money payment to cover personal incidental expenses when such is not available from personal income or other sources.
4. The agency will determine and redetermine the financial capacity of the patient and/or legally liable relatives to make payments or contributions toward the costs of hospital care, and will take appropriate action as may be necessary for collection of such payments or contributions.
5. The agency will cooperate with the hospital in providing social services for recipient-patients:
 - a. within the hospital as specific service responsibilities may be delegated; and
 - b. outside the hospital as may be appropriate in planning, effecting and supporting release to an alternative method of care.
6. The agency will maintain a case record for each recipient-patient, including a social study showing current personal and social needs and a plan of service, and an evaluation of the patient's financial resources and a plan for use of such resources in meeting needs. Information from such records will be made available to the hospital as necessary to carry out the plan of service.

E. The Essex County Overbrook Hospital and the Division of Public Welfare jointly agree:

1. Guides and instructions will be provided to the hospital and the agency as required to discharge their respective responsibilities.
2. Medical and social information will be exchanged by the hospital and the agency on a professional and confidential basis as necessary to carry out the plan of service for each recipient-patient.
3. The hospital and the agency will jointly review the care, treatment and progress of each recipient-patient, at intervals not to exceed three months.
4. The effectiveness of operations under this agreement and the benefits attained for recipient-patients will be evaluated periodically; and the provisions of the agreement will be revised, at least annually, as necessary to achieve its purposes.

Dated: April 24, 1967

Essex County Overbrook Hospital

Approved:

by: /s/ Charles A. Matthews
Charles A. Matthews, Director
Board of Freeholders of Essex County

/s/ Lloyd W. McCorkle
Lloyd W. McCorkle, Commissioner
Department of Institutions and Agencies

Division of Public Welfare

/s/ Lloyd B. Wescott
Lloyd B. Wescott, President
State Board of Control of
Institutions and Agencies

by: /s/ Irving J. Engelman
Irving J. Engelman, Director

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T A B L E O F C O N T E N T S

CHAPTER S-2000

INTRODUCTION

S-2000.	Introduction	S-2000. - S-2003.
S-2001.	Definition of Primary Medical Services	S-2000. - S-2003.
S-2002.	Definition of Related Medical Services	S-2000. - S-2003.
S-2003.	Requirement of Eligibility for Primary Medical Services	S-2000. - S-2003.
S-2010.	Eligible Hospitals	S-2010. - S-2010.2
.1	Requirements	S-2010. - S-2010.2
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APPENDIX

<u>Appendix Number</u>	<u>Subject</u>	<u>Reference</u>
I	Qualified Psychiatric and Tuberculosis Hospitals	S-2010.2

Part II	Scope of Services and Rates of Payment
S-2000	Introduction

S-2000. INTRODUCTION

S-2001. Definition of Primary Medical Services

The term "primary medical services" refers to the three general classes of health service for which payment of medical assistance is authorized by the MAA law (Chapter 222, P.L. 1962, section 2). These are hospitalization, nursing home care and home health care.

S-2002. Definition of Related Medical Services

The term "related medical services" refers to specified health services necessarily incident to the primary medical services, which specified services are either stated in the MAA law (section 3), or are inherent to the provision of the primary medical services. See section S-2200. of this Manual Supplement as to related medical services for patients in public hospitals.

S-2003. Requirement of Eligibility for Primary Medical Services

In accordance with the provisions of the MAA law a person is eligible for medical assistance only upon establishment of his need for one of the three primary medical services. When such need has been established, and the person found otherwise eligible for MAA, the costs of related medical services may be included in the grant of medical assistance (see section S-2200.). The fact that a person may require or has incurred expense for one of the related medical services does not of itself provide a basis of eligibility for MAA.

Part II	Scope of Services and Rates of Payment
S-2000	Introduction - Eligible Hospital

S-2010. ELIGIBLE HOSPITAL

When a person is determined eligible for MAA, and requires care and treatment in a public hospital for mental diseases or tuberculosis, medical assistance can be provided only while such person is receiving service in an eligible hospital.

.1 Requirements

An eligible public hospital for mental diseases is one which meets the requirements for a qualified psychiatric hospital under Title XVIII, section 1861 (f) of the Social Security Act. An eligible public hospital for tuberculosis is one which meets the requirements for a qualified tuberculosis hospital under Title XVIII, section 1861 (g) of the Social Security Act.

.2 Certification

The New Jersey State Department of Health is the State agency designated to act for the Federal Social Security Administration in the certification of qualified medical facilities. A formal communication from the State Department of Health shall be sufficient evidence that a hospital for mental diseases or tuberculosis meets the requirements of Title XVIII of the Social Security Act. (See S-2000. Appendix I for the current listing of eligible hospitals.)

QUALIFIED PSYCHIATRIC AND TUBERCULOSIS HOSPITALS

Psychiatric Hospitals

New Jersey State Hospital at Greystone Park
New Jersey State Hospital at Trenton
New Jersey State Hospital at Marlboro
New Jersey State Hospital at Ancora, Hammonton
New Jersey Neuro-Psychiatric Institute, Princeton
Essex County Overbrook Hospital, Cedar Grove

Tuberculosis Hospitals

New Jersey Sanitorium for Chest Diseases, Glen Gardner
Essex County Sanitorium, Verona

NOTE: Above listing as stated in communication from the New Jersey State Department of Health, dated January 17, 1967.

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CHAPTER S-2100

PRIMARY MEDICAL SERVICES

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Part II	Scope of Services and Rates of Payment
S-2100	Primary Medical Services - Hospitalization

S-2100. PRIMARY MEDICAL SERVICES

S-2110. HOSPITALIZATION

.1 Statutory Definition

Medical assistance shall be granted on behalf of eligible individuals who require hospitalization, which is defined by statute as "in-patient hospital ward services."

.2 Interpretation

This statutory definition is interpreted to mean any health services necessary for diagnosis or treatment of an illness or injury, provided upon admission to a public or voluntary general hospital, or hospital for special care such as mental diseases or tuberculosis.

For the purposes of this Manual Supplement, the term "hospital" shall have the meaning as stated in Section 1861 (e) of the Federal Social Security Act, namely, "an institution which —

- "(1) is primarily engaged in providing, by or under the supervision of physicians, to in-patients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- "(2) maintains clinical records on all patients;
- "(3) has bylaws in effect with respect to its staff of physicians;
- "(4) has a requirement that every patient must be under the care of a physician;
- "(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
- "(6) has in effect a hospital utilization review plan;
- "(7) in the case of an institution in any state in which state or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved by the agency of such state or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

Part II	Scope of Services and Rates of Payment
S-2100	Primary Medical Services - Hospitalization

S-2110. HOSPITALIZATION (Cont'd.)

- .2 "(3) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals."

The term "ward services," otherwise referred to as "general service," means that professional and other personal services are provided by the staff of the hospital without a medical assistance payment therefor in addition to or supplementation of the approved rate for hospitalization, and without any additional charge to or obligation for payment on the part of the patient or any other person. All patients in state and county hospitals for mental diseases and tuberculosis receive "ward services" within the meaning of the statute.

For the standards and rates for hospitalization see section S-2400.

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T A B L E O F C O N T E N T S

CHAPTER S-2200

RELATED MEDICAL SERVICES

S-2200. Related Medical Services

S-2200.

Part II

Scope of Services and Rates of Payment

S-2200

Related Medical Services

S-2200. RELATED MEDICAL SERVICES

As to patients in public hospitals for mental diseases and tuberculosis, the costs of related medical services are included in the per diem rate for hospitalization or are provided for by coverage under Title XVIII of the Social Security Act.

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T A B L E O F C O N T E N T S

CHAPTER S-2300

PERSONAL INCIDENTAL EXPENSES

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Part II	Scope of Services and Rates of Payment
S-2300	Primary Medical Services - Hospitalization

S-2300. PERSONAL INCIDENTAL EXPENSES

.1 Statutory Definition

The Statute provides that when an individual is otherwise eligible for a grant of medical assistance there may be included therein "the cost of a reasonable allowance for personal incidental expenses; provided, however, that such costs cannot be met through other resources available to the individual or through any other program of public assistance."

.2 Interpretation

This statutory definition is interpreted to mean items required for personal cleanliness and grooming, and miscellaneous necessary expenditures for reading materials, writing materials, etc.; special clothing requirements; life insurance premiums; and insurance premiums for Blue Cross and Blue Shield, or commercial policies providing equivalent coverage.

S-2301. Payment Through Other Resources

The standards of financial eligibility for MAA are such as to allow the application of certain income to meet personal expenses. Accordingly, when such income is available to an individual found eligible for MAA, the grant of medical assistance shall not include the cost of an allowance for personal incidental expenses.

S-2302. Payment Through MAA

Whenever the circumstances are such that the grant of medical assistance may include the cost of an allowance for personal incidental expenses, such cost shall be determined in accordance with the standards and rates set forth in section S-2700.

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CHAPTER S-2400

STANDARDS AND RATES FOR HOSPITALIZATION

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APPENDIX

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(i)

New Jersey Department of Institutions and Agencies Division of Public Welfare	Transmittal Letter MAA-S #3	Page Date 6/67	Replaces Page Dated 1/67
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Part II	Scope of Services and Rates of Payment
S-2400	Standards and Rates for Hospitalization

S-2400. STANDARDS AND RATES FOR HOSPITALIZATION

.1 Rates

Current rates in accordance with federal law and regulation, are set forth in S-2400 Appendix I. Current Medicare rates are adopted as an interim standard pending further determinations of reasonable cost.

S-2401. Services Provided in Public Psychiatric and Tuberculosis Hospitals

When the client's need for hospitalization has been determined in accordance with the provisions of sections S-3250. and S-3620., the standards and rates for hospitalization shall be in accordance with the currently effective per diem rates as set forth in S-2400 Appendix I.

(Refer to Section S-3541. for payment procedures.)

S-2402. Supplementary Payment for Services Provided in Voluntary Hospitals

When a client must be transferred to a voluntary hospital for an authorized medical service which cannot be provided in the public hospital, and the costs of care in the voluntary hospital are not included in the per diem rate of the public hospital, the standards and rates for supplementary payment for such costs shall be the Blue Cross rate effective during the period of care in voluntary hospital, or the charges of the voluntary hospital, whichever is less.

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S-2400 - APPENDIX I

PER DIEM RATES

Effective with billing for August, 1967

New Jersey Neuro-Psychiatric Institute	17.10
New Jersey Sanatorium for Chest Diseases at Glen Gardner	22.10
New Jersey State Hospital at Ancora	10.20
New Jersey State Hospital at Greystone Park	8.70
New Jersey State Hospital at Marlboro	13.30
New Jersey State Hospital at Trenton	9.90
Essex County Overbrook Hospital, Cedar Grove	10.70
Essex County Sanatorium, Verona	21.70

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T A B L E O F C O N T E N T S

CHAPTER S-2700

STANDARDS AND RATES FOR PERSONAL INCIDENTAL EXPENSES

S-2700. Standards and Rates for Personal Incidental Expenses S-2700.

APPENDIX

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Part II	Scope of Services and Rates of Payment
S-2700	Standards and Rates for Personal Incidental Expenses

S-2700. STANDARDS AND RATES FOR PERSONAL INCIDENTAL EXPENSES

The standards and rates for personal incidental expenses are as itemized below:

- a. Personal care items - \$7.00 per month;
- b. Clothing in accordance with the Categorical Assistance Budget Manual Section 312.a (see S-2700 Appendix I);
- c. Life insurance premiums in an amount not exceeding a payment required to provide a policy yielding total benefits of \$500.00 or less;
- d. Premiums for Blue Cross and Blue Shield, or commercial policy providing equivalent coverage, in an amount equal to actual cost.

SPECIAL CLOTHING REQUIREMENTS

Excerpts from Categorical Assistance Budget Manual

Section 312.a: An individual may under specific circumstances need an allowance for special clothing. Special clothing requirements shall be provided on the basis of actual need (as verified) and at reasonable cost. The clothing standard in the Standards and Sources Section of the Categorical Assistance Budget Manual may be used as a guide for determining adequacy, kind, quality, and probable years of wear. An allowance for special clothing may be included in the client's budget only in the following situations:

Where a client, who because of a physical or mental incapacity, is unable to do his own shopping for clothing and does not have a relative or interested person in whom he has confidence who could do this shopping for him, the clothing allowance as a basic requirement shall not be included in the client's budget. However, in all such cases, the clothing requirement shall be granted as a special circumstance requirement and the client's clothing needs shall be reviewed at regular intervals of not more than six months.

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T A B L E O F C O N T E N T S

CHAPTER S-3000

INTRODUCTION

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Part III
S-3000!

The Individual and Medical Assistance for the Aged
Introduction

S-3000. INTRODUCTION

S-3001. Community Responsibility for Individual Need

The community recognizes that the welfare of the individual is essential to the community as a whole. As one of the numerous services which have been created in response to this principle, public assistance is provided so that needy persons can secure a minimum but adequate standard of living. The program of MAA is specifically intended to make necessary and proper health services available to aged persons who might otherwise forego such services or become financially dependent in the course of obtaining them.

S-3002! Health Problems as a Factor of Individual Need

It is well recognized that health problems are a factor of individual need. When necessary and proper services are not provided for an individual in relation to an illness or disability, need can result from inability to undertake employment and depletion of income and resources. When an individual has insufficient funds to provide for a standard of living compatible with decency and health, a failure to provide for this need can result in illness and disability.

S-3003! Basic Principles of Administration

The basic principles of administration set forth in section 2004! of the Manual of Administration for other categorical assistance programs are equally applicable to MAA. (See S-3000.-Appendix I.)

BASIC PRINCIPLES OF ADMINISTRATION

Excerpts from Manual of Administration - Section 2004.

2004. Basic Principles of Administration

The following principles of administration are inherent in the fundamental concept that assistance shall be administered in accordance with standards and methods designed to strengthen the person's self-respect, and to facilitate the attainment of the maximum degree of socio-economic independence of which he is capable.

.1 Opportunity to Make Application

Any person believing himself eligible shall be assured an opportunity to make application (includes reapplication) for financial assistance and other services provided through the assistance programs.

.2 Decision to Make Application

The decision to make application for assistance rests with the person or his authorized agent.

.3 Recognition of Individual and his Problem

The individual requesting help shall be recognized as a person who is seeking a solution to a problem. It is the responsibility of the agency to help him in identifying the problem, to explain to him whether the problem does or does not come within the scope of the agency's function, and to inform him of other appropriate services and resources in the community which are available.

.4 Client Primary Source of Information

The client shall be considered the primary source of information about himself and his circumstances in determining his eligibility for assistance. However, it is the basic legal responsibility of the agency to make the determination of eligibility. The agency has a statutory duty to explore all available information which is necessary, relevant and material to the issue of eligibility. Therefore, additional and secondary sources are used when necessary, with the client's knowledge and consent.

.5 Client Self-Directing

The client shall direct his affairs insofar as he is physically and mentally able. This principle is based on the fact that economic dependency does not deprive a needy person of his civil rights nor does it release him from his normal duties as a responsible member of the community.

.6 Opportunity to Withdraw

An applicant shall be assured an opportunity to withdraw his application at any point between his request for assistance and determination of his eligibility or ineligibility by the agency. The decision to withdraw rests with the applicant or his authorized agent.

.7 Prompt Consideration and Notification

Each application shall be considered promptly and impartially. Subsequently, each applicant shall be notified promptly in writing of the decision on his eligibility. These principles hold also for a recipient when any change in his circumstances indicates a change in his requirements or status.

.8 Uniform Basis for Determining Eligibility

The eligibility of all applicants for financial assistance, and of all recipients for continuing assistance, shall be determined by uniform and objective standards.

.9 Assistance to All Eligible Persons

Assistance shall be paid to every eligible applicant and shall not be withheld from any eligible person so long as any payments are being made under a specified categorical assistance program in this State.

.10 Assistance by Money Payments or Vendor Payments

Assistance shall be granted in the form of money payments through checks to the recipient, his legal guardian, or, under certain specified conditions, to other persons on the recipient's behalf; or in the form of vendor payments to providers of health services.

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.11 No Duplication of Assistance

A recipient of one form of public assistance shall not receive assistance for the same period through another public assistance program except as permitted by the laws governing the respective programs.

.12 Adherence to Law Administrative Policy

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

.13 Appeal and Fair Hearing

The client shall have the right to request a fair hearing on the action or inaction of the agency whenever he believes that he has not been given full consideration under the law. A fair hearing shall be conducted by an impartial official of the Department of Institutions and Agencies in accordance with prescribed procedures.

.14 Confidential Nature of Information

Information about the client and his circumstances shall not be disclosed except to those persons and agencies entitled to such information by law or regulation.

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S-3100. THE APPLICATION PROCESS

S-3101. Definitions

.1 Application Process

The application process includes all activity relating to a request for medical assistance. It begins with the first statement to the BIS that an individual wishes to receive medical assistance and continues in effect until there is an official disposition of the application.

.2 Applicant

An applicant is an individual who has made an affirmative decision personally or through an authorized agent (as defined below, S-3101.3) to apply for medical assistance following an interpretive interview, and whose application has not been officially disposed of by the BIS. The term "applicant" also includes the authorized agent when reference is made to interviews or communications with an individual who is incapable of acting on his own behalf and for whom an application for assistance has been made by such authorized agent, as provided in section S-3101.3.

.3 Authorized Agent

A legally appointed guardian shall always be recognized as an authorized agent to initiate and participate in the processing of an application for medical assistance.

An individual who is a patient in a public hospital for mental diseases or tuberculosis is subject to a disability which impedes action on his own behalf. Consequently, the BIS, subject to section S-3112, shall accept a staff member designated by the Medical Director of the hospital in which the person is receiving care as an authorized agent for the purpose of initiating and processing an application for medical assistance.

.4 Authorized Agent for Persons Alleged to be Mentally Incompetent

If an individual is alleged to be mentally incompetent and is not represented by a legal guardian the following persons, in order of priority as listed, may act as authorized agents for the sole purpose of initiating an application for Medical Assistance:

- a. A relative by blood or marriage;
- b. A staff member of an institution or facility in which the person is receiving care who has been designated by the institution to do so;
- c. A physician or attorney of whom the person is respectively a patient or client.

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S-3101. Definitions (Cont'd.)

.5 Application (Terms used to Classify)

- a. A new application is an affirmative oral or written request for medical assistance from or on behalf of an individual who has never previously requested medical assistance in any county in the State under that program.
- b. A reapplication is an affirmative oral or written request for medical assistance by or on behalf of an individual whose previous application for MAA was rejected in any county in the State and for whom reconsideration is requested of his current eligibility under the same program.
- c. A reopened application is an affirmative oral or written request by or on behalf of a former recipient of MAA in any county in the State for reconsideration of his current eligibility for the same program.
- d. A transfer application is a written request for medical assistance under MAA by or on behalf of an individual who at the time of registration is still receiving medical assistance from the welfare board of another county from which he has moved.
- e. Pending application is the general term for application, reapplication, reopened application, or transfer application prior to official disposition.

.6 Registration

Registration is the action of the BIS in making an official record of and assigning a control number to an application.

S-3101. Definitions (Cont'd.)

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S-3101. Definitions (Cont'd.)

.10 Medical Assistance

Medical assistance is a payment of the money amount(s) authorized by the BIS and issued in the form of a check to the provider(s) of an authorized health service or, in the case of a personal incidentals allowance, to the recipient or his representative.

S-3102. Responsibilities in the Application Process

.1 The Division of Public Welfare

Pursuant to statutory authority the Department of Institutions and Agencies, through the Division of Public Welfare, establishes policy and procedure on the application process consistent with law and Federal requirements, and supervises the operation of and compliance with the policy and procedure so established.

.2 The Bureau of Institutional Services

The BIS has responsibility in the application process to:

- a. Interpret the purpose and eligibility requirements of the program and indicate the applicant's rights and responsibilities under its provisions;
- b. Receive applications;
- c. Make known to the applicant appropriate resources and services both within the agency and the community, and, if necessary, assist him in using them;
- d. Assist the applicant in exploring his eligibility for assistance, including consideration of his available income and resources;
- e. Determine and report initial eligibility promptly;
- f. Assure the prompt issuance of payments to eligible persons and prompt notification to ineligible persons; and
- g. Account to the Division of Public Welfare for all applications.

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S-3102. Responsibilities in the Application Process (Cont'd.)

•3 Responsibilities of the Applicant

As a participant in the application process, the applicant has the responsibility to:

- a. Explain the problem which brought him to the BIS and what he thinks the agency can do to help him;
- b. Assist the BIS in securing evidence that corroborates his statements; and
- c. Report promptly any change affecting his circumstances.

S-3103. Policy and Procedure on Prompt Disposition

.1 Normal Standards of Reasonable Promptness

The maximum period of time normally essential to process an application between the date of application and the date of effective disposition is thirty days.

"Date of effective disposition," as used in the preceding paragraph means:

- a. In the case of an approved application, the date on which first payment is issued to the applicant, or the date on which written notice of approval is sent to him, whichever is earlier;
- b. In the case of a denied application, the date on which written notification, informing the applicant of his lack of eligibility and reasons therefore, is sent to him;
- c. In the case of a withdrawn application, the date which written notification, confirming to the client that the agency has taken cognizance of his voluntary withdrawal, is sent to him;
- d. In the case of a dismissed application, the date on which written notification, informing the applicant of the dismissal and the reasons therefore, is sent to him; and, with respect to an applicant who died, whose whereabouts is unknown, or for whom an application was erroneously registered, the date on which the decision to dismiss the application is determined by the BIS.

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S-3103. Policy and Procedure on Prompt Disposition (Cont'd.)

.2 Exceptions from Normal Standards

It is recognized that there will be exceptional cases where the proper processing of an application cannot validly be completed within the 30 day period specified above. Where substantially reliable evidence either of eligibility or ineligibility is still lacking at the end of the designated period, the application shall be continued in pending status in preference to an arbitrary or hasty disposition based on insufficient evidence. In each such case, however, the BIS shall be prepared to demonstrate that the delay resulted from one of the following:

- a. Circumstances wholly within the applicant's control; or
- b. A determination to afford to an applicant, whose proofs of eligibility have been inconclusive, further opportunity to develop additional evidence of eligibility before final action on this application; or
- c. An administrative or other emergency that could not reasonably have been avoided; or
- d. Circumstance wholly outside the control of both the applicant and the BIS.

