

CHAPTER 63

LONG-TERM CARE SERVICES

Authority

N.J.S.A. 30:4D-6a(4)(a) and b(14); 30:4D-6.7 and 6.8; 30:4D-7, 7a, b and c; 30:4D-12; Section 1919 of the Social Security Act; 42 U.S.C. § 1396r; 42 C.F.R. 483; and P.L. 1985, c.303.

Source and Effective Date

R.1999 d.364, effective September 24, 1999.
See: 31 N.J.R. 1759(a), 31 N.J.R. 3116(a).

Executive Order No. 66(1978) Expiration Date

Chapter 63, Long-Term Care Services, expires on September 24, 2004.

Chapter Historical Note

Chapter 63, Skilled Nursing Home Services Manual, was adopted as R.1971 d.163, effective September 22, 1971. See: 3 N.J.R. 206(b).

Chapter 63, Skilled Nursing Home Services Manual, was repealed and Chapter 63, Long-Term Care Services Manual, was adopted as new rules by R.1979 d.126, effective March 29, 1979. See: 10 N.J.R. 190(b), 11 N.J.R. 248(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, General Provisions, was readopted as R.1984 d.123, effective March 21, 1984. See: 16 N.J.R. 204(a), 16 N.J.R. 896(a).

Pursuant to Executive Order No. 66(1978), Subchapter 3, Cost Study, Rate Review Guidelines and Reporting System for Long-Term Care Facilities, was readopted as R.1984 d.573, effective November 29, 1984. See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services Manual, was readopted as R.1989 d.622, effective November 29, 1989. See: 21 N.J.R. 2752(a), 21 N.J.R. 3918(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services, was readopted as R.1994 d.624, effective November 23, 1994, and former Subchapters 1, 2, 2A and 4, and Appendix I were repealed and Subchapter 1, General Provisions, Subchapter 2, Nursing Facilities Services, and Appendices A through Q were adopted as new rules, and Subchapter 5, Audits, was recodified as Subchapter 4 by R.1994 d.624, effective January 3, 1995. See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services, was readopted as R.1999 d.364, effective September 24, 1999. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:63-1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF) and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. Although the scope of the Long-Term Care Services chapter encompasses other long-term care facilities such as governmental psychiatric hospitals, inpatient psychiatric services/programs for the under 21 (residential treatment centers) and intermediate care facilities/mentally retarded (ICF/MRs), the following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement applies to all the above cited long-term care facilities.

Case Notes

Radioactive application of regulation valid. In re: Medicaid Long Term Care Services Bulletin 84-2, 212 N.J.Super. 48, 513 A.2d 967 (App.Div.1986), certification denied 526 A.2d 125, 107 N.J. 31.

Denial of request for reclassification from low to medium salary region assignment not inequitable. *Rosewood Manor, Inc. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 20.

10:63-1.2 Definitions

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

“Advance directive” means a written instruction relating to the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney for health care.

“Air fluidized therapy bed” means a device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects).

“Case management” means a process by which the Division of Medical Assistance and Health Services Medical Social Care Specialist monitors the provision of nursing facility care to assure timely and appropriate provider responses to changes in care needs and delivery of coordinated services.

“Case mix” means a system of staffing and reimbursement for nursing services based on variation in patient acuity and care needs that influences the type and amount of service needed.

“Clinical audits” means a method of utilization control under the enforcement authority of Section 1902(a)(30)(A) of the Social Security Act, in accordance with 42 CFR 456.1(b)(1), to monitor the utilization of and payment for nursing facility care and services reimbursable under the Medicaid State Plan.

“Comprehensive assessment” means a process conducted by each member of the interdisciplinary team which, for each resident, identifies problems; determines care needs; and in conjunction with the resident and his or her significant other or legal representative, results in an interdisciplinary plan of care.

“Consultant pharmacist” means a pharmacist licensed by the New Jersey State Board of Pharmacy who meets the qualifications in N.J.A.C. 10:51-3.3.

“Conventional nursing facility”—see nursing facility.

“Department of Health” (DOH) means the New Jersey State Department of Health.

“Division of Developmental Disabilities (DDD)” means the Division of Developmental Disabilities within the New Jersey State Department of Human Services.

“Division of Mental Health and Hospitals (DMH & H)” means the Division of Mental Health and Hospitals within the New Jersey State Department of Human Services.

“Health Services Delivery Plan (HSDP)” means an initial plan of care prepared by the Regional Staff Nurse during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

“Interdisciplinary care plan” means the care plan developed by the interdisciplinary team which includes measurable objectives and time tables to meet the resident's medical, nursing, dietary and psychosocial needs that are identified through the comprehensive assessment process.

“Interdisciplinary team” means a team consisting of a physician and a registered professional nurse and may also include other health professions relative to the provision of needed services. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

“Low airloss therapy bed” means a bed frame that is equipped with air sacs which are grouped into zones corresponding to various body areas. The air sacs are inflated by a constant flow of air, some of which is directed through the air sacs to the patient surface.

“Medicaid occupancy level” means the average number of Medicaid recipients and recipients of public assistance under P.L.1947, c. 156, as amended (C44.8-107 et seq.) residing in a NF divided by the total number of licensed beds in the facility during the billing month.

“Medical director” means a physician licensed under New Jersey State law who is responsible for the direction and coordination of medical care in a nursing facility.

“Medical evaluation team (MET)” means a team of Medicaid professionals consisting of a physician consultant, a regional staff nurse (RSN), a regional pharmaceutical consultant, a Medical Social Care Specialist I (MSCS I) and a Medical Social Care Specialist II (MSCS II) who are assigned to the Medicaid District Office (MDO). A MET has the responsibility to review medical, nursing, and social information as well as any other supporting data in order to evaluate the need for long-term care, determine the level of care needed, the feasibility of alternate care, the quality of care given and the outcome of service. Members of the MET may review each recipient or potential recipient as individual team members or may perform the review as a multidisciplinary team.

“Medical social care specialist (MSCS)” means a social worker employed by the Division of Medical Assistance and Health Services who performs case management as required by N.J.A.C. 10:63.

“Medical staff” means one or more licensed physicians who act as the attending physician(s) to Medicaid recipients in a nursing facility.

“Minimum data set (MDS)” means a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing facility resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

“Nursing facility (NF)” means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid recipients (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases which require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

“Occupational therapist” means a person who is registered by the American Occupational Therapy Association,

1383 Piccard Drive, P.O. Box 1725, Rockville, MD 20849-1725, or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

“Physical therapist” means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and the American Physical Therapy Association, 1111 N. Fairfax St., Alexandria, VA 22314 or its equivalent; and if practicing in the State of New Jersey, is licensed by the State of New Jersey, or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable, and also meets all applicable Federal requirements.

“Physician’s services” means those services provided within the scope of medical practice as defined by the laws of New Jersey and those services which are performed by or under the direct personal supervision of the physician.

1. “Physician” means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.

2. “Direct personal supervision” means services which are rendered in the physician’s presence.

“Pre-admission screening (PAS)” means that process by which all Medicaid eligible recipients seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF receive a comprehensive needs assessment by the Regional Staff Nurse to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D-17.10. (P.L.1988, c. 97).

“Pre-admission screening and annual resident review (PASARR)” means that process by which all individuals with mental illness (MI) or mental retardation (MR) are screened prior to admission to a NF and annually thereafter in order to determine the individual’s appropriateness for NF services, and whether the individual requires specialized services for his or her condition.

“Prior authorization” means approval granted by the Division of Medical Assistance and Health Services through the appropriate Medicaid District Office (MDO) for payment for NF or before other Medicaid covered services are rendered to a Medicaid recipient, in accordance with this chapter.

“Regional staff nurse (RSN)” means a registered professional nurse employed by the Division of Medical Assistance and Health Services who performs health needs assessments as required by this chapter.

“Rehabilitative and/or restorative nursing care” means nursing care provided by a registered professional nurse, or under the direction of a registered professional nurse, qualified by experience in rehabilitative or restorative nursing care.

“Rehabilitative services” means physical therapy, occupational therapy, speech-language pathology services, and the use of such supplies and equipment as are necessary in the provision of such services.

“Resident” means a Medicaid eligible or potentially eligible recipient residing in an NF.

“Respiratory care practitioner” means an individual credentialed by the State Board of Respiratory Care, to practice respiratory care under the direction or supervision of a physician pursuant to State of New Jersey P.L.1971, c. 60; P.L.1974, c. 46; and P.L.1978, c. 73, amended August 1991.

“Section Q” means the resident classification portion of the standardized resident assessment (SRA) instrument which identifies an individual NF resident’s nursing service requirements based on the standards at N.J.A.C. 10:63-2.2(a).

“Skilled nursing facility (SNF)” means a free-standing institution or an identifiable part of an institution which meets all the State and Federal requirements for participation in the Medicare Program as a skilled nursing facility.

“Social services” means those services provided to meet the emotional and social needs of the Medicaid recipient and significant other or guardian at the time of admission, during treatment and care in the facility, and at the time of discharge.

“Special care nursing facility (SCNF)” means a NF or separate and distinct unit within a Medicaid certified conventional NF which has been approved by the Division of Medical Assistance and Health Services to provide care to New Jersey Medicaid recipients who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 10:63-2, Nursing Facility Services.

“Specialized services for mental illness (MI)” mean those services offered, in accordance with 42 CFR 483.120, when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24-hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and as early as possible, to permit functioning at a level where less than specialized services are appropriate. Specialized services go beyond the range of services which a NF is required to provide.

“Specialized services for mental retardation (MR)” mean those services offered, in accordance with 42 CFR 483.120, when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills. Specialized services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an intermediate care facility for the mentally retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

“Speech-language pathologist” means a person who has a certificate of clinical competence from the American Speech and Hearing Association; meets all applicable Federal regulations; has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate, and, if practicing in the State of New Jersey is licensed by the State of New Jersey; or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable.

“Standardized Resident Assessment (SRA)” means an instrument developed by the State to report minimum data set requirements, including resident assessment protocols and additional State mandated data, which results in a comprehensive, standardized assessment of a NF resident’s functional capabilities and service requirements.

“Track of care” means the designation of the setting and scope of Medicaid services determined by the PAS process conducted by the RSN following assessment of the Medicaid eligible or potentially eligible Medicaid recipient, as follows:

1. “Track I” means long-term NF care.
2. “Track II” means short-term NF care.
3. “Track III” means long-term care services in a community setting.

“Transfer of ownership” means, for reimbursement purposes, a change in the majority ownership that does not involve related parties, related corporations or public corporations. “Majority ownership” is defined as an individual or entity who owns more than 50 percent of the facility.

“Waiting list” means the standardized listing, maintained in chronological order by the NF, of the names of all individuals seeking admission to a Medicaid participating NF who have completed a written application.

Amended by R.2001 d.1, effective January 2, 2001.
See: 32 N.J.R. 2859(a), 33 N.J.R. 54(a).

Added "Transfer of ownership" to section.

Case Notes

County hospital which did not participate in pre-adoption rulemaking proceedings is not entitled to an agency or court hearing to explore reasons underlying regulations prescribing methodology for fixing rates paid for Medicaid patient care at long-term care facility; regulations not arbitrary or unreasonable. *Bergen Pines County Hospital v. New Jersey Dept. of Human Services*, 96 N.J. 456, 476 A.2d 784 (1984).

Adoptive parents who provided outstanding care for medically fragile child should not have been punished by having child removed from necessary community based services waiver program. *K.S. v. DMAHS*, 96 N.J.A.R.2d (DMA) 7.

Conditions of blindness and profound retardation established appropriateness of residential long-term pediatric care placement. *N.C. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 34.

Presumption of reasonableness of agency's rate methodology not rebutted by sufficient evidence; burden of proof improperly shifted to agency at hearing (Director's Final Decision). *Morris View Nursing Home v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 561 (1983), affirmed per curiam Dkt. No. A-973-83 (App.Div.1985).

Rate reimbursement system challenged by facility utilizing minimum staffing report prepared for other purposes by the Department of Health; Division of Medical Assistance and Health Services not bound by Department of Health determinations; denial of increased rate reimbursement not unreasonable agency action. In re: *Preakness Hospital*, 8 N.J.A.R. 389 (1983).

7. Fees and other expenses incurred in connection with the construction, purchase, alteration or leasing of land, buildings, and fixed equipment; and

8. Fees and other expenses incurred in financing or refinancing of the NF itself or any of its assets.

(b) The rules promulgated herein have been developed with the following objectives and considerations:

1. The departments should not concern themselves with the method and attendant costs with which individuals NFs are financed and constructed or the arrangements under which they are acquired or leased.

2. While not concerning themselves about the costs, financing and so forth, of individual NFs the departments mandate with respect to the reasonableness of cost requires it to develop this rate component upon the presumption of reasonable facility costs and prudent financing.

3. Private capital should be attracted into the industry with a reasonable rate of return, which should recognize that the existence of the certificate of need process to control the supply of NFs in relation to demand, removes several risks inherent in most free enterprise situations.

(c) The departments believe that the above objectives can best be met by establishing an aggregate "capital facilities allowance" (CFA). The aggregate annual CFA for building, land, and movable equipment shall constitute the maximum reasonable reimbursement for depreciation (except automobiles), rentals of buildings and equipment (except automobiles), interest on all indebtedness, and amortization of leasehold improvements. Reimbursement shall be limited to the lower of:

1. The total actual NF expenses for depreciation, interest and rental; or
2. The aggregate capital facilities allowance for building, land, and movable equipment.

(d) The following considerations will be addressed in determining the CFA:

1. Buildings (see N.J.A.C. 10:63-3.11);
2. Land and land improvements (see N.J.A.C. 10:63-3.12);
3. Equipment (routine moveable) (see N.J.A.C. 10:63-3.13);
4. Maintenance and replacements (see N.J.A.C. 10:63-3.14);
5. Property insurance (see N.J.A.C. 10:63-3.15);
6. Economic occupancy level (see N.J.A.C. 10:63-3.16).

As amended, R.1984 d.573, effective December 16, 1984.
See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Deleted (a)8 and recodified (a)9 to (a)8.
Recodified from 10:63-3.9 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).
Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).
Amended by R.1996 d.147, effective March 18, 1996.
See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Case Notes

Nursing home was not entitled to prospective hardship relief amounting to perpetual lease pass-through for its reimbursement rate. *Stratford Nursing and Convalescent Center, Inc. v. Kilstein*, D.N.J.1991, 802 F.Supp. 1158, affirmed 972 F.2d 1332.

Nursing home was not entitled to full reimbursement for rent or for dispensing non-legend drugs. *White House Nursing Home v. DMAHS*, 93 N.J.A.R.2d (DMA) 114.

Long-term care facility's expert's appraisal not preferred. *Matter of Elizabeth General Medical Center*, 93 N.J.A.R.2d (DMA) 51.

In establishing rate of reimbursement for Medicaid patients in an addition to a facility, an agency is required to use the actual interest rate paid in financing the addition in establishing the amortization rate. *Medicenter of Lakewood v. Dept. of Human Services*, 4 N.J.A.R. 26 (1983).

10:63-3.11 Buildings and fixed equipment

(a) The CFA for buildings and fixed equipment will be based upon appraised value as follows:

1. For NFs beginning operation before January 1, 1978, the CFA will be determined based upon appraised 1977 replacement costs derived from nationally recognized construction cost manuals, less wear and tear and subject to reasonableness limits as described in (c), (d) and (e) below.

2. For NFs, or significant additions to existing NFs, beginning operation on or after January 1, 1978, the appraised value will be determined at the time construction is completed, based upon price levels derived from nationally recognized construction cost manuals, subject to reasonableness limits as described in (c), (d) and (e) below.

(b) The appraisals are to be conducted by an agent designated by the State.

(c) Reasonableness limits on plant square feet will be set at 110 percent of the median plant square feet per available bed of all proprietary and voluntary NFs which had over 20 percent Medicaid patient days in the base period. Separate reasonableness limits will be developed for governmental NFs by the same method. NFs not substantially complying with current State and Federal space requirements or carrying space waivers will be excluded from this calculation.

(d) A reasonableness limit on appraised value per square foot will be established as follows:

1. For NFs beginning operation before January 1, 1978, at 110 percent of the median appraised value, at

1977 price levels, of proprietary and voluntary NFs which had over 20 percent Medicaid days in the base period;

2. For NFs beginning operation on or between January 1, 1978, and December 31, 1984, at the original reasonableness limit as determined from (d)1 above, increased for inflation by 15 percent for the first year and 10 percent for each succeeding year;

3. For facilities beginning operation on or after January 1, 1985, at the reasonableness limit determined for 1984, incremented annually by a factor for inflation which is the average of percentages representing cost increases derived from:

i. The Marshall Swift Valuation Index for the Eastern District; published by Marshall and Swift, 1617 Beverly Blvd., P.O. Box 26307, Los Angeles, California; and

ii. Inflation factors published by the U.S. Department of Labor, Bureau of Labor Statistics for New York and Northeastern New Jersey;

4. For significant additions to existing NFs beginning operation since January 1, 1978, at the original reasonableness limit as determined from (d)1 above, increased by a factor for inflation (see (d)2 above). A single weighted reasonableness limit for the entire NF will be calculated based upon the square footage and the corresponding construction cost factors of the building as originally appraised and the appraised addition(s); and

5. A separate reasonableness limit will be developed for governmental NFs by the same method.

(e) The reasonable limits as described above will be combined to allow for square feet in excess of that established limit where value per square foot is less than that limit for each class of long term care facility.

(f) The CFA for buildings and fixed equipment will be determined by applying the appropriate interest or amortization rate, described in (f)1 and 2 below, to the reasonable appraised value of the building and fixed equipment.

1. Interest rate:

i. For NFs beginning operation before January 1, 1978, the interest rate is equal to the Medicare return on equity rate for the 12 month period ending with December of 1976 (10.719 percent).

ii. For NFs, or significant additions to existing NFs, beginning operation between January 1, 1978 and September 30, 1985, the interest rate is equal to the Medicare return on equity rate published at the inception of operations.

iii. For NFs, or significant additions to existing NFs, beginning operations between October 1, 1985 and September 30, 1993, the interest rate is equal to 150 percent of the Medicare return on equity rate published at the inception of operations.

iv. For NFs, or significant additions to existing NFs beginning operations on or after October 1, 1993, the interest rate is equal to 150 percent of the applicable interest rate at the inception of operations as indicated by the Table of Average Interest Rates on Special Issues of Public-Debt Obligations Issued to the Federal Hospital Insurance Trust Fund as published by the Office of the Actuary of the Federal Health Care Financing Administration.

2. The amortization rate shall be equal to the ratio of annual debt service (principal and interest) to original principal required to amortize a loan in 25 equal installments, with an interest rate equal to the appropriate above defined "interest rate".

(g) For the first 25 years of the life of a NF beginning with the year of construction, the amortization rate will be applied to the reasonable appraised value of the building and fixed equipment.

(h) Beyond the 25th year after construction, the interest rate will be applied to the reasonable appraised value of buildings and fixed equipment.

(i) For NFs built-in multiple stages, a weighted average year of original construction will be established by weighing licensed beds by the age of the component multiple stages of the building in which the beds are located. Where inequities could result from this calculation, homes with suitable records may request that the weighted average year of construction be calculated based upon plant square feet constructed.

(j) For NFs with residential and/or sheltered care patients, data relative to common areas will be apportioned to nursing patients based upon base period licensed beds. After making such apportionments, appraised values will be subject to the reasonableness screens described in (c), (d) and (e) above and, where applicable, to the weighted average year of construction calculations described in (i) above. This proration will not be redetermined for subsequent years in the absence of significant changes in facilities or in patient mix.

(k) For LTCF's NFs which were converted to NFs use from other uses, the year of conversion will be used provided the conversion costs exceeded the acquisition cost of the building and building equipment. Otherwise, the original year of construction will be used.

(l) For existing NFs the State will not increase the CFA rate in future years should the Table of Average Interest Rates on Special Issues of Public-Debt Obligations issued to the Federal Hospital Insurance Trust Fund as published by the Office of the Actuary of the Federal Health Care Financing Administration increase.

(m) The departments will review, on an individual basis, situations where the strict application of the provisions of this section would be inappropriate under particular circumstances, such as:

1. Situation where an existing debt must be refinanced in connection with obtaining funds to expand existing NFs;
2. The inability of NFs to obtain 25-year financing.

As amended, R. 1983 d.73, effective March 21, 1983.

See: 14 N.J.R. 743(a), 15 N.J.R. 443(a).

Language concerning financing through a governmental authority.

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

New (e); recodify (e)-(o) as (f)-(p).

Amended by R.1985 d.705, effective January 21, 1986.

See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).

(n)2 deleted; 3 recodified to 2.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.10 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Case Notes

In establishing rate of reimbursement for Medicaid patients in an addition to a facility, an agency is required to use the actual interest rate paid in financing the addition in establishing the amortization rate. *Medicenter of Lakewood v. Dept. of Human Services*, 4 N.J.A.R. 26 (1983).

10:63-3.12 Land

(a) The CFA for land will be based upon appraised value of land and land improvements determined by an agent designated by the State of New Jersey as follows:

1. For NFs beginning operation before January 1, 1978, the 1977 value of land and land improvements;
2. For NFs beginning operation on or after January 1, 1978, the value of land and land improvements as of the completion of construction;
3. For additions to existing NFs beginning operation on or after January 1, 1978, the value of additional land acquired or additional land improvements made as of the completion of construction of the addition. Land or land improvements previously included in a facility's appraisal will not be reappraised in determining value of an addition to a facility;

4. For replacement facilities beginning operation on or after January 1, 1978, the value of additional land acquired or additional land improvements made as of the completion of construction. Land or land improvement included in the original facilities appraisal will not be reappraised in determining value of a replacement facility;

5. Land and land improvement value will be subject to reasonable limits with respect to:

- i. Reasonable land area;
- ii. The total reasonable appraised value of reasonable land area.

6. Reasonableness limits for land and land improvements will be the same as defined for property taxes on land in N.J.A.C. 10:63-3.7. For NF's beginning operation on or after January 1, 1978, the original reasonableness limit for reasonable appraised value will be increased by a factor for inflation, which factor will be the same as described in N.J.A.C. 10:63-3.11(d)2. For acquisitions of land related to addition(s) to building or building replacements, a single weighted reasonableness limit for the entire NF land evaluation will be calculated based upon acreage and the appraisal land limit factors of land as originally appraised, and the land-appraised addition(s) to land.

(b) The applicable interest rate developed for a facility per N.J.A.C. 10:63-3.11(f) will be applied to the reasonable appraised land value.

(c) The provisions of N.J.A.C. 10:63-3.11(l) through (m) will also apply to CFA for land.

(d) For LTCF's providing residential or sheltered care, reasonable appraised values for land will be prorated to nursing care patients based upon their proportion of base period total beds. This proportion will not be redetermined in the absence of significant changes in patient mix.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

(d) added "re" to determined.

Recodified from 10:63-3.11 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

10:63-3.13 Moveable equipment

(a) The moveable equipment allowance will be based upon the median requirements per bed at 1977 price levels. This median will be determined by:

1. Selecting new NFs built since 1969 which had over 20 percent Medicaid days in the base period.
2. Incrementing their original expenditures for moveable equipment to 1977 price levels by applying an appropriate index of inflation in equipment costs.

3. Converting these inflated expenditures to cost per bed and ranking Statewide.

(b) The allowance per licensed bed will be determined by applying to this median cost the applicable interest rate developed per N.J.A.C. 10:63-3.11(f).

(c) Inasmuch as this allowance will be based upon the current replacement cost of new equipment, it will be deemed to provide for unusually large expenditures for maintaining old equipment (the departments consider it to be purely a management prerogative as to when to replace, rather than repair, old equipment). A provision for ongoing routine equipment maintenance and replacements will be included in the maintenance and replacements allowance as described in N.J.A.C. 10:63-3.14.

As amended, R.1974 d.573, effective December 16, 1984.
 See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).
 Recodified from 10:63-3.12 and amended by R.1994 d.624, effective January 3, 1995.
 See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).
 Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).
 See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

10:63-3.14 Maintenance and replacements

(a) An allowance for the maintenance of land, land improvements, building and equipment and for replacement of equipment will be developed for Class I and Class II facilities and each type of Class III facility as follows:

1. Expenditures for this purpose in the base period for Class I, Class II and each type of Class III of NF which had over 20 percent Medicaid days in the base period will be adjusted to price levels at the midpoint of the base period through the application of the inflation factor to reported costs for fiscal years ending prior to December. Class III NFs will not be excluded due to percentage of Medicaid days.

2. Homes which were substantially expanded or modernized during this period will be excluded from calculations described in (a)3 below.

3. For the remaining NFs, maintenance and replacement costs per plant square foot at base period price levels will be calculated for each class of NF. Mathematical techniques will be used to determine a general formula describing the relationships between expenditures per plant square foot for maintenance and replacements and factors such as age of buildings, estimated building replacement costs, and so forth.

4. The 15 percent highest and 15 percent lowest extremes in actual expenditures compared with this general formula will then be removed from further calculations, except for Class III NFs. The same mathematical techniques will then be applied to the remaining 70 percent of the data to develop the formula to be used to calculate a reasonable allowance for each class of NF for maintenance and replacement.

5. Seventy percent of the costs of leasing equipment will be recognized as "maintenance and replacement" costs.

6. Each NF's maximum total allowance per reasonable plant square foot for any one year will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. 10:63-3.7(a)1, 2 and 3.

i. For Class III NFs which are approved as a combination of Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. 10:63-3.3(a)3ii, the reasonable limit for maintenance and replacements will be determined by multiplying the current costs of maintenance and replacement attributable to each type of SCNF patient times the respective cost per square foot maintenance and replacement cost limits. The products will be totalled, and then divided by the total current cost of maintenance and replacement expenses. The resulting combined cost limit will then be multiplied by the reasonable long term care square feet of the SCNF to determine the maintenance and replacement screen.

	(1)	(2)	(3)
	Cost	Limit	Total
Vent	A	C	E
Other	B	D	F
Total	G		H

Weighted limit per square foot = H/G.
 Total reasonable limit = Weighted limit × Square feet.

7. Base period expenditures in excess of this minimum allowance may be carried forward and applied in future years in which expenditures are below their respective maximum allowance.

i. Actual expenditures that are below the limits for the base period, may be carried and applied to excess expenditures in subsequent years. The following example illustrates how two typical NFs would be affected. Savings are indicated in parentheses, for example, (20.00) means a savings of \$20.00.

Year No. 1	NF A	NF B	
Actual expenditures	\$130.00	\$ 80.00	
Limit	100.00	100.00	
Excess (savings) carried forward	30.00	(20.00)	
Year No. 2	NF A	Example 1	Example 2
Actual expenditures	\$ 60.00	\$ 85.00	
Carried forward	+ 30.00	+ 30.00	
Total eligible	90.00*	\$115.00	
Limit	105.00	\$105.00	
Carried forward to Year No. 3	\$(15.00)	\$ 10.00	
Year No. 2	NF B	Example 1	Example 2
Actual expenditures	\$120.00	\$130.00	
Limit	\$105.00	\$105.00	
	NF A	NF B	
Plus carried forward	+ 20.00	+ 20.00	

Revised limit	\$125.00	\$125.00
Carried forward to Year No. 3	\$ (5.00)	\$ 5.00

* Included in rates

8. Expenditures for replacements, capitalized maintenance and leases will be prorated to nursing patients, based upon the ratio of nursing square feet (including a prorated share of common areas) to total plant square feet.

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

(a)1: Deleted old text and substituted new text.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.13 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

10:63-3.15 Property insurance

(a) An allowance for property insurance will be developed for each home as follows:

1. Base period property insurance costs per dollar of appraised value and per dollar of 1977 replacement costs will be calculated for all Class I NFs. Separate calculations will be made for Class II facilities and each type of Class III facility.

2. Mathematical techniques will be applied to this data to develop formulas describing the normal relationships between property insurance costs and appraised values and estimated replacement costs. Separate formulas will be developed for urban and non urban NFs.

3. The procedures described in N.J.A.C. 10:63-3.14 will be used to eliminate extremes and to develop the formula to be used to calculate the reasonableness limit for property insurance, except for the calculation of Class III limits.

4. Each NF's reasonableness limit per reasonable plant square foot will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. 10:63-3.7(a)1 and 2.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Added text in (a)1 "A separate calculation will be made for governmental facilities."

Recodified from 10:63-3.14 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

10:63-3.16 Target occupancy levels

(a) A target occupancy level of 95 percent of licensed bed-days (excluding quiet beds) will be used to develop the reasonable per diem amounts of the following rate components:

1. Property taxes;
2. Utilities;
3. Special amortization;
4. CFA for:
 - i. Buildings and building equipment;
 - ii. Land and land improvements;
 - iii. Moveable equipment;
 - iv. Maintenance and replacements;
 - v. Property insurance; and

5. Actual NF expenses for depreciation, rental, interest, and amortization in accordance with N.J.A.C. 10:63-3.10(c).

(b) For Class III NFs, if the base period Medicaid occupancy is 80 percent or greater, the target occupancy for the rate components in (a) above will be 90 percent.

(c) For rates implemented on or after July 1, 2000, target occupancy shall be calculated as follows:

1. For those nursing facilities that are at or above 90 percent occupancy, the reasonable base period costs shall be divided by actual base period patient days.

2. For those nursing facilities that are above 85 percent but below 90 percent as documented in the NF cost report, a review of the previous year's occupancy shall determine which of the two following options shall be used:

i. If the previous year's occupancy is at or above 90 percent, the reasonable base period costs shall be divided by actual base period patient days.

ii. If the previous year's occupancy is also less than 90 percent, the reasonable base period costs shall be divided by 90 percent of licensed bed days.

3. For those nursing facilities that are below 85 percent occupancy, the reasonable base period costs shall be divided by 90 percent of licensed bed days.

4. Actual base period patient days shall include paid bed hold days.

(d) For new Class I and Class II facilities an occupancy rate of 80 percent will be used for provisional rates during the first year of operation subject to retroactive adjustments to actual occupancy should it exceed 80 percent (but no higher than 95 percent will be used).

(e) For new Class III NFs, an occupancy rate of 80 percent will be used for provisional rates during the first year of operation. The retroactive adjustment from an interim to an actual rate for the first year of operation shall use actual occupancy should it exceed 80 percent (but no

higher than 95 or 90 percent will be used, as determined by (a) or (b) above).

(f) If base period patient days exceed licensed bed days calculated per (a) above, then the target occupancy will be entered at 95 percent of actual base period patient days.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

"Target" substituted for "largest".

Recodified from 10:63-3.15 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1999 d.74, effective March 1, 1999.

See: 30 N.J.R. 3191(a), 31 N.J.R. 678(b).

Rewrote (c).

10:63-3.17 Restricted funds

(a) Where donor restricted funds have been expended for operating purposes and, accordingly have been reported as an expense recovery/elimination, the availability and use of such funds will not be taken into account in establishing rates to the extent that they produce actual unit costs below the median unit costs and NF's developed for determining reasonableness. (It should be noted that the availability or use of such funds will not be taken into account at all with respect to CFA calculations.)

(b) The intent of this provision is to exclude, in screening, expenditures made from donor-restricted funds, but not to "appropriate" such funds where they result in net costs below the median.

Recodified from 10:63-3.16 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Case Notes

Hiring of contract nurses not mandated; adjustment for costs not required. *Morristown Rehabilitation Center Inc. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 10.

10:63-3.18 Adjustments to base period data

(a) As described elsewhere in this subchapter, with the exception of capital items, rates will be based upon reasonable actual base period costs. This section provides for adjustments to reasonable base period costs in establishing prospective rates.

1. Appropriate adjustments will be made to reasonable base period costs for the effect of changes between the base period and the prospective rate period in:

- i. State or Federal standards of care;
- ii. Definitions of "routine patient care services" reimbursable in Medicaid per diems;

iii. Limitations on total or per diem amounts of special patient care services reimbursable in Medicaid per diems.

2. NFs may also request that cost in addition to base period expenditures be included in the prospective rates owing to:

i. Actions mandated by governmental authorities and/or approved by same in the certificate of need process ("legal" changes):

ii. Desires to increase the quality of care above that attainable at base period cost levels ("management" changes).

iii. Appointment of a special medical guardian required to authorize emergency medical treatment for a patient.

iv. Emergency evacuation of a facility which was conducted consistent with an Emergency Management Evacuation Procedure which has been duly adopted and fully implemented by the facility. Costs in additions to base period expenditures for emergency evacuation shall be only those extraordinary costs which are directly related to evacuation, and routine costs which exceed base period levels as a direct result of the emergency evacuation.

3. With respect to requests for management changes, the departments will take the position that it is not a prerogative of a rate setting body to unilaterally make or amend social policies, especially with respect to the appropriateness of current allocations of State resources to the care of indigent NF patients. Accordingly, in the absence of other compelling reasons, management changes will be approved only in areas where quality has been found to be marginal by health facility inspection and actual costs are commensurately low.

4. Where legal and management changes have been approved and the approved costs are not expended in the prospective rate period, the unspent amount will be recovered from the NF.

5. In the case of significant items, the departments may exclude the effects of legal and management changes from rates until the change is effected, and if necessary, new appraisals made.

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Deleted (a)4 and recodified (a)5 to (a)4.

Amended by R.1986 d.69, effective March 17, 1986.

See: 17 N.J.R. 1736(a), 18 N.J.R. 561(a).

(a)4 added; old (a)4 renumbered to (a)5.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

(a)4 added.

Recodified from 10:63-3.17 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Case Notes

Inflation factor calculation valid and reasonable (Director's Final Decision). In re: Waterview Nursing Home, 8 N.J.A.R. 231 (1981), affirmed per curiam Dkt. No. A-3363-80 (App.Div.1982).

10:63-3.19 Inflation

(a) A provision will be added to reasonable base period costs to provide for inflation/deflation between the base

period and the prospective rate period. Changes in two factors will be used to develop this provision.

1. Average hourly earnings of manufacturing employee in New Jersey as published by the Bureau of Labor Statistics (weighted 60 percent);

CHAPTER 69

AFDC-RELATED MEDICAID

Authority

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193; the Balanced Budget Act of 1997, Public Law 105-33; Section 1902(a)8, 1902(a)10, 1902(c) and Section 1931(a) of the Social Security Act (42 U.S.C. § 1396a(a)8, 1396a(a)10, 1396a(e) and 1396u-1(a) respectively); 42 C.F.R. 435.2 through 435.170 and 436.100 through 436.128; N.J.S.A. 30:4D-1 et seq.; N.J.S.A. 44:10 -3, P.L. 1997 c.13, 14, 37, 38 and 352.

Source and Effective Date

R.1999 d.233, effective July 19, 1999.
See: 31 N.J.R. 1009(a), 31 N.J.R. 1960(a).

Executive Order No. 66(1978) Expiration Date

Chapter 69, AFDC-Related Medicaid, expires on July 19, 2004.

Chapter Historical Note

Chapter 69, Reimbursement to Pharmaceutical Consultants in Long-Term Care Facilities, was adopted as R.1976 d.6, effective January 9, 1976. See: 7 N.J.R. 504(a), 8 N.J.R. 70(c).

Chapter 69, Reimbursement to Pharmaceutical Consultants in Long-Term Care Facilities, was repealed by Emergency Repeal R.1976 d.216, effective July 12, 1976. See: 8 N.J.R. 385(c).

Chapter 69, Hearing Aid Assistance to the Aged and Disabled, was adopted as new rules by R.1988 d.250, effective June 6, 1988. See: 20 N.J.R. 519(a), 20 N.J.R. 1220(a).

Pursuant to Executive Order No. 66(1978), Chapter 69, Hearing Aid Assistance to the Aged and Disabled, was readopted as R.1993 d.281, effective May 14, 1993. See: 25 N.J.R. 228(a), 25 N.J.R. 2589(a).

Pursuant to Reorganization Plan No. 001-1996, Chapter 69, Hearing Aid Assistance to the Aged and Disabled, was recodified as N.J.A.C. 8:83B, effective October 15, 1997. See: 29 N.J.R. 4679(a).

Chapter 69, AFDC-related Medicaid, was adopted as new rules by R.1999 d.233, effective July 19, 1999. See: Source and Effective Date.

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SUBCHAPTER 1. AFDC-RELATED MEDICAID IN NEW JERSEY

10:69-1.1 Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, enacted August 22, 1996, implemented Federal welfare reform. The new Federal law eliminated the Aid to Families with Dependent Children (AFDC) program and created a Temporary Assistance for Needy Families (TANF) block grant for states to provide time-limited cash assistance. New Jersey's block grant program is established as Work First New Jersey (WFNJ) in accordance with the Work First New Jersey Act, P.L. 1997, c.13, c.14, c.37 and c.38. P.L. 104-193 also required that the regulations governing a state's eligibility for AFDC-related Medicaid in effect in the State as of July 16, 1996, must continue to determine eligibility for AFDC-related Medicaid. This chapter is the continuation of the appropriate AFDC-related Medicaid rules.

10:69-1.2 Purpose and scope

The purpose of this chapter is to set forth the policies and procedures necessary for the orderly and equitable provision of AFDC-related Medicaid on a Statewide basis. It is binding on the county boards of social services (CBOSSs) and enforceable by the Division of Medical Assistance and Health Services (DMAHS). Questions of interpretation shall be resolved by the Division of Medical Assistance and Health Services.

10:69-1.3 Administrative organization

(a) The Department of Human Services is the administrative unit of State government which has the responsibility for the Medicaid program and is designated under Federal law as the "single State agency."

(b) The Division of Medical Assistance and Health Services is the administrative unit of the Department responsible for the general policies governing the administration of medical assistance, and for effecting the issuance of rules and administrative bulletins to implement statutory provisions and to coordinate the administration of medical assistance with the Division of Family Development. The Division of Medical Assistance and Health Services provides for the payment of claims, evaluates health services rendered under the program, maintains administrative liaison with the other Departmental divisions, and establishes incapacity under the AFDC-related Medicaid program.

(c) The Division of Medical Assistance and Health Services has local Medicaid District Offices (MDOs) throughout the State. The role of these offices is to act as a liaison with providers of health services; provide information about Medicaid to beneficiaries and members of the community; and provide information about Medicaid to, and cooperate with, appropriate agencies in order to ensure maximum utilization of the services available through the Medicaid program.

10:69-1.4 AFDC-related Medicaid

(a) The AFDC-related Medicaid program is a State program with Federal participation. It is designed to make payments to providers for medical care and services on behalf of certain individuals whose income is determined to be inadequate to enable them to secure quality medical care at their own expense.

(b) The Aid to Families with Dependent Children-related Medicaid program is composed of three segments:

1. AFDC-C related Medicaid, through which medical assistance is provided for children and their natural or adoptive parents or certain designated relatives with whom they were living, when they are financially eligible and deprived of parental support and care by reason of death, continued absence, or incapacity of one or both parents;
2. AFDC-F related Medicaid, through which medical assistance is provided to families with children when both parents are in the home, neither is incapacitated and the principal earner meets the Federal definition of unemployment; and
3. AFDC-N related Medicaid, through which medical assistance is provided to families with children when both parents are in the home and are not incapacitated but have inadequate income for support of the family.

(c) Information, applications and staff agency personnel shall be available to assist non-English speaking applicants for AFDC-related Medicaid income maintenance programs listed in N.J.A.C. 10:69-1.8. Spanish language program material is routinely prepared by the Division and distributed to county agencies. Minority program materials in languages other than Spanish may be prepared based on knowledge of the population served by programs under the auspices of the Division.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (a), substituted "income is" for "resources are" preceding "determined"; and in (b)3, deleted a reference to resources.

10:69-1.5 Definitions

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

"Adequate notice" means notice to a client of the county board of social services (CBOSS) decision or action which must state the nature, effective date, factual and legal basis of the decision or action, and the right to a fair hearing.

"Adjusted gross income" means, in self-employment, the net income as determined by subtracting the cost of producing the income from total gross earnings.

"AFDC" means the former Aid to Families with Dependent Children.

"AFDC-related Medicaid" means medical assistance provided to families who would otherwise qualify for AFDC or deemed to qualify for AFDC if the program were still in existence.

"Agency" means the county board of social services.

"Applicant" means parent or parent-person who applies for AFDC-related Medicaid and whose application has not been officially acted upon by the CBOSS.

"Application process" means all activity performed by the eligibility staff until there is an official disposition of the application.

"Approved application" means an applicant has been determined to be eligible for AFDC-related Medicaid.

"Authorized representative" means an individual (or organization) whom a client designates orally or in writing to act on his or her behalf, or, in cases of incompetency, the person designated to act for the client.

"Beneficiary" means the family unit of parent(s) or parent-person(s) and child(ren) of eligible age who have been found eligible for AFDC-related Medicaid including any individual who is an eligible member of such family.

"Boarder, roomer, roomer-boarder" means a person, other than a member of an eligible unit, whose acceptance in the household is a business arrangement based upon payment in cash for board, room, or room and board.

"BQC" means the Bureau of Quality Control in the Division of Medical Assistance and Health Services.

"Calculated earned income" means amount of earned income remaining after applicable disregards and deductions have been subtracted from total gross earnings. This is the accountable amount to be used in determining the eligible unit's total income.

"Capacity of a legally responsible relative (LRR) to support" means the amount of contribution to be anticipated from an LRR.

"Caretaker relative" means the legally responsible adult or adults residing with the children for whom the application for presumptive eligibility is being made. This definition is used for application of presumptive eligibility only (see N.J.A.C. 10:69-12).

"Carnegie unit" means the credit given for the successful completion of one year's study in one subject in a secondary school. Four Carnegie units per year represents full time attendance.

"Case record" means the official file of forms, chronological narrative, correspondence and other documents pertinent to the application and eligibility of client case record. It constitutes a complete record which supports the decisions and actions of the CBOSS on a case.

"Categorical program" means a program established by the Federal Social Security Act for the purpose of enabling a state to furnish assistance to financially eligible individuals or families who meet specific eligibility requirements.

"CBOSS" means the county board of social services.

"CBOSS Director" means the county board of social services Director or staff member to whom he or she has delegated specified responsibility.

"Child born of unmarried parents" means a child born to a mother who is not married to the father of such child.

"Child of eligible age" means a child up to the age of 18 or a child up to the age of 19 if a full-time student in a secondary school, or in the equivalent level of vocational or technical training and reasonably expected to complete the program before reaching age 19.

"Client" means an all inclusive term including an applicant or beneficiary of Medicaid.

“Collateral investigations” means contacts with individuals other than members of the applicant’s immediate household made with the knowledge and consent of the applicant(s).

“County board of social services” means the county agency designated to administer the AFDC-related Medicaid program.

“County residence” relates only to identification of the CBOSS charged by law with responsibility for the official receipt, registration and processing of applications, and is not an eligibility requirement and does not limit the opportunity for any person residing in New Jersey to qualify for Medicaid.

“CSP” means Child Support and Paternity Program.

“DDD” means the Division of Developmental Disabilities.

“Denied application” means a determination that, for a specific reason, the applicant is ineligible for AFDC-related Medicaid.

“Dependent child” means an eligible child, living in New Jersey with a parent or other enumerated relative.

“Deprivation” means where death, incapacity or continued absence of one or both natural or adoptive parents causes the loss of parental support.

“Desertion” denotes a willful abandonment of duty in violation of a legal obligation; failure to provide support and maintenance or to perform other duties owed to the family members, thus depriving them of care.

“DFD” means the Division of Family Development.

“Dismissed application” means recognition that eligibility need not be considered further because the applicant moved to another state during the application process or cannot be located, or the application was registered in error.

“Disregards” means the amount of earned income discounted in the AFDC programs according to Federal and/or State regulations.

“Division of Employment Services (DES)” means the office within the State Department of Labor responsible for administration of Unemployment Insurance and Temporary Disability Benefits programs.

“Division of Medical Assistance and Health Services” means office within the State Department of Human Services responsible for supervision of the administration of the AFDC-related Medicaid program.

“DMAHS” means Division of Medical Assistance and Health Services.

“DVRs” means the Division of Vocational and Rehabilitation Services.

“DYFS” means the Division of Youth and Family Services in the Department of Human Services.

“Eligible medical institution” means a facility or specified section thereof certified as an approved institution for the purpose of treating acute illness (private or general hospitals) or providing care for the chronically ill (nursing homes or intermediate care facilities).

“Eligible unit” means those family members who apply for and are eligible to receive AFDC-related Medicaid.

“Emancipated” means a child released from the duty to serve and obey his or her parent(s) and having the right to his or her earnings. Emancipation may be expressed or implied from the circumstances.

“Family size” means, in an LRR’s household, those persons identified in N.J.A.C. 10:69-11.3 (members of the eligible unit are not included).

“Financially eligible” means meeting the income standards in this chapter.

“Gross earned income” means the total earnings of members of the eligible unit before applicable disregards and deductions are subtracted.

“Head of household” means the individual who is recognized by other members of the household as having primary responsibility for financial control and direction of the household.

“Incapacity” means physical or mental defect, illness or impairment, supported by competent medical testimony, of such a debilitating nature as to reduce substantially or eliminate the parent’s ability to support or care for the otherwise eligible child, which is expected to last for a least 30 days.

“Incompetent (certified)” means certified by a court of law as incompetent.

“Inquiry” means any request for information about assistance programs which is not a request for application.

“Institution in New Jersey” means a total facility, or a designated part thereof, that include the following:

1. Hospital—general or special;
2. Nursing facility (NF);
3. Public psychiatric or tuberculosis hospital;
4. Certified section of State operated institution for the mentally retarded; or

5. Intermediate care facility for the mentally retarded (ICF/MR).

“Institution outside New Jersey” means a public or voluntary medical institution which is licensed, certified or approved by the proper authority of the jurisdiction in which the institution is located, so that the costs of care and services provided therein may be paid. Evidence of such license, certification or approval shall be obtained from the Division of Medical Assistance and Health Services.

“LRR” means legally responsible relative.

“Mandatory payroll deductions” means Federal, State and city withholding taxes; Social Security; unemployment compensation taxes; and garnishments as verified by legal document in possession of the employer.

“MDO” means Medicaid District Office in the Division of Medical Assistance and Health Services.

“Medicaid” means a Federal/State program administered by the Division of Medical Assistance and Health Services providing for payment of claims for and evaluation of health services.

“Medicaid Special” means Medicaid coverage available to any dependent child under 21 or an independent child under age 21, who meets the qualifications at N.J.A.C. 10:69-4.

“Needy person” means a person who lacks sufficient income and resources to maintain the AFDC-related Medicaid level of living.

“New application” means the filing of an application request for AFDC-related Medicaid from an individual/family who has never previously requested AFDC-related Medicaid in any county in the State under that program.

“N.J.A.C.” means New Jersey Administrative Code.

“Noneligible person” means a person ineligible for AFDC-related Medicaid either due to age, relationship, or for incurring a penalty of ineligibility.

“Official discharge from an institution” means legal discharge of a patient from the institution in which he or she has been confined.

“Ownership of real or personal property” means any and all rights, title or interest, legal or equitable, to such property.

“Parent-minor” means a parent of a child or children who is himself or herself under the age of 18.

“Parent-person” means certain relatives of a child who, in the absence of a natural or adoptive parent, assume parental responsibility.

“Penalty of ineligibility” means when a member(s) of an eligible unit has incurred a penalty for not complying with program requirement(s) and such member(s) is excluded from the eligible unit.

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

“Per capita” means an amount equal to one individual’s share of the total (allowance, cost, income, etc.).

“Personal interview” means face-to-face discussion between individuals.

“Policy” means guidelines, limited by and consistent with law, which control CBOSS and DMAHS staff in carrying out AFDC-related Medicaid programs.

“Primary wage earner” means principal earner and shall be referred to as the principal earner in this chapter.

“Principal earner” means the parent who earned the greater amount of income in the 24-month period immediately preceding the month of application for AFDC-F or -N.

“Reapplication” means a written request for AFDC-related Medicaid by an individual who has previously applied for, but never received, AFDC-related Medicaid under that program in any county in the State.

“Recovery” means the process whereby the CBOSS seeks the repayment of AFDC-related Medicaid improperly or properly obtained.

“Redetermination of eligibility” means investigation of all facts and circumstances relating to the beneficiary’s application for continuation of AFDC-related Medicaid.

“Referral” means a request from an agency, institution, or individual on behalf of another individual who is interested in applying for AFDC-related Medicaid; or a request from the CBOSS to another agency.

“Registration” means the action of the CBOSS in creating an official record of and assigning a control number to an application.

“Rejected application” means an inclusive term covering applications which have been denied, dismissed, or withdrawn.

“Relatives, legally-responsible” means relatives held to be legally responsible by the laws of this State, as identified in N.J.A.C. 10:69-3.

“Release without discharge” means an arrangement under which a patient in an institution is, for a special purpose, permitted to reside outside the institution, and includes extended visit and convalescent leave.

“Reopened application” means a written request for Medicaid by an individual who has previously received AFDC-related Medicaid under that program in any county in the State.

“Request for local administrative review” means any clear expression (oral or written, by letter or otherwise) by a client or his or her authorized representative that he or she wishes to present his or her case in a proceeding before the CBOSS director or his or her delegated representative. This is not to be confused with a request for a fair hearing.

“Resident” means a person who is living in the State for other than a temporary purpose and who has no intention of moving from the State.

“Retirement, Survivors and Disability Insurance (RSDI)” means the Federal program administered by the Social Security Administration (SSA) which provides protection to workers and their families against loss or stoppage of earnings resulting from retirement at age 62 or older, death or disability.

“Return to state of origin” designates the desire of a family who has resided in New Jersey for a relatively short period to return to the state from which it came.

“RSDI” means Retirement, Survivors and Disability Insurance.

“Social Security payment” means RSDI benefit.

“Sponsoring adult” means an individual 18 or older, including the applicant or the adult with whom the applicant resides, who may assist in making an application for presumptive eligibility. This definition is used for the application presumptive eligibility only (see N.J.A.C. 10:69-12).

“Spouse” means a husband or wife of a specified individual.

“SSA” means the Social Security Administration.

“SSI” means the Federal Supplemental Security Income Program, including State supplemental payments administered through this program for aged, blind or disabled of any age.

“State institution” means any institutional facility for the mentally ill or retarded, penal institution or veteran’s hospital under the jurisdiction of the State of New Jersey.

“Total income” means the sum of all recognized income of the eligible unit, including unearned and calculated earned income.

“Transfer application” means a request for AFDC-related Medicaid for an individual who is presently receiving AFDC-related Medicaid under the same program in another county within the State.

“Vendor payment” means a check drawn to the order of a person or facility for providing goods or services to or for the client, representing payment for such goods or services.

“Withdrawn application” means an oral or written request by an applicant that the CBOSS terminate its activity on his or her application.

Amended by R.2000 d.266, effective July 3, 2000.

See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

Added “Caretaker relative” and “Sponsoring adult”.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In “Financially eligible”, deleted “and/or resource” preceding “standards”; in “Noneligible person”, deleted “excess resources,” preceding “age”; and deleted “Available resource”, “Exempt resource”, and “Potential resource”.

SUBCHAPTER 2. THE APPLICATION PROCESS

10:69-2.1 General provisions

(a) Any person who believes he or she and his or her children are eligible for AFDC-related Medicaid shall be given the opportunity to apply without delay. Applicants shall be informed by the county board of social services about the eligibility requirements and their rights and obligations in applying for and receiving assistance. The decision to apply rests with the applicant. The applicant has the right to withdraw the application before eligibility or ineligibility has been determined.

(b) County board of social services staff shall move with all reasonable speed in accepting, processing and recommending action on applications for assistance. If an applicant is eligible, an AFDC-related Medicaid Eligibility Card shall be issued as eligibility is established. The agency’s standards of promptness for acting on applications or re-determining eligibility shall not be a basis for delay in granting AFDC-related Medicaid.

(c) This subchapter describes briefly the steps followed by the eligibility determination worker in determining an applicant’s eligibility to receive AFDC-related Medicaid.

10:69-2.2 Provisions governing the initial contact

(a) The application process begins with an individual’s initial contact with the agency and ends with a decision by the county board of social services as to the eligibility for Aid to Families with Dependent Children related Medicaid (AFDC-related Medicaid). Both the applicant and the eligibility worker have an affirmative responsibility in verifying and documenting eligibility.

(b) Initial contact may be an inquiry, a referral or an application:

1. Inquiry means any request for information about medical assistance programs, which is not a request for an application. A record is necessary only when the inquiry requires follow-up action.

2. Referral means a request from a public or private agency or individual for medical assistance on behalf of another individual. All referrals shall be recorded with appropriate facts, and the disposition noted.

3. Application means a written request for AFDC-related Medicaid by natural or adoptive parent(s), parent-person(s), parent-minor, or responsible person acting on his or her behalf.

(c) There are five types of application:

1. A written request for medical assistance by an individual who has never previously applied under that program in any county in the State;

2. A written request for medical assistance by an individual who has previously applied for, but never received, assistance under that program in any county in the State;

3. A written request for medical assistance by an individual who has previously received assistance under that program in any county in the State, that is, a reopened application;

4. A written request for medical assistance from an individual who is presently receiving AFDC-related Medicaid under the same program in another county in the State; and

5. AFDC-related Medicaid applicants may be eligible for retroactive Medicaid benefits. The eligibility worker shall ask if the family has unpaid medical bills from the three months prior to the month of application and will provide the applicant with appropriate forms.

10:69-2.3 Purpose and scope of first contact

(a) The responsibility of the agency during the initial contact shall include, but not be limited, to:

1. Determining and explaining the medical assistance program for which the client may be eligible and informing the client how and where to apply;

2. Advising individual of general requirements of the application process, for example, the necessity of contacting certain relatives and of certain other collateral contacts with an explanation of the right of the applicant to confidentiality and to be primary source of information. The application form includes a blanket consent statement. The client should be informed that he or she is consenting to have the county board of social services (CBOSS) contact others by signing this form. The applicant is also required to sign a waiver allowing the CBOSS to obtain State income tax information. The eligibility worker shall specifically advise each applicant that by signing the waiver he or she is granting such an authorization. In addition to such oral explanations, the individual shall be provided with the pamphlet, Medicaid Rights and Responsibilities;

3. Advising individual that Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination in determining eligibility for AFDC-related Medicaid;

4. Determining whether the individual does indeed wish to apply with full understanding of the need to verify essential eligibility factors and the requirement for a personal interview;

5. Taking the application without delay; and

6. Advising a pregnant woman that she may make application for New Jersey Care ... Special Medicaid Programs.

10:69-2.4 Completion of forms

(a) The applicant will be fully assisted by the eligibility worker or by any person of his or her choice in completing the Application and Affidavit for AFDC-related Medicaid (PA-1J). Form PA-1J is used to apply for AFDC-related Medicaid.

(b) The applicant's signature(s) and the date of application are required. The PA-1J requires three signatures of the applicant(s). In addition to the first page and the affidavit, the applicant(s), with the exception of non-needy parent-persons who do not request medical assistance for them, shall sign a release which authorizes the CBOSS to obtain State income tax information.

1. In AFDC-C-related Medicaid, a written application and the authorization to obtain State income tax information is to be signed under oath by the applicant himself or herself or, when the applicant is incapacitated or alleged incompetent (N.J.A.C. 10:69-3.12(b)), by someone acting responsibly for him or her.

i. When both parents are in the home, both shall be required to sign the application and the authorization to obtain State income tax information except that if a parent is unavailable to sign the application and the authorization to obtain State income tax information for reasons beyond the family's control, one signature will suffice. In that event, the non-signatory parent shall be required to annex his or her signature as promptly as he or she is available for such purposes.

ii. A non-needy parent-person who does not make application for AFDC-related Medicaid for himself or herself is required to sign the application but is not required to sign the authorization to obtain State income tax information. This exception does not apply to natural or adoptive parents.

2. In AFDC-F and -N, a written application and the authorization to obtain State income tax information shall be completed and signed by both parents. If one parent is unavailable to sign the application, see (b)1i above.

(c) The eligibility worker shall review the application to make sure it is complete and to check any apparent discrepancy or confusion in the information provided by the applicant with him or her, arriving at a resolution if possible in order to process the application.

(d) The application shall be registered immediately and a number assigned in the series designed for the applicable program. A reapplication or reopened application shall be assigned its previous number if within the same county.

10:69-2.5 Registration of applications

(a) Official registration of an application shall include:

1. Entry in an application register under appropriate classification; and
2. Assignment of a registration number.

(b) Registration shall be completed on the same day application is made, or, if application is made outside the CBOSS office, registration shall be completed within three working days.

10:69-2.6 Eligibility for Aid to Families with Dependent Children (AFDC)-related Medicaid

(a) Eligibility for AFDC-related Medicaid is based upon certain criteria such as age, relationship, residence in the State, alien status and upon other criteria relevant to each segment.

(b) Eligibility for the AFDC-C-related Medicaid segment is based on financial need and deprivation of parental support and care by reason of mental or physical incapacity, absence or death of one or both parents.

(c) Eligibility for the AFDC-F segment is based on financial need when both parents are in the home, neither is incapacitated and the parent who is the principal earner meets the Federal definition of unemployment.

(d) Eligibility for the AFDC-N-related Medicaid segment shall be determined when both parents are present in the home and are not incapacitated, there is insufficient income for support of the family and the family does not meet the Federal criteria for the AFDC-F segment.

(e) All AFDC-F and -N clients shall be advised that their eligibility for these segments is based on the fact that there are two parents who are not incapacitated in the home and that, if a parent dies, becomes incapacitated or leaves the household, this fact should be brought to the attention of their eligibility worker so that an application for AFDC-C-related Medicaid and/or referral to SSI can be considered.

(f) Income standards for persons eligible under the AFDC-C-related Medicaid, -F-related Medicaid and -N-related Medicaid appear in Schedule II or III, as appropriate, at N.J.A.C. 10:69-10.3.

Special amendment, R.2000 d,411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (d), deleted "or other resources" following "insufficient income".

10:69-2.7 Financial need

The eligibility worker shall determine financial eligibility (need) of the eligible family members by Form 105, if appropriate, in accordance with this subchapter.

10:69-2.8 Eligibility factors other than need

(a) In verifying eligibility, the eligibility worker shall take whatever action is necessary to assure that all relevant documentation is promptly obtained. The eligibility worker shall assist in obtaining verification documentation if the applicant requests help. The applicant shall cooperate fully consistent with his or her rights including confidentiality and consent.

(b) The eligibility worker shall explain to the applicant that children up to the age of 18 and children up to the age of 19 if they are full-time students in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19 are eligible for AFDC-related Medicaid. Program completion is defined as the day of ceremonial graduation.

(c) The relationship between adoptive parent and child(ren) in AFDC-related Medicaid is as follows:

1. The eligibility worker shall explain to the applicant that in order to apply for AFDC-related Medicaid, he or she shall be either the natural or adoptive parent or eligible to serve as a parent-person of the eligible child(ren). An applicant who is a parent-person has the option of applying either for the child(ren) or him or herself as a needy parent-person, or for the child(ren) only. The advantages and disadvantages of each option shall be thoroughly discussed.

2. The eligibility worker shall explain that for AFDC-F and -N segments the child(ren) shall be natural or adoptive to the two parents who are applying.

3. If not eligible for AFDC-related Medicaid, eligibility for any Medicaid program shall be explored.

(d) Rules concerning Social Security numbers are as follows:

1. The AFDC-related Medicaid applicant shall supply the CBOSS with the Social Security number of each member of the eligible unit or apply for a Social Security number for any such person who does not already have one (see (d)3 and 5 below).

2. The eligibility worker shall record, in the appropriate spaces on FAMIS Form 105 and Form PA-1J (Application and Affidavit for AFDC-Medicaid related), the Social Security number of each person who is included in the AFDC-related Medicaid case.

3. The CBOSS shall obtain a supply of Social Security Form SS-5, sufficient to accommodate all AFDC-related Medicaid applicants and eligible individuals that do not already have Social Security numbers. Upon application for AFDC-related Medicaid, the applicant shall be required to sign as many SS-5 forms as needed for the eligible family. The eligibility worker shall complete Form SS-5 on the basis of information provided by the applicant. Completed forms shall be forwarded to the county's respective Social Security Administration District Office (SSA/DO). A copy of the SS-5 form shall be retained in the case record, and a copy given to the client if so requested.

i. The eligibility worker shall record in the case record the date upon which Form SS-5 was prepared.

ii. If any applicant refuses to provide or apply for the appropriate Social Security number(s), the CBOSS shall declare such person ineligible for AFDC-related Medicaid benefits. The eligibility of that individual shall be terminated in accordance with N.J.A.C. 10:69-2.15.

(1) For a "newborn" child, whose birth certificate may not be readily available, the completion time for the SS-5 is extended to the first day of the second month after the birth of the child.

(2) A signed and certified hospital document may be accepted in lieu of a birth certificate, provided that it contains the same information that would appear on a birth certificate, that is, child's name, date of birth, place of birth, mother's name, mother's residence, and father's name.

iii. AFDC-related Medicaid applicants who are legal residents of the United States in accordance with the provisions of the U.S. Immigration and Naturalization Service (INS), but not United States citizens, shall have Form PA-55, County Board of Social Services Alien Referral to Social Security (SSA) District Office for Social Security Number Application, processed at the SSA/DO in order to be enumerated.

(1) For enumeration purposes, not all U.S. born individuals are U.S. citizens. These individuals may include former U.S. citizens who are now citizens of another country. Additionally, children of foreign diplomats or other temporary aliens who are born in the U.S. while their parents are in the U.S. are considered citizens of the parents' home country. Such individuals shall not be referred to the SSA/DO unless the individual is a legal U.S. resident as stated above.

(2) Form PA-55 is to be used to refer legal residents of the United States as determined by the Immigration and Naturalization Service, who are not U.S. citizens, to the SSA/DO. Liaisons in the SSA/DO have been instructed to return the bottom portion of that form to the specified CBOSS. For quality control purposes, the bottom portion of Form PA-55 is to be filed in the case record and shall serve as acceptable documentation that the individual has applied for a Social Security number.

(3) Each CBOSS is to create a tickler file to monitor the flow of referral forms (PA-55s) and receipts of acknowledgment (bottom portions of Form PA-55). Immediately upon receipt of such acknowledgment, CBOSSs shall input the filing date of the SS-5 form on the 105 form, thereby providing tracking for the issuance of Social Security numbers, and file the acknowledgment in the case record.

4. Procedures for verifying Social Security numbers are as follows:

i. The CBOSS shall verify the Social Security numbers (SSNs) provided by the eligible family with the Social Security Administration (SSA) by submitting them through FAMIS. Benefits shall not be denied, delayed or terminated for an otherwise eligible family pending SSN verification. Once the SSNs have been verified, the CBOSS shall make a permanent annotation to the case file to prevent unnecessary reverification of the SSN in the future.

5. AFDC-related Medicaid benefits shall not be denied, delayed, or terminated pending issuance or verification of a Social Security number so long as the applicant/beneficiary has complied with the provisions of (d)1 through 4 above.

6. Every applicant for and recipient of Medicaid benefits is required to furnish a valid Social Security number to the CBOSS as a condition of eligibility for Medicaid. Any applicant or recipient who does not already have a Social Security number shall be required to apply for same. In addition, (d)2 through 5 above shall apply to Medicaid recipients.

(e) Rules concerning enumeration at birth are as follows:

1. Participating hospitals have entered into an agreement with the New Jersey Department of Health and Senior Services, Bureau of Vital Statistics, to initiate the enumeration process for newborns while the parent is in the hospital at time of the birth. This process is undertaken through a program implemented by SSA entitled "Hospital Enumeration at Birth Project." This process is for the convenience of the parent and is optional.

10:69-2.14 Administrative action on application

The eligibility worker shall review all appropriate forms for completeness and accuracy, and give them to his or her supervisor. The supervisor shall examine the forms for consistency of applicant's statements, completion of all necessary information and correct income computations. If acceptable, the supervisor shall indicate his or her approval by signing. If not acceptable, the forms shall be returned to the eligibility worker for correction.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).
See: 32 N.J.R. 3598(a).

Deleted "and resource" following "correct income" in the second sentence.

10:69-2.15 Notice of approval, disapproval and pending status and other information to client

(a) If immediate need is not apparent and a decision of approval or disapproval is not reached within 30 days of application, the CBOSS shall notify the applicant in writing of this fact and the reason for the delay. If the lack of decision is due to circumstances within the control and knowledge of the applicant, the county board of social services shall remind the applicant of the steps he or she must take to enable the county board of social services to make a decision. This notice shall include a sentence in Spanish cautioning the client that it relates to his or her eligibility for AFDC-related Medicaid and if he or she does not understand the notice he or she should contact the CBOSS.

(b) When a decision is reached, the applicant shall be notified in writing of this decision (approved or disapproved).

(c) If the application is denied, the notice of disapproval shall meet the requirements in N.J.A.C. 10:69-6. In addition, for an applicant whose application has been denied for any reason other than death, the notification shall include:

1. An explicit statement of the reason for ineligibility;
2. A copy of the document entitled "Fair Hearings in the Aid to Families with Dependent Children Program";
3. Advice concerning the family's right to reapply whenever they believe that their circumstances have changed such that the stated reasons for ineligibility no longer exist; and
4. Information about the food stamp program and other potentially available services.

(d) If the application is approved, the client shall be advised in writing:

1. Of the effective date of Medicaid eligibility;
2. That an advance statement shall be sent at least 10 calendar days prior to implementation of any adverse decision affecting future eligibility;

3. Of the client's right to a fair hearing;

4. Of the client's rights and responsibilities under the program for which he or she has been approved (see N.J.A.C. 10:69-2.2(a)3 and 2.3(a));

5. Of his or her obligation to report all relevant changes in circumstances, including but not limited to, family size, income, employment, and change in parent-person status;

6. Of the use of the Medicaid Eligibility Card; and

7. That he or she may qualify for a number of additional services which the eligibility worker will describe briefly and explain where to apply for these services.

(e) Notification to a beneficiary whose application has been approved following change of residence from another county shall include a statement that:

1. The beneficiary has been found to be a resident of this county for purposes of Medicaid coverage; and
2. Future determination of eligibility will be made by this county board of social services (CBOSS) rather than by the CBOSS of the county of previous residence.

(f) When the coverage is based on an earnings projection (see N.J.A.C. 10:69-11.14), a notice shall be sent advising the client that the coverage for the next month will be terminated unless he or she provides wage verification as required. Such notice shall specify the date by which the verification must be received.

(g) Clients shall also be advised in writing that if he or she is dissatisfied with any action or inaction of the county board of social services, he or she may request a hearing. He or she shall be informed of the steps that are to be followed in making such a request in accordance with the requirements in N.J.A.C. 10:69-6.

(h) A client shall be provided a copy of the written application with any attachments upon request.

(i) In any case initially referred by, or known to be receiving assistance or service from, a public health or welfare agency, social service, legal services or other interested agencies, notice of disposition of the case or any aspect in which that organization has been involved shall be sent to such agency with the consent of the client in the following manner:

1. If, after thorough discussion of the medical coverage potentially available and the application requirements, the person definitely declines to apply, the interested agency shall be promptly informed.
2. If the person applies and the application is approved, the interested agency shall be notified as promptly as possible, including the date of Medicaid eligibility.

3. If the person applies and the application is denied, dismissed or withdrawn, the agency shall be promptly informed.

4. The interested agency shall be kept informed of any developments in a case so long as the issue involved is the same or related to the issue about which the agency has expressed interest unless the client withdraws his or her consent.

10:69-2.16 Withdrawal

(a) The agency shall officially recognize the applicant's action through written notification within five working days of the applicant's request for withdrawal.

(b) This notification shall include a statement that the applicant's decision has been recognized and recorded by the agency, that no further action is being taken on his or her application, and a reminder that he or she has the right to reapply at any time.

10:69-2.17 Dismissal of application when client cannot be located

When it is necessary to dismiss an application because an applicant cannot be located, a notice shall be sent to the person's last known address.

10:69-2.18 Verification

(a) Verification of facts essential to eligibility is required in all segments of the AFDC-related Medicaid program (see N.J.A.C. 10:69-3.2 through 3.7). The eligibility worker shall verify all income.

1. The CBOSS shall try to verify all necessary information within the required time but shall not penalize the client if the CBOSS, through no fault of the client, is unable to obtain documentation.

(b) The CBOSS shall verify the age of all children for whom application is made and their relationship to the natural or adoptive parent(s) or parent-person(s) with whom they live. (See N.J.A.C. 10:69-3.2 through 3.7.)

(c) The CBOSS shall verify the deprivation factor in AFDC-C related Medicaid.

1. The death of the parent(s) shall be verified.

2. Incapacity shall be validated through the medical review team's action expressed in Form PA-8.

3. Continued absence shall be verified in accordance with criteria in N.J.A.C. 10:69-3.

(d) The CBOSS shall verify school attendance in a school, college, training or vocational program of dependent children ages 16 to 19 at the time of application as an eligibility criterion of AFDC-related Medicaid (see N.J.A.C. 10:69-10.5(a) and 10.9).

(e) The CBOSS shall verify the client's county of residence, whether temporary or permanent. (See N.J.A.C. 10:69-3.29.)

(f) Earnings may be verified from voucher records or statements in writing submitted by the employed person, subject to additional verification as required by this chapter.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (a), deleted "and resources" at the end of the second sentence; deleted former (d); and recodified former (e) through (g) as (d) through (f).

10:69-2.19 Use of PA-1C as an application request

(a) Individuals who were admitted to a hospital and were subsequently referred to the CBOSS through the use of Form PA-1C, AFDC-related Medicaid Inquiry, may be eligible for AFDC-related Medicaid benefits from the date the PA-1C was completed, provided:

1. Such individual was an inpatient at the time the referral was made;

2. Except for good cause, including, but not limited to, hospitalizations lasting for three or more months, the homebound status of the applicant, the CBOSS was unable to schedule a timely application appointment, or the hospital failed to inform the applicant to apply at the CBOSS, the individual applies for AFDC-related Medicaid benefits within three months after the referral is made.

i. If the CBOSS determines that the individual had good cause for not applying within three months, an extension may be granted for an additional three months.

ii. Newborns of eligible women are deemed to have applied and shall be added to the Medicaid case, effective the date of birth, upon receipt of a valid Form PA-1C.

SUBCHAPTER 3. ESTABLISHING PROGRAM ELIGIBILITY IN AFDC-RELATED MEDICAID

10:69-3.1 Establishing eligibility for AFDC-related Medicaid

(a) This subchapter presents in detail the program eligibility factors that must be considered in making determinations related to the AFDC-C, -F and -N segments.

(b) A decision regarding eligibility shall be made within 30 days of application.

10:69-3.2 Documentation and recording of program eligibility requirements

Fundamental to the establishment of eligibility for AFDC-related Medicaid is the documentation of eligibility requirements.

10:69-3.3 Sources of evidence regarding eligibility

(a) Applicants and beneficiaries are in all instances the primary source of information about themselves and their families. It is the responsibility of the agency to determine eligibility and, as necessary, to secure verification from secondary sources. Such verification information shall be limited to those facts that are essential to establish eligibility and shall be obtained only with the consent of the client. It shall be explained to the client that verification is necessary and lack of consent to obtain it shall make processing of the application eligibility impossible.

(b) The client's statements regarding his or her eligibility are evidence. For purposes of AFDC-related Medicaid, the client's statements must be consistent and certain facts must be documented. The applicant shall be informed that the CBOSS needs to document the facts regarding certain eligibility criteria and that this process shall include contacting collateral sources as necessary:

1. Public records are preferred evidence and investigation of these sources shall be exhausted before other sources are used.

2. Sources of collateral evidence to establish eligibility include, but are not limited to, the following: birth, death and marriage certificates, church records, immigration and naturalization papers, census records, school records, military service records, court records, employment records, records of public or private welfare agencies, voting records, medical records, personal records, and affidavits from knowledgeable persons.

(c) Only evidence to corroborate facts essential to eligibility shall be sought. In determining the relative validity of the sources of evidence in (b), the agency should bear in mind the type and source of document.

(d) Affidavits shall be used only when other sources have failed or have produced inconclusive data. Documentation obtained in this manner shall be taken under oath from a person who has factual knowledge of the relevant circumstances. The affidavit shall show the circumstances under which this person has known the applicant as well as the factual basis of his or her statements relating to the applicable eligibility requirements.

(e) While it is usually desirable to obtain evidence in written form, personal inspection of records by the agency personnel, where permission can be secured, is an acceptable practice and is often quicker and simpler. (See also N.J.A.C. 10:69-3.5.)

10:69-3.4 Verification of income

(a) All beneficiaries of AFDC-related Medicaid must meet the criteria for financial need.

(b) Earned and unearned income verification is as follows:

1. The eligibility worker shall verify, either through examination of pay stubs or with the client's employer, the amount of gross earned income.

2. All unearned income shall be verified by examination of benefit check or by contact with the company or agency granting such benefit. Social Security benefit information verification may be accomplished through the Automated Benefit Information Exchange (ABIE)/ Beneficiary and Earnings Data Exchange (BENDEX) and/or State Verification and Exchange System (SVES) (see N.J.A.C. 10:69-8.2 concerning SVES).

3. Previous sources of support shall be explored with the applicant.

4. Legally responsible relatives shall be contacted for evaluation of their capacity to support (see N.J.A.C. 10:69-5.9).

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (b)4, deleted the former introductory paragraph, and deleted (i) designation.

10:69-3.5 Recording of documentation

All information, written or oral, including sources and methods of documentation, shall be recorded on Form PA-1J, Application and Affidavit for AFDC-related Medicaid and included in the case record. See N.J.A.C. 10:69-7.3 concerning documentation procedures.

10:69-3.6 Issuance of summons or subpoena

(a) When all other means of determining facts and circumstances concerning an application for assistance has been exhausted, the county board of social services director may:

1. Issue a subpoena to a third party in the State who has necessary and relevant information and require that pertinent records and other documents be produced for examination; and

2. Administer oaths for the purpose of such examinations.

(b) Action for contempt of court may be initiated when such person fails to obey a subpoena issued by the county board of social services director or to testify to facts and circumstances pertinent to the application for assistance.

(c) The refusal of such person to cooperate shall not disqualify applicant.

10:69-3.7 Eligible unit

(a) The eligible unit shall be comprised of those family members who apply for and are eligible to receive AFDC-related Medicaid. It shall include one or more eligible children unless such child is a beneficiary of SSI or is excluded from the eligible unit in accordance with (c) below.

1. The eligible unit for AFDC-C or -F shall include any blood-related or adoptive brothers and sisters living in the same household and who are otherwise eligible for AFDC-C or -F. This requirement does not apply to stepbrothers or stepsisters.

(b) When a beneficiary of SSI payments is a family member, he or she shall not be included in the eligible unit.

1. When all eligibility factors are present in a two-person family, the individual not receiving SSI benefits shall comprise an eligible unit of one; this applies to a parent as well as to a child; thus, the only eligible individual may be the parent or parent-person, and the appropriate AFDC-related Medicaid eligibility shall be for that individual only.

2. There may be cases in which the beneficiary count shall be one or two adults and no children depending on whether one or both parents are present in the eligible unit.

(c) For families in receipt of AFDC-related Medicaid on October 1, 1992, a child born to the AFDC-related Medicaid parent beneficiary on or after August 1, 1993 shall be included in the eligible unit for the provision of AFDC-related Medicaid.

(d) Any child included in AFDC-related Medicaid eligible unit who subsequently becomes a parent-minor and either establishes his or her own separate AFDC-related Medicaid eligible unit or remains in the eligible unit of the parent or caretaker relative shall be entitled to AFDC-related Medicaid.

(e) An individual who incurs a penalty of ineligibility shall not be included in the eligible unit and his or her needs shall not be taken into account in determining the family's need for AFDC-related Medicaid. (See N.J.A.C. 10:69-3.14 regarding income of a noneligible parent.)

(f) The term child in AFDC-related Medicaid shall be understood to refer to one or more eligible children residing in the home of the applicant parent(s).

1. The relationship of the child(ren) to the parent or parent-person applying for AFDC-C or the child(ren) to the natural or adoptive parents applying for AFDC -F or -N shall be established by use of documentary or nondocumentary sources of evidence. Some examples of these types of evidence are given in N.J.A.C. 10:69-3.3(b)2.

(g) Potential eligibility for other programs is as follows:

1. The CBOSS shall explore potential eligibility for AFDC-C or -F before determining eligibility for AFDC-N.

2. When applicant family members, including a disabled or blind child, appear to be eligible for other programs (for example, Supplemental Security Income), the advantages and disadvantages of each program shall be explained to the applicant. He or she shall have the right to decide under which program(s) he or she wishes to apply. In the event an applicant parent(s) is found to be eligible for another program of AFDC-related Medicaid coverage, such parent(s) may nevertheless apply for AFDC-C,-F or -N as appropriate, for the eligible child(ren) only.

10:69-3.8 Applicant and eligible unit AFDC-C,-F and-N

(a) The term applicant in AFDC-C refers to the parent(s) or parent-person(s) who makes an affirmative decision to apply for Medicaid or, when the applicant is incapacitated or alleged incompetent, someone acting responsibly for him or her (see N.J.A.C. 10:69-2.4(b)1) in order to maintain and provide for one or more dependent children of eligible age who are in his or her care or custody. It may also include the stepparent, at the applicant's option, if the marriage meets the qualifications of N.J.A.C. 10:69-10.33. If the AFDC-C related Medicaid beneficiary parent marries a non-needy individual on or after October 1, 1992 and the provisions of N.J.A.C. 10:69-10.34 apply, the AFDC-C beneficiary natural or adoptive parent, the stepparent and that stepparent's own natural or adoptive child(ren) as well as the natural or adoptive AFDC-C beneficiary parent shall be excluded from the eligible unit.

1. When the applicant applying for AFDC-C based on continued absence of a natural or adoptive parent is himself or herself a natural or adoptive parent, he or she must apply for himself or herself and children of eligible age, unless such parent is an SSI beneficiary in which case he or she may apply for the eligible children only (see N.J.A.C. 10:69-3.7).

2. When the applicant in AFDC-C is a parent-person, he or she has the option of applying for himself or herself and the eligible children or only for the eligible children in his or her care and custody.

3. In all AFDC-C cases, an application shall be signed by the adult member(s) or parent-minor (see N.J.A.C. 10:69-3.11(a)) of the unit for which AFDC-related Medicaid coverage is requested.

4. When the AFDC-C child(ren) lives with a parent-person(s), the application shall be executed by the parent-person who shall be the designated payee.

i. A pregnant woman under age 21 should be evaluated for eligibility for Medicaid Special under the criteria established in N.J.A.C. 10:69-12.

ii. A pregnant women who does not qualify for Medicaid Special should be evaluated against the eligibility criteria in N.J.A.C. 10:72. If the applicant meets all the eligibility requirements for the New Jersey Care ... Special Medicaid Programs requirements except for income, the application shall be referred to NJ KidCare (see N.J.A.C. 10:79) for possible eligibility.

iii. Eligibility for AFDC-related Medicaid following the birth of the child is based on the requirements and standard for AFDC-C, -F, or -N, whichever is applicable.

(b) The term applicant in AFDC-F and -N refers to natural or adoptive parents, not incapacitated, both of whom shall be required to execute the formal written application unless one such parent is not available for reasons beyond the family's control. This parent shall be required to sign as promptly as he or she is available for such purpose. (See N.J.A.C. 10:69-2.13 relevant to companion cases.)

(c) To be eligible for AFDC-C, an individual must be either a citizen of the United States or an eligible alien. (See N.J.A.C. 10:69-3.9 for alien status that may qualify an individual for AFDC-related Medicaid.)

1. Income of those ineligible individuals who are parents of otherwise eligible children shall be considered available to the eligible family and shall be calculated in accordance with the stepparent deeming formula at N.J.A.C. 10:69-2.9.

2. Medicaid coverage through AFDC-related Medicaid shall not be granted to an ineligible alien or to aliens admitted as students or visitors. However, United States citizen/eligible alien children of illegal aliens may still be eligible to receive AFDC-C, -F or -N segment-related Medicaid. The situations described in (c)2i through iii below serve as illustrations of how to determine AFDC-C, -F, or -N status for U.S. citizen/eligible alien children of ineligible aliens.

i. In the case of one ineligible alien parent with U.S. citizen/eligible alien children, the children shall be eligible for Medicaid as AFDC-C due to parental deprivation (one parent is absent). The eligible unit shall consist of the U.S. citizen/eligible alien children. There is no Medicaid eligibility for the ineligible alien parent but his or her income shall be counted as available to the eligible unit in accordance with N.J.A.C. 10:69-11.9(d).

ii. If one parent is an eligible alien, or U.S. citizen and qualifies the children for Medicaid as AFDC-F segment, the children and eligible alien/citizen parent shall be eligible for Medicaid under the -F segment. The other parent's income shall be counted as available to the eligible unit in accordance with N.J.A.C. 10:69-11.9(d) but he or she is ineligible for Medicaid.

iii. If one or both parents are not eligible aliens or U.S. citizens and the parents do not meet the criteria to qualify the children for Medicaid under the AFDC-F segment, the children may, if otherwise eligible, qualify for NJ KidCare coverage if they are U.S. citizens/eligible aliens. If both parents are ineligible aliens, the parents' income is counted as available to the eligible unit in accordance with N.J.A.C. 10:69-11.9(d) and the children form an -N segment unit of their own. If one parent is an ineligible alien and the other parent is an eligible alien/U.S. citizen, the children plus the eligible alien/U.S. citizen parent form an AFDC-N segment unit.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (c)1, deleted "and resources" following "Income".

10:69-3.9 AFDC-related Medicaid citizenship/eligibility requirements

(a) In order to be eligible for the Medicaid program, an individual must be a citizen of the United States, or an alien lawfully admitted for permanent residence, or an alien approved for temporary residence who can be classified as an eligible alien in accordance with this chapter.

1. The term "citizen of the United States" includes persons born in Puerto Rico, Guam, the Virgin Islands, Swain's Island, American Samoa, and the Northern Mariana Islands.

(b) The following aliens if present in the United States prior to August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to full Medicaid benefits:

1. An alien lawfully admitted for permanent residence;
2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;
3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;
4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;
5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act;
6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the Immigration law in effect prior to April 1, 1980;
7. An alien who is granted status as a Cuban or Haitian entrant as defined by section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty in the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain legal aliens who are victims of domestic violence and when there is a substantial connection between the battery or cruelty suffered by an alien and his or her need for Medicaid benefits, subject to certain conditions described below:

i. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent;

ii. The alien has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household of the alien and the spouse or parent acquiesced to such battery or cruelty;

iii. The alien's child has been battered or subjected to extreme cruelty in the United States by the spouse or the parent of the alien (without the active participation of the alien in the battery or cruelty); or

iv. The alien's child has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household as the alien and the spouse or parent acquiesced to and the alien did not actively take part in such battery or cruelty.

v. In addition to the conditions described in (b)12i through iv above, if the individual responsible for the battery or cruelty continues to reside in the same household as the individual who was subjected to such battery or cruelty, then the alien shall be ineligible for full Medicaid benefits.

vi. The county board of social services shall apply the definitions "battery" and "extreme cruelty" and the standards for determining whether a substantial connection exists between the battery or cruelty and the need for Medicaid as issued by the Attorney General of the United States under his or her sole and unreviewable discretion.

(c) The following aliens entering the United States on or after August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to Medicaid benefits:

1. An alien lawfully admitted for permanent residence but only after having been present in the United States for five years;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act but only after the alien has been present in the United States for five years;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the Immigration law in effect prior to April 1, 1980, but only after the alien has been present in the United States for five years;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty with the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain aliens who are victims of domestic violence as specified in (b)12 above, but only after the alien has been present in the United States for five years.

(d) Any alien who is not an eligible alien as specified in (c) and (d) above, is ineligible for Medicaid benefits. Any such alien is, if a resident of New Jersey and if he or she meets all other Medicaid eligibility requirements, entitled to Medicaid coverage for the treatment of an emergency medical condition only.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- i. Placing the patient's health in serious jeopardy;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition includes all labor and delivery for a pregnant woman. It does not include routine prenatal or post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(e) Persons claiming to be citizens and eligible aliens shall provide the county board of social services with documentation of citizenship or alien status.

(f) As a condition of eligibility, all applicants for AFDC-related Medicaid (except for those applying solely for services related to the treatment of an emergency medical condition) shall sign a declaration under penalty of perjury that they are a citizen of the United States or an alien in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant's behalf shall complete the same written declaration under penalty of perjury. When the applicant or other person for whom the application is being made is an alien, the applicant's alien status shall be verified through evidence provided by the applicant with the United States Immigration and Naturalization Service. (Refer to N.J.A.C. 10:69-2 for alien verification procedures through the Systemic Alien Verification for Entitlements (SAVE) program.)

1. The following are acceptable documentation of United States citizenship:

- i. A birth certificate;

3. When a parent has been determined "incapacitated" by reason of a temporary defect, illness, or impairment and no residual effects are anticipated upon recovery, such a parent shall be considered no longer "incapacitated" upon statement by the treating physician that he or she is able to resume full time gainful employment in his or her previous or a similar occupation.

(h) The following concern refusal to undergo diagnostic evaluation, treatment or related services:

1. In situations where a parent applicant claims to be "incapacitated" but refuses to undergo diagnostic evaluations considered by the Disability Review Section as essential to a determination of his or her "incapacity," the entire family is ineligible for the AFDC-C segment. However, refusal shall not affect the eligibility of his or her spouse and child for AFDC-F or -N.

2. The CBOSS shall make every effort to establish the facts of eligibility on the basis of available evidence in spite of the refusal to undergo diagnostic evaluation.

3. If the family is eligible for Medicaid, the parent claiming incapacity shall be included if the incapacity can be established and the agency determines that the refusal is reasonable based on any of the following criteria:

i. The client is fearful of undergoing treatment, although such fear may appear to be unrealistic or emotional in origin or even irrational, if it is intense enough to adversely affect the result of treatment and a physician recommends against it;

ii. The client might suffer loss of a faculty, or the residual use of a remaining faculty, and he or she is unwilling to take the risk;

iii. The client has religious convictions that do not, in his or her judgment, permit him or her to undergo the recommended treatment; or

iv. The resistance to treatment is an element of the defect, illness or impairment itself.

4. An individual cannot be required to undergo treatment as a condition of eligibility.

(i) An incapacitated parent should be advised of services available through the social service unit and in the community.

(j) Payment for medical expenses incurred on behalf of an AFDC-C-related Medicaid (incapacitated) applicant in the determination of initial eligibility shall be the responsibility of the CBOSS and made from the administration account. The CBOSS shall advise the physician that payment of the fee will be at the applicable rate contained in the schedule of fees for professional and diagnostic services set forth at N.J.A.C. 10:71-3.13(l). Transportation for diagnostic evaluations shall be made available.

10:69-3.16 Continued absence of parent from the home

(a) The county board of social services shall make every reasonable effort to locate an absent parent in order to

obtain support payments. An absent parent shall be given the opportunity to voluntarily support his or her child, but it shall be explained to both parents that the extent of support shall be established by the court.

(b) Each applicant and beneficiary is required to cooperate in obtaining support and establishing paternity whenever necessary as a condition of eligibility for AFDC-related Medicaid in accordance with the procedures set forth in N.J.A.C. 10:69-11.

(c) "Continued absence from the home" (see N.J.A.C. 10:69-2.8(d)) may be for any reason. The following are some of the ways to establish absence:

1. Documentary proof of divorce, pending divorce, or separation agreement (that is, official legal documents, court or attorney records or newspaper accounts) may be indicative of "continued absence from the home" but shall be verified and documented in the case file.

2. A parent shall be considered absent from the home during a period of incarceration. There is a possible situation that a parent whose imprisonment is expected to be of short duration may also be "incapacitated." Where this appears to be so, consideration shall be given to possible eligibility under the "incapacity" factor rather than the "absence" factor.

i. Evidence to substantiate "absence" when a parent is incarcerated in the State penal or correctional institution shall be secured by use of Forms PA-17B and PA-17C. When the "tear sheet" has been returned and the date of release determined, the CBOSS shall immediately redetermine the basis of continued eligibility and note it in file.

ii. With regard to the absent parent's incarceration in a county or municipal jail, the CBOSS shall need to develop a procedure in cooperation with each jail within its jurisdiction regarding exchange of information both at time of initial AFDC-C application and at time of release of incarcerated parents. PA-17B and PA-17C are not appropriate and shall not be used for local jails. Procedures established by the CBOSS with regard to county and municipal jails may vary from a formal procedure to personal telephone contacts or visits, provided the information required is obtained and acceptable to the CBOSS. In situations where the absent parent is incarcerated in another county, it is recommended that the CBOSS of such county be consulted regarding its method for contacting county and municipal jails and a mutually agreeable decision made as to which county will contact the jail.

3. A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home. The CBOSS shall verify such court-imposed sentence and document its findings in the case record prior to case validation.

i. Such parent shall not be eligible for AFDC-related Medicaid benefits.

ii. Income, if any, of such a parent shall be treated in accordance with N.J.A.C. 10:69-11.3(b).

iii. For child support and paternity purposes, the family is considered to be intact and is not subject to the CSP process.

4. A parent who has been deported from the United States shall be considered "continuously absent from the home." There must be proof of the deportation by inspection of an official notice or statement in possession of the applicant, or by obtaining written confirmation from the Immigration authorities. The information should include the date and conditions of deportation. The current address of the deported parent and his or her circumstances should also be obtained from the applicant parent, if known, and noted in the eligibility file.

5. A parent who is separated from his or her family because of uniformed service shall not be considered "continuously absent from the home" if such absence is occasioned solely by reason of active uniformed service. If, however, continued absence would exist irrespective of performance of uniformed service (for example, desertion of the family before or after entry into uniformed service or divorce), eligibility for AFDC-C may be established. Such findings shall be noted in the eligibility file.

i. When a parent serving in the uniformed services is not continuously absent from the home, the family may be eligible under the AFDC-F or-segment.

ii. "Uniformed service" is defined to mean the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, Public Health Service of the United States, and the National Guard.

6. When a parent is temporarily absent in order to receive treatment for a mental or physical illness, defect or impairment, the family should be considered under the incapacity factor.

7. When the natural parents of a child are not married to each other and one lives apart from the children, a continuing relationship between the parents is not of itself evidence of a continuing relationship with the children. When there is no evidence of a continuing relationship between the absent parent and child(ren), "continuous absence" applies.

(d) The following concern the eligibility of a child born of unmarried parents:

1. The eligibility of a child is not affected by the fact that he or she was born of unmarried parents. The initiation of proceedings to determine paternity and to establish financial responsibility of reputed father shall not be a condition of eligibility.

2. Parents of a child born of unmarried parents are equally responsible for his or her support.

i. A father may voluntarily establish the fact of his paternity and establish with the CBOSS the extent of his ability to support his child. Voluntary support payments do not legally establish paternity and cannot be enforced in the absence of legally established paternity. A mother may initiate proceedings to establish paternity and/or gain support from the reputed father. She shall be informed of the advantages to the child of having paternity established legally such as certain inheritance rights and social security benefits. (See N.J.A.C. 10:69-8.5(c).)

3. Court action may be necessary to establish paternity or to obtain support; in the absence of the mother's willingness to initiate such proceedings, the county board of social services cannot refuse to establish Medicaid eligibility but may initiate proceedings (see N.J.A.C. 10:69-11.9(d)). This provision shall be fully explained to each applicant mother of a child born of unmarried parents.

4. By law, the CBOSS are authorized to initiate proceedings to establish paternity and responsibility for support of a child born of unmarried parents who is a beneficiary of AFDC-related Medicaid (see N.J.A.C. 10:69-11.9). This authority should be used only when neither parent is willing to initiate proceedings. Filiation proceedings should be initiated in the Family Division of Superior Court.

(e) A parent may be considered continuously absent from the home when a condition of desertion is established. A desertion may already be a matter of public record, or may be alleged or presumed.

1. Desertion may be established by verifying that a parent has been convicted of desertion, charged with desertion by indictment or by filing of a complaint with the court or named as defendant in an action for divorce on grounds of desertion. Methods of verification would include records of the county prosecutor's office, juvenile and domestic relations court, municipal court where the complaint was filed, or, in the case of a divorce action documents or records in the possession of the applicant, appropriate court or attorneys.

2. Where desertion has not been established but the applicant alleges that the child for whom he or she is applying has been deserted, the factor of continuing absence by reason of "desertion" shall be considered. The CBOSS shall request of the applicant/beneficiary, during the completion of the application (Form PA-1J), information relating to the deserting parent's whereabouts and ask applicant/beneficiary to acknowledge such desertion. By signing the application, the client attests to the accuracy and verity of his or her statements.

i. The continuing effort to locate absent parents is a responsibility of the CBOSS. Since the law permits use of Social Security numbers to aid in location of deserting parents, the CBOSS shall make every effort to obtain such information.

(f) A parent shall be considered "continuously absent from the home" when by mutual agreement, not legal action, the parents have informally separated, for example, one parent is out of the home and such absent parent is not exercising responsibility as a member of the household consistent with the definition of "continued absence" although he or she may be making or demonstrating to the CBOSS his or her "intent" to make some financial contribution to the family.

(g) The CBOSS is charged with the general responsibility of reducing the extent of the beneficiary family's reliance on AFDC-related Medicaid. In striving for this objective, the CBOSS shall attempt to effect a resumption of medical support provided to the AFDC-related Medicaid family by the absent parent within the ability of such parent. In cases of absent parent(s) whose whereabouts are unknown, the CBOSS will forward Form PA-450 to the State Parent Locator Service (see N.J.A.C. 10:69-11.9).

1. This is a service to aid and supplement local efforts; the basic obligation for locating parents rests with the county's parent locator service.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).
See: 32 N.J.R. 3598(a).

In (c)3, deleted former ii and recodified former iii and iv as ii and iii.

10:69-3.17 Work criteria; determination of principal earner

(a) In order to determine qualification for AFDC-F and -N eligibility, a determination shall first be made as to which parent is the principal earner in that family.

1. The "principal earner" or primary wage earner is whichever parent earned the greater amount of income in the 24-month period immediately preceding the month of application for AFDC-F or -N. This designation thereafter shall apply for each consecutive month for which the family receives AFDC-F or -N.

2. When either parent can qualify as the principal earner because both parents earned an identical amount of income in such 24-month period, the principal earner shall be whichever parent earned the greater amount of income in the most recent consecutive six-month period of such 24-month period.

3. If both parents earned an identical amount of income in such six-month period, the CBOSS shall designate which parent shall be the principal earner.

(b) AFDC-F segment eligibility for families with either natural or adoptive parents in the home is based on depriva-

tion of parental support to the children in that family due to unemployment of the parent who is designated the principal earner. Form PA-22, Employment Criteria for AFDC-F families, is to be used by the CBOSS in determining eligibility for AFDC-F. Form PA-22 may be reproduced by each CBOSS. After the initial application, the CBOSS shall reexamine Form PA-22 whenever the circumstances surrounding employment in a two-parent household change. To qualify for AFDC-F, the following criteria shall be met.

1. The principal earner has been unemployed or underemployed for at least 30 days prior to the receipt of AFDC-related Medicaid;

i. Unemployed or underemployed is defined as:

(1) Not working at all;

(2) Working less than 100 hours a month; or

(3) Participating in work which exceeds the 100 hour per month standard but is intermittent and the excess hours are of a temporary nature, as evidenced by the fact that the principal earner was under the 100 hours standard for the two prior months and is expected to be under the standard during the next month;

2. The principal earner has not, without good cause, within such 30-day period prior to the receipt of AFDC-related Medicaid, refused a bona fide offer of employment or training for employment;

3. The principal earner has not refused to apply for or accept unemployment compensation for which he or she qualifies;

i. An individual shall be deemed "qualified" for unemployment compensation under the State's unemployment compensation law if he or she would have been eligible to receive such benefits upon filing application, or he or she performed work not covered by such law which, if it had been covered, would (together with any covered work he or she performed) have made him or her eligible to receive such benefits upon filing application;

ii. The applicant shall also be informed that refusal to apply for or accept unemployment compensation for which he or she qualifies will render the principal earner and the second ineligible for Medicaid; and

4. The principal earner has six or more quarters of work (as described in (b)4i below), no more than four of which may be quarters of work over his or her lifetime as defined in (b)4i(2) below, within any 13 calendar-quarter period ending within one year prior to the application for such aid; or, within such one-year period, received unemployment compensation under an unemployment compensation law of a State or of the United States; or was qualified (see (b)3i above) for such compensation under the State's unemployment compensation law.

i. A "quarter of work" with respect to any individual means a period (of three consecutive calendar months ending on March 31, June 30, September 30, or December 31) in which:

(1) The individual received earned income of not less than \$50.00;

(2) The individual attended full-time, an elementary school, a secondary school, or a vocational or technical training course that is designed to prepare the individual for gainful employment, or in which such individual participated in an education or training program established under the Job Training Partnership Act, Public Law 97-300; or

(3) The individual participated in the Community Work Experience Program or WIN (Work Incentive Program) prior to October, 1990, or the Job Opportunities and Basic Skills Training Program (JOBS/REACH or FDP in New Jersey).

(c) AFDC-N segment eligibility for families with both natural or adoptive parents in the home when the principal earner does not satisfy the Federal work criteria delineated in (b) above is based on the deprivation of parental support to the children in that family due to underemployment of the primary wage earner (principal earner). The following additional sanctions shall apply in AFDC-N segment cases if financial eligibility is the result of voluntary cessation of employment without good cause.

1. If AFDC-N segment financial eligibility is the result of voluntary cessation of employment without good cause as set forth at N.J.A.C. 10:86, including cessation of employment due to inappropriate work habits by either of the applicant parents, regardless of reason, within 90 days prior to the date of application for AFDC-related Medicaid, neither of the parents shall be included in the eligible family. This penalty shall extend for a period of 90 days beginning with the date of the termination of employment. Eligibility shall be considered only for the children in such instances.

i. At the end of the 90-day penalty period, the parents may be granted assistance under AFDC-N so long as other non-financial eligibility requirements are satisfied and financial need exists.

2. If an employed primary wage earner (principal wage earner) voluntarily ceases employment for whatever reason without good cause (see N.J.A.C. 10:86), both parents' needs shall be deleted from the eligible family under AFDC-N.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (b), deleted former 3, and recodified former 4 and 5 as 3 and 4, and in the new 4, amended internal references.

10:69-3.18 Residence requirements

The law requires that an applicant for or beneficiary of assistance shall reside in New Jersey. Any person who responds affirmatively to the question on the application "Do you plan to continue living in New Jersey?" fulfills this requirement. The requirement is also satisfied when the person resides in the State having entered with a job commitment or is seeking employment even if he or she is currently unemployed.

10:69-3.19 Temporary absence from State

(a) A beneficiary family may leave the State for up to a one-month period with no resultant effect upon Medicaid eligibility. If absence from the State shall exceed or is anticipated to exceed the one month period, the family shall immediately notify the county board of social services in order to request continuation of Medicaid for a three-month period following the month of departure, or any portion thereof. Such notice of intent to temporarily leave the State and request to continue Medicaid should be given to the CBOSS as far in advance of a planned absence as possible. Approval of such Medicaid continuation may be granted by the CBOSS quarterly for a period not to exceed one year. Authorization for extension of assistance beyond one year requires approval of the Division of Medical Assistance and Health Services.

(b) Upon establishment of the fact that the beneficiary family still considers its permanent residence to be New Jersey and that it plans to return thereto, continuation of Medicaid may be granted for the following reason(s):

1. Ill health;
2. Inability to travel of one or more members;
3. Mental or physical welfare; or
4. Family responsibility (for example, settling affairs of deceased).

(c) Medicaid coverage shall not be automatically continued without inquiry with respect to a beneficiary family that leaves New Jersey when there has been no information provided to the agency establishing that the absence is purely temporary. All beneficiary families shall be advised that it is their responsibility to notify the CBOSS personally or in writing and arrange in advance, so far as possible, for any plan to leave New Jersey for any period in excess of one month if they wish Medicaid coverage to be continued during absence from the State. The decision whether or not to leave New Jersey, whether it is for permanent removal or temporary absence, shall rest with the beneficiary family and does not require official approval or disapproval by the agency.

(d) Whenever a beneficiary family wishes to leave New Jersey either to establish a permanent place of abode or for a temporary visit, they shall be advised of the effects of this

plan on their eligibility for continued Medicaid during the temporary absence.

(c) When the entire family unit leaves the State for a temporary visit, the provisions of N.J.A.C. 10:69-3.21 through 3.22 shall apply.

10:69-3.31 Legally responsible relatives (LRRs)

(a) Certain relatives are legally considered responsible to provide support if financially able and may be a source of income for an AFDC-related Medicaid applicant or beneficiary. The CBOSS shall determine the capacity of LRRs to contribute to the support of AFDC-related Medicaid applicants and beneficiaries.

(b) The county board of social services director is authorized under specified circumstances to apply to the appropriate court for a support order. In cases where a court order appears to be the only means of insuring consistent and actual support, the applicant/beneficiary may elect to receive from the CBOSS the grant for which he or she is eligible and request the CBOSS to collect the support payments. (See N.J.A.C. 10:69-3.36.) The applicant shall be fully informed of these provisions and their impact:

1. The following chart identifies relatives who are recognized as legally responsible under AFDC-related Medicaid:

<u>Legally Responsible Relative</u>	<u>AFDC-related Medicaid Program</u>
Spouse	X
Child under age 55	X
Parent of a child under 18 or of a child over age 18 who is not an AFDC-related Medicaid parent or parent-person	X

(c) All legally responsible relatives shall be contacted in completing the investigation:

1. Regardless of where the relative lives, it is the responsibility of the eligibility worker to obtain the necessary information by the most direct and practical method.

i. The legally responsible relative shall be the primary source of the information required to evaluate his or her capacity to support.

ii. When the evidence submitted by the relative is inadequate or shows a discrepancy, or he or she is unable to submit evidence, he or she shall understand that it shall be necessary for the agency to obtain verification directly from his or her employer, bank and so forth.

(d) Legally responsible relatives shall be reevaluated at least once every 12 months. See N.J.A.C. 10:69-5.3 regarding reevaluation and situations in which contact need not be made.

(e) Priorities of obligations to support legally responsible relative are:

1. A person's obligation to support those relatives for whom he or she is legally responsible takes precedence over voluntarily assumed obligations.

2. Responsibility of a person for the support of his or her own minor children takes priority over any obligations for other relatives.

(f) The eligible unit shall not be eligible for AFDC-related Medicaid when the amount of the legally responsible relative's evaluated capacity to support equals or exceeds their adjusted allowance and this support is actually provided to the eligible unit.

1. The LRR's contribution shall be considered available only when there is affirmative and persuasive evidence that such amount or its equivalent in goods or services is in fact provided to members of the eligible unit. (For details see N.J.A.C. 10:69-3.7.)

2. When any LRR fails or refuses to provide any portion of his or her contribution the agency shall, within 30 days, take appropriate action in accordance with available procedures to compel contribution in the amount of the adjusted allowance or the evaluated capacity to support, whichever is less.

3. Whenever the LRR fails or refuses to furnish information concerning his or her ability to support members of the eligible unit, it shall be deemed a failure or refusal to provide support as required by law.

i. In such cases the agency shall take appropriate action within 30 days, in accordance with available procedure to secure judicial determination of the LRR's ability to support the eligible unit member(s). Until such determination is made, each LRR shall be considered a potential resource.

4. For a LRR in the home of the eligible unit, see N.J.A.C. 10:69-3.10(b)5.

(g) When it has been determined by judicial process that a child of an applicant for or beneficiary of AFDC-related Medicaid has been abandoned, deserted or not supported by the applicant or beneficiary during his or her minority, such person is legally excused and relieved of obligation and shall not be considered a legally responsible relative.

(h) When an individual (under the age of 19) who is himself or herself a parent lives in the same home as his or her own parent(s) or legal guardian(s), and the adolescent parent applies for AFDC-C or -F, the income of such parent(s) or legal guardian(s) shall be considered available to the eligible unit in accordance with the deeming provisions of N.J.A.C. 10:69-10.45 and 10.46.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (d), substituted "12" for "six" following "at least once every" in the first sentence.

10:69-3.32 Support orders for legally responsible relatives

(a) The county board of social services director has authority, after due investigation, to direct a legally responsible relative to pay toward the support of an applicant for or beneficiary of AFDC-related Medicaid.

(b) Upon failure of such relative to comply, the director shall so certify in writing to the county court or to the court of juvenile and domestic relations of the county, whereupon such court may, after hearing, "order and adjudge the able relative or other persons responsible for the support of such applicant to pay such sum or to deliver to the court or to the County Board of Social Services director such other pledge or guaranty as the circumstances may require in the discretion of the court for each such applicant."

(c) The county board of social services may also bring appropriate action in a court of competent jurisdiction to recover any sum of money due for Medicaid coverage given any person under this chapter against any person chargeable by law for the support of such persons.

(d) Where the relative from whom support is sought is a resident of another state and the county board of social services is unsuccessful in securing information and/or voluntary contributions commensurate with the evaluated capacity to support, either by direct correspondence or through an appropriate AFDC-related Medicaid agency, the procedures provided in the Uniform Reciprocal Enforcement of Support Act, N.J.S.A. 2A:4-30.24 et seq., shall apply.

(e) When there is evidence that a relative is failing to comply with the order of the county board of social services director, the director shall follow the legal procedure as provided in (b) above. Where there is failure to comply with the order of a court, the county board of social services shall consult with the probation department or with the court that placed the order.

(f) With respect to AFDC-C segment, it shall be recognized that the presence of a stepparent in the home does not relieve either natural parent of duty to support a child.

(g) An order to support should not be sought against a reputed father of a child born of unmarried parents until paternity has been judicially established.

(h) The following concern the inability of a legally responsible relative to comply with an order:

1. Where there is evidence that a relative is not able or no longer able to comply with the order of the director, there shall be prompt reevaluation of capacity to support, and the order shall be voided or the amount adjusted, as appropriate.

2. Where such situation is found to exist in respect to a relative under court order to support, the terms of the order cannot be changed except by amendment by the court itself after review. The county board of social services will assist in initiating amendment proceedings in such cases.

(i) Where the amount of support actually received, under court order and otherwise, exceeds the per capita share of the income standard for the family size for the individual for whose benefit it is paid, the client shall be informed of the right to choose whether to leave the eligible unit and have the benefit of all the income or to remain in the eligible unit. All consequences including those with regard to Medicaid shall be clearly and explicitly explained. This provision also applies to other legally designated income. (See N.J.A.C. 10:69-11.17.)

10:69-3.33 (Reserved)

Special repeal, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Section was "Assignment or transfer of property".

10:69-3.34 Liquidation of all debts, claims, interests, settlements, and trust funds

(a) Members of the eligible family shall take all necessary and reasonable action to avail themselves of funds for support from others who owe or may owe money to them or who are holding funds for them. Any funds made available by such action shall be considered as income to the eligible family, except as provided in N.J.A.C. 10:69-3.36(b).

1. When a trust fund exists for a member of the eligible family, the CBOSS shall determine whether or not the funds are currently accessible. If accessible, the funds represent a source of funds for support and shall be considered in determining eligibility.

i. When a trust fund is not currently accessible and it exists at the time of application, the client shall, as a condition of eligibility, make a bona fide presentation of a petition to the appropriate court for release of the funds for current and future support. The agency shall assist the client if necessary.

(1) When a trust fund is not currently accessible and came into being during the term of the assistance case, the agency shall present a petition to the appropriate court for release of funds for current and future support. The client shall, as a condition of continuing eligibility, provide whatever cooperation may be necessary in the presentation of the petition.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Rewrote (a).

10:69-3.35 Repayment

(a) The CBOSS shall, in all circumstances, take appropriate action to recover all AFDC-related Medicaid improperly granted. The action taken shall be in accordance with the appropriate sections of this chapter, N.J.A.C. 10:49 and any other applicable authority.

1. Recoveries of funds applicable to more than one CBOSS shall be divided according to the mutual agreement of the directors of the CBOSSs involved.

(b) Properly granted AFDC-related Medicaid coverage rules are as follows:

1. Repayment of Medicaid coverage in the AFDC-related Medicaid program (all segments) is required in certain cases in which Medicaid coverage is provided for treatment where another third party is responsible for payment of the medical services. Medicaid coverage is granted while the beneficiary(s) awaits receipt of funds from some other source. See N.J.A.C. 10:69-3.40 for rules on liquidation of non-exempt real property. See N.J.A.C. 10:69-3.39 regarding repayment following liquidation of other pending claims.

(c) Rules when agreement to repay is not required are as follows:

1. Agreements to Repay are not to be used in any Medicaid program.

2. Upon signing an application for AFDC-related Medicaid (PA-1J), the applicant or beneficiary automatically assigns all support rights (whether for past due or future support) to the CBOSS. The signing of an Agreement to Repay is therefore not required when the pending payment arises from potential entitlement to payment of support from a relative.

10:69-3.36 Action by CBOSS upon voluntary liquidation

(a) Upon voluntary liquidation of a claim or interest, and the family is currently receiving AFDC-related Medicaid, the CBOSS shall evaluate the situation to determine the family's continued eligibility for Medicaid coverage.

(b) Rules on continued eligibility arising from sale of exempt resources (see N.J.A.C. 10:69-12.2 for exempt resources) are as follows:

1. The CBOSS shall not terminate eligibility when the proceeds from the sale of an exempt resource are promptly reinvested in another exempt resource of the same type. Funds designated by the client as being reserved for such reinvestment, including any interest accrued during the period, may be held for up to three months, provided the funds are held in escrow or are otherwise unavailable for daily living expenses. The three-month period may be extended upon written approval of the Division of Medical Assistance and Health Services.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Rewrote (a); and deleted former (c).

10:69-3.37 (Reserved)

Special repeal, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Section was "Liquidation of nonexempt real property".

10:69-3.38 Strikers

(a) AFDC-related Medicaid benefits shall not be payable for any month in which any caretaker relative with whom the child is living, is, on the last day of such month, participating in a strike. Additionally, no individual's needs shall be included in determining the amount of AFDC-related Medicaid payable for any month to a family if, on the last day of the month, such individual is participating in a strike.

1. The term "strike" includes any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted interruption of operations by employees.

2. The term "participating in a strike" means an actual refusal in concert with others to provide services to one's employers.

SUBCHAPTER 4. MEDICAID SPECIAL**10:69-4.1 General provisions**

(a) An individual under age 21, who would not have qualified as a dependent child for AFDC-related Medicaid, whether or not he or she lives with his or her parent(s), may be eligible for Medicaid Special.

1. An individual under age 21 who would not have qualified as a dependent child for AFDC-related Medicaid shall be evaluated for Medicaid Special in accordance with this subchapter, but without regard to income or resources, if that individual was, at age 18, in foster placement under the supervision of the Division of Youth and Family Services with his or her maintenance paid in whole or in part from public funds. Such individual shall be eligible for medical coverage up to the age of 21.

(b) When the individual lives in the same household as his or her birth or adoptive parent(s), financial eligibility shall in all cases include the parent's(s') income. If applicable, the deemed income of the stepparent shall be included. For the determination of financial eligibility of an individual under the age of 21, he or she shall be considered to be in an eligible family consisting of the applicant, his or her parent(s) and the parent(s) dependent children.

(c) When an individual does not live with his or her birth or adoptive parent(s), eligibility shall be determined for an eligible family of one, considering only the individual's income (see N.J.A.C. 10:69-4.1(c) regarding LRRs).

1. If the individual is married and living with his or her spouse, they shall be considered an eligible family of two and all income of both parties shall be considered.

(d) Rules concerning pregnant women under age 21 are as follows:

1. Medicaid Special may be provided to a pregnant woman under age 21 if the pregnant woman meets all the Medicaid Special requirements as set forth in this chapter.

2. Eligibility is determined for an eligible family of two, or more if a multiple pregnancy (woman and unborn children), based on her income only, or, if she is married and living with her spouse, on an eligible family of three or more (woman, spouse and unborn children) including income of both spouses. Medicaid coverage does not include the spouse even though his income is included in the eligibility determination.

i. The income and household size provision at (d)2 above cannot be used prior to the date it was medically determined the woman became pregnant.

ii. A pregnant woman with other dependent children should be assisted in making immediate application for AFDC-related Medicaid based on AFDC rules in effect as of July 16, 1996 and for TANF cash assistance. If she is found ineligible under AFDC-related Medicaid rules, the CBOSS shall determine potential eligibility for New Jersey Care . . . Special Medicaid Programs coverage for pregnant women (see N.J.A.C. 10:72).

iii. After the birth of the child, so long as the mother was eligible for and receiving Medicaid Special benefits at the time of the birth of the child(ren), and the child(ren) resides with her, the child(ren) remains eligible for Medicaid for period of one year, whether or not application has been made.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Deleted references to resources throughout; and in (a), added 1.

10:69-4.2 Determination of eligibility; Medicaid Special

(a) All appropriate rules in this chapter regarding income shall apply in determining financial eligibility. Requirements related to employment or training or job search activities, school attendance of a child, the birth of additional children, and parent minors not residing with specified applicants/beneficiaries are not applicable in the determination of eligibility for Medicaid Special. Sanctions relating to the Child Support and Paternity program shall not be imposed on applicants for Medicaid Special.

(b) Earned income shall be calculated in accordance with AFDC-C and -F procedures found in this chapter.

1. Work First New Jersey/GA payments whether in the form of cash, check or assistance order or a combination of the above shall be countable as income for purposes of determining eligibility for Medicaid Special. If the individual is ineligible for Medicaid Special due to this income, he or she shall be evaluated for the Medically Needy Program as a child or if disability is alleged, for New Jersey Care . . . Special Medicaid Programs.

(c) Obligations of LRRs who live in the same household as the applicant/beneficiary are accounted for in the eligibility determination process. No further evaluation or pursuit of contributions from such LRRs is required. Actual contributions from parents outside the household shall be considered in all eligibility determinations but pursuit of non-voluntary contributions from parents outside the household shall be made only by or on behalf of applicant/beneficiaries under the age of 18. Contributions from a spouse outside the household shall be sought in all cases.

(d) Medicaid Special is available only for U.S. citizens or eligible aliens. (See N.J.A.C. 10:69-3.9 requirements related to alien status.)

(e) Eligibility for Medicaid Special does not include eligibility for burial expenses, nor do the Medicaid extension benefits apply.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (a), deleted a former second sentence, and inserted a reference to applicants/beneficiaries.

10:69-4.3 College students and Medicaid Special

(a) A student's permanent residence is considered to be with his or her parents even though he or she is temporarily absent to attend college. A student shall be determined "not living with parents" only when the CBOSS has verified that all of the following conditions exist:

1. The student lives apart from his or her parents for reasons other than convenience of attending school;

2. His or her parents do not provide one-half or more of his or her support; and

3. His or her parents did not claim the student as an exemption on their most recent Federal income tax return or they affirm that the student will not be claimed on their next return.

(b) Eligibility shall be determined on a semester basis inclusive of vacations during such semester. When a student is not actually attending college classes during other periods, such as summer vacations or other breaks of one month or more, a separate eligibility determination shall be required based on current circumstances.

(c) Income from all sources shall be applied in determining eligibility of college students not living with his or her parent(s), except that educational loans and grants shall be treated in accordance with N.J.A.C. 10:69-10.8. All earnings of the student shall be considered for purposes of Medicaid Special (see N.J.A.C. 10:69-4.2(b)).

(d) See N.J.A.C. 10:69-4.2 for other factors relating to eligibility.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (c), deleted former third and fourth sentences.

SUBCHAPTER 5. CONTINUING ELIGIBILITY IN AFDC-RELATED MEDICAID

10:69-5.1 Continuing eligibility defined

(a) The eligibility of each case shall be redetermined at regular intervals.

(b) The eligibility worker shall be alert to indications of change in need for financial assistance or change in circumstances that may affect the eligible unit's continuing Medicaid eligibility.

10:69-5.2 Requirements for periodic redetermination

(a) Redetermination is a review of factors affecting AFDC-related Medicaid eligibility, including, but not limited to, continued parental deprivation, or changes in income. At the redetermination, the parent(s) shall complete an application for continuation for Medicaid. If a redetermination is not conducted and the CBOSS is responsible, the right of the client to continued Medicaid shall not be jeopardized.

(b) For beneficiaries of AFDC-related Medicaid, all factors of eligibility shall be redetermined at least every 12 months. No case shall be terminated before evaluating eligibility, using data available from other sources, such as the Food Stamp or Work First programs. All cases determined ineligible for AFDC-Medicaid shall be screened for eligibility under all other program options. Referrals shall be coordinated to ensure that continuous coverage of benefits is available to the beneficiary, as applicable.

(c) Redeterminations shall be conducted in each case at least once every 12 months, but, at the beneficiary's option, the beneficiary may mail in the redetermination form to the CBOSS.

(d) It is the responsibility of the CBOSS to maintain a control file to assure that redeterminations are undertaken and acted upon at intervals as prescribed by this section. The redetermination time interval shall be contingent upon

the month in which an initial Medicaid card is issued, rather than on such factors as the date of application or final validation of eligibility. For example, an AFDC-related Medicaid case receiving an initial Medicaid card in July shall have a redetermination completed prior to the January card issuance so that the effective date of the redetermination shall be January 1.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Rewrote (a) through (c).

10:69-5.3 Process of redetermination

(a) Beneficiaries shall be personally interviewed regarding the application for continuation of Medicaid. The eligibility worker shall assist the beneficiary in the completion of the application form, providing explanation as necessary. If the beneficiary cannot read, the contents of the form shall be read to him or her. Upon request, the client shall be given a copy of his or her executed application form, with any attachments. Signature requirements shall be the same as for initial application. The contact shall focus on discussion of the eligibility factors, which are subject to change and shall include information about any change in agency policy or procedure that affects the beneficiary's status. There shall also be a reevaluation of the family's need for social services. When the parent is represented by a protective payee or has a representative payee, such person shall also be interviewed. A summary report including all pertinent information shall be made for each contact with the parent(s), parent-person(s) or collateral sources.

(b) In each redetermination, it is the responsibility of the eligibility worker to complete the appropriate forms.

1. When there is a pending claim, the appropriate procedure in N.J.A.C. 10:69-3.35 shall be followed.

(c) Attention shall be given to any change in residence that may affect county responsibility.

(d) Eligibility with respect to age and school attendance shall be evaluated for a child who is nearing the age beyond which he or she is no longer eligible. The eligibility of the family shall be evaluated when the youngest child is nearing the age and school situation beyond which he or she will no longer be eligible.

10:69-5.4 Competency status in AFDC-related Medicaid

(a) The eligibility worker should be alert to the development of medical or mental problems that may affect the adequate functioning of the parent. Such evidence shall be submitted to the Disability Review Section for special review.

(b) If it is the finding of the CBOSS that the parent or parent-person has demonstrated such inability to manage

the medical care of the child, the Medicaid card can be issued to a third party. In such cases, the client shall be fully advised of his or her rights.

10:69-5.5 Institutional status in AFDC-related Medicaid

Upon the parent's(s') or parent-person's(s') admission to an institution, the eligibility worker should be alert to the initiation of "temporary payee" as provided in N.J.A.C. 10:69-4.7.

10:69-5.6 Requirements with respect to deprivation of parental support or care in AFDC-C

(a) Since eligibility in AFDC-C is based on the fact that the needy child has been deprived of parental support or care by reason of the death, continued absence from home, or mental or physical incapacity of a natural or adoptive parent, it is necessary to reevaluate these factors in determining continuing eligibility. A family may continue to be eligible for AFDC-C although the original reason for "deprivation" has changed. This may occur when an absent parent dies or, although returned to the home, is incapacitated. Such change in status shall be appropriately noted in the case record.

(b) When eligibility is based on deprivation of parental support or care by reason of the continued absence of a parent, the evaluation of continued eligibility shall include a determination that the absence still exists and, if not, whether there is another basis for eligibility.

(c) The following concern incapacity status for a natural or adoptive parent:

1. There shall be redetermination that "incapacity" exists in every case in which the eligibility of the family is based on the incapacity of a natural or adoptive parent.

2. The Disability Review Section, Division of Medical Assistance and Health Services shall designate the review date for the CBOSS. "Incapacity" shall be considered as continuing until the Disability Review Section officially determines that such incapacity no longer exists. The eligibility worker shall prepare Form DRS-2A, Interim Medical-Social Report, for the redetermination review. The CBOSS shall maintain controls on review dates so that any specific medical information or reports requested by the Disability Review Section may be obtained. In addition, the Disability Review Section shall maintain a control file in order to ensure appropriate and timely reevaluation by that Section. The Disability Review Section will notify county boards of social services one month in advance of cases scheduled for such review by means of Form DRS-5.

3. In any case in which, subsequent to a finding of "approved," the incapacitated parent becomes a beneficiary of Federal disability benefits or SSI benefits for reasons other than age, this of itself shall be considered conclusive proof of continuing incapacity, and the CBOSS shall disregard the "review date" for submittal to the Disability Review Section.

4. It is the responsibility of the eligibility worker to submit the record to the Disability Review Section for special review if available evidence raises question of continuing incapacity during the interval between redetermination review dates. The special review shall be requested through use of Form DRS-2A, Interim Medical-Social Report, together with all material previously submitted.

(d) When, subsequent to a finding of "approved" on the "incapacity" factor, the CBOSS learns that the parent has obtained full-time employment at normal rate of pay for a job appropriate to his or her capacity, then incapacity no longer exists.

(e) The following concern when an "incapacitated" natural or adoptive parent is in institution:

1. In cases where AFDC-C has been granted on the basis that a natural or adoptive parent will be receiving care for a physical or mental illness in a public or private institution, it shall be necessary for the eligibility worker to check periodically with the family, and in some cases with the institution, regarding the incapacitated parent's progress and discharge.

2. As soon as the date of discharge is known, or if the CBOSS learns that the parent has already been discharged to his or her home, the CBOSS shall submit the required record material to the Disability Review Section as appropriate to the situation; that is, if official determination of incapacity had already been made, the previous record shall be submitted for review with a completed Form DRS-2A; if the case had not been previously submitted, then a DRS-2 giving current situation and Form DRS-1 (Examining Physician's Report) shall be submitted. Whenever practical, the DRS-1 form should be prepared by a staff physician of the institution.

3. An abstract of the hospital record may be accepted in place of Form DRS-1, when the parent is in the hospital or has been released within the past three months. The client's consent in writing for release of the information shall accompany the request.

10:69-5.7 Marriage or remarriage

In AFDC-C, when eligibility is based on the absence of one parent and the remaining parent marries or remarries, such marriage or remarriage does not in and of itself terminate eligibility but does require prompt redetermination of financial need and eligible unit composition in accordance with N.J.A.C. 10:69-10.33 or 10.34, as applicable.

10:69-5.8 Special conditions relating to parent(s) in AFDC-F and -N

(a) When a parent becomes absent from the home and continuous absence is established (N.J.A.C. 10:69-2.8(e)), the AFDC-F or -N case shall be transferred to the AFDC-C segment. No interruption of Medicaid shall result if AFDC-C eligibility begins with the absence.

(b) When a parent becomes hospitalized, incapacitated, committed to a mental institution or incarcerated in a penal institution and the CBOSS has evidence that this condition will continue beyond 30 days, the case shall be transferred to the AFDC-C segment. No interruption of Medicaid shall result if AFDC-related Medicaid eligibility begins with such aforementioned situation.

10:69-5.9 Legally responsible relatives capacity to support

(a) Each legally responsible relative's capacity to support shall be reevaluated at least once in each 12-month period and adjustments made as indicated (see N.J.A.C. 10:69-3.31(d)).

(b) Each legally responsible relative shall be contacted unless it can be verified that the relative:

1. Is receiving public or private financial assistance;
2. Has no source of support except fixed income, such as pension, retirement benefits or statutory benefits, and there was no capacity to support at time of last evaluation;
3. Is himself or herself dependent upon a relative (other than the client) for support;
4. Is receiving care in an institution for a mental or physical condition, or is in a penal institution and has no capacity to support; or
5. Cannot reasonably be anticipated to have experienced a change in income since the last evaluation that would affect his or her capacity to support. (The eligibility worker will consult with his or her supervisor when this appears to be the situation.)

(c) When a decision is made that it is not necessary to reevaluate capacity to support for one of the reasons in (b) above, the justification for such decision shall be recorded in the case record with notation of any plan for making contact in the future.

(d) The CBOSS shall avoid making routine requests of other county boards of social services or of out-of-State agencies to contact relatives for reevaluation of capacity to support. When, after careful evaluation of the need for such service, it is considered essential to request an interview, the letter of request shall clearly identify both the nature and the purpose of the desired service.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (a), substituted "12-month" for "six-month"; and deleted (a)1.

10:69-5.10 Recording and recommendation for changes in AFDC-related Medicaid eligibility

A complete summary report of pertinent information shall be made for each contact with a beneficiary, which shall clearly state the basis for any recommendation for

termination of Medicaid. A new redetermination form shall be completed for each redetermination.

10:69-5.11 Notice of agency decision

(a) Each applicant shall receive timely and adequate written notice of any change in Medicaid eligibility status in accordance with N.J.A.C. 10:69-6.

(b) If the notice of intention to terminate Medicaid eligibility is related to identification of possible fraud, beneficiaries are entitled to:

1. Timely notice in certain cases of probable fraud (see N.J.A.C. 10:69-3.39 through 3.44); and
2. Seven days notice shall be considered timely when, in the judgment of CBOSS director, there is substantiated evidence that client is receiving Medicaid coverage through willful fraud (see N.J.A.C. 10:69-9.15 through 9.18).

10:69-5.12 Periodic notice to client

(a) The client shall be informed periodically (at least once every 12 months) of his or her continuing obligation to furnish accurate and timely information to the CBOSS concerning changes in income or other circumstances which may affect the receipt of benefits. The applicant shall receive, and have explained if necessary, a copy of the pamphlet Medicaid Rights and Responsibilities. This pamphlet shall be given to the applicant at the time of application and at each redetermination if the beneficiary has not retained the copy previously provided. The client shall inform the CBOSS of any change as soon as possible but in no event later than two weeks after the change takes place. Failure of the client to so inform the CBOSS shall constitute willful withholding of information.

(b) The client, by the signing of an affidavit, agrees that he or she has received the pamphlet, has been informed of his or her rights and obligations as stated in the pamphlet, and understands them.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (a), substituted "12 months" for "six months"; and "receipt of benefits" for "amount of the grant" in the first sentence.

10:69-5.13 Extension of Medicaid benefits

(a) Extended Medicaid benefits shall be provided former AFDC-related Medicaid families in accordance with the provisions of this section for a period of 24 months beginning with the month in which the family would have no longer have otherwise been