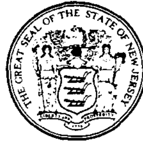

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

MICHELE K. GUHL
Commissioner

MARGARET A. MURRAY
Director

(REISSUED)

MEDICAID COMMUNICATION NO. 99-12 **DATE:** August 10, 1999

TO: County Welfare Agency Directors
New Jersey Care...Special Medicaid Program Supervisors

SUBJECT: Outreach to Disabled Children

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) introduced a change in the criteria which the Social Security Administration uses to make childhood disability determinations. This change effected a reexamination of disability status for approximately 6,000 New Jersey children (known as "Zebley" children).

As a result of this activity, a number of children have been reinstated, or have lost benefits, or are in the process of being evaluated for continuing Supplemental Security Income (SSI) benefits by the Social Security Administration. The State of New Jersey has automatically continued Medicaid coverage to children who lost their SSI/Medicaid benefits during this process through the aged, blind and disabled segment of the New Jersey Care...Special Medicaid Program on an interim basis.

Cases which have been terminated by the Social Security Administration for not meeting the new disability criteria have been systemically converted to the New Jersey Care...Special Medicaid Program and appear on the Medicaid eligibility file as Program Status Code (PSC) 290. The attached lists include: (1) those children in your county who were terminated from SSI and converted, (2) those children who were terminated and converted and show duplicate Medicaid eligibility under another program, and (3) monthly conversion reports for the periods January through July 1999.

In order to establish ongoing eligibility for these children, we are asking you to use these lists to outreach the parents/guardians in order that a redetermination of eligibility may take place. While these children are protected until age 18 under former disability criteria, they are not exempt from income eligibility factors. A disability determination by the DMAHS Disability Review Team will be warranted in some cases and will employ the standards previously used by the Social Security Administration.

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The attached new forms, PA-5C and PA-6C, will document the necessary data in an abbreviated manner and will be used when submitting these cases as required to the Division for disability review. It is very important to identify the child's Zebley status on the Medical-Social Information Report-Children: PA-6C. **(Please note that the above forms will also be used for all child disability cases being referred to the Division.)** In addition to the completed Confidential Medical-Psychiatric Examining Physician Report-Children: PA-5C, the parent/guardian may submit any additional medical documentation that will support their disability claim.

For purposes of this outreach, no redetermination of disability will be required for children under age 5 or for children who will turn age 18 within two years. However, a redetermination of financial eligibility will be required according to existing policy. Disability redetermination dates will be designated in the same manner as all other Disability Review cases, on an as needed basis.

In evaluating program options, including current dual eligibility, we ask that you consider what program is best suited for that child and family. Where two active numbers exist, terminate eligibility under the other program accordingly. For example, if the child is a member of a TANF household and receives AFDC-related Medicaid, the child should remain eligible as a member of the TANF household and the New Jersey Care eligibility should be terminated on the system. Additionally, please note that if the child remains eligible as a Zebley child, s(he) would not be included as a member of a Plan A NJ KidCare household.

If eligibility is continued for the child under a Medicaid program other than New Jersey Care disability, it is important to document the child's Zebley status in the case record for future reference with regard to the eligibility guarantee. Accordingly, if eligibility is terminated under another Medicaid program, it is vital that your agencies develop an internal mechanism to refer these children for an eligibility determination under New Jersey Care.

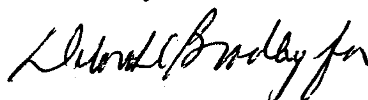
In order to facilitate the outreach process, we have provided you with some mailing labels and an attached sample outreach letter which you may adapt as necessary for your use. In addition, we suggest that you plan your outreach mailings by birthdate or similar phased methodology, so that your agencies and the Division's Disability Review Team may better manage the volume of cases.

Since the lists are time limited and subject to change, we suggest that you screen each name on the Medicaid eligibility file to determine the appropriate case action prior to the mailing of an outreach letter. In addition, we ask that you work each name on the list, establish a case record where warranted and update the Medicaid eligibility file as necessary. For any cases that you were unable to render a final disposition, please advise the Division's Office of Beneficiary and

of their cases by the Social Security Administration, we plan to provide you with future updates to the attached lists for your agency's follow-up.

Thank you for your cooperation in this matter and your mutual interest in providing continuing Medicaid coverage to this group of children. If you have any questions regarding this matter, please contact the field service staff assigned to your county.

Sincerely,



Margaret A. Murray
Director

MAM:S
Attachments (3)
c: Christine Grant, Commissioner
Susan C. Reinhard, Ph.D., Deputy Commissioner
Department of Health and Senior Services

David C. Heins, Director
Division of Family Development

Charles Venti, Director
Division of Youth and Family Services

D R A F T

Dear Parent/Guardian:

Recent welfare reform legislation changed the definition of childhood disability for purposes of establishing Medicaid eligibility. As a result, our records show that your child may have lost his or her Supplemental Security Income (SSI) and Medicaid benefits received through the Social Security Administration.

However, the State of New Jersey has continued your child's Medicaid coverage through the New Jersey Care...Special Medicaid program. Your child will continue to qualify for this program as long as (s)he continues to meet the Social Security Administration's previous definition of disability as well as meet the current financial requirements of the program.

In order to determine your child's ongoing Medicaid eligibility, it is important for you to contact the County Board of Social Services to schedule an appointment as soon as possible. As a result of your appointment, a financial and disability review will be initiated. In order to facilitate that process, the enclosed PA-5C form must be completed by the attending physician or psychiatrist and submitted as part of that review with our agency. You may also submit any additional supporting medical records.

To initiate the application process on behalf of your child, or if you have any questions, please contact at . Thank you for your cooperation in this matter.

Sincerely,

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CONFIDENTIAL MEDICAL-PSYCHIATRIC EXAMINING PHYSICIAN'S REPORT: CHILDREN

Client Name: ______________________ Case Number ______________________

Address: ______________________ County: ______________________

DOB: ________ Sex: ______ Grade: ____ Social Security Number: ______________________

To Be Completed by Physician

MEDICAL SUMMARY: (Primary diagnosis must be supported by copies of laboratory findings, discharge summaries, consultative reports, etc.)

A. Primary Diagnosis: ______________________

1. Date of Onset: ____ 2. Cause: Congenital ___ Disease: ___ Injury: ___

Minor Diagnosis: ______________________

1. Date of Onset: _____ 2. Cause: Congenital: ___ Disease: ___ Injury: ___

HOSPITALIZATIONS (if any): ______________________

____

____

____

C. CHARACTERISTICS OF MAJOR DISABILITY: Static (stable) ____ Progressive ____ Improving: ____

D. EDUCATIONAL/VOCATIONAL FUNCTIONAL ABILITY:

1. In your opinion could this individual now attend regular school or voacational program as a full time student at school he/she formerly attended? ___ Yes ____ No

If "no" could individual now attend a special education program in the community? ____ Yes ____ No
If "no" could individual now attend a special education program within a structured residential treatment program or inpatient psychiatric treatment center? ____ Yes ____ No If "no" specify: ______________________

2. In your opinion will this individual ever be able to return to a regular community school or vocational program or begin full-time employment? ____ Yes ____ No

If "yes" approximately when could individual return to regular school?
____ Less than or about one year (estimate date _______)
____ More than one year (estimate date ______)
____ More than one year, unable to provide a date, will depend on progress in treatment.

3. If individual is considered incapacited to the extent that he/she cannot attend regular school, cannot work and does not have the skills to live either with his/her family or independently, is it your opinion that the duration of the incapacity will be:
____ Less than 30 days
____ More than 30 days but less than 90 days
____ More than 90 days but less than 6 months
____ More than 6 months but less than 1 year
____ More than one year (Please specify)

NAME: ______________________________

4. Additional comments or remarks (including opinion you may have as to this individual's mental/physical ability to engage full time in school or training or any useful employment on a regular and predictable basis, etc.
____
____
____

E. PHYSICAL LIMITATIONS: (If there are limitations, check below, and specify cause & degree of limitation.)

Standing ____ Walking ____ Climbing ____ Stooping ____ Bending ____ Lifting ____ Use of hands: ______

Comments: ______________________________

F. GENERAL INFORMATION: Height ______ Weight ______ Blood Pressure: ______

G. SPECIAL SENSES PROBLEM: (Forward copy of latest eye/hearing evaluation.) ______________________________

H. ORTHOPEDIC PROBLEM: Specify the range of motion of all impaired joints (in degree). Comment on alleged pain sites, evidence of spasm or tenderness. Is there evidence of motor loss, muscle weakness, reflex or sensory loss?
____
____

J. CARDIAC PROBLEM: Forward copies of abnormal test results.

K. NEUROLOGICAL EVALUATION: Is there a history of convulsions? ____ Yes ____ No (If yes, describe character and frequency, duration of history of attacks, whether controlled by drugs, name of drugs, cause and diagnosis of convulsions, known. ______________________________
____
____

L. REATMENT PLAN: (Explain) ______________________________
MEDICATIONS: ______________________________

M. PSYCHIATRIC EVALUATION:

1. Is client disoriented? ___ Yes ___ No Has he/she lost control of any of his mental faculties? ___ Yes ___ No
If "yes" explain: ______________________________
____

2. Does client suffer from an obvious mental or emotional disturbance, psychosis, mental retardation, etc.?
____ Yes ____ No If "yes" explain and cite psychiatric opinion and test results, if any, supporting such opinion.
____
____

3. Does patient in your opinion have sufficient mental ability, judgement or competence to make decisions concerning his/her well being (appropriate to his/her age), including the handling of money? ____ Yes ____ No If no explain:
____

N. PERTINENT DIAGNOSTIC AIDS: Give date and cite the results of any significant and pertinent laboratory or diagnostic studies which you possess or to which you have had access to in making this evaluation:
____
____

O. Duration of Your Treatment of this client. ______________________________

P. Client's/family's compliance to treatment: ______________________________

NAME: ______________________________

Q. Is the client's disability related to the use of illegal drugs or alcohol? ______________________________

R. Broad Functional Limitations: Assess the severity of any broard developmental and functional limitations in the areas below.

FUNCTION	**DEGREE OF LIMITATION**			
	No Evidence Limitation	Less than Marked	Marked	Extreme
Cognitive/ Communicative (all ages)	______	______	______	______
Motor (all ages)	______	______	______	______
Social (all ages)	______	______	______	______
Responsiveness to Stimuli (birth to attainment of age 1)	______	______	______	______
Response to Personal Contact (age 3 to attainment of age 18)	______	______	______	______
Concentration, Persistence, or Pace (age 3 to attainment of age 18)	______	______	______	______

I hereby certify that these statements are based on curent and past examinations of the patient and that they are true to my best knowledge , information and belief.

Date ________ Signature of Physician: ______________________________ Specialty: ______________

Address: ______________________________ Physician's Phone Number: ______________

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAL-SOCIAL INFORMATION REPORT: CHILDREN

County Board of Social Services: ________________________ Date of Application: ______________

Case No. ________________ Related Case No. _________________ Social Security No.___________

CLIENT'S NAME: ________________________Birth Date: ______ Place of Birth: ________________

Address:

____

(Street) (City) (State) (Zip Code)

PROGRAM: ZEBLEY ( ) Yes ( ) No Male ( ) Female ( )

( ) MEDICAID ONLY ( ) MEDICAID MODEL WAIVER ( ) MEDICALLY NEEDY ( ) CCPED

( ) ACCAP ( ) NEW JERSEY CARE

CURRENT LIVING ARRANGEMENT OF APPLICANT ( ) Home ( ) Institution or Facility

____

Name of Institution/Facility Date Admitted

____

Address

IF THE CLIENT LIVES AT HOME, INDICATE THE NAMES, AGES & RELATIONSHIP TO THE CLIENT:

____

____

INDICATE ANY PLAN FOR CHANGE IN LIVING ARRANGEMENT & REASON: ______________________

____

EDUCATION/VOCATIONAL

Highest grade completed: Elementary ___ High School ___ College ___ English: Yes ___ No __

Can client speak foreign language? Yes ____ No ____ Indicate age client left school: _________

Indicate any vocational or other training skills or hobbies: ________________________________

Indicate any work history: ____

CLIENT NAME: ______________________________ CASE NO. __________________________

INSURANCE: Has application been made for SSI? ( ) Yes ( ) No If yes, please indicate date of application and submit a copy of the SSA determination. If there is any other information regarding health care coverage, please indicate:

SOCIAL EVALUATION AND PLAN

Describe the way in which the client appears to be disabled, that is, observable physical of the disease or impairment (i.e. ability to walk, stand, lift, climb, bend, carry, etc.):

Does the client use any assistive devices such as cane, brace, special shoe, hearing aid(s), etc.? Indicate any other factors which contribute to client's malfunctioning or incapacity.

Describe any evidence of specific conflict or difficulties in client's behavior toward others, including family:

Other significant information or comments to an understanding of the client and or his/her family situation:

Any history of use of street drugs and/or alcohol? ( )Yes ( ) No
Specify:

Date of Interview: ________ ______________________________ (Agency Worker) ________________ (Phone Number) ________ (Date)

Personal Interview? Yes / No (Circle) ______________________________ (Supervisor) ________________ (Phone Number) ________ (Date)