.3 Notification

When the final disposition of an application is delayed beyond 30 days, written notification shall be sent to the applicant on or before the expiration of such period, such notification to contain information as follows:

- a. If the reason for delay comes within the description of a. or b. above, the applicant shall be reminded that the BIS has been waiting for him to take certain action, or shall be informed that it is necessary for him to provide certain additional information, and that he should notify the BIS promptly whether or not he can furnish such additional information; and that unless the BIS hears from him within 30 days it will be assumed that he is no longer interested in establishing eligibility for medical assistance and the application will therefore be denied.

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S-3103. Policy and Procedure on Prompt Disposition (Cont'd.)

- .3 b. If the reason for delay comes within the description of c. or d. above, the applicant shall be informed of the reason for delay and the time within which he may expect to receive either a notice of final action or further advice from the BIS.

.4 Agency Controls

[The BIS shall arrange operational procedures and establish appropriate operational controls to expedite the processing of applications and assure the maximum possible compliance with these standards. These include staff meetings and conferences, instructional memoranda, prescribed forms and administrative reviews.

Control records on the exceptional cases shall disclose at any time the identity of all applications which have been in pending status for more than 30 days, and the reasons therefore. Such records shall be adequate to make possible the preparation of a report of such information at any time that it might be requested by the Division of Public Welfare.

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The Application Process - Intake Policy and Procedure

S-3110. INTAKE POLICY AND PROCEDURE

"Intake" is an inclusive term applied to activities in relation to requests for medical assistance and service. The "intake process" should not be terminated until the person understands whether, and how, the BIS can help with the problem, what other specific sources of help are available, or if such be the case, that there is no resource known to BIS to meet his situation.

S-3111. Clearances

.1 Clearance with Division of Public Welfare

All inquiries and referrals shall be cleared with the master index, and any previous information on file shall be made available to the worker for the initial interview.

.2 Clearance with Other Agencies

It will frequently be necessary or helpful to clear with other public or private agencies directly, either before or during the application process, when available information shows or indicates the client is known to another agency. Except in very unusual situations where circumstances require otherwise, collateral contacts shall not be undertaken until the applicant or his authorized agent, has formalized his request for assistance by signing an application form PA-1. It shall be explained that by signing he recognizes his responsibility and obligation to cooperate with the BIS where it is necessary for the agency to consult other sources of information. In addition, whenever the need to consult other sources arises, the client shall be informed what specific persons and sources the BIS plans to contact to help him establish his eligibility and why it is necessary to see or write to such persons or sources.

S-3112. Application Policy and Procedure

No written application shall be executed nor any application registered before a personal interview with the prospective applicant, or with an authorized agent when the applicant is too ill or too handicapped physically or mentally to supply the necessary information. In case of interview with the authorized agent, the worker must record in the narrative the reason why the applicant could not be interviewed

.1 Who Has Right to Apply

There shall be recognition of the individual's right to file an application and have his eligibility formally determined if that is the wish, even though the information immediately available indicates clearly that the individual is not eligible and this has been explained to him.

a. The general principle shall be that any person 65 years of age or older who believes himself to be eligible has the right to apply for assistance for himself.

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The Application Process - Intake Policy and Procedure

Application Policy and Procedure (Cont'd.)

- ## .2 Applications for MAA

An application for medical assistance on Form PA-1, Application for Public Assistance (S-3100, Appendix I), is made to the BIS.

Initial Interview Concerning Applications for MAA

- ## General Scope of Initial Interview

The initial interview shall be directed toward:

- a. Providing an opportunity to evaluate the individual situation;
- b. Interpreting the eligibility requirements, the scope of the investigation including resources and the ability of relatives to support, the periodic review of eligibility, etc., to enable a decision as to making an application;
- c. If the decision is to make application, execution of Application Form PA-1;
- d. Securing as much factual data as practical in relation to determination of eligibility; and
- e. Planning the next steps to be taken by the applicant and the BIS.

- ### Decision on Filing Application

The basic principle shall be that the individual or his authorized agent shall make the decision whether or not to make application for medical assistance or to defer decision. It shall also be explained that there is a right to withdraw the application at any point before official determination of eligibility is completed by the BIS.

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S-3113. Initial Interview Concerning Applications for MAA (Cont'd.)

.3 When Application May be Accepted for Registration

As a general rule, applications shall be accepted and processed as soon as there is an affirmative decision to apply for medical assistance following an interpretive interview.

Form PA-1 is executed by the applicant with the assistance of the case-worker, and he shall be given a duplicate for his own records.

.4 Special Factors for Interpretation

a. The following special factors shall be interpreted as the individual's situation may require:

- 1) The nature of allowances for medical services;
- 2) The nature of allowances for personal incidental expenses;
- 3) The principle that all income, including contributions from relatives, is taken into consideration;
- 4) The principle that available cash resources, if any, over the prescribed maximum, must be used to meet current needs before assistance is granted;
- 5) The principle of adjusting the amount of payment as either requirements or income change; and
- 6) The responsibility of applicant to report changes in his circumstances.

b. Every applicant shall be given preliminary information about payment procedures covering:

- 1) Vendor payment for all medical services; and
- 2) Issuance of check in single cash amount for the month covering personal incidental expenses, if allowable.

c. Every applicant shall have explained to him his right to Fair Hearing and his attention directed to the statements on the reverse of Application Form PA-1.

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.5 Closing the Initial Interview

a. Instructions as to what further information and records the applicant is to obtain himself, and what further steps the BIS must take to establish his eligibility; and

.6 Recording the Interview

The initial interview, whether or not an application is completed, shall be dictated and recorded promptly.

When a prospective applicant for MAA has been adjudicated mentally incompetent, and is represented by a legal representative, the BIS shall, upon proof of such appointment, recognize such person as representative of the client for all purposes consistent with the appointment, including execution of an application form.

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S-3115. Registration Procedures

1 Application

Official registration of an application consists of the following steps:

- a. Entry in application register (Form PA-9B) with appropriate classification as new, reapplication, reopened application, or transfer in.
- b. Assignment of case control number (registration number.)
(See S-3100., Appendix VII.)
- c. Preparation of Form PA-9, Registration Card.

2 Referral

Official registration of a referral consists of the following steps:

- a. Entry in referral register (Form PA-9C) with appropriate classification of reason for referral (i.e., report or transfer.)
- b. If transfer, assignment of new case control number (registration number.)
- c. If transfer, preparation of Form PA-9, Registration Card.

3 Promptness of Registration

So far as possible registration shall be completed on the same day that an application is made or a referral received. If the application is made outside of the BIS office, registration shall be completed within two working days.

S-3116. Assignment of Pending Applications for Completion of Eligibility Determination

Each application shall be assigned within three working days by issuing to a caseworker a copy of the application and a Form PA-22A (See S-3800, Appendix II) on which have been entered the case name and number. A follow-up or tickler system shall be maintained for all pending applications, and shall be checked on a weekly basis by the person(s) immediately responsible for supervision of casework staff.

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S-3117. Effective Date of Application

.1 Policy

In the contrast with other programs of public assistance, the statute establishing MAA contemplates retroactive payments of medical assistance, related to the date of the application, when eligibility has been affirmatively determined. In order to carry out the purposes of the statute, the effective date of the application to be entered on Form PA-1 shall be the date when the individual or his authorized agent (see S-3101.3) applies for medical assistance following an interpretive interview.

.2 Utilization

The effective date of the application shall be used as the date of registration of the application and shall be used in determining the period for which authorized payments of medical assistance shall be made.

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The Application Process - Process of Establishing Eligibility

PROCESS OF ESTABLISHING ELIGIBILITY

The investigation will normally require a visit to the client, contacts with relatives and other persons or agencies, examination of various records, and correspondence. However, it is neither necessary nor efficient to corroborate information once received from a reliable source, or to duplicate the investigation of an agency or official, unless there are apparent discrepancies or the information is unreliable because of the passage of time.

A visit to the client at the hospital where he may be is an essential element in developing an understanding of the client in relation to his particular needs and problems. However, in certain situations it will be necessary to establish initial eligibility through interviews with the staff of the hospital and collateral investigation.

There may be individual situations where the BIS and the hospitals determine that an immediate visit with the client is not desirable or feasible. In such cases the granting of assistance should not be delayed merely to accomplish such a visit, but in no event shall more than one monthly payment of medical assistance be made before a visit to the client.

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The Application Process - Process of Establishing Eligibility

S-3121. Planning Completion of Eligibility Determination

The caseworker's first step upon assignment of an application is to review all recorded data available in the files of BIS, the Division of Public Welfare, the hospital and the County Adjuster. The purpose of this review is to learn what kind of a person the client is, what additional facts are needed, the most efficient methods to obtain the information, whether special problems exist and how urgent they are. Systematic planning of the investigation will save time and effort and assure prompt service to the applicant.

S-3122. The Field Visit

An interview with the relatives of the applicant is an important step in the development of a satisfactory relationship with the client and other members of his family. The caseworker learns with experience to judge quickly the best method for putting the family at ease so that there may be a satisfactory exchange of accurate information. Every effort should be made to achieve privacy, even in institutional settings.

.1 Purpose of Field Visit

In general and considering the health services required, the purposes of the field visit are to

- a. provide the family an opportunity to explain the client's situation, raise questions, talk about his special needs, and be identified and understood in their relation to his particular situation;
- b. provide opportunity to interpret the program to other members of the family, particularly legally responsible relatives, and discuss their ability to support and willingness to provide certain items of need for the client;
- c. develop a relationship between the worker and the family which will enable the worker to understand and evaluate the interpersonal relationships within the family, and the soci-economic and health conditions existing in the household;
- d. obtain additional verification of facts by examination of evidence in the family's possession, or to consult them about other possible sources of evidence;

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The Field Visit (Cont'd.)

- .1 e. interpret or reinterpret specifically to the family those aspects of continuing relationship with BIS which are important in terms of meeting needs adequately and promptly, or which affect eligibility or the amount of medical assistance; e.g., when income or resources increase or decrease, or there are changes in the family situation or living arrangements, etc.

Collateral Investigation

Definition

"Collateral investigation" shall refer to contacts with individuals other than members of client's immediate family, such as employer, lawyer, physician, landlord, neighbor; with business organizations, such as banks or insurance companies; with the County Adjuster; with social and health agencies or institutions; and to checking or consulting relevant documents and public records not in the possession of the client or his family.

General Policy

The primary purpose of collateral contacts is to verify or supplement or clarify discrepancies regarding essential information supplied by or on behalf of the client. An additional purpose is to secure information from or to secure the advice and help of others in order to plan with the client and his family for his total welfare.

Except in very unusual situations where circumstances require otherwise, collateral contacts shall not be undertaken until the applicant or his authorized agent, has formalized his request for medical assistance by signing an application Form PA-1. It shall be explained that by signing he recognizes his responsibility and obligation to cooperate with the Bureau of Institutional Services where it is necessary for the agency to consult other sources of information. In addition, whenever the need to consult other sources arises, the client shall be informed what specific persons or sources the Bureau of Institutional Services plans to contact to help him establish his eligibility and why it is necessary to see or write such persons or resources.

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S-3123.1 Collateral Investigation (Cont'd.)

.2 (Cont'd.)

The client must understand, however, that it is the BIS which is responsible for determining whether he is or is not eligible. If he is unwilling to have the necessary inquiries made and is unable or unwilling to secure the required information from such sources himself, then it shall be explained to him that BIS will be unable to make an affirmative determination. In this situation, unless he wishes to withdraw his application he must expect that it will be denied by BIS.

[For detailed policy and procedure on establishing eligibility in respect to specific requirements see Chapter S-3200 and Chapter S-3300.]

.3 Selection and Method

In planning the use of collateral sources of information, the selection should be in terms of their value to the client and the BIS in such case, and should not be made routinely. The client will usually be able to help select the most likely sources of information about himself.

The number of contacts required will depend upon the reliability of the information when obtained, the reliability of the informant, and the completeness and authenticity of the records consulted.

The method of contact, personal interview, telephone or correspondence (letter or standard form) will depend on the nature and purpose of the information sought.

a. Documents and Public Records

Judgment should be exercised in respect to checking or requesting information from such public records as vital statistics, court records, county records, (deeds and mortgages) and from financial institutions such as banks, postal savings, etc. Routine checking of all cases is time consuming, would unnecessarily delay eligibility determination for many cases, and add to administrative costs. For instance, unless there is good reason to believe the applicant once owned or had an interest in real property, it should not be necessary to check the county records; or, if the applicant has a piece of evidence showing him to be of eligible age and such evidence appears to be acceptable proof, it would be wasteful of time and effort to request proof from vital statistics records merely to build up further proof in the record.

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S-3123. Collateral Investigation (Cont'd.)

.3 a. (Cont'd.)

It is usually desirable to obtain data from these sources in written form. However, where permission can be secured for inspection of records by BIS personnel the practice is acceptable and is often quicker and simpler.

b. Individuals and Agencies

Persons who know the client, or who have knowledge of his situation, should not be consulted unless it is believed they can provide information which is necessary to establish eligibility or helpful to a better understanding of the client and his needs.

When practical, it is generally more satisfactory to interview individuals, particularly if their relationship with the client has been on a personal basis; but again, judgment must be used since some individuals will not wish to give the time for a personal interview, or the data desired is simple and a telephone call is satisfactory and quicker.

In respect to securing information from the staff and records of another agency, the same judgment should be exercised as to when and how to contact. Of course, any specific procedures agreed to by BIS and other community agencies, or provided for in regulations, should be observed.

4 Confidentiality and Collateral Investigation

Whether the collateral contact is made in person, by telephone, or correspondence, the information provided must be in sufficient detail to assure that the individual receiving the request understands what the BIS wants and to elicit interest and cooperation. However, the information given should be limited to relevant material and should never extend to discussion of social or economic aspects of the client's situation which are not essential to accomplish the purpose of the contact.

A like respect for confidentiality is accorded any information supplied by the collateral source. [See S-3920. for policy on Safeguarding Information.]

Part III	The Individual and Medical Assistance for the Aged
S-3100	<u>The Application Process - Process of Establishing Eligibility</u>

S-3124. Evaluation and Recording

When the necessary investigation is complete the worker makes a final evaluation of the data obtained. It is important to select and weigh the facts carefully to assure that all eligibility factors have been adequately verified to establish that the applicant is or is not eligible. Hearsay evidence and personal opinions of individuals should be weighed but discounted if not consistent with verified information.

The worker makes an evaluation of resources and the effect on eligibility to receive medical assistance. [See S-3300., Financial Eligibility, and Categorical Assistance Budget Manual.]

All facts pertaining to eligibility are recorded on required case record forms or in the narrative report as appropriate. This includes preparation of Form PA-3F, Eligibility Summary and Determination for Medical Assistance for the Aged; and a summary statement in respect to referral to other community resources, steps to resolve certain problems with applicant and his family, and follow-up on potential resources as appropriate to the individual situation.

S-3125. Recommendation for Agency Decision

The caseworker is initially responsible for the recommendation as to whether the application should be approved or denied. If the recommendation is for approval, the recommendation includes:

- a. The amount of the regular monthly payment for personal incidental expenses, if any;
- b. The amount of excess income and/or resources available to be applied to the cost of authorized medical services; and
- c. The date as of which client is eligible for payment of medical assistance.

The caseworker signs the Eligibility Summary and Determination for Medical Assistance for the Aged, Form PA-3F or initials a typescript signature.

Part III The Individual and Medical Assistance for the Aged
S-3100 The Application Process - Process of Establishing Eligibility

S-3126. Supervisory Review and Approval

It is recognized that in some instances the caseworker will wish to consult supervisory personnel prior to arriving at the recommendation. A worker should be expected to complete the investigation and formulate the recommendation in the average case prior to supervisory review.

Every application, reapplication or reopened application shall be reviewed by a supervisory staff member prior to disposition, but the detail in which it is reviewed may vary according to the nature of the case and the supervisor's knowledge of the caseworker's competence.

Any difference of opinion between caseworker and supervisor should be resolved by conference, and, if necessary, the issue should be referred to a higher administrative level for disposition.

All recommendations concerning disposition of applications shall be approved in writing by the supervisor following review, either by signature or initialed typescript signature.

S-3127. Disposition of Application

An application, subsequent to supervisory approval, shall be promptly acted upon by the following methods.

.1 Action by Area Supervisor

The normal method for disposing of applications recommended for approval shall be by the Area Supervisor, who has the same authority to make case decisions other than approvals. All such decisions shall be subject to review and amendment by the Division of Public Welfare.

.2 Action by Division of Public Welfare

The only applications which should be held for initial approval by the Division of Public Welfare are those which require special review of the facts or of problems affecting eligibility, interpretation of policy, etc.

Part III	The Individual and Medical Assistance for the Aged
S-3100	The Application Process - Process of Establishing Eligibility

S-3128. Notice of Decision

Each applicant shall receive prompt written notice of every decision which relates to his eligibility; except, of course, an individual who has died or who cannot be located.

Designation of personnel responsible for preparation of decision notices shall be at the discretion of the BIS. However, it shall be the primary responsibility of the caseworker to see that prompt appropriate notice is sent. It shall be the responsibility of supervisory personnel to see that not only do all notices include the minimum content and enclosures required by State policy, but also sufficient explanatory detail to assure the client's understanding of the basis for the agency's decision.

[See S-3400., Decision Concerning Eligibility]

Part III The Individual and Medical Assistance for the Aged
S-3100 The Application Process - Death of Applicant
 During the Application Process

S-3130. DEATH OF APPLICANT DURING THE APPLICATION PROCESS

In accordance with statute, no grant of medical assistance may be made prior to the filing of an application; but when eligibility for MAA is determined, payment of assistance may include authorized costs for medical services incurred on and after the date of application, or within 30 days of the date of application in the case of hospitalization. Accordingly, the death of an applicant subsequent to the filing of an application for MAA does not of itself negate vendor payments of medical assistance for authorized medical services received prior to death and within the period permitted by law.

When an application for MAA has been filed by or on behalf of an individual by execution of a Form PA-1, and such individual dies before the application process is completed, the BIS shall continue action necessary for disposition of the application. If it is determined that eligibility existed prior to death, whether or not there was opportunity for completing the interpretive interview, the application shall be approved in relation to the costs of authorized medical services received prior to death.

S-3131. Deceased Applicant's Estate as a Resource for Costs of Medical Services

In circumstances contemplated by section S-3130., the estate of the deceased applicant shall be considered the primary resource for payment of costs of medical services received prior to death, and payment of medical assistance shall not be made for any of such costs which can be met from the estate of the deceased individual.

S-3132. Evaluation of Deceased Applicant's Estate

e. If the net value of the estate, after application of the appropriate exemptions, is less than the costs of approved medical services received prior to the death of the applicant, a grant of medical assistance shall be made for the balance of the costs of such medical services.

AREA NO: XXXXXXXXXXXXXXXXXXXX

APPLICATION FOR PUBLIC ASSISTANCE

CASE NAME _____
 (Last) (First) (Middle)

 (Street Address)

 (P. O. Address) (Zip Code)

Municipality in which above
address is actually located _____

To be filled in by County Welfare Board

Registration No. _____

Related Registration Nos. _____

Date Registered _____

Status: ☐ NA ☐ RA ☐ RO ☐ TR ☐ CA

I have been informed by a representative of the county welfare board of the eligibility requirements as established by State law and regulation for _____

I do hereby apply for such assistance for each person listed below who, to the best of my knowledge and belief, is in need and meets these eligibility requirements:

Name (Last name first)	Sex	Birth Date	Name (Last name first)	Sex	Birth Date

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that I must furnish certain information to the county welfare board to establish eligibility and extent of need for public assistance; that the county welfare board will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the county welfare board and will furnish pertinent documents and arrange for verification of such information by other persons and agencies having knowledge thereof, when so requested. I understand that the information obtained will be used ONLY in connection with the application for or receipt of assistance.

I also understand that it is my duty to report immediately to the county welfare board any change in living conditions, family situation, or receipt of money from any source.

I am fully informed and aware of the contents of this application, and know that making false statements, or failure to reveal information by me or causing others to conceal information to support this application, or failure to keep the welfare board informed of changes in my circumstances, including finances, employment or other resources, would be a violation of the law for which penalties have been fixed.

(Signature of Each Applicant)

(Signature of Authorized Agent)

(Address of Authorized Agent) (Zip Code)

STATE OF NEW JERSEY

COUNTY OF _____

Personally appeared before me _____ who being duly sworn according to law, depose(s) and say(s) that the statements made in connection with this application for assistance are true and correct.

worn and Subscribed to before me this _____ day of _____ 19 _____

(Representative of Agency)

(SEE OTHER SIDE FOR COMPLAINT AND FAIR HEARING EXPLANATION)

YOUR RIGHT TO A FAIR HEARING

If you are a person seeking or receiving assistance and you are dissatisfied with any action or lack of action by the county welfare board, you have a right to ask for a fair hearing.

Some of the reasons why people request fair hearings are: (1) agency delays in accepting or reaching decisions on assistance applications; (2) a person believes that the amount of assistance he receives is incorrect or is not sufficient to meet his needs; (3) a person believes that a suspension of his assistance is not reasonable; (4) a person thinks that he is eligible for assistance and should receive it although his application has been denied or his assistance payment has been discontinued; and (5) a person is dissatisfied because his assistance is being given to someone else to control or spend for him.

It is important for you to remember that a fair hearing must be requested within a reasonable time. Usually a fair hearing request must be made within ninety days of the action or lack of action about which you are dissatisfied.

If it is reasonably possible, the county welfare board is expected to complete action within thirty days on applications for Assistance for the Blind, Assistance for Dependent Children, Medical Assistance for the Aged, and Old Age Assistance, and within sixty days in Disability Assistance. If you are an applicant for assistance under any of these programs except Disability Assistance, you are entitled to receive notice on or before the end of thirty days of the final action taken on your application or be given an explanation if a further delay is unavoidable. If you are an applicant for Disability Assistance, you are entitled to the same notice or explanation on or before the end of sixty days.

A fair hearing is only one of the ways or methods used to review complaints. When the fair hearing method is used, the Commissioner of Institutions and Agencies or his representative reviews the complaint. If you request a fair hearing, arrangements are made for a suitable time and place for holding the

hearing. You and other persons, including your witnesses or representatives, if any, and representatives of the county and State assistance agencies, participate in the hearing to provide information and answer questions needed to reach a decision. The fair hearing decision is binding on all parties concerned but may be appealed to the New Jersey Superior Court, Appellate Division.

You can request a fair hearing by writing or calling your county welfare board or by addressing a request to the Department of Institutions and Agencies, Division of Public Welfare, P. O. Box 1627, Trenton, New Jersey 08625.

You do not have to request a fair hearing in order to receive prompt consideration and review of your complaint by the county welfare board or by the State Division of Public Welfare. The county welfare board and the State Division of Public Welfare are required to promptly review any requests you make to them for an informal review of your complaint and to do everything possible within the laws and regulations to adjust your complaint in a simple and informal manner without requiring that you file a fair hearing request and participate in a more formal hearing. All you have to do to get prompt attention and an informal review of a complaint is to ask for it at the county welfare board either by letter or verbally or you can write directly to the State Division of Public Welfare, Box 1627, Trenton, New Jersey 08625.

You, as a person seeking or receiving assistance, have a free choice to request either (1) an informal review of your complaint by the county welfare board or State Public Welfare Division or (2) a formal review by the Commissioner of Institutions and Agencies or his representative in a fair hearing. If you choose to ask for an informal review of your complaint by the county welfare board or the State Division of Public Welfare and the result of the review should be unsatisfactory, you still have the right to then request a fair hearing.

A STATEMENT CONCERNING HOME VISITS

The determination of eligibility for assistance normally requires a home visit prior to authorization of an initial payment of assistance, and at prescribed periods while assistance is being received. These home visits are the responsibility of the staff of the county welfare board.

In addition, the State Division of Public Welfare is required to conduct a continuing review of public assistance programs.

In this connection staff of the State Division, in a selected number of cases, will make home visits similar to the kind made by the county welfare board caseworker. Representatives of the State Division will have identification cards.

Your cooperation in providing information to the county and State representatives will make it possible to provide the assistance and services to which you are entitled.

DEPARTMENT OF INSTITUTIONS AND AGENCIES

Lloyd W. McCorkle, Commissioner

Application for Public Assistance
Form PA 1
Instructions for Use

Purpose

The Application for Public Assistance, Form PA-1, is the same form as used in all programs of categorical assistance. It is designed to serve the following purposes:

1. To provide a means whereby an individual, or someone acting as his authorized agent (see MAA Manual Supplement, S-3101.3), can formalize the intention to apply for public assistance;
2. to provide basic information concerning the applicant as required to process the application;
3. to provide a statement by or on behalf of the applicant as to personal responsibility for revealing, and authorizing other sources to release, accurate information required for determining initial and continuing eligibility; and
4. to provide a statement advising the applicant or his authorized agent of the right to fair hearing.

Method of Preparation

1. The caseworker first conducts an interview with the applicant or his authorized agent to make clear the mutual responsibilities inherent in the application process (see MAA Manual Supplement S-3102, S-3340.3).
2. If an intention to apply is expressed by or on behalf of the applicant, the caseworker prepares the Form PA-1 in triplicate from information provided by the applicant or his authorized agent.
3. The original and a copy of each application is given to the Senior Clerk of the Area Office for registration and referral for processing. A copy of the application is given to the applicant or his authorized agent.

Entries

1. All entries should be made legibly in pen and ink. If facilities are available, an original and copy should be typed before signing and the typed copy given to the applicant or his authorized agent.
2. Enter the Area number.
3. Case Name: enter completely and accurately the name of the patient-applicant, including the full middle name, if any; if an alias is known, enter under the line provided preceded by "a/k/a".
4. Street Address: if known, enter the municipality and county where the applicant resided immediately prior to entering hospital.
5. P.O. Address: enter the name of public institution where applicant is a patient.

6. Municipality in which above address is actually located: indicate the municipality in which the above institution is located.
7. Registration No.: Enter the institution code designation, number designation and letter code assigned to county chargeable.
8. On blank line in first paragraph enter "Medical Assistance for the Aged."
9. Listing of person for whom application made:
 - a. Name: enter "See above."
 - b. Sex: use code letters "M" or "F".
 - c. Birth Date: enter month, day and year so far as available from applicant or hospital records; if no birth record information available, but social history indicates applicant is of eligible age, enter "Over 65".
10. Applicant or authorized agent, as appropriate, signs on line indicated. If signature is by authorized agent, enter printed or typed name and title.
11. Affidavit:
 - a. Enter name of county where hospital located.
 - b. Enter name of person signing the application (i.e., patient-applicant or authorized agent) and swearing to or affirming the accuracy of the information provided.
 - c. Enter date application signed.
 - d. Signature and title (normally "Caseworker") of person taking the application and affidavit.

METHOD OF ASSIGNING CASE CONTROL NUMBER

The case number (registration number) is constructed in the following manner:

- the two digit institutional code number of the hospital providing care, plus
* the five digit identifying (serial) number assigned to the patient by the
hospital, plus
the single letter county code of the county of charge.

SAMPLES:

0134567P - patient at Greystone Park; Morris settlement
0268932J - patient at Trenton; Hudson settlement
0354321V - patient at Marlboro; Union settlement
0406234A - patient at Ancora; Atlantic settlement
0572964T - patient at NPI; Somerset settlement
1507891G - patient at Essex County Mental Hospital, Essex settlement

- * If assigned identifying (serial) number has less than 5 digits, prefix zero(s)

Institutional Code Numbers

01 - State Hospital, Greystone Park
02 - State Hospital, Trenton
03 - State Hospital, Marlboro
04 - State Hospital, Ancora
05 - Neuro-Psychiatric Institute
11 - Atlantic County Mental Hospital
12 - Burlington County Mental Hospital (Evergreen Park)
13 - Camden County Psychiatric Hospital
14 - Cumberland County Mental Hospital
15 - Essex County Mental Hospital
16 - Hudson County Hospital for Mental Diseases
64 - Hospital for Chest Diseases, Glen Gardner
65 - Any county hospital for chest diseases

County Codes

A - Atlantic	J - Hudson	S - Salem
B - Bergen	K - Hunterdon	T - Somerset
C - Burlington	L - Mercer	U - Sussex
D - Camden	M - Middlesex	X - Union
E - Cape May	N - Monmouth	W - Warren
F - Cumberland	P - Morris	Y - State Charge
G - Essex	Q - Ocean	No Letter - Undetermined,
H - Gloucester	R - Passaic	Application Pending

APPLICATION REGISTER AND CONTROL - FORM PA-9B

Instructions for Use

Purpose

The Application Register, Form PA-9B, is designed to serve the following purposes:

1. to provide a complete listing, entered chronologically by order of receipt in the Area Office, of all applications for MAA on behalf of patients in those hospitals served by the particular Area Office;
2. to provide a control on the handling of each application by the Area Office staff from the time of receipt to final disposition, including a check on the time span from date of application to date of disposition;
3. to provide for a statistical count of the number of applications received during a calendar month;
4. to provide for a monthly statistical count of applications received by status;
5. to provide for a monthly statistical count of applications disposed of by manner of disposition; and
6. to provide for a statistical count of the number of applications pending as of the end of the month.

Method of Maintenance

1. An Application Register will be maintained in each Area Office in the post binder provided. Responsibility for the Register will normally be assigned to the Senior Clerk.
2. Applications will be registered immediately in order as received during the calendar month. A new page 1 will be started as of the first day of each calendar month. (In initiating the program all applications taken during January 1967 will be registered as of the month of January, using consecutive page numbers in the Register.)
3. Entries will be made by hand, with care to assure legibility.
4. Pages of the Register will be kept in the post binder until there has been disposition of all applications registered for a calendar month. The pages for each month can then be removed, stapled and filed chronologically by month and year.

Entries

1. Enter on each page the Area number, the month and year of registration, and the page number for the month.
2. Use all lines consecutively for registration, from 1 through 35. If it is necessary to strike out any line entry because of clerical error, also strike out the line number in the first column.
3. Case Number - Enter the case number as appearing on the application. (Form PA-1.) In cases where the county chargeable is not known at the time of registration, omit the county letter code suffix, but enter later when county chargeability has been determined and indicated on Form PA-3F.
4. Name - Enter the full name, in the manner indicated, as appearing on the application.
5. Hospital - Enter the name of the hospital where the applicant is a patient (i.e., Greystone, Marlboro, Trenton, Ancora, NPI, Glen Gardner, Overbrook, Ess. Co. San.); check against proper code shown by first two digits of the case number.
6. Date of Birth - Enter birthdate as appearing on the application; check that this indicates age as 65 years or older.
7. Date of Application - Enter date as appearing on the application; check against any inconsistency with day on which application is received for registration.
8. Application Status (See MAA Manual Supplement, S-3101.5) - Enter check in proper column if status is known at the time of registration; otherwise enter later when determined by Central Index Clearance (Form PA-9D) or caseworker's investigation. (If CI Clearance shows no previous County Welfare Board MAA case number, enter application status as "NA"; if CI Clearance shows a previous County Welfare Board MAA case number, application status will be entered subsequently as determined by the caseworker in reviewing the welfare board record.)
9. PA-9/Central Index Clearance - Under "Sent", enter date PA-9 and PA-9D are sent to Central Index. Under "Rec'd.", enter date PA-9D is received from Central Index with information as to previous case numbers.
10. Application Assignment - Under "Date", enter the date that copy of PA-1, together with PA-9A and PA-22A, is given to Supervisor for processing. Under "Case Section or Worker", enter last name of the Supervisor, or case section number, depending upon the administrative policy of the Area Office. (In the initial stages of the program when all supervisory positions may not be filled, application assignment may be directly to a caseworker as determined by the Area Supervisor.)

11. Remarks - Enter any appropriate notation which may explain or clarify the pending status of an application. (For example, when processing of an application is delayed beyond 30 days and an explanatory communication is sent to the hospital and/or applicant, enter date and addressee of the communication.)

12. Disposition - Make entry in this column when disposition of the application is approved by the Area Supervisor. Under "Code" (See MAA Manual Supplement, S-3101.7) enter:

"A" for approved;
"D" for denied;
"DM" for dismissed; or
"W" for withdrawn.

Under "Date" enter the date on which the Area Supervisor signed the PA-3F or PA-3G, whichever is earlier.

Statistical Count

1. For the count of applications received during a month, utilize the numbers in the first column of the pages of the Register for that month.
2. For the monthly count of applications received by status, count the number of checks in each of the four columns under "Application Status."
3. For the monthly count of applications disposed of, count the number of dispositions in the last column totally and separately by code (i.e., A, D, DM, W.)
4. For the count of applications pending at the end of the month, count the number of blank lines in the last column.
5. At the close of business on the last day of each month a count shall be made of the above items and the totals entered at the bottom of the appropriate columns.

REFERRAL REGISTER AND CONTROL-FORM PA-9C

Instructions for Use

Purpose

When an Area Office servicing a patient requires information from a hospital or other source which is within the jurisdiction of another Area Office, such information will be secured by referral and report. Similarly, when a recipient-patient is transferred from one hospital to another, the responsibility for service will be transferred by referral from one Area Office to the other.

The Referral Register, Form PA-9C, is designed to provide a control on the handling of each referral by the Area Office staff from the time of receipt to final disposition, including a check on the time span from date of receipt to date of disposition.

Method of Maintenance

1. A Referral Register will be maintained in each Area Office in the post binder provided. Responsibility for the Register will normally be assigned to the Senior Clerk.
2. Referrals will be registered immediately in order as received during the calendar month. According to Area Office practice depending upon the number of referrals received per month, a new page 1 will be started as of the first day of each calendar month, or each new month indicated by an interval of lines in the Register with the designation of the month entered in the "Name" column.
3. Entries will be made by hand, with care to assure legibility.
4. As may be convenient for handling the Register, those pages showing disposition of all referrals registered may be removed and filed chronologically by month and year.

Entries

1. Enter on each page the Area number, the month and year of registration, and the page number for the month.
2. Case Number of Referral - Enter the case number as appearing on the referral memorandum.
3. Name - Enter the full name, in the manner indicated, as appearing on the referral memorandum.

4. Hospital Where Patient - Enter the name of the hospital where the patient is receiving care when the referral is processed (i.e., Greystone, Marlboro, Trenton, Ancora, NPI, Glen Gardner, Overbrook, Ess. Co. San.). In the case of an inter-hospital transfer, this would be the hospital to which transfer is made.
5. Date Referral Rec'd. - Enter the date when referral memorandum is stamped as received.
6. Referred For: Report/Transfer - check proper column as indicated by purpose of the referral memorandum.
7. Referral Assignment - Under "Date", enter date that referral memorandum with any accompanying material is given to Supervisor for processing. Under "Case Section or Worker", enter last name of Supervisor, or case section number, depending upon the administrative policy of the Area Office.
8. Remarks - Enter any appropriate notation which may explain or clarify the pending status of an application. (For example, when supplementary information must be requested in order to process a referral, enter date and addressee of the communication.)
9. Date of Disposition: As applicable, under "Report Returned" enter date completed report is mailed to the Area Office which made the referral. As applicable, under "Case Accepted" enter date memorandum mailed to the sending Area Office advising of acceptance of an inter-hospital transfer.
10. Case Transfer - In case of inter-hospital transfer, enter under "New Case Number" the case number by which the case will thereafter be identified as the result of the transfer. Under "PA-9 Sent" enter date registration card is sent to Central Index showing new and prior case numbers.

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T A B L E O F C O N T E N T S

CHAPTER S-3200

ELIGIBILITY FACTORS OTHER THAN FINANCIAL

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Part III

The Individual and Medical Assistance for the Aged

S-3200

Eligibility Factors Other Than Financial

S-3200. ELIGIBILITY FACTORS OTHER THAN FINANCIAL

Eligibility must be established in relation to each legal requirement for the program of Medical Assistance for the Aged to provide a valid basis for granting assistance or a valid reason for denial of assistance.

The applicant is the most logical source of information about himself and his affairs. In working with him the BIS exercises judgment as to how much information the applicant may reasonably be expected to secure, and at what point BIS should offer direct help in securing evidence to establish eligibility. The BIS does not initiate inquiries automatically to sources other than the applicant, or merely as a matter of convenience to the BIS. However, when the client is physically or mentally unable to act for himself or when his lack of education would make it difficult for him to write letters, complete necessary forms, etc., he should be given direct help in securing the necessary information.

The following general policy and procedure shall be observed:

.1 Sources of Evidence

The client's statements regarding his eligibility are evidence. However, for purposes of public assistance, the client's statements must be consistent and otherwise meet prudent tests of credibility and verification required by the BIS. If his statements are incomplete or questionable, they shall be supplemented and substantiated by corroborative evidence from other pertinent sources.

.2 Recording Evidence

All evidence considered by the agency in determining eligibility shall be recorded in appropriate parts of the case record.

The Individual and Medical Assistance for the Aged

S-3210. AGE

S-3211. Legal Requirement

S-3212. Special Provisions and Evidence of Age

•1 Arbitrary Date of Birth

In those instances when the year of birth can be determined but not the exact date, the arbitrary date of July 1 shall be assumed to be the month and day of birth.

2 Date of Eligibility

In respect to the age requirement, an applicant is eligible from the first of the month in which the required age is attained.

3 Evidence of Age

The general policy shall be that the applicant shall support his statement that he is of eligible age by presenting one acceptable record of age. However, if the record initially available from the client or other sources does not support the client's statement, then further evidence shall be sought and evaluated in relation to the initial evidence. As a general rule, records shall be used which are at least one year old.

There must be proof that the applicant is at least 65 years old. It is not necessary to establish the exact age.

4 Sources of Evidence of Age

See S-3200 Appendix I for a list of suggested acceptable sources of evidence of age and their use.

The Individual and Medical Assistance for the Aged

Eligibility Factors Other Than Financial - Residence

S-3221. State Residence (Cont'd.)

If an individual leaves New Jersey with intent to establish a place of abode elsewhere, or for an indefinite period for purposes other than a temporary visit, or if he decides to remain indefinitely in the place outside New Jersey to which he had gone for a temporary visit, he ceases to be a resident of New Jersey and becomes ineligible to receive medical assistance.

The Individual and Medical Assistance for the Aged

Eligibility Factors Other Than Financial - Residence

.4

3) the applicant entered the institution or establishment from another state less than twelve months prior to date of application for MAA.

Part III	The Individual and Medical Assistance for the Aged
S-3200	Eligibility Factors Other Than Financial - Residence

S-3222. County Residence (Cont'd.)

- .4 e. When an applicant was a patient in a public or voluntary general hospital the hospital shall not be considered to have been the customary place of abode regardless of the length of stay therein.
- f. When an applicant was a patient in an institution for the mentally ill, the mentally deficient, the tuberculous or in a veterans facility, such institution shall not be considered to have been the customary place of abode regardless of the length of stay therein.
- g. In the circumstances set forth in d., e., and f. the customary place of abode shall be that county where the applicant last resided, regardless of the length of such residence, prior to entering the institution, establishment, non-profit or charitable home, general hospitals or facility.
- h. An applicant who has been adjudged mentally incompetent and for whom a legal guardian has been appointed, has residence based on his own customary place of abode and not on that of his guardian. Changes in the client's customary place of abode, when arranged by or permitted by the guardian, will result in changes in the client's residence, whether or not there is a change in the residence of the guardian, in conformity with the same provisions as for clients without legal guardian.
- .5 Patient Admitted Directly from Out-of-State
- If a patient has been admitted to the hospital directly from out-of-state, and chargeability cannot be determined by the rules set forth in .1, .2, .3 or .4 above, the county share of the costs of medical assistance will be charged to appropriations made to the hospital by the unit of government responsible for its administration.

S-3230.

S-3230. CITIZENSHIP

New Jersey Department of
Institutions and Agencies
Division of Public Welfare

S-3250. - S-3251.2

The Individual and Medical Assistance for the Aged

S-3250. NEED FOR MEDICAL SERVICES

S-3251. Release from the Hospital

.1 Release for Temporary Period with Plan for Return

After a client has been released for a temporary period, the plan may be changed so that the release will be continued indefinitely if a satisfactory adjustment is made. In such case the policy in .2 will apply.

2 Release for Indefinite Period without Discharge

A client may be released from the hospital without discharge but with no plan for return if a satisfactory adjustment is made. In such case, in order to provide for observation of the adjustment, eligibility for medical assistance continues

- a. so long as the client does not require support from any source of public funds, and
- b. until a bill is received showing no days of hospital care for a full calendar month.

No payment shall be authorized for the days of absence from the hospital.

S-3260.

The Individual and Medical Assistance for the Aged

ment Fees or Similar Charges

PROHIBITION AGAINST ENROLLMENT FEES OR SIMILAR CHARGES

No fees, premiums or any similar charges whatsoever may be imposed upon any applicant or recipient as a condition of eligibility for medical assistance.

Part III	The Individual and Medical Assistance for the Aged
S-3200	Eligibility Factors Other than Financial - Involuntary Detention

S-3270. INVOLUNTARY DETENTION

An individual committed to, and involuntarily detained in, a public hospital is eligible for Medical Assistance for the Aged when the purpose of the commitment is to provide care and treatment for mental illness or tuberculosis, and such individual can be released to an alternative plan of care solely by administrative action of the hospital. However, an individual involuntarily detained in a public hospital is not eligible for Medical Assistance for the Aged when the detention results from a legal process growing out of a violation of law, and such individual cannot be released from the hospital except by court order.

SOURCES OF EVIDENCE OF AGE

Excerpts from Manual of Administration - Section 2200

2213. Sources of Evidence of Age

.1 a. Birth Certificate of Applicant

A properly authenticated birth certificate issued at the time of the applicant's birth or as a delayed certificate gives conclusive evidence of age.

1) An applicant born in New Jersey may secure a birth certificate from the Bureau of Public Health Statistics, Division of Vital Statistics and Administration, New Jersey Department of Health, Trenton. However, an applicant will generally find it more convenient to apply for his birth certificate directly at the proper municipal bureau of vital statistics. An applicant may obtain his copy without cost if he indicates that the information is to be used in his application for public assistance.

2) An applicant born outside of New Jersey but in the United States may obtain a birth certificate by writing the division of vital statistics of the State Health Department in the proper State. Exceptions to this are the cities of Baltimore, Boston, New York, and the District of Columbia, which keep the original records in the Municipal Bureau of Vital Statistics. Massachusetts is also an exception in that its Division of Vital Statistics is part of its Department of State.

3) A birth certificate will sometimes fail to show the given name of the applicant or will show an entirely different name. In these instances, the agency shall make every effort to clear up the inadequacy or inconsistency through other sources of evidence. If the inadequacy of the original certificate cannot be conclusively resolved, the agency shall weigh all available evidence and decide whether or not the certificate corroborates the age of the applicant. All the determining factors entering into the decision shall be recorded in detail in the case record.

4) Birth certificates which may have been changed in accordance with Chapter 174, New Jersey Laws of 1938, shall be carefully evaluated. This regulation provides that corrections to birth and marriage certificates may be made "by the person who made the original report. . .or by any other person having personal knowledge of the matters sought to be corrected which other persons shall state such matters on his oath."

The New Jersey Bureau of Public Health Statistics incorporates in its transcription both the original and corrected records, together with the name of the person making such a correction. A corrected record shall not be accepted as conclusive proof of age without additional substantiating evidence. When municipal records cannot be examined personally, a copy of both the original and corrected records shall be requested.

5) Chapter 21, New Jersey Laws of 1942, provides that unrecorded births may be recorded "by any person who has definite knowledge of the facts concerning the birth or by the person whose birth is being recorded, provided substantiating documentary proof is submitted and noted upon the certificate by the person before whom the affidavit is taken." An applicant is able in this way to record his birth upon submitting substantiating documentary proof.

In requesting birth certificates from the Bureau of Public Health Statistics, the agency shall request the date when the certificate was filed. The agency shall seek additional evidence if the filing date of the birth certificate is less than three years before the time of application.

b. Birth Certificate or Death Record of Another Person

The birth certificate or death record of a person other than the applicant may indirectly help in determining the applicant's age. For example, the birth certificate of a child generally shows the age of the parent and is considered adequate evidence of the age of both the parent and child. Even if the parent's age is not given, it may be assumed that he was not less than fifteen years old at the time of the birth of the first child. Other information given by the applicant in conjunction with these data may help to determine that he is even older than shown by the document submitted.

Similarly, the death record of a child which gives the child's age at the time of death may enable the agency to determine the applicant's age.

c. Marriage Certificates

The ages of the contracting parties and the date of marriage will be presented in an authenticated marriage certificate. Information from these records are available in the same way as original birth records. Consideration may have to be given to the fact that certain persons understate or overstate age at the time of marriage due to the difference in the ages of the couple.

.2 Church Records

Evidence of age may be secured from various church records, such as baptismal, membership, first communion, confirmation, marriage, and the like.

.3 Records of Foreign Born Applicants

Foreign born applicants may have their age determined through records which resulted from their immigration, such as passports, immigration records, naturalization records, etc.

a. If the passport is unavailable, inquiry may be made regarding the applicant's application for a passport to the United States Department of State, Washington, D.C.

b. Immigration records after July 1, 1924, may be considered conclusive evidence. Since that date, each immigrant must support his declared date of birth with documentary proof.

Information regarding immigration records is usually available from the Immigration and Naturalization Service in the district of entry. The United States Department of Labor at Washington, D.C., may be used also to locate immigration records. Requests for this information shall include the following data:

The exact spelling of the immigrant's name as used at the time of arrival in this country,

The date and port of entry,

The name of the ship, and

Any other available identifying information.

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c. Age may frequently be determined through documents issued in connection with applications for citizenship. Papers covering declaration of intention to become a naturalized citizen may state the person's age at the time of declaration. When no age is given, the person can be considered as having been at least 18 years old at the time of declaration.

d. Naturalization papers usually give the age of the naturalized person. Even if no age is given, the person can be considered to have been at least 21 years of age at the time of naturalization unless he derived his citizenship through the naturalization of someone else. For example, naturalization papers issued for a parent frequently list the names and ages of the children under 21 at the time.

If naturalization papers are unavailable, the proper court of naturalization shall be contacted for information.

At time the United States Department of Labor at Washington, D.C., will be able to furnish naturalization records. A request for such material shall include the following information:

The name of the person as spelled at the time of naturalization,

The location of the court issuing the naturalization certificate,
and

The date of naturalization.

.4 Census Records, Federal and State

a. Evidence of age may be secured from federal census records only after other evidence is not available from State and local records. Requests for information are to be filed with the U.S. Department of Commerce, Bureau of the Census, Pittsburg, Kansas on the form furnished for this purpose, with all pertinent identifying information, such as the applicant's address at the time of the census.

The fee charged for each search of the federal census records is a proper administrative cost.

b. Evidence of age may be secured from the census records of New Jersey taken on a State-wide basis during 1905 and 1915. The State census records show the age and name of every member of the families enumerated. In requesting information, it is essential that the address of the applicant at the time of the census be given.

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The charge for public assistance agencies is \$.50 for each address searched in each year. Requests should be addressed to the Registrar of Vital Statistics, State Department of Health, Trenton.

.5 School Records

Evidence of age may be secured from school records in which the applicant's age or years of attendance are given.

.6 Military Service Records, Federal and State

Government records of enlistment with and discharge from the armed forces ordinarily state the age of the person who has experienced military service.

a. An applicant who served with the armed forces of the United States may have in his possession certain records of his military service which present evidence of age. If these records are not available, then the United States Department of Defense shall be contacted for information. In requesting information from this source, the following information should be given as a minimum:

The full name of the person,

The dates of service, i.e., enlistment and discharge,

The places of enlistment and discharge,

Organization and rank, and

The approximate date and place of birth.

b. An applicant who served with the State Militia or the National Guard will also have certain records of his local military service. If these are not available, then the office of the State Adjutant-General, Department of Defense, Trenton, shall be contacted.

.7 Court Records

Evidence of age may be secured from various records maintained by different county, state, or federal courts of law. Some examples of court records are legal commitments, adoption records, divorce records, etc.

a. Records of legal commitments of the mentally ill or delinquent maintained by the county courts in New Jersey will present the applicant's age.

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b. An applicant who was adopted before his twenty-first birthday may obtain evidence of his age from the adoption decree granted throughout the proper county court.

c. Records of divorce or legal separation indicate the age of the applicant at the time of the event. Requests for information on divorces may be made to the Clerk, Superior Court, State House, Trenton, N.J.

Any discrepancy in the name of the applicant as shown in such records should be cleared through other sources of evidence.

.8 Employment Records

Records resulting directly or indirectly from employment, such as records maintained by employers, labor unions, the Federal Security Agency, etc., may give evidence of age.

a. Employment records maintained by former employer in private industry may show the age of the applicant at the time of his employment.

In weighing evidence from this source, consideration shall be given to the common tendency of older persons to misrepresent themselves as younger while younger persons misrepresent themselves as older in order to secure employment.

b. Federal Civil Service records generally show the age of the applicant before and during the time of his employment. Such records are kept for a comparatively short time by the United States Civil Service Commission, Washington, D.C. It may also be helpful to contact the United States Pension Board.

c. State Civil Service records will similarly show the age of the applicant. Such records are available at the New Jersey Civil Service Department, Trenton.

d. Records on file with labor union such as the American Federation of Labor or the Congress for Industrial Organization will show the age of the applicant at the time of his admission to membership.

e. In order to secure employment in covered industry, the working individual must have his age recorded by the Federal Security Agency in respect to Old Age and Survivors Insurance. In using this source, the agency shall submit a request for information on revised Form OA-20 in triplicate to the local field office of the Social Security Agency serving the area in which the applicant lives.

.9 Records of Public and Private Welfare Agencies

Records kept by public and private welfare agencies will generally show the age of the applicant at the time of agency contact.

Any records which may have been made in anticipation of referral to public assistance shall be carefully examined.

.10 Town and County Histories and Genealogies

Histories and genealogies maintained by some communities and counties are sources of evidence of age.

.11 Voting Records

Enrollment or registration records of voting districts will generally show the age of the applicant. However, the fact that age is not always stated correctly at the time of enrollment shall be considered.

.12 Bank and Postal Savings Records

Evidence on age may be secured from bank and postal savings records where the applicant may have been required to give his age as a means of identification when he opened his account.

.13 Fraternal Organization Records

Records of fraternal organizations may present the age of members at the time of admission to membership. Such records are often maintained by the local chapters of the fraternal organizations.

.14 Medical Records

a. Medical records of hospitals, clinics and institutions may give the authentic birth date.

b. An authenticated hospital record of birth is acceptable as conclusive evidence of age.

c. Other medical records of hospitals, clinics and medical institutions will generally show the age of the applicant at the time of his admission for emergency or continued care. However, the fact that the applicant himself may not have given the information must be considered.

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d. Records maintained by such non-medical institutions as welfare houses, almshouses, orphanages, jails, prisons, reformatories, etc., will generally show the applicant's age at the time of his admission.

e. The records of the family physician and/or midwife who were in attendance at the time of birth frequently provide the date of birth and the name of the applicant.

f. Other records of physicians, such as patient file, will provide additional evidence of age. However, the value of the evidence presented in these records depends upon the age of the record.

.15 Personal Records

The applicant may have any number of the above sources of evidence in his possession or readily accessible to him. In addition, he may have other sources of evidence of which he is the sole possessor, such as the family bible, other family records, insurance policies, licenses of various sorts, award letters, etc.

It is recommended that personal records submitted by the applicant or by another person in his behalf be returned to the owner after they have served their purpose.

a. Evidence of age may be obtained from the applicant's family bible in which successive entries of birth have been made. The reliability of these entries is open to question if they appear to be of recent origin or to have been tampered with. Their reliability is increased if the particular entry for the applicant in the bible can be determined to be of considerable age or when the information on the applicant appears in chronological order of the entries on other family members.

b. Other family records which may furnish evidence of age include birthday books, old diaries, old letters, embroidered samplers, family pictures with dates and ages, prizes with dates and ages, dated newspaper clippings, and the like.

c. Current, lapsed, cash-surrendered, or paid-up insurance policies in the applicant's possession will show his age at the time of issuance. In evaluating the evidence secured from insurance records, it shall be kept in mind that people frequently understate their age for insurance purposes.

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d. Licenses of various sorts, such as fishing, hunting, boating, driving, vending, professional, and the like will generally present evidence of age.

e. The applicant's letter of award for Old Age and Survivors Insurance Benefits from the Federal Security Agency is acceptable evidence that the person is past 65 years of age.

f. Award letters by other federal agencies, such as the United States Veterans Administration, may also include information on the applicant's age.

.16 Affidavits

Evidence of age presented in affidavit form by reliable and disinterested persons are considered the least desirable sources of evidence. Affidavits may be used, however, when efforts to secure evidence from other sources have failed or have produced inconclusive data. In these instances, affidavits shall be taken under oath from a person who has objective, factual knowledge of the applicant's age. The affidavit shall show the circumstances under which the affiant has known the applicant and the factual basis for his statements in regard to the applicant's age. It is essential that the affidavit indicate more than mere opinion.

The following example indicates the nature of a valid affidavit:

The affiant states that he believes the applicant to be over 65 years of age since he (the affiant) himself, now aged 50, was married in 1927 at the age of 25 at the applicant's home, and his best man, also 25, was the youngest of the applicant's three sons.

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FINANCIAL ELIGIBILITY

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Part III

The Individual and Medical Assistance for the Aged

S-3300

Financial Eligibility

S-3300. FINANCIAL ELIGIBILITY

.1 Definitions

a. Single Person

A client who is unmarried, a widow, widower, divorced, separated;
or a married client who was living apart from his spouse immediately
before entering a hospital.

b. Married Person

A client who was living with his spouse immediately before entering
a hospital.

Part III	The Individual and Medical Assistance for the Aged
S-3300	Financial Eligibility - Income and Resources
	Separate Eligibility Factors

S-3310. INCOME AND RESOURCES - SEPARATE ELIGIBILITY FACTORS

- .1 The income and resources of a client shall be recognized as separate eligibility factors.
- .2 To be eligible for MAA, the client must have both income and resource eligibility. For example, a client who has no income may not be eligible because he has excess resources; conversely, a client who has no resources may not be eligible because his income exceeds the income eligibility factor.

S-3320. INCOME ELIGIBILITY

Income means all monies being received on a recurring basis at the time of application or eligibility redetermination. It includes monies received as income from employment or business, income from investments, trusts, estates, contributions, or benefits from OASDI, workmen's compensation, railroad retirement, Veterans Administration, union, lodges, etc. (When benefits are granted for special purposes in accordance with intent of the law under which they are provided, such as education, rehabilitation, medical costs, etc., such benefits shall be recognized as a resource applicable only to the particular requirements for which they are granted.)

- a. When such income recurs at monthly intervals or less it shall be budgeted as monthly income.
- b. When such income recurs at intervals greater than a month, prorate the amount of income on a monthly basis between the periods of payment, provided that such income shall not be pro-rated to cover monthly periods in advance of the actual receipt of the income.

Income of a spouse does not include monies being received by him as representative payee, guardian or legal representative of a client.

When the income eligibility of a single person is being determined, consider only the income of the client.

When the income eligibility of a married person is being determined, consider the income of the client and spouse.

Earned income shall be determined in accordance with Categorical Assistance Budget Manual Section 503, as applicable (See S-3300, Appendix I.)

The Individual and Medical Assistance for the Aged

Financial Eligibility - Income Eligibility

3) When a client has received continuous hospital care for six consecutive months, the exemption of income for shelter continuity shall not be recognized and the client's income and resource eligibility shall be redetermined as necessary.

Part III The Individual and Medical Assistance for the Aged
S-3300 Financial Eligibility - Income Eligibility

S-3322. Income Eligibility for Hospitalization for
Mental Diseases and Tuberculosis (Cont'd.)

.3 Married Person

a. When a married client is receiving hospital care, all income of the client and of the spouse is considered separately in determining financial capacity to pay for the costs of care.

1) All income of the client, subject to appropriate exemptions other than shelter continuity, shall be considered available to meet the authorized costs of hospital care.

2) All income of the spouse shall be applied in using Schedule I, Determination of Financial Capacity to Pay for Care or Service (S-3300, Appendix II). If there is a financial capacity, action shall be taken as provided in S-3340, Relative Responsibility.

b. When the spouse of the client is also in need of hospital care or nursing home care, each shall be considered as a single person for purposes of determining income eligibility. Where applicable, allow the exemption for shelter continuity to the person having the greater amount of income.

.4 Allowable Income for Personal Expenditure

A hospital, based upon evaluation of the circumstances of a client, may determine that such client requires, and has capacity to use, an amount of income for personal expenditure to enhance the medical/social plan of care and treatment. Upon written notice of such determination (Notice of Income Reserved for Personal Expenditure - Form PA-3K), there shall be exempted from the client's income for personal expenditure, the amount stated in the notice, or the excess of such amount over the currently effective exemption for personal care items. (See S-2700.)

.5 Reserve Fund

a. In anticipation of costs involved in adjustment to an alternative plan of care, or in anticipation of death while hospitalized, there shall be exempted, after deduction of other appropriate exemptions, an amount up to the balance of client's monthly income for such period as required to establish, together with available cash resources, a reserve fund of \$500. When income and/or cash resources have once been exempted in the amount of \$500, no further income exemption to replenish the reserve fund shall be allowed except as provided in S-3322.5b.

The Individual and Medical Assistance for the Aged

Financial Eligibility - Income Eligibility

Income Eligibility for Hospitalization for Mental Diseases and Tuberculosis (Cont'd.)

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Part III	The Individual and Medical Assistance for the Aged
S-3300	Financial Eligibility - Income Eligibility

S-3322. Income Eligibility for Hospitalization for Mental Diseases and Tuberculosis (Cont'd.)

- .6 b. 1) d) amount authorized on a monthly basis for other personal incidental expenses (S-2300.);
- e) amount authorized to establish or replenish a reserve fund (S-3322.5.)
- 2) When the cost of hospitalization for any month exceeds the balance of available monthly income, as determined in 1) above, a payment of medical assistance will be made in the amount of this excess.
- 3) When the balance of available monthly income, as determined in 1) above, exceeds the potential cost of thirty-one days of hospital care, the client is ineligible for medical assistance.

S-3332. Resource Eligibility for Hospitalization for Mental Diseases and Tuberculosis

a. Resource eligibility for hospitalization for mental diseases or tuberculosis is determined initially for a period of three months unless b. below is applicable.

b. When a client has been receiving continuous hospital care for six consecutive months, resource eligibility shall be determined or redetermined, whichever is applicable, on a six month basis.

a. A single client has resource eligibility for an initial three month period when value of all resources, as defined in section S-3330.1 a., is \$900 or less.

b. When medical evidence indicates that the client will probably be returning to his home within the following three months, his resource eligibility shall continue on the same basis as set forth in a. above for an additional period not to exceed three months.

c. When a client has received continuous hospital care for six continuous months, he has resource eligibility when the value of all cash resources does not exceed the reserve fund amount of \$500.

d. Subject to S-3332.4, when the value of all cash resources exceeds the amounts set forth in a. or c. above, the excess shall be considered available to meet the authorized costs of hospital care. If such excess is sufficient to meet the potential cost of three full months of hospital care, the client is ineligible for medical assistance but there shall be a reevaluation at the end of the three month period.

Part III The Individual and Medical Assistance for the Aged
S-3300 Financial Eligibility - Resource Eligibility

S-3332. Resource Eligibility for Hospitalization for
Mental Diseases and Tuberculosis (Cont'd.)

.3 Married Person

- a. A married client has resource eligibility for an initial three month period when the value of all cash resources, as defined in section S-3330.1 a., is \$1500 or less.
- b. When medical evidence indicates that the married client will probably be returning to his home within the following three months, his resource eligibility shall continue on the same basis as set forth in a. above for an additional period not to exceed three months.
- c. When a married client has received continuous hospital care for six consecutive months, or b. above is not applicable, he has resource eligibility when the value of all cash resources does not exceed \$900 for his spouse plus the reserve fund amount of \$500.
- d. Subject to S-3332.4, when the value of all cash resources exceeds the amounts set forth in a. or c. above, the excess shall be considered available to meet the authorized costs of hospital care. If such excess is sufficient to meet the potential cost of three full months of hospital care, the client is ineligible for medical assistance but there shall be a reevaluation at the end of the three month period.
- e. When the spouse of the client is also in need of hospital care or nursing home care, each shall be considered as a single person for purposes of determining resource eligibility.

.4 Availability of Resources to Meet Costs of Hospital Care

Although all cash resources as defined in S-3330.1, by whomever held, are accountable in determining eligibility, and must be considered in application of the allowable exemptions for the client and the spouse, any excess over such exemptions cannot be considered available to meet the costs of care until the funds are received by the hospital. Accordingly, resource eligibility, and availability of excess cash resources to meet the costs of hospital care, shall be determined in relation to the amount of client's funds on deposit with the hospital, so long as active efforts are being taken to effect payment to the hospital of any other excess cash resources.

Part III	The Individual and Medical Assistance for the Aged
S-3300	Financial Eligibility - Resource Eligibility

S-3333. Health Insurance or Health Benefit Plans

 .1 General Policy

 All benefits from Hospital Insurance and Supplementary Medical Insurance (Title XVIII, Parts A and B, Social Security Act), Blue Cross, Blue Shield, health and accident insurance plans, and all other independent health insurance plans shall be considered as resources to be applied as reimbursement against the cost of the medical services for which they are available.

Part III

The Individual and Medical Assistance for the Aged

S-3300

Financial Eligibility - Relative Responsibility

S-3340. RELATIVE RESPONSIBILITY

.1 Relatives are a Resource

- a. Relatives, whatever the relationship, are a possible resource. It is and shall be the duty of the BIS to determine the willingness of relatives to contribute to the medical assistance for the client by rendering financial aid or other service.
- b. Contacts with relatives should be made with the knowledge and assent of the applicant. Although his application for public assistance contains an acknowledgment of his responsibility to assist the agency in necessary efforts to secure information from all sources including relatives, nevertheless, in any specific situation, he has the choice of whether or not he wishes the contact made. If he refuses to allow contact to be made, his application may be either withdrawn or denied. In such instance, the individual should be told that he has the right to reapply at any time.
- c. The BIS shall determine what contributions the relative is currently contributing or is willing to contribute to the cost of medical assistance on behalf of the client.

.2 Income from Relatives

Only the amount of monies actually being contributed voluntarily (i.e., not subject to court order) by a relative or relatives on a recurring basis is considered as income.

.3 Client Information on LRR

The agency shall inform a client as to the following:

- a. In determining his eligibility and granting of medical assistance, certain relatives are considered as a resource;
- b. failure of an LRR to make available his evaluated capacity to pay part or full authorized costs of medical assistance does not affect the client's eligibility for medical assistance; and
- c. when an LRR fails to make available his evaluated capacity, appropriate action will be taken to recover amounts to the extent of the LRR's evaluated capacity for the medical assistance granted.

S-3341. Legally Responsible Relatives in MAA

In determining the ability of relatives to contribute to medical assistance for the client, consider only the financial capacity of the children, and of the spouse when living separate and apart from the client.

The Individual and Medical Assistance for the Aged

Financial Eligibility - Relative Responsibility

.1 Ability of LRR to Contribute

2 Appropriate Method

Child - Schedule II, Determination of Financial Capacity to Contribute to Care or Service. (See S-3300, Appendix III.)

LRR's capacity to contribute to the cost of hospital care shall be determined on a monthly basis and shall be directly related to each of the calendar months in which care was received by the client and for which payment is claimed by the hospital.

.1 Financial Capacity and Payments by LRR

2 Action When Evaluated Capacity Not Available

When an LRR fails or refuses to make available the amount of his determined financial capacity toward part or full payment of the costs of hospital care, the BIS shall take appropriate action in accordance with Categorical Assistance Budget Manual Sections 606.2 and 607. (See S-3300. Appendix IV.)

Part III	The Individual and Medical Assistance for the Aged
<u>S-3300</u>	<u>Financial Eligibility - Agreement to Repay</u>

S-3350. AGREEMENT TO REPAY

The requirement of an agreement to repay shall not apply to patients in public hospitals for mental diseases and tuberculosis in consideration of the statutory lien imposed by the hospital (See S-3330.1 b).

S-3370. COURT ORDERS DIRECTING PAYMENT OR CONTRIBUTION

When there is a currently effective order of a court of competent jurisdiction directing payment by the patient or contribution by a legally responsible relative toward the cost of hospital care, the amount stated in the order shall be accepted as the financial capacity of the patient or relative. However, the BIS shall take appropriate action to inform the court of any subsequent change in circumstances which may justify review of the order.

EARNED INCOME OF A CLIENT

Excerpts from Categorical Assistance Budget Manual

503. EARNED INCOME OF A CLIENT

503.1 METHODS FOR DETERMINING BUDGETABLE EARNED INCOME OF AN OAA, DA, AND ADC CLIENT

a. From employment.

1. A client's budgetable earned income will be considered as the total wages, bonuses and commissions, etc., in cash or in kind, currently received from the employer less deductions by the employer for withholding taxes, union dues, any compulsory contributions to a retirement plan, group insurance plan, and garnishments, and less the following:
 - (a) expenses of employment which are not personal but necessary for continued employment such as tools, transportation, material, special uniforms, child care, etc., if not furnished by the employer;
 - (b) when applicable, the expenses of employment due to participation in employment activities such as expenses for recreation groups, contributions to welfare and gift funds, coffee breaks, etc.;
 - (c) the monthly amount for personal expenses of employment, whether full or part-time and regardless of the age of the client. This item includes the additional costs of food, clothing and personal incidentals. (See Section 503.2).
2. Deductions for any other purposes will not be recognized, and if they are being made this amount should be added to the net sums actually received by the employee in order to determine budgetable earned income.
3. Earnings shall be verified from voucher records or statements in writing submitted by the employed person, subject to additional verification as required by agency standards.

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4. Where a client's weekly or monthly earnings are of irregular amounts, the current income for budgetable purposes shall be the average earnings computed from the 8 weeks' experience immediately preceding the determination.

b. From self-employment

1. Earned income from self-employment (other than when earned income is from roomers, boarders and/or roomer-boarders) is considered to be the net profit from a business enterprise, farming, etc. Net profit is the total revenue less the cost of producing the revenue (business expenses). Expenses such as income tax payments, lunches, etc., are not to be considered as business expenses.
2. Budgetable earned income from self-employment is the net profit as defined in 1. less income taxes and Social Security taxes when required, and less the applicable personal expense of employment (see Section 503.1-a.-1., and Section 503.2).
3. Persons who are self-employed shall be required to submit evidence of business receipts and expenditures as the basis for a sound estimate of budgetable income. If the person is unable to submit satisfactory records, an evaluation based on current operations as observed and reported by the worker shall be made.

c. Payments made to or on behalf of any person under Title I or II of the Economic Opportunity Act of 1964

1. Payments made to or on behalf of any person under Title I or II of the Economic Opportunity Act of 1964.

The term payments as used for this purpose **refers** to amounts paid to individuals who are recipients of benefit payments under the Economic Opportunity Act of 1964.

(a) Enrollees or student participants in Title I projects as Jobs Corps (Title I-A) and Neighborhood Youth Corps (Title I-B) and students employed under the College Work Study Program (Title I-C) are recipients of benefit payments under the EOA programs.

(b) Community Action Programs

Payments made to individuals under Community Action Programs sometimes qualify as benefit payments for purposes of disregard of income.

(1) Payments to Trainees

Community Action trainees are individuals enrolled in community action training programs who do not engage in substantial work activities and who do not receive their payments in the form of wages. All payments to such persons in connection with their training shall be considered as benefit payments.

(2) Payments to Resident Non-Professionals

"Resident non-professionals" are persons whose status or relationship to the Community Action Program is determined, by the public welfare agency, to meet all of the following criteria:

- they are so designated by the community action agency; and
- they are selected primarily on the basis of residence in a target area or membership in the target population; and
- they work and concurrently receive training as health aides, teacher's aides, neighborhood workers, survey workers, etc.

Such persons are regarded as beneficiaries only on a partial and temporary basis. For each of the first 12 months only of combined work and training as a "resident non-professional," only the first \$150 a month shall be recognized as a benefit payment to which the disregard of income applies. If such worker is retained after the first 12 months, he is to be regarded in all respects as a member employee and his payments shall be regarded as earned income (503.1a) not subject to any further "benefit payment" exemptions.

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- (3) Individuals employed by Community Action agencies, other than those determined to be "resident non-professionals," are regarded in all respects as regular employees and their wages shall be regarded as earned income from employment in accordance with 503.1-a.

d. Method for:

1. Disregarding income received as "benefit payments" under Title I and II of the Economic Opportunity Act of 1964; and
 2. Applying "earned income exemption" and determining earned income of an AB client.
 - (a) Deduct from gross earnings expenses of employment which are not personal but necessary for continued employment, such as tools, material, and special uniforms, if not furnished by the employer.
 - (b) From the amount in (a) above, disregard the first \$85 per month and one-half of the excess above \$85; except that with respect to "resident non-professionals," as defined in 503.1-c, disregard, of the first \$150, the first \$85 and one-half of the remainder, and only for the first 12 months.
 - (c) From the amount remaining after any deductions specified in (b), deduct expenses of employment as set forth in Section 503.2-a., plus any other personal expenses such as transportation to and from work, child care, etc.
 - (d) The remainder of income shall be recognized as income to the family unless Section 501.2-a-2 or 501.2-b-2 is applicable.
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503.2 MONTHLY AMOUNT FOR PERSONAL EXPENSES OF EMPLOYMENT

- a. Monthly amount for personal expenses of employment.....\$40.00
When the person works either full or part-time and regardless of age of client, use the monthly amount for expenses of employment.
- b. When the monthly earnings of the person are less than his total monthly expenses of employment (Section 503.1-a.-1. and Section 503.1-b.-2.) neither the expenses of employment nor the income shall be included in the budget.

503.3 FROM SEASONAL EARNINGS

Seasonal earnings refers to income from work which is only available during certain periods of the year and shall be considered in the same manner as prescribed in Sections 503.1-a.-1, 503.1-b., and 503.1-c., whichever is applicable.

503.4 NET INCOME TO CLIENT FROM ROOMER(S), ROOMER-BOARDER(S) AND
TABLE-BOARDER(S)*

503.41 Roomer(s) and Roomer-Boarder(s)

- a. In situations where the person's shelter cost is for shelter cost only and does not include any of the household need items, the net income to the person from roomer(s) and roomer-boarder(s) who are living in the home with the person is to be determined as follows:
 1. Add the appropriate cost figure as set forth below and the per capita share of the actual cost of shelter.
 2. Subtract the total monthly cost to the person from the monthly amount paid. The difference is the net income.
- b. In situations where the shelter cost includes one or more, but not all, of the household need items, the net income from roomer(s) and roomer-boarder(s) is to be determined as follows:
 1. Add the appropriate cost figure as set forth below and the per capita share of the actual cost of shelter.

* See Section 604.6 when legally responsible relative is roomer-boarder in home of client.

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2. Total the appropriate monetary allowance(s) for the item(s) provided with the shelter cost.
3. Subtract the sum of 2. from 1.
4. Subtract the result of 3. from the monthly amount paid. The difference is the net income.

503.42 Table-Boarder(s)

- a. Subtract the appropriate cost figure, as set forth below, from the monthly amount paid to the person.
- b. The difference is the net income.

503.43 Cost Figures

- a. Roomer (cost figures include light, housecleaning supplies, water, fuel, bed and bathroom linens and laundry of same) \$12.00
- b. Table-Boarder (cost figures include food, cooking fuel, housecleaning supplies, refrigeration and water \$40.00
- c. Roomer-Boarder (cost figures include food, utilities, housecleaning supplies, fuel, refrigeration, water, bed and bathroom linens and laundry of same) \$46.00

503.44 Net Income from Roomer(s) and Roomer-Boarder(s) when Shelter Cost Includes All Household Needs

- a. Divide the rental cost by the number of persons living in the home to determine the per capita share of the rental.
- b. Roomer(s)
 1. Subtract from the per capita share of the rental cost the sum of the appropriate per capita allowances (based on the number of persons eating in the home) for cooking and refrigeration.

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2. Add \$2.00* to the result of b.-1.
3. Subtract the results of b.-2 from the amount paid to the client; the difference is the net income.

c. Roomer-Boarder(s)

1. Determine the appropriated food allowance for the roomer-boarder(s) using the food allowance for a child age 13-21 [regardless of actual age of roomer-boarder(s)] and the appropriate family size.
2. Add to the per capita share of the rental the appropriate food allowance and \$2.00*.
3. Subtract the sum, as determined in c.-2 from the amount paid to the person. The difference is the net income.

503.45 The entry of income to the person in his budget shall be limited to the net monthly income as computed according to Sections 503.41, 503.42 or 503.44, whichever is applicable. It is to be assumed that all roomer(s), table-boarder(s) and roomer-boarder(s) in the home of a person are paying an amount that is at least equal to the cost.

* (This amount represents the approximate monthly cost of maintenance and replacement for non-durable house furnishings other than household supplies. This amount has been included in the cost figures identified in Section 503.43.)

503.5 NET INCOME FROM APARTMENTS AND/OR HOUSEKEEPING UNITS IN HOME

In such situations, determine the net income by deducting the actual operating costs from the gross income; the following method shall be used.

a. Determine the shelter cost:

1. If the person owns his home -

the sum of the actual yearly cost of home ownership (i.e., taxes, special assessments, interest, mortgage, insurance, sewer charges, water, etc.) divided by 12 to determine the monthly cost.

2. If the person rents his home -

the monthly rent is the shelter cost.

3. Divide the monthly shelter cost by the number of rooms in the whole house to determine a room cost. Multiply the room cost by the number of rooms in each apartment or housekeeping unit to determine the shelter cost per unit.

b. Where the person furnishes heat or any other utility item with rent:

1. Determine on an actual expenditure basis the average monthly cost of the item(s) furnished.

2. If the cost of any of the utility items are included in the total cost, subtract the appropriate monetary allowance for the item(s).

c. Subtract the sum of the monthly shelter cost and the monthly cost of utility items included with rent (a. plus b.), if any, from the total rental income paid. The difference is the net income.

d. Costs for maintenance and repair shall be included in accordance with Section 307.

SCHEDULE I

Determination of Financial Capacity to Pay for Care or Service

Application

Schedule I is a scale based on a low cost level of living. It is applied to the monthly gross income of the spouse of a client in order to determine financial capacity to pay for the costs of care or service in a public hospital for mental diseases or tuberculosis.

Policies and Standards

1. It is recognized that families who are in no way dependent on public assistance customarily make changes in their living patterns in order to meet emergencies or to obtain additional items of living. Accordingly, it is recognized that a legally responsible relative may sometimes need to make some readjustment in the standard of living of himself and his immediate family in order to provide in part or total for a relative who is, or is applying to become, a public assistance client.
2. The financial capacity of each legally responsible relative of the client must be determined.
3. Before determining a legally responsible relative's financial capacity, the agency shall have ascertained the amount that such relative will voluntarily pay toward the cost of medical assistance on behalf of the client. (See MAA Manual Supplement, S-3340.1.)
4. Where it is determined that a legally responsible relative does not have any financial capacity, then the amount, if any, he may have voluntarily offered to pay shall be accepted as satisfactory.
5. It shall be recognized that a person's obligation to support those relatives for whom he is legally responsible takes precedence over any voluntary preference on his part to support relatives or other persons for whom he is not legally responsible.

Procedure

1. Family Size

In determining family size, include the spouse and the following persons in the household of the spouse:

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- a. Spouse's legal dependents who are unemancipated and under 21 years of age; and
- b. spouse's legal dependents who are blind or disabled.

2. Income Generally

- a. In determining monthly gross income, consider all income as defined in MAA Manual Supplement, S-3320.1 for the twelve (12) months immediately preceding the evaluation of financial capacity.
- b. In those cases where there has been no appreciable change in income in the past year, the average for the most recent period of four (4) months may be accepted as satisfactory evidence of the average for the last year, but income for the entire twelve (12) month period may be considered if the individual so requests and makes the necessary information available.
- c. In situations where the LRR's income either increases or decreases in the four (4) months preceding the determination of financial capacity, the average income for the most recent four (4) months shall be considered for purposes of determining financial capacity.

3. Income - Special Rules

- a. When a person is receiving food or lodging or both as part of his income, his total gross income shall be determined as follows:

The gross cash payment plus the monetary value of the maintenance received as used by the employer for tax purposes (the employer's monetary evaluation for payment of social security and withholding taxes).

- b. With respect to any child for whom an LRR is providing support, any net income of such child shall be counted as income of the LRR unless information is provided by the LRR to substantiate that he by actual practice is foregoing both directly and indirectly all claim to that income.
- c. If an LRR has either related or unrelated roomers or roomer-boarders living in the home, the method as outlined in Categorical Assistance Budget Manual, Section 503.4 shall be used to determine the net income to the LRR from such roomers or roomer-boarders.
- d. When an LRR has an emancipated child living in the home, such child shall be considered as a roomer or roomer-boarder, and Categorical Assistance Budget Manual, Section 503.4 shall be used to determine the net income to the LRR.

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- e. When an LRR has a child who is turning over all his income to a parent, add this income to the parents' income and include the child as a member of the LRR's family unit size.

4. Extraordinary Expenses

The following types of extraordinary expenses shall be considered, in the manner specified, as affecting the LRR's financial capacity.

a. Legally Responsible Relative's Contribution to Persons other than the Client

When an LRR is supporting or making contribution to support (including judicial orders for support) of a parent, child, grandparent or grandchild who is not living in the home with the LRR, the actual amount of such contribution shall be subtracted from the LRR's monthly income. These persons shall not be included in the determination of family size.

b. Medical Obligations

Where the average monthly cost for medical services exceeds the appropriate amount as indicated below, the amount of the monthly excess shall be subtracted from the LRR's monthly income:

Family Size

1	-	\$17.00
2	-	23.00
3	-	30.00
4	-	34.00
5	-	41.00
6 or more	-	45.00

c. Educational Expenses

If educational expenses are being incurred for a member of the family for whom free educational facilities are not available, proceed as follows:

- (1) when the member of the family is being maintained at home, the verified cost of tuition, fees, books and transportation shall, when pro-rated on a twelve (12) month basis, be subtracted from the LRR's monthly income;
- (2) when the member of the family is being maintained away from home, the verified costs of tuition, fees, book and transportation, plus any cost of maintenance in excess of \$450 per annum shall, when pro-rated on a twelve (12) month basis, be subtracted from the LRR's monthly income.

d. Indebtedness Due to Catastrophic Events

When an LRR, whether before or following the determination of financial capacity, is required to incur debts due to catastrophic events, other than medical, over which he had no control (for example: fire, flood, etc.) the verified monthly amount of payments necessary to liquidate these debts shall be subtracted from his monthly income. Whenever an LRR has been determined not to have a financial capacity to pay toward the cost of medical assistance for a specified period in order to liquidate the indebtedness due to catastrophic events, the agency shall reevaluate the LRR's financial capacity at the date set for full payment of the debt.

e. Extraordinary Expense Arising from Major Health or Social Problems

- (1) Situations may arise in which an LRR may have an extraordinary need, other than those identified above, and in the judgement of the agency this need involves an expense which is extraordinary, and not manageable within the exemptions, and should be recognized in order to be fair and reasonable.
- (2) Each such case shall be brought to the attention of the Central Office of BIS for approval prior to the recognition of this expense as an amount to be subtracted from the LRR's monthly income.

5. Resources Other Than Income

Although the application of the Schedule does not provide for evaluating resources other than income, it is not intended that the agency shall totally disregard the LRR's other financial resources. However, it is not intended that the agency shall consider the total amount of the LRR's savings and similar resources in evaluating financial capacity.

As to resources of the LRR other than income the agency shall limit its consideration to bank accounts, savings bonds, stocks and other securities. The value of such items in combination shall be considered in evaluating financial capacity only when such value significantly exceeds the appropriate amounts as follows:

Family Size*

1	-	\$ 8,160
2	-	11,160
3	-	14,280
4	-	16,440
5	-	19,680
6	-	21,360

* For each additional person in the family over 6, add \$1200.

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8 or more
\$ 300 - 309.99								
310 - 319.99								
320 - 329.99	\$ 10.00							
330 - 339.99	13.00							
340 - 349.99	17.00							
350 - 359.99	20.00							
360 - 369.99	24.00							
370 - 379.99	27.00							
380 - 389.99	30.00							
390 - 399.99	35.00							
400 - 409.99	39.00	\$10.00						
410 - 419.99	42.00	13.00						
420 - 429.99	46.00	16.00						
430 - 439.99	49.00	20.00						
440 - 449.99	55.00	23.00						
450 - 459.99	59.00	26.00						
460 - 469.99	62.00	29.00	\$10.00					
470 - 479.99	66.00	34.00	12.00					
480 - 489.99	69.00	37.00	15.00					
490 - 499.99	75.00	41.00	18.00					
500 - 509.99	79.00	44.00	21.00					
510 - 519.99	83.00	47.00	24.00					
520 - 529.99	87.00	53.00	27.00					
530 - 539.99	90.00	56.00	31.00	\$10.00				
540 - 549.99	98.00	60.00	34.00	13.00				
550 - 559.99	101.00	63.00	37.00	16.00				
560 - 569.99	105.00	67.00	40.00	18.00				
570 - 579.99	109.00	73.00	43.00	21.00				
580 - 589.99	113.00	76.00	48.00	23.00				
590 - 599.99	121.00	80.00	52.00	27.00				

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8 or more
\$ 600 - 609.99	\$125.00	\$83.00	\$54.00	\$30.00				
610.- 619.99	129.00	87.00	58.00	32.00				
620 - 629.99	133.00	94.00	61.00	35.00				
630 - 639.99	137.00	98.00	66.00	38.00				
640 - 649.99	146.00	101.00	70.00	42.00				
650 - 659.99	150.00	105.00	73.00	45.00	\$10.00			
660 - 669.99	154.00	109.00	74.00	48.00	12.00			
670 - 679.99	158.00	116.00	77.00	50.00	13.00			
680 - 689.99	162.00	120.00	80.00	53.00	14.00			
690 - 699.99	172.00	124.00	86.00	58.00	16.00	\$10.00		
700 - 709.99	176.00	128.00	90.00	61.00	18.00	12.00		
710 - 719.99	180.00	132.00	93.00	64.00	21.00	14.00		
720 - 729.99	184.00	140.00	97.00	67.00	23.00	16.00		
730 - 739.99	189.00	144.00	100.00	70.00	26.00	18.00	\$10.00	
740 - 749.99	199.00	148.00	106.00	75.00	30.00	20.00	12.00	
750 - 759.99	203.00	152.00	110.00	78.00	34.00	22.00	16.00	
760 - 769.99	208.00	156.00	114.00	81.00	38.00	26.00	19.00	
770 - 779.99	212.00	165.00	118.00	84.00	45.00	28.00	21.00	
780 - 789.99	217.00	169.00	121.00	87.00	49.00	30.00	23.00	\$10.00
790 - 799.99	228.00	173.00	129.00	93.00	54.00	33.00	25.00	12.00
800 - 809.99	232.00	177.00	132.00	96.00	56.00	35.00	26.00	14.00
810 - 819.99	237.00	182.00	136.00	99.00	60.00	37.00	29.00	16.00
820 - 829.99	241.00	191.00	140.00	102.00	64.00	41.00	31.00	17.00
830 - 839.99	246.00	196.00	144.00	105.00	70.00	43.00	33.00	19.00
840 - 849.99	257.00	200.00	152.00	112.00	74.00	46.00	35.00	21.00
850 - 859.99	262.00	204.00	156.00	115.00	78.00	49.00	37.00	22.00
860 - 869.99	267.00	208.00	159.00	118.00	82.00	51.00	41.00	25.00
870 - 879.99	271.00	219.00	163.00	122.00	86.00	53.00	43.00	26.00
880 - 889.99	276.00	223.00	167.00	125.00	90.00	56.00	45.00	28.00
890 - 899.99	289.00	228.00	176.00	132.00	95.00	60.00	47.00	30.00

SCHEDULE I - continued

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8 or more
\$ 900 - 909.99	\$293.00	\$232.00	\$180.00	\$135.00	\$100.00	\$62.00	\$49.00	\$31.00
910 - 119.99	298.00	236.00	184.00	139.00	104.00	65.00	52.00	34.00
920 - 929.99	303.00	248.00	188.00	142.00	108.00	67.00	55.00	36.00
930 - 939.99	308.00	252.00	192.00	145.00	112.00	70.00	56.00	38.00
940 - 949.99	321.00	257.00	201.00	153.00	119.00	74.00	58.00	40.00
950 - 959.99	326.00	261.00	205.00	156.00	122.00	77.00	60.00	41.00
960 - 969.99	331.00	266.00	209.00	160.00	125.00	79.00	63.00	45.00
970 - 979.09	336.00	278.00	213.00	163.00	128.00	82.00	65.00	46.00
980 - 989.99	341.00	282.00	217.00	167.00	131.00	84.00	67.00	48.00
990 - 999.99	355.00	287.00	226.00	175.00	138.00	89.00	69.00	50.00
1000 -1009.99	360.00	291.00	232.00	179.00	141.00	92.00	71.00	52.00
1010 -1019.99	365.00	296.00	236.00	182.00	144.00	95.00	74.00	55.00
1020 -1029.99	370.00	309.00	240.00	186.00	147.00	97.00	78.00	57.00
1030 -1039.99	375.00	314.00	244.00	189.00	150.00	100.00	80.00	59.00
1040 -1049.99	390.00	318.00	253.00	198.00	158.00	105.00	82.00	61.00
1050 -1059.99	395.00	323.00	259.00	201.00	161.00	108.00	85.00	63.00
1060 -1069.99	400.00	327.00	264.00	205.00	164.00	111.00	87.00	65.00
1070 -1079.99	406.00	341.00	268.00	209.00	167.00	114.00	90.00	67.00
1080 -1089.99	411.00	346.00	272.00	212.00	170.00	116.00	92.00	69.00
1090 -1099.99	426.00	351.00	280.00	222.00	178.00	120.00	94.00	71.00
1100 -1109.99	432.00	356.00	288.00	226.00	181.00	124.00	97.00	72.00
1110 -1119.99	437.00	361.00	293.00	229.00	185.00	128.00	99.00	74.00
1120 -1129.99	442.00	370.00	297.00	233.00	188.00	131.00	101.00	76.00
1130 -1139.99	448.00	380.00	306.00	237.00	191.00	133.00	104.00	79.00
1140 -1149.99	464.00	385.00	314.00	247.00	200.00	139.00	107.00	81.00
1150 -1159.99	470.00	390.00	318.00	251.00	203.00	143.00	109.00	83.00
1160 -1169.99	475.00	395.00	323.00	255.00	207.00	146.00	112.00	85.00
1170 -1179.99	480.00	405.00	327.00	258.00	210.00	148.00	114.00	87.00
1180 -1189.99	486.00	410.00	332.00	262.00	213.00	151.00	116.00	90.00
1190 -1199.99	503.00	415.00	345.00	273.00	222.00	158.00	118.00	91.00

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8 or more
\$1200 -1209.99	\$509.00	\$420.00	\$350.00	\$277.00	\$226.00	\$161.00	\$121.00	\$93.00
1210 -1219.99		425.00	354.00	281.00	245.00	164.00	122.00	95.00
1220--1229.99		431.00	359.00	284.00	249.00	167.00	124.00	97.00
1230 -1239.99		440.00	363.00	295.00	253.00	170.00	127.00	99.00
1240--1249.99		446.00	372.00	299.00	256.00	173.00	129.00	102.00
1250--1259.99		452.00	380.00	303.00	260.00	176.00	132.00	105.00
1260--1269.99		457.00	387.00	306.00	265.00	180.00	136.00	107.00
1270--1279.99		462.00	391.00	310.00	272.00	183.00	138.00	109.00
1280--1289.99		467.00	396.00	321.00	278.00	186.00	141.00	111.00
1290--1299.99		484.00	412.00	325.00	281.00	189.00	144.00	113.00
1300--1309.99		489.00	415.00	329.00	287.00	195.00	146.00	118.00
1310 -1319.99		495.00	420.00	332.00	293.00	200.00	148.00	120.00
1320 -1329.99		500.00	425.00	336.00	296.00	204.00	150.00	123.00
1330 -1339.99		505.00	430.00	340.00	303.00	207.00	152.00	125.00
1340 -1349.99		511.00	439.00	344.00	306.00	210.00	155.00	127.00
1350 -1359.99		516.00	447.00	357.00	310.00	214.00	157.00	130.00
1360 -1369.99		521.00	455.00	361.00	318.00	218.00	160.00	131.00
1370 -1379.99		526.00	460.00	365.00	321.00	221.00	163.00	133.00
1380 -1389.99		532.00	465.00	370.00	325.00	225.00	165.00	135.00
1390 -1399.99		537.00	470.00	374.00	329.00	231.00	172.00	137.00
1400 -1409.99		545.00	475.00	387.00	333.00	240.00	176.00	139.00
1410 -1419.99		555.00	480.00	391.00	336.00	243.00	178.00	142.00
1420 -1429.99		560.00	485.00	396.00	344.00	246.00	181.00	145.00
1430 -1439.99		566.00	490.00	400.00	352.00	249.00	184.00	149.00
1440 -1449.99		570.00	495.00	404.00	357.00	253.00	190.00	150.00
1450 -1459.99		575.00	505.00	409.00	360.00	262.00	191.00	152.00
1460 -1469.99		580.00	513.00	413.00	364.00	266.00	193.00	155.00
1470 -1479.99		585.00	520.00	417.00	368.00	269.00	196.00	157.00
1480 -1489.99		590.00	525.00	421.00	372.00	272.00	199.00	160.00
1490 -1499.99		595.00	530.00	425.00	376.00	276.00	202.00	163.00

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8 or more
\$1500 -1509.99		\$600.00	\$535.00	\$430.00	\$380.00	\$284.00	\$210.00	\$166.00
1510 -1519.99				433.00	383.00	285.00	212.00	168.00
1520 -1529.99				438.00	387.00	292.00	215.00	170.00
1530 -1539.99				442.00	392.00	296.00	218.00	173.00
1540 -1549.99				447.00	397.00	306.00	221.00	176.00
1550 -1559.99				450.00	402.00	314.00	229.00	180.00
1560 -1569.99				453.00	407.00	320.00	232.00	182.00
1570 -1579.99				457.00	412.00	327.00	235.00	184.00
1580 -1589.99				460.00	417.00	333.00	238.00	187.00
1590 -1599.99				465.00	422.00	340.00	240.00	190.00

For every \$10 of increase in income, increase capacity \$3.

New Jersey Department of Institutions & Agencies
Division of Public Welfare

SCHEDULE I - continued

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8 or more
\$1500 -1509.99		\$600.00	\$535.00	\$430.00	\$380.00	\$284.00	\$210.00	\$166.00
1510 -1519.99				433.00	383.00	285.00	212.00	168.00
1520 -1529.99				438.00	387.00	292.00	215.00	170.00
1530 -1539.99				442.00	392.00	296.00	218.00	173.00
1540 -1549.99				447.00	397.00	306.00	221.00	176.00
1550 -1559.99				450.00	402.00	314.00	229.00	180.00
1560 -1569.99				453.00	407.00	320.00	232.00	182.00
1570 -1579.99				457.00	412.00	327.00	235.00	184.00
1580 -1589.99				460.00	417.00	333.00	238.00	187.00
1590 -1599.99				465.00	422.00	340.00	240.00	190.00

For every \$10 of increase in income, increase capacity \$3.

SCHEDULE II

Determination of Financial Capacity to Contribute to Care or Service

Application

Schedule II is a scale based on a moderate level of living. It is applied to the monthly gross income of a child of a client in order to determine financial capacity to contribute toward the costs of care or service in a public hospital for mental diseases or tuberculosis.

Policies and Standards

1. It is recognized that families who are in no way dependent on public assistance customarily make changes in their living patterns in order to meet emergencies or to obtain additional items of living. Accordingly, it is recognized that a legally responsible relative may sometimes need to make some readjustment in the standard of living of himself and his immediate family in order to provide in part or total for a relative who is, or is applying to become, a public assistance client.
2. The financial capacity of each legally responsible relative of the client must be determined.
3. Before determining a legally responsible relative's financial capacity, the agency shall have ascertained the amount that such relative will voluntarily contribute toward the cost of medical assistance on behalf of the client. (See MAA Manual Supplement, S-3340.1.)
4. Where it is determined that a legally responsible relative does not have any financial capacity, then the amount, if any, he may have voluntarily offered to contribute shall be accepted as satisfactory.
5. It shall be recognized that a person's obligation to support those relatives for whom he is legally responsible takes precedence over any voluntary preference on his part to support relatives or other persons for whom he is not legally responsible.
6. When a relative who has a financial capacity to contribute is legally responsible for two or more clients, the financial capacity may be allocated according to the relative's wishes provided that the amount allocated to any one client does not exceed the potential cost of thirty-one days of hospital care.

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Procedure

1. Family Size

In determining family size, include the LRR, his or her spouse and any relative of the LRR or spouse who is and has been customarily living in the home and for whom the LRR or spouse is providing support. When the amount of support for any such relative is less than \$50 per month, do not include this relative in determining family size but subtract the actual amount of monthly support from the LRR's monthly income.

2. Income Generally

- a. In determining monthly gross income, consider all income as defined in MAA Manual Supplement, S-3320.1 for the twelve (12) months immediately preceding the evaluation of financial capacity.
- b. In those cases where there has been no appreciable change in income in the past year, the average for the most recent period of four (4) months may be accepted as satisfactory evidence of the average for the last year, but income for the entire twelve (12) month period may be considered if the individual so requests and makes the necessary information available.
- c. In situations where the LRR's income either increases or decreases in the four (4) months preceding the determination of financial capacity, the average income for the most recent four (4) months shall be considered for purposes of determining financial capacity.

3. Income - Special Rules

- a. When a person is receiving food or lodging or both as part of his income, his total gross income shall be determined as follows:

The gross cash payment plus the monetary value of the maintenance received as used by the employer for tax purposes (the employer's monetary evaluation for payment of social security and withholding taxes.)

- b. With respect to any child for whom an LRR is providing support, any net income of such child shall be counted as income of the LRR unless information is provided by the LRR to substantiate that he by actual practice is foregoing both directly and indirectly all claim to that income.

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- c. If an LRR has either related or unrelated roomers or roomer-boarders living in the home, the method as outlined in Categorical Assistance Budget Manual, Section 503.4 shall be used to determine the net income to the LRR from such roomers or roomer-boarders.
- d. When an LRR has an emancipated child living in the home, such child shall be considered as a roomer or roomer-boarder, and Categorical Assistance Budget Manual, Section 503.4 shall be used to determine the net income to the LRR.
- e. When an LRR has a child who is turning over all his income to a parent, add this income to the parents' income and include the child as a member of the LRR's family unit size.

4. Legally Responsible Relative Is Married and Both Husband and Wife Have Income

When the relative whose financial capacity is being determined is a married person, and both the husband and wife have income, proceed as follows:

- a. for family size of two, consider only the income of the LRR and include the spouse in determining family size;
- b. for family sizes of three or more, consider only the income of the LRR and exclude the spouse in determining family size.

5. Extraordinary Expenses

The following types of extraordinary expenses shall be considered, in the manner specified, as affecting the LRR's financial capacity.

- a. Legally Responsible Relative's Contribution to Persons other than the Client

When an LRR is supporting or making contribution to support (including judicial orders for support) of a separated or divorced spouse, or a parent, child, grandparent or grandchild who is not living in the home with the LRR, the actual amount of such contribution shall be subtracted from the LRR's monthly income. These persons shall not be included in the determination of family size.

- b. Medical Obligations

Where the average monthly cost for medical services exceeds the appropriate amount as indicated below, the amount of the monthly excess shall be subtracted from the LRR's monthly income:

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Family Size

1	-	\$17.00
2	-	23.00
3	-	30.00
4	-	34.00
5	-	41.00
6 or more	-	45.00

c. Educational Expenses

If educational expenses are being incurred for a member of the family for whom free educational facilities are not available, proceed as follows:

- (1) when the member of the family is being maintained at home, the verified cost of tuition, fees, books and transportation shall, when pro-rated on a twelve (12) month basis, be subtracted from the LRR's monthly income;
- (2) when the member of the family is being maintained away from home, the verified costs of tuition, fees, books and transportation, plus any cost of maintenance in excess of \$450 per annum shall, when pro-rated on a twelve (12) month basis, be subtracted from the LRR's monthly income.

d. Indebtedness Due to Catastrophic Events

When an LRR, whether before or following the determination of financial capacity, is required to incur debts due to catastrophic events, other than medical, over which he had no control (for example: fire, flood, etc.) the verified monthly amount of payments necessary to liquidate these debts shall be subtracted from his monthly income. Whenever an LRR has been determined not to have a financial capacity to contribute to the cost of medical assistance for a specified period in order to liquidate the indebtedness due to catastrophic events, the agency shall reevaluate the LRR's financial capacity at the date set for full payment of the debt.

e. Extraordinary Expense Arising from Major Health or Social Problems

- (1) Situations may arise in which an LRR may have an extraordinary need, other than those identified above, and in the judgment of the agency this need involves an expense which is extraordinary, and not manageable within the exemptions, and should be recognized in order to be fair and reasonable.

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- (2) Each such case shall be brought to the attention of the Central Office of BIS for approval prior to the recognition of this expense as an amount to be subtracted from the LRR's monthly income.

6. Resources Other Than Income

Although the application of the Schedule does not provide for evaluating resources other than income, it is not intended that the agency shall totally disregard the LRR's other financial resources. However, it is not intended that the agency shall consider the total amount of the LRR's savings and similar resources in evaluating financial capacity.

As to resources of the LRR other than income the agency shall limit its consideration to bank accounts, savings bonds, stocks and other securities. The value of such items in combination shall be considered in evaluating financial capacity only when such value significantly exceeds the appropriate amount as follows:

Family Size*

1	-	\$ 8,160
2	-	11,160
3	-	14,280
4	-	16,440
5	-	19,680
6	-	21,360

* For each additional person in the family over 6, add \$1200.

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8
\$ 300 - 309.99								
310 - 319.99								
320 - 329.99								
330 - 339.99								
340 - 349.99								
350 - 359.99								
360 - 369.99								
370 - 379.99	\$10.00							
380 - 389.99	13.00							
390 - 399.99	16.00							
400 - 409.99	18.00							
410 - 419.99	21.00							
420 - 429.99	23.00							
430 - 439.99	27.00							
440 - 449.99	30.00							
450 - 459.99	33.00							
460 - 469.99	35.00							
470 - 479.99	38.00							
480 - 489.99	41.00							
490 - 499.99	44.00	\$10.00						
500 - 409.99	46.00	12.00						
510 - 519.99	49.00	14.00						
520 - 529.99	52.00	17.00						
530 - 539.99	57.00	19.00						
540 - 549.99	60.00	22.00						
550 - 559.99	63.00	25.00						
560 - 569.99	66.00	28.00						
570 - 579.99	68.00	30.00						
580 - 589.99	72.00	33.00						
590 - 599.99	74.00	35.00						

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8
\$ 600 - 609.99	\$77.00	\$38.00						
610 - 619.99	80.00	40.00						
620 - 629.99	83.00	43.00						
630 - 639.99	90.00	45.00						
640 - 649.99	93.00	48.00	\$10.00					
650 - 659.99	96.00	53.00	13.00					
660 - 669.99	99.00	55.00	15.00					
670 - 679.99	102.00	58.00	18.00					
680 - 689.99	109.00	61.00	20.00					
690 - 699.99	112.00	63.00	23.00					
700 - 709.99	115.00	66.00	25.00					
710 - 719.99	119.00	69.00	28.00					
720 - 729.99	122.00	71.00	30.00					
730 - 739.99	130.00	74.00	32.00	\$10.00				
740 - 749.99	133.00	77.00	35.00	12.00				
750 - 759.99	137.00	83.00	37.00	14.00				
760 - 769.99	140.00	86.00	39.00	16.00				
770 - 779.99	143.00	88.00	42.00	18.00				
780 - 789.99	152.00	91.00	44.00	21.00				
790 - 799.99	155.00	94.00	48.00	23.00				
800 - 809.99	159.00	101.00	51.00	25.00				
810 - 819.99	162.00	104.00	53.00	27.00				
820 - 829.99	166.00	107.00	56.00	29.00				
830 - 839.99	176.00	109.00	58.00	32.00				
840 - 849.99	179.00	112.00	61.00	34.00				
850 - 859.99	183.00	120.00	63.00	36.00				
860 - 869.99	186.00	123.00	65.00	38.00				
870 - 879.99	189.00	126.00	68.00	40.00				
880 - 889.99	200.00	129.00	70.00	44.00	\$10.00			
890 - 899.99	204.00	132.00	73.00	46.00	12.00			

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8
\$ 900 - 909.99	\$207.00	\$140.00	\$76.00	\$48.00	\$14.00			
910 - 919.99	211.00	144.00	78.00	51.00	15.00			
920 - 929.99	215.00	147.00	81.00	53.00	16.00			
930 - 939.99	225.00	150.00	83.00	55.00	18.00			
940 - 949.99	230.00	153.00	86.00	57.00	20.00			
950 - 959.99	234.00	162.00	89.00	59.00	24.00	\$10.00		
960 - 969.99	238.00	165.00	92.00	62.00	28.00	11.00		
970 - 979.99	241.00	168.00	95.00	64.00	30.00	12.00		
980 - 989.99	254.00	172.00	98.00	69.00	34.00	14.00		
990 - 999.99	257.00	175.00	100.00	71.00	36.00	16.00		
1000 -1009.99	261.00	185.00	103.00	74.00	40.00	17.00		
1010 -1019.99	265.00	188.00	106.00	76.00	43.00	19.00		
1020 -1029.99	269.00	192.00	110.00	78.00	45.00	20.00	\$10.00	
1030 -1039.99	282.00	195.00	113.00	84.00	47.00	22.00	12.00	
1040 -1049.99	290.00	198.00	116.00	86.00	49.00	24.00	14.00	
1050 -1059.99	294.00	209.00	118.00	89.00	50.00	25.00	15.00	
1060 -1069.99	298.00	212.00	121.00	91.00	52.00	27.00	16.00	
1070 -1079.99	312.00	216.00	127.00	94.00	54.00	28.00	18.00	
1080 -1089.99	316.00	219.00	129.00	100.00	59.00	30.00	19.00	\$10.00
1090 -1099.99	320.00	223.00	132.00	103.00	61.00	35.00	20.00	12.00
1100 -1109.99	324.00	238.00	134.00	105.00	63.00	36.00	22.00	13.00
1110 -1119.99	328.00	241.00	137.00	108.00	65.00	38.00	23.00	14.00
1120 -1129.99	343.00	245.00	140.00	110.00	66.00	40.00	25.00	15.00
1130 -1139.99	347.00	248.00	145.00	117.00	71.00	41.00	29.00	16.00
1140 -1149.99	351.00	256.00	149.00	120.00	73.00	43.00	30.00	17.00
1150 -1159.99	356.00	260.00	151.00	122.00	75.00	45.00	31.00	18.00
1160 -1169.99	360.00	265.00	154.00	125.00	78.00	46.00	33.00	20.00
1170 -1179.99	365.00	272.00	157.00	127.00	80.00	48.00	34.00	21.00
1180 -1189.99	370.00	275.00	163.00	130.00	85.00	52.00	36.00	22.00
1190 -1199.99	375.00	280.00	169.00	135.00	87.00	53.00	37.00	24.00

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8
\$1200 -1209.99	\$380.00	\$286.00	\$172.00	\$138.00	\$89.00	\$55.00	\$39.00	\$25.00
1210 -1219.99	385.00	292.00	176.00	140.00	91.00	57.00	40.00	27.00
1220 -1229.99	389.00	296.00	179.00	143.00	94.00	59.00	41.00	28.00
1230 -1239.99	393.00	300.00	182.00	151.00	99.00	63.00	45.00	29.00
1240 -1249.99	410.00	303.00	187.00	157.00	102.00	68.00	46.00	30.00
1250 -1259.99	414.00	317.00	191.00	160.00	104.00	70.00	48.00	31.00
1260 -1269.99	418.00	321.00	195.00	162.00	106.00	75.00	49.00	33.00
1270 -1279.99	423.00	325.00	198.00	165.00	108.00	77.00	51.00	34.00
1280 -1289.99	427.00	329.00	201.00	169.00	115.00	79.00	55.00	35.00
1290 -1299.99	432.00	333.00	204.00	174.00	117.00	81.00	56.00	38.00
1300 -1309.99	436.00	347.00	215.00	177.00	119.00	83.00	58.00	39.00
1310 -1319.99	441.00	351.00	218.00	180.00	122.00	88.00	59.00	40.00
1320 -1329.99	446.00	355.00	221.00	183.00	124.00	90.00	61.00	42.00
1330 -1339.99	451.00	359.00	224.00	186.00	128.00	92.00	63.00	43.00
1340 -1349.99	455.00	363.00	228.00	190.00	131.00	96.00	65.00	46.00
1350 -1359.99	460.00	365.00	234.00	195.00	133.00	101.00	67.00	48.00
1360 -1369.99	464.00	369.00	239.00	198.00	136.00	103.00	68.00	49.00
1370 -1379.99	468.00	373.00	242.00	201.00	138.00	105.00	70.00	50.00
1380 -1389.99	472.00	378.00	246.00	204.00	140.00	107.00	72.00	51.00
1390 -1399.99	476.00	382.00	249.00	207.00	144.00	109.00	74.00	55.00
1400 -1409.99	480.00	386.00	252.00	217.00	148.00	116.00	76.00	56.00
1410 -1419.99	485.00	391.00	259.00	220.00	150.00	118.00	78.00	58.00
1420 -1429.99	490.00	395.00	264.00	223.00	153.00	120.00	79.00	59.00
1430 -1439.99	495.00	399.00	268.00	226.00	155.00	122.00	81.00	61.00
1440 -1449.99	500.00	403.00	271.00	229.00	158.00	124.00	83.00	64.00
1450 -1459.99		407.00	275.00	240.00	162.00	126.00	86.00	66.00
1460 -1469.99		412.00	278.00	243.00	166.00	129.00	88.00	67.00
1470 -1479.99		416.00	283.00	246.00	168.00	131.00	90.00	69.00
1480 -1489.99		420.00	290.00	250.00	171.00	133.00	91.00	70.00
1490 -1499.99		423.00	294.00	253.00	173.00	135.00	93.00	74.00

SCHEDULE II - continued

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8
\$1500 -1509.99		\$427.00	\$298.00	\$258.00	\$176.00	\$137.00	\$95.00	\$76.00
1510 -1519.99		431.00	301.00	261.00	184.00	139.00	100.00	77.00
1520 -1529.99		435.00	305.00	264.00	187.00	146.00	102.00	79.00
1530 -1539.99		440.00	311.00	267.00	190.00	149.00	104.00	80.00
1540 -1549.99		444.00	318.00	271.00	192.00	151.00	106.00	85.00
1550 -1559.99		450.00	322.00	274.00	195.00	153.00	107.00	86.00
1560 -1569.99		455.00	325.00	277.00	200.00	155.00	110.00	88.00
1570 -1579.99		461.00	329.00	281.00	204.00	163.00	113.00	89.00
1580 -1589.99		464.00	333.00	285.00	207.00	165.00	115.00	91.00
1590 -1599.99		468.00	336.00	289.00	209.00	167.00	117.00	93.00
1600 -1609.99		473.00	340.00	292.00	212.00	170.00	119.00	96.00
1610 -1619.99		476.00	344.00	296.00	215.00	172.00	121.00	97.00
1620 -1629.99		480.00	347.00	299.00	220.00	180.00	127.00	99.00
1630 -1639.99		485.00	350.00	303.00	224.00	182.00	129.00	100.00
1640 -1649.99		490.00	354.00	306.00	227.00	185.00	131.00	102.00
1650 -1659.99		500.00	358.00	309.00	230.00	187.00	133.00	107.00
1660 -1669.99			362.00	312.00	233.00	190.00	136.00	109.00
1670 -1679.99			366.00	315.00	236.00	194.00	141.00	111.00
1680 -1689.99			370.00	319.00	240.00	198.00	143.00	112.00
1690 -1699.99			373.00	322.00	244.00	200.00	145.00	114.00
1700 -1709.99			377.00	326.00	246.00	203.00	147.00	119.00
1710 -1719.99			381.00	329.00	249.00	205.00	149.00	121.00
1720 -1729.99			385.00	333.00	251.00	208.00	152.00	123.00
1730 -1739.99			390.00	336.00	254.00	217.00	156.00	124.00
1740 -1749.99			396.00	340.00	257.00	219.00	158.00	126.00
1750 -1759.99			401.00	344.00	260.00	222.00	160.00	130.00
1760 -1769.99			408.00	347.00	264.00	224.00	162.00	132.00
1770 -1779.99			413.00	350.00	268.00	227.00	164.00	134.00
1780 -1789.99			419.00	353.00	271.00	230.00	172.00	136.00
1790 -1799.99			425.00	357.00	274.00	234.00	174.00	137.00

SCHEDULE II - continued

Gross Monthly Income	Monthly Capacity to Contribute by Family Size							
	1	2	3	4	5	6	7	8
\$1800 -1809.99			\$430.00	\$361.00	\$277.00	\$236.00	\$176.00	\$139.00
1810 -1819.99			435.00	365.00	280.00	239.00	178.00	145.00
1820 -1829.99			441.00	369.00	283.00	242.00	180.00	147.00
1830 -1839.99			445.00	373.00	286.00	244.00	188.00	149.00
1840 -1849.99			450.00	376.00	289.00	247.00	190.00	151.00
1850 -1859.99			456.00	381.00	292.00	249.00	192.00	152.00
1860 -1869.99			462.00	386.00	295.00	252.00	194.00	159.00
1870 -1879.99			468.00	390.00	298.00	255.00	197.00	161.00
1880 -1889.99			475.00	396.00	305.00	257.00	200.00	163.00
1890 -1899.99			483.00	400.00	309.00	260.00	204.00	165.00
1900 -1909.99			490.00	405.00	313.00	263.00	206.00	166.00
1910 -1919.99			496.00	410.00	318.00	264.00	208.00	170.00
1920 -1929.99			505.00	415.00	324.00	269.00	210.00	174.00
1930 -1939.99				421.00	330.00	273.00	212.00	175.00
1940 -1949.99				428.00	336.00	276.00	214.00	177.00
1950 -1959.99				435.00	342.00	280.00	217.00	179.00
1960 -1969.99				440.00	347.00	285.00	220.00	181.00
1970 -1979.99				448.00	353.00	290.00	224.00	183.00
1980 -1989.99				455.00	360.00	295.00	228.00	185.00
1990 -1999.99				463.00	366.00	300.00	235.00	187.00
2000 -2009.99				470.00	374.00	305.00	240.00	189.00
2010 -2019.99				478.00	380.00	310.00	245.00	191.00
2020 -2029.99				485.00	388.00	315.00	250.00	193.00
2030 -2039.99				492.00	396.00	320.00	254.00	196.00
2040 -2049.99				500.00	404.00	325.00	258.00	200.00
2050 -2059.99					410.00	330.00	264.00	204.00
2060 -2069.99					416.00	335.00	268.00	208.00
2070 -2079.99					424.00	340.00	274.00	212.00
2080 -2089.99					430.00	345.00	278.00	215.00
2090 -2099.99					437.00	350.00	285.00	220.00
2100 -2109.99					445.00	355.00	290.00	225.00

For each \$20 increase in income, increase capacity \$5.

ENFORCEMENT OF LRR CONTRIBUTIONS

Excerpts from Categorical Assistance Budget Manual

- 606.2 When any Legally Responsible Relative not living in the same household with the client, fails or refuses to make available to the client or family budget unit all or any portion of his monthly evaluated capacity to support, and this has been verified, such amount shall not be entered as income in the budget. However, in every such case, the agency shall, within 30 days, take appropriate action in accordance with available procedure to compel contribution in the amount of the budget deficit or the evaluated capacity to support, whichever is less.
607. EFFECT OF LEGALLY RESPONSIBLE RELATIVE'S REFUSAL TO FURNISH NECESSARY INFORMATION
- 607.1 Whenever the Legally Responsible Relative fails or refuses to furnish or produce information concerning his ability to support the client, it shall be deemed a failure or refusal to provide support for the client as required by law.
- 607.2 In every such case, the agency shall take appropriate action within 30 days in accordance with available procedure to secure judicial determination of the Legally Responsible Relative's ability to support the client in the amount determined.

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T A B L E O F C O N T E N T S

CHAPTER S-3400

DECISION CONCERNING ELIGIBILITY

S-3400.	Decision Concerning Eligibility	S-3400. - S-3410.
S-3410.	Certification of Eligibility	S-3400. - S-3410.
S-3420.	Notice to Client	S-3420.
S-3430.	Notice to Vendor	S-3430.
S-3440.	Notice to County Chargeable	S-3440.

APPENDIX

<u>Appendix Number</u>	<u>Subject</u>	<u>Reference</u>
I	Effective Date and Expiration Date	S-3410

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S-3400 - APPENDIX I

- b. information received - 4/27/67; verified as requiring change in billing status - 5/8/67; effective date - 5/1/67.

2. Expiration date - last day of sixth month after the effective date.

D. Termination (Transaction type 4)

- 1. Effective date (termination due to adequate income or resources) - first of month in which adequate income and/or resources become available to recipient-patient.

- Examples:
- a. income and/or resources available 7/2/67; effective date - 7/1/67;
 - b. income and/or resources available 7/27/67; effective date - 7/1/67.

- 2. Effective date (termination due to other reasons) - date of death, discharge, release, transfer, etc.

E. Inter-hospital Transfer (Transaction type 5)

- 1. Effective date - day following the date of termination at hospital from which transferred.

Example: transferred from Greystone Park to Trenton on 6/3/67; termination date (transaction type 4) - 6/3/67; effective date of transfer (transaction type 5) - 6/4/67.

- 2. Expiration date - last day of month in which transfer took place.

Example: transferred from Greystone Park to Trenton on 6/3/67; expiration date 6/30/67.

Part III	The Individual and Medical Assistance for the Aged
S-3400	Decision Concerning Eligibility - Certification

S-3400. DECISION CONCERNING ELIGIBILITY

S-3410. CERTIFICATION OF ELIGIBILITY

When an official determination has been made by the BIS that an individual is eligible for MAA, the Area Supervisor or his designated representative shall execute a Form PA-3G, Certification of Eligibility for Medical Assistance for the Aged - Hospitalization for Mental Diseases and Tuberculosis, showing

- a. identification of the individual by name and case number;
- b. the date of application for medical assistance;
- c. a statement that the individual (1) has been found eligible for hospitalization, (2) is in a designated hospital, (3) is entitled to medical assistance covering the cost of hospitalization at approved rates, and (4) is or is not entitled to an allowance for personal incidental expenses;
- d. the amount of income and/or cash resources, if any, which must be deducted from the cost of hospitalization in any month to determine the maximum amount of payment authorized;
- e. the effective date of the certification, from and after which date the cost of authorized medical services may be met by payments of medical assistance;
- f. the expiration date of the certification, after which date the cost of any medical service cannot be charged against medical assistance in the absence of a recertification; and
- g. the date of execution and signature of the Area Supervisor or his designated representative.

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S-3420.

Part III	The Individual and Medical Assistance for the Aged
S-3400	Decision Concerning Eligibility - Notice to Client

S-3420. NOTICE TO CLIENT

A copy of the certification of eligibility for MAA shall be sent to the individual identified thereon or his legal representative.

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S-3440.

Part III	The Individual and Medical Assistance for the Aged
<u>S-3400</u>	<u>Decision Concerning Eligibility - Notice to County Chargeable</u>

S-3440. NOTICE TO COUNTY CHARGEABLE

A copy of the certification of eligibility shall be sent to the welfare board of the county determined to be chargeable for the county share of the costs of medical assistance.

EFFECTIVE DATE AND EXPIRATION DATE

A. Initial Certification - Application Approved (Transaction type 1)

1. Effective date - date of admission to the hospital, or date 30 days prior to the date of application, whichever is later; cannot be earlier than January 1, 1967.

Examples:

- a. admission - 8/14/53; application - 1/25/67; effective date - 1/1/67.
- b. admission - 3/1/67; application - 3/20/67; effective date - 3/1/67.
- c. admission - 3/1/67; application - 4/10/67; effective date - 3/11/67.

2. Expiration date - last day of sixth month after the effective date.

Examples:

- a. effective date - 1/1/67; expiration date - 7/31/67.
- b. effective date - 3/25/67; expiration date - 9/30/67.

B. Continuance (Transaction type 2)

1. Effective date - date when caseworker recommends continued eligibility without change in billing status.
2. Expiration date - last day of sixth month after the effective date.

Examples:

- a. effective date - 7/5/67; expiration date - 1/31/68.
- b. effective date - 7/26/67; expiration date - 1/31/68.

C. Recertification (Transaction type 3)

1. Effective date - first day of next month following the receipt of information which is determined to require change(s) in billing status.

Examples:

- a. information received - 4/3/67; verified as requiring change in billing status - 4/15/67; effective date - 5/1/67.

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S-3400 - APPENDIX I

- b. information received - 4/27/67; verified as requiring change in billing status - 5/8/67; effective date - 5/1/67.

2. Expiration date - last day of sixth month after the effective date.

D. Termination (Transaction type 4)

1. Effective date (termination due to adequate income or resources) - first day of month in which adequate income and/or resources become available to recipient-patient.

- Examples:
- a. income and/or resources available 7/2/67; effective date - 7/1/67;
- b. income and/or resources available 7/27/67; effective date - 7/1/67.

2. Effective date (termination due to release without discharge and without support from public funds - S-3251.2) - first of second month following first full calendar month when no days of hospital care provided.

Example: released 8/15/67; no days of hospital care for September as shown by bill received 10/26/67; effective date - 11/1/67.

3. Effective date (termination due to other reasons) - date of death, discharge, release, transfer, etc.

E. Inter-hospital Transfer (Transaction type 5)

1. Effective date - day following the date of termination at hospital from which transferred.

Example: transferred from Greystone Park to Trenton on 6/3/67; termination date (transaction type 4) - 6/3/67; effective date of transfer (transaction type 5) - 6/4/67.

2. Expiration date - last day of month in which transfer took place.

Example: transferred from Greystone Park to Trenton on 6/3/67; expiration date 6/30/67.

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T A B L E O F C O N T E N T S

CHAPTER S-3500

PAYMENTS OF MEDICAL ASSISTANCE

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S-3510.	Authorization of Payment	S-3500. - S-3512.2
S-3511.	Federal Requirements	S-3500. - S-3512.2
S-3512.	Basic Rules for State Program	S-3500. - S-3512.2
.1	Nature of Payment	S-3500. - S-3512.2
.2	Authorization of Payment	S-3500. - S-3512.2
.3	Types of Payment	S-3512.3 - S-3512.4
.4	Limitations on Payment	S-3512.3 - S-3512.4
S-3520.	Methods of Payment	S-3520. - S-3523.2
S-3521.	Medical Services	S-3520. - S-3523.2
S-3523.	Personal Incidental Expenses	S-3520. - S-3523.2
.1	Limitations	S-3520. - S-3523.2
.2	Authorized Custodians	S-3520. - S-3523.2
S-3530.	Period Covered	S-3530. - S-3534.
S-3531.	Basic Rule as to Month of Service	S-3530. - S-3534.
S-3532.	Hospitalization	S-3530. - S-3534.
S-3534.	Prohibition Against Concurrent Receipt of OAA and MAA	S-3530. - S-3534.
S-3540.	Time of Payment	S-3540. - S-3542.
S-3541.	Hospitalization	S-3540. - S-3542.
.1	Initial Payments	S-3540. - S-3542.
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T A B L E O F C O N T E N T S

CHAPTER S-3500

PAYMENTS OF MEDICAL ASSISTANCE

S-3542.	Personal Incidental Expenses	S-3540. - S-3542.
S-3550.	Responsibility for Payment	S-3550.

Part III	The Individual and Medical Assistance for the Aged
S-3500	Payments of Medical Assistance - Authorization of Payment

S-3500. PAYMENTS OF MEDICAL ASSISTANCE

S-3510. AUTHORIZATION OF PAYMENT

S-3511. Federal Requirements

In accordance with Federal requirements, the authorization of payments of medical assistance must be a formal agency record signifying that the amounts to be paid for medical services are for eligible individuals, and are otherwise proper under the State Plan. Authorization must be over the signature of a responsible agency official, and must be supported by

a. bills from vendors specifying the individual receiving service, the service received, the date of service and the amount of the charges; and

b. certifications of eligibility for MAA.

S-3512. Basic Rules for State Program

.1 Nature of Payment

Payments of medical assistance shall be made only for

a. medical services duly authorized and provided to eligible recipients at approved rates, or

b. personal incidental allowances required by and specifically approved for eligible recipients.

.2 Authorization of Payments

Payments of medical assistance made following execution of a certification of eligibility for MAA are authorized by the Area Supervisor, or his designated representative.

See Part IV, and reference therein as to procedure for authorization of payment.

S-3512. Basic Rules for State Program (Cont'd.)

When it has been determined and stated in the certification of eligibility that the client has income and/or cash resources against which the cost of hospitalization must first be charged, authorization of payments of medical assistance shall be made only upon verification that the stated amount of income and/or cash resources has been deducted from the total amount payable at the currently approved rates for the services provided during the effective period of the certification of eligibility.

S-3520. METHODS OF PAYMENT

All approved costs of hospitalization shall be paid for by vendor payments.

Approved allowances for personal incidental expenses shall be paid for by money payments.

See section S-2300. for limitations on payment for personal incidental expenses.

a. When necessary because of the physical or mental condition of a recipient, payments of medical assistance for personal incidental expenses shall be made through the medical director, or his designated representative, as authorized custodian.

b. Payment under this method shall be made by check drawn to the order of "_____, authorized custodian", with the name(s) of the client(s) and the amount(s) of individual entitlement being shown on the check or on an attached listing.

Part III

The Individual and Medical Assistance for the Aged

S-3500

Methods of Payment - Period Covered

S-3530. PERIOD COVERED

S-3531. Basic Rule as to Month of Service

Whenever the term "month" is used in respect to payments of medical assistance, it shall mean the calendar month within which a health service was received or a money payment made for personal incidental expenses.

S-3532. Hospitalization

Payments of medical assistance for hospitalization may be made for services received subsequent to the date of application for MAA, and for services received within 30 days prior to the date of application.

S-3534. Prohibition against Concurrent Receipt of OAA and MAA

In order to be eligible for Federal matching, no payment of medical assistance on behalf of any individual may be made through MAA for services received during any month within which such individual receives a payment of assistance through OAA, except for the month of admission to or release from the hospital.

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S-3540. - S-3542.

Part III	The Individual and Medical Assistance for the Aged
S-3500	Methods of Payment - Time of Payment

S-3540. TIME OF PAYMENT

S-3541. Hospitalization

.1 Initial Payments

Payments of medical assistance for services received prior to the date of execution of a certification of eligibility may be made at any time following such certification.

.2 Subsequent Payments

Payments of medical assistance for hospitalization shall be made upon receipt of billings from the hospital.

S-3542. Personal Incidental Expenses

Payments of medical assistance for personal incidental expenses shall normally be issued during the month for which the allowance is being made. In the case of an immediate need for additional funds which may be allowed as personal incidental expenses an additional payment may be authorized at any time during the month.

Part III	The Individual and Medical Assistance for the Aged
<u>S-3500</u>	<u>Methods of Payment - Responsibility for Payment</u>

S-3550. RESPONSIBILITY FOR PAYMENT

The BIS shall be responsible for payment of medical assistance for the costs of hospitalization, and payments of medical assistance for personal incidental expenses.

T A B L E O F C O N T E N T S

CHAPTER S-3600

DETERMINATION OF CONTINUING MEDICAL ELIGIBILITY

S-3600.	Determination of Continuing Medical Eligibility	S-3600. - S-3612.
S-3610.	Basic Requirements	S-3600. - S-3612.
S-3611.	Federal Requirements	S-3600. - S-3612.
S-3612.	State Requirements	S-3600. - S-3612.
S-3620.	Process of Redetermination	S-3620. - S-3622.
S-3621.	Time Periods	S-3620. - S-3622.
S-3622.	Method	S-3620. - S-3622.

Part III The Individual and Medical Assistance for the Aged
S-3600 Determination of Continuing Medical Eligibility - Basic Requirements

S-3600. DETERMINATION OF CONTINUING MEDICAL ELIGIBILITY

S-3610. BASIC REQUIREMENTS

S-3611. Federal Requirements

The Federal regulations require that a State Plan must "include methods for --- periodically (not to exceed twelve months) determining the individuals's need for medical and remedial care and services. Such methods must provide for a physician's or dentist's determination of the need for medical care and services and for other authorized practitioners' determination of the need for remedial care and services."

S-3612. State Requirements

The BIS shall redetermine the client's need for hospitalization in accordance with the time periods specified in section S-3620.

The Individual and Medical Assistance for the Aged

S-3620. PROCESS OF REDETERMINATION

S-3621. Time Periods

S-3622. Method

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T A B L E O F C O N T E N T S

CHAPTER S-3700

LIENS AND RECOVERIES

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S-3702.	State Law	S-3700. - S-3702.
S-3710.	Liens	S-3710. - S-3712.
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S-3712.	Statutory Lien Imposed by Hospital	S-3710. - S-3712.
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S-3726.	Benefits under Part A, Title XVIII, Federal Social Security Act	S-3720. - S-3726.
S-3740.	Distribution of Funds Recovered or Reimbursed	S-3740.

(1)

Part III
S-3700

The Individual and Medical Assistance for the Aged
Liens and Recoveries

S-3700. LIENS AND RECOVERIES

S-3701. Federal Law

The Social Security Act states that the State Plan must "provide that no lien may be imposed against the property of an individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgement of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan."

S-3702. State Law

The New Jersey statute establishing the program of MAA directs that there be issued rules and regulations necessary "to secure for the State of New Jersey the maximum Federal financial participation . . . and otherwise to accomplish the purposes of this act, including specifically the following . . . to prescribe methods and procedures for repayment or recovery of medical assistance granted; provided, however, that no lien may be imposed against the property of any individual prior to his death on account of medical assistance granted or to be granted under this act (except pursuant to the judgement of a court on account of assistance incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance correctly paid on behalf of such individual under this act."

Part III	The Individual and Medical Assistance for the Aged
S-3700	Liens and Recoveries - Liens

S-3710. LIENS

S-3711. General Rule

No encumbrance of any kind shall be imposed against any property of an applicant or a recipient prior to his death because of assistance paid or to be paid on his behalf through the program of Medical Assistance for the Aged (except pursuant to the judgement of a court on account of assistance incorrectly paid on behalf of a recipient.)

S-3712. Statutory Lien Imposed by Hospital

The validity and value of any lien established by the hospital for costs not paid for through MAA will neither be depreciated nor enhanced by the granting of medical assistance.

Part III	The Individual and Medical Assistance for the Aged
S-3700	Liens and Recoveries - Recoveries

S-3720. RECOVERIES

S-3721. After Death

- y Recovery of medical assistance correctly paid may be effected from the estate of the recipient after his death and the death of his surviving spouse, if any.

S-3722. Medical Assistance Incorrectly Paid

Recovery of medical assistance incorrectly paid may be effected during the lifetime of the recipient pursuant to a judgement for the value of such payment entered by a court of competent jurisdiction.

S-3723. Voluntary Repayment

The limitation on effecting recoveries during the lifetime of a recipient does not apply to circumstances where the recipient voluntarily initiates and makes repayment of medical assistance received.

S-3724. Payment Not Subject to Federal Matching

The limitation on effecting recoveries during the lifetime of a recipient does not apply to payments of medical assistance for personal incidental expenses, since Federal participation is not allowable for such payments.

S-3725. Funds Received by Representative Payees, Guardians or Legal Representatives

The limitation on effecting recoveries during the lifetime of a recipient does not apply to benefits, pensions, annuities or other funds received by a representative payee, guardian or legal representative, other than the hospital, who has a legal responsibility to use such funds for the benefit of the recipient.

S-3726. Benefits under Part A, Title XVIII, Federal Social Security Act

The limitation on effecting recoveries during the lifetime of a recipient does not apply to benefits under Part A, Title XVIII, Federal Social Security Act, paid to the hospital, on behalf of a recipient, covering days of service for which payment has been authorized through Medical Assistance for the Aged.

Part III	The Individual and Medical Assistance for the Aged
S-3700	<u>Liens and Recoveries - Distribution of Funds Recovered or Reimbursed</u>

S-3740. DISTRIBUTION OF FUNDS RECOVERED OR REIMBURSED

Whenever any recovery or reimbursement is effected of funds paid as medical assistance, the funds so recovered or reimbursed shall be distributed to the Federal, state and county governments in the same proportion as the original payment was charged.

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T A B L E O F C O N T E N T S

CHAPTER S-3800

SOCIAL SERVICES

S-3800.	Social Services	S-3800. - S-3811.1
S-3810.	Evaluation of Need for Social Services	S-3800. - S-3811.1
S-3811.	Record of Classifications and Services	S-3800. - S-3811.1
.1	Requirement as to Form PA-22A	S-3800. - S-3811.1
.2	Purposes of Form PA-22A	S-3811.2 - S-3811.3
.3	Completion of Form PA-22A	S-3811.2 - S-3811.3
S-3820.	Social Services Incident to Assistance Payment	S-3820. - S-3822.
S-3821.	Services During In-patient Care	S-3820. - S-3822.
S-3822.	Services after Release from the Hospital	S-3820. - S-3822.
S-3823.	Services to Support Planning for Alternative Care	S-3822. - S-3823.
S-3824.	Other Social Services	S-3823. - S-3824.
S-3830.	Counselling and Referrals	S-3830.

APPENDIX

<u>Appendix Number</u>	<u>Subject</u>	<u>Reference</u>
I	The Social Study	S-3810.
II	Record of Classification and Services (Form PA-22A)	S-3811.
III	Defined Services	S-3824.

Part III	The Individual and Medical Assistance for the Aged
S-3800	Social Services - Evaluation of Need for Social Services

S-3800. SOCIAL SERVICES

S-3810. EVALUATION OF NEED FOR SOCIAL SERVICES

Although the MAA program is intended to provide for medical needs rather than all of the elements of income maintenance, the effectiveness of the assistance granted will still be related to the provision of social services which may be required by the individual client. It follows, therefore, that during the process of eligibility determination and during the subsequent period of eligibility the caseworker shall obtain medical and social information through a social study (see S-3800, Appendix I) sufficient to indicate:

- a. the attitude of the client and his family toward the illness or disability;
- b. the relationship between the client and his family;
- c. the limitations of the client in personally providing for his personal needs and the management of his affairs;
- d. The potential of the client for return to his own home or community; and
- e. those social services which should be provided as required prior to, at the time of and subsequent to release from the hospital, including referral and follow-up with any needed community agency or resource.

S-3811. Record of Classifications and Services

As part of the application process the caseworker shall initiate required entries on the Form PA-22A, Record of Classification and Services. (See S-3800, Appendix II)

.1 Requirement as to Form PA-22A

Form PA-22A, Record of Classification and Services, shall be progressively completed during the application process and following determination of eligibility.

S-3811. Record of Classifications and Services (Cont'd.)

Form PA-22A serves the following purposes:

- ### •3 Completion of Form PA-22A

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The Individual and Medical Assistance for the Aged

Social Service - Incident to Assistance Payment

SOCIAL SERVICES INCIDENT TO ASSISTANCE PAYMENT

Whenever the circumstances of a client indicate the need for social services supplementing and supporting the grant of medical assistance, the BIS, making full use of professional consultation, should provide such services.

Services During In-patient Care

For clients eligible for medical assistance during in-patient care relevant social services would include:

- a. enabling the client and his family to understand and plan for the social implications of the particular illness or disability;
- b. enlisting and maintaining interest of family members and friends;
- c. assisting with personal or family problems;
- d. providing opportunities for using and developing special skills or special interests;
- e. planning with family and appropriate hospital staff for return to own home or community in an alternative plan of care;
- f. enabling the family to understand and accept the social implications of return to the home and community; and
- g. encouraging communication and visiting.

Services after Release from the Hospital

For former recipients of medical assistance who are released from the hospital, relevant social services would include counselling and other services which will enable them

- a. to understand and carry out the hospital's recommendations for continuing needed care and services;
- b. to plan for and select the alternative care arrangements most appropriate to their diagnosed physical and mental condition and their personal needs, assuring freedom of choice;

The Individual and Medical Assistance for the Aged

Social Services - Incident to Assistance Payment

Services after Release from the Hospital (Cont'd.)

- d. to secure and use required services available from the care arrangements and community resources;

Services to Support Planning for Alternative Care

a. developing alternative care arrangements, such as services in own or relative's homes, homemaker services, foster family care, nursing homes, and social care facilities;

By law, persons released from a hospital for reasons other than discharge remain patients of the institution and shall be returned at any time upon order of the medical director. (R.S. 30:4-107)

Discharged patients requiring readmission to a public hospital shall be returned through normal emergency procedures by certification of two physicians pending formal court commitment proceedings. (R.S. 30:4-34, 36, 37, 38.)

Part III	The Individual and Medical Assistance for the Aged
S-3800	Social Services - Incident to Assistance Payment

S-3823. Services to Support Planning for Alternative Care (Cont'd.)

- b. identifying geographical areas or types of care arrangements requiring priority of effort to overcome unmet needs and resources;
- c. maintaining an inventory of currently available alternative care arrangements;
- d. evaluating continued availability, suitability and quality of alternative care resources; and
- e. providing information and referral of available alternative care resources to area offices of BIS and county welfare boards.

S-3824. Other Social Services

In addition to services specifically related to in-patient care or alternative methods of care, recipient-patients and former recipients may require social services of a more general nature. See S-3800 Appendix III, as to such services to be provided as defined problems are identified.

Part III	The Individual and Medical Assistance for the Aged
<u>S-3800</u>	<u>Social Services - Counselling and Referrals</u>

S-3830. COUNSELLING AND REFERRALS

It must be anticipated that persons found ineligible for MAA will have social needs for which help is not directly available from BIS during in-patient care or upon release from the hospital. Accordingly, as an element of social service the BIS, in cooperation with the hospitals and the county welfare boards, should be prepared to recommend and assist in referrals to other agencies and facilities, or applications for other public assistance programs.

The Social Study

The social study is part of the casework process and is developed through the worker-client relationship. This is of particular significance in an MAA program where the major thrust is directed toward prevention of financial dependence through provision of adequate financial assistance and other required social services in relation to medical care.

The broad public assistance purpose is to provide or secure for applicants and their families services that are directed toward the alleviation and/or prevention of their financial dependency with its inherent problems and long term effects. The way in which these purposes are accomplished can help to ease the family situation and stimulate the use of family strengths, or can further intensify family problems. The effect or impact is never neutral.

In many instances families and individuals will know little or nothing of the MAA program or its limits and functions, and contacts in most cases will be initiated by the BIS worker. This coming together of family, client and worker around problems created by the need for hospitalization would constitute the beginning of the case-work and social study processes.

It is at this point also that the worker undertakes a continuing process of exploration, interpretation, and support, through which a working relationship will be established. Within the framework of the extended MAA program this relationship will take place between the BIS worker and various family members in most cases.

1. Purpose of the Social Study is to determine the nature of the client's problem, to identify service needs, and to formulate a plan of service designed to enable the client and/or family to work toward the resolution of problems related to mental illness, hospitalization, and aftercare.

In this connection it should be remembered that a service should not be regarded as an end in itself but rather as a means toward achieving the desired goal.

2. General Guides to the Use of the Social Study Outline - within the framework of the family relationship, the worker initiates the social study by obtaining pertinent facts, both objective and subjective, about the individual or family under study and his (their) situation and needs, and by assembling and interrelating these facts so as to highlight:

- a. the nature of the problem and the specific factors that constitute the core of the difficulty, and;

- b. the persons involved, their feelings and reactions with respect to the problem and their ability to cope with it; in other words, to make such persons "come alive."

With this purpose in mind, the social study outlines should be used flexibly and with selectivity, in accordance with the nature of the specific problem. Only those facts should be recorded that have relevance to the particular situation under study and that contribute to the worker's understanding of it.

As the social study is an on-going process which continues throughout the worker-client relationship the worker will, at the time of eligibility redetermination and at such other times as may be indicated, review and evaluate changes in the family or individual situation and the implications of these changes for further case planning; or the worker may develop new insights with respect to the situation and the meaning it has for the persons involved. When such developments occur, a supplemental statement summarizing these changes and/or this new understanding, and properly updated, shall be added to the original social study. This new material shall be recorded in accordance with appropriate headings taken from the social study outline including, when necessary, a revised evaluation and plan of treatment.

Thus, through the social study it is possible to ascertain and clarify the facts of the situation as the worker understands it, as it is seen and felt by the client, and as it changes over a period of time.

3. Factors Applicable

The outline provided in Section 6. shall be used in making a social study. The study should account for those elements of the outline which are relevant to the particular case situation, and in receiving cases this may be done by inclusion in the study or by reference to material in the case record. Parts V and VI of the outline must be included in every study reflecting consideration of all relevant information required by the social study outline.

4. Recording of Services - it is anticipated that the Social Study will be incorporated in and become part of the on-going case record. As the services included in the Recommended Plan of Service are actually provided, these too shall be recorded, and as it becomes possible to evaluate the effects of these services in terms of the objectives originally established, such evaluation shall be added.

5. Termination of Services - when the need for service no longer exists, or when, after careful consideration, it appears that a sufficient period of time has elapsed and that further continuation of service is of no avail, the service shall be terminated and the action taken and the reason therefore shall be recorded.
6. Outline for the Social Study
 - I. Identifying information - case name and number.
 - II. Presenting problem that applicant or recipient brings to the hospital, showing major aspects of the problem including diagnosis and prognosis.
 - III. Social situation:
 - marital status;
 - educational background;
 - health status - if under care for problems of physical or mental health, the nature of the illness or disability and how it affects the individual's functioning; clients hospital course and special problems relating to family situation - patient management - discharge needs; relatives and friends as potential sources of emotional and/or financial support, and interpersonal problems created or emphasized by illness; interests and activities; community contacts.
 - IV. Living arrangements - indicate whether client lived alone, in rooming or boarding facility, or other special arrangement; if living with family, list other family members and relationship to client.
 - V. Evaluation - based on the facts given above, the ways in which they are related to each other, the meaning they have for client, and their implications for treatment, summarize briefly:
 - the nature of the problem; how it affects the client and family; their pattern of living, and what it means to them;

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what the client and family would like to do about the problem; evaluation of their strengths and capacities for coping with it;

services potentially available through relatives and other interested individuals; through the agency and other community resources.

VI. Recommended plan of service - with respect to the problems noted above, and in order of priority for action, enter:

service goals as worked out in cooperation with hospital social service staff; goals and resources that might be used; and expectation as to family and client understanding and readiness to accept and cooperate in the treatment plan; possible support supplementation needed through coordination of other public assistance programs.

Completion of Form PA-22A

1. Prepare a form for each application for medical assistance. Enter appropriate identifying information as to case name, number, etc., and date of application.
2. When the eligibility and social studies are completed enter date(s). Completion of the initial social study is considered a defined social service.
3. Under "Quarterly Evaluation and Classification" enter date(s) of quarterly review(s), and "yes" or "no" regarding alternative care potential based upon the medical-social and psychiatric recommendations of the hospital and BIS staff.
4. Under "Semi-annual Eligibility Review", enter initial due date as first of the sixth month following the date case opened. When eligibility review completed, enter date completed and subsequent due date as first of the sixth month thereafter.
5. Based on the initial social study and any subsequent revisions, identify the service(s) required for each case in accordance with the listing of major service areas. (As to "other social services" see S-3800, Appendix III.) Enter date in column headed "Date Service Need Identified" opposite the appropriate major service area(s).
6. Enter the fiscal year, and check the specific month(s) in which particular services are provided.
7. A dictated entry in the case record must substantiate each check indicating service(s) provided. The dictated entry should elaborate on the nature and purpose of the service. All services given should be further supported by the initial social study and subsequent revisions.
8. Quarterly evaluations and reviews include a review of the social service needs of a case, with updating of the social study stressing any necessary changes in plan. If in the course of evaluation and classification a new service area is defined, and/or service is provided, this action will be recorded appropriately on the PA-22A and supported by dictation in the case record.

MAA SUPPLEMENT

RECORD OF CLASSIFICATION AND SERVICES

CASE NAME _____		CASE NUMBER _____		PRIOR CASE NUMBER(S) _____	
BIRTHDATE _____		DATE LAST ADMITTED TO HOSPITAL _____		MARITAL STATUS _____	
		SEX _____		RACE _____	
		RELIGION _____			
DATE OF APPLICATION _____		QUARTERLY EVALUATION AND CLASSIFICATION:			
ELIGIBILITY STUDY COMPLETED (DATE) _____		POTENTIAL FOR ALTERNATIVE CARE WITHIN NEXT THREE MONTHS:			
SOCIAL STUDY COMPLETED (DATE) _____		DATE _____ YES _____ NO _____ DATE _____ YES _____ NO			
DATE CASE OPENED _____		DATE _____ YES _____ NO _____ DATE _____ YES _____ NO			
DATE CASE CLOSED: MAA ELIGIBILITY _____		SEMI-ANNUAL ELIGIBILITY REVIEW			
SOCIAL SERVICES _____		DATE DUE _____ DATE COMPLETED _____			
		DATE DUE _____ DATE COMPLETED _____			
MAJOR SERVICE AREAS		DATE SERVICE NEED IDENTIFIED		FISCAL YEAR _____ SOCIAL SERVICES PROVIDED (CHECK MONTH)	
				JULY AUG SEPT OCT NOV DEC JAN FEB MAR APR MAY JUNE	
SERVICES AT INTAKE					
COUNSELLING AND/OR REFERRAL					
SERVICES DURING IN-PATIENT PERIOD					
ENCOURAGEMENT OF PATIENT-FAMILY CONTACT.					
AID RESOLUTION OF FAMILY PROBLEMS HINDERING PLANNING FOR PATIENT.					
PROMOTE UNDERSTANDING AND PLANNING REGARDING SOCIAL IMPLICATIONS OF ILLNESS.					
OTHER SOCIAL SERVICES					
SERVICES SUPPORTING ALTERNATIVE CARE PLANNING					
ASSIST PATIENT, FAMILY AND HOSPITAL STAFF WITH ALTERNATIVE CARE PLANS.					
ASSIST PATIENT AND FAMILY ADJUSTMENT TO ALTERNATIVE PLAN OF CARE.					
OTHER SOCIAL SERVICES					
SERVICES FOLLOWING HOSPITAL RELEASE					
ENSURING CONTINUITY OF CARE BY SUPPORT OF HOSPITAL RECOMMENDATIONS.					
ASSIST THOSE RESPONSIBLE FOR CARRYING OUT HOSPITAL RECOMMENDATIONS.					
SECURE AND COORDINATE COMMUNITY SERVICES AND RESOURCES					
ARRANGE AND/OR ASSIST WITH REHOSPITALIZATION.					
OTHER SOCIAL SERVICES					

DEFINED SERVICES

PART II - PROBLEMS AND RELATED SOCIAL SERVICES

A. Individuals in need of protection

1. Case classification by problem

Persons who because of physical or mental limitations are:

- a. unable to act in their own behalf
- b. seriously limited in the management of their affairs
- c. neglected or exploited
- d. living in unsafe or hazardous conditions

.2 Scope of defined services

Service to and in behalf of such persons in:

- a. enlisting participation of relatives, friends and other resources in needed planning and protection
- b. securing and maintaining safe living conditions
- c. improving personal, home and money management
- d. securing and using needed medical services and, when indicated, assisting in arranging for group care in medical or social care facilities
- e. securing legal services and protection, including assistance to guardians and aid in the restoration of legal rights

DEFINED SERVICES

PART II - PROBLEMS AND RELATED SOCIAL SERVICES

B. Individuals requiring services to remain in or return to their own homes or communities

1. Case classification by problem

Persons with physical and mental conditions who:

- a. require special care at home to avoid unnecessary placement in institutions, or
- b. are able to return to own home or community if special care is arranged and needed services are available

2. Scope of defined services

Service to and in behalf of such persons in:

- a. planning for needed adjustments and management in own home
- b. planning for appropriate living arrangements
- c. enlisting interest and aid of relatives, friends and other resources
- d. securing needed medical services in own home
- e. securing institutional care as needed
- f. planning for return to own home or community

DEFINED SERVICES

PART II - PROBLEMS AND RELATED SOCIAL SERVICES

C. Individuals with potentials for self-support in whole or in part

1. Case classification by problem

Persons:

- a. whose condition indicates the possibility of immediate self-support
- b. who have not had a previous evaluation of their self-support potential, or
- c. who have a good employment history and a strong desire for independence

2. Scope of defined services

Service to help such persons in exploring interests and potentials for self-support and in:

- a. assisting with personal or family problems deterring self-support
- b. assessing of health condition, employment skills and employment potentials
- c. securing and using needed medical care
- d. when indicated, securing training opportunities and securing and maintaining appropriate employment aids essential to travel and employment

DEFINED SERVICES

PART II - PROBLEMS AND RELATED SOCIAL SERVICES

D. Individuals with potentials for self-care

1. Case classification by problem

Persons with any of the following specified problems related to physical or mental impairment:

- a. living quarters, furnishings or equipment unsuited to adult's physical or mental condition
- b. inability to perform household tasks or activities of daily living
- c. inability to obtain or use medical resources
- d. lack of mobility for maintenance of contacts with friends, relatives or for community participation

2. Scope of defined services

Service for such persons in:

- a. making needed adjustments in living arrangements and home management
- b. enlisting the interests and services of relatives and volunteers
- c. meeting daily needs of personal care
- d. securing and using medical resources, and
- e. providing opportunities for using and developing skills or special interests

DEFINED SERVICES

PART II - PROBLEMS AND RELATED SOCIAL SERVICES

E. Individuals who are isolated or estranged from family

1. Case classification by problem

Persons separated from relatives or living in isolated situations:

- a. without means of communication or of maintaining participation in community life
- b. with little or no contact with adults or children
- c. with strained family relationships or lack of family participation in planning for and meeting the needs of the adult

2. Scope of defined services

Service for such persons in:

- a. enlisting and maintaining interest of family members
- b. encouraging communication and visiting
- c. enlisting participation of family members in planning to meet current and predictable needs

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T A B L E O F C O N T E N T S

CHAPTER S-3900

OTHER ADMINISTRATIVE RESPONSIBILITIES

S-3900.	Other Administrative Responsibilities	S-3900. - S-3910.
S-3910.	Complaints, Appeals and Fair Hearings	S-3900. - S-3910.
S-3920.	Safeguarding Information	S-3920.
S-3930.	Nondiscrimination	

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S-3900. - S-3910.

Part III	The Individual and Medical Assistance for the Aged
S-3900	Other Administrative Responsibilities - Fair Hearings

S-3900. OTHER ADMINISTRATIVE RESPONSIBILITIES

S-3910. COMPLAINTS, APPEALS AND FAIR HEARINGS

The policies and procedures concerning complaints, appeals and fair hearings shall apply to the program of MAA in the same manner and extent as to other categorical assistance programs. (See Manual of Administration, Section 2920.)

Part III	The Individual and Medical Assistance for the Aged
S-3900	Other Administrative Responsibilities - Safeguarding Information

S-3920. SAFEGUARDING INFORMATION

The provisions of Ruling 20, Confidential Nature of Records shall apply to the program of MAA in the same manner and extent as to other categorical assistance programs.

Part III The Individual and Medical Assistance for the Aged
S-3900 Other Administrative Responsibilities - Nondiscrimination

S-3930. NONDISCRIMINATION

The policies and procedures concerning nondiscrimination shall apply to the program of MAA in the same manner and extent as to other categorical assistance programs. (See Manual of Administration, Section 2990.)

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T A B L E O F C O N T E N T S

CHAPTER S-4000

FINANCING ASSISTANCE PROGRAM

S-4000.	Financing Assistance Program	S-4000. - S-4010.
S-4010.	Sources of Funds, State and Local	S-4000. - S-4010.
S-4020.	State and Local Participation in Expenditures for Assistance and Administration	S-4020. - S-4020.5

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S-4000. - S-4010.

Part IV

Financial Administration

S-4000

Financing Assistance Program

S-4000. FINANCING ASSISTANCE PROGRAM

S-4010. SOURCES OF FUNDS, STATE AND LOCAL

State of New Jersey Plan for Old Age Assistance, Disability Assistance and Assistance for Dependent Children transmitted by letter dated February 16, 1960 with an effective date of January 1, 1960 applies. Hereafter this plan will be referred to as "State Plan, 1960".

The Rulings referred to in State Plan, 1960 have been amended, where necessary, to incorporate the requirements of the Medical Assistance for the Aged program.

Part IV

Financial Administration

S-4000 Financing Assistance Program - State and Local Participation

S-4020. STATE AND LOCAL PARTICIPATION IN EXPENDITURES FOR ASSISTANCE AND
ADMINISTRATION

- .1 The proportion of expenditures for assistance and administration to be paid by each level of government

a. Assistance

After deducting the earned Federal share from the total assistance cost, the State share of the balance is 60%, the County share 40%.

b. Administration

Administrative expenses of the State agency are paid from State funds and the State General Fund account reimbursed at the end of each calendar quarter for the earned Federal share for administration on a post-audit basis. The State share of administrative cost accordingly amounts to 25 to 50 percent of the federally matchable expenditures and 100 percent of the non-federally matchable expenditures for administration.

- .2 Method of apportioning State and Federal funds among localities

The method of calculating the combined participation of State and Federal funds advanced to the county welfare boards is uniform but, percentage-wise to total cost, such combined State and Federal participation varies county by county depending on the pattern of distribution by amounts of all individual assistance payments in the respective county and depending on the amount of administrative cost eligible for Federal matching. Chapter 222, Laws of 1962 prescribed the apportionment of cost of Medical Assistance for the Aged.

- .3 Use of equalization funds

State Plan, 1960 applies.

- .4 State review and control of local budgets or estimates of funds to be made available and used for public assistance

State Plan, 1960 applies.

- .5 Limiting conditions upon the availability and expenditure of State and local funds

State Plan, 1960 applies.

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T A B L E O F C O N T E N T S

CHAPTER S-4100

FISCAL OPERATIONS

S-4100. Fiscal Operations

S-4100. - S-4100.7

Part IV

Financial Administration

S-4100

Fiscal Operations

S-4100. FISCAL OPERATIONS

- .1 Officials designated, and their authority, to receive, have custody of, and disburse Federal, State, and local funds for public assistance

State Plan, 1960 applies.
- .2 System of depositing Federal, State, and local funds, allotting or otherwise making funds available for expenditure, and transferring funds between the State and its local subdivisions

State Plan, 1960 applies.
- .3 Policies governing maintenance of fiscal and accounting controls, State and local

State Plan, 1960 applies.
- .4 Types of Financial Reports required of local units and extent to which local expenditures are currently substantiated

State Plan, 1960 applies.
- .5 Procedures used by the State agency in preparing the quarterly statements of expenditures for submittal to the Social Security Administration

State Plan, 1960 applies.
 - a. Procedures for obtaining accurate total of assistance payments

The Bureau reconciles the amount of assistance, as assembled by the accounting unit, to figures assembled by the statistical unit. These records are used in completing the quarterly statement and are used in verifications by State and Federal auditors.
- .6 Audits of State and Local Expenditures for assistance and administration

State Plan, 1960 applies.
- .7 Authority and practice of State fiscal officials for audit of expenditures

State Plan, 1960 applies.

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T A B L E O F C O N T E N T S

CHAPTER S-4200

AUTHORIZATION AND DISBURSEMENT OF ASSISTANCE PAYMENTS

S-4200. Authorization and Disbursement of Assistance Payments S-4200.

Part IV	Financial Administration
S-4200	Authorization and Disbursement of Assistance Payments

S-4200. AUTHORIZATION AND DISBURSEMENT OF ASSISTANCE PAYMENTS

State Plan, 1960 applies except that following is substituted for V.C.3.f., "Established schedule for releasing payments and deadline dates for authorizing awards".

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T A B L E O F C O N T E N T S

CHAPTER S-4300

COLLECTIONS AND RECOVERIES

S-4300. Collections and Recoveries

S-4300.

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S-4300.

<u>Part IV</u>	<u>Financial Administration</u>
<u>S-4300</u>	<u>Collections and Recoveries</u>

S-4300. COLLECTIONS AND RECOVERIES

State Plan, 1960 applies.

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T A B L E O F C O N T E N T S

CHAPTER S-4400

ADMINISTRATIVE COST

S-4400. Administrative Cost

S-4400.

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S-4400.

Part IV

Financial Administration

S-4400

Administrative Cost

S-4400. ADMINISTRATIVE COST

State Plan, 1960 applies.

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T A B L E O F C O N T E N T S

CHAPTER S-5000

STATISTICS AND RESEARCH

S-5000. Statistics and Research

S-5000.

Part V

Statistics and Research

S-5000

Statistics and Research

S-5000. STATISTICS AND RESEARCH

State of New Jersey Plan for Old Age Assistance, Disability Assistance and Assistance for Dependent Children transmitted by letter dated February 16, 1960 with an effective date of January 1, 1960 applies. Hereafter this plan will be referred to as "State Plan, 1960".

The Rulings referred to in State Plan, 1960 have been amended, where necessary, to incorporate the requirements of the Medical Assistance for the Aged program.

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T A B L E O F C O N T E N T S

CHAPTER S-6000

PERSONNEL ADMINISTRATION

S-6000.	Federal Requirements	S-6000.
S-6100.	State Merit System	S-6100.
S-6200.	Case Load and Supervisory Standards	S-6200.

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Part VI

Personnel Administration

S-6000

Federal Requirements

S-6000. FEDERAL REQUIREMENTS

The Federal Social Security Act in section 2 (a) of Title I requires that "a State plan for ... medical assistance for the aged must ... provide ... [for] establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods ...".

Part VI

Personnel Administration

S-6100

State Merit System

S-6100. STATE MERIT SYSTEM

The provisions of the New Jersey Civil Service Law (R.S., Title 11) shall apply to State personnel administering the program of MAA.

Part VI

Personnel Administration

S-6200

Case Load and Supervisory Standards

S-6200. CASE LOAD AND SUPERVISORY STANDARDS

Case load and supervisory standards required as a condition of Federal financial participation shall apply to the Bureau of Institutional Services.

For recipients who are in alternative care arrangements, the case load standard shall not exceed 60 cases per worker. For recipients who are in-patients in congregate institutions, the case load standard shall not exceed 100 cases per worker. For mixed case loads, the appropriate standard shall be computed from these ratios.

The standard of not more than 5 workers per supervisor applies throughout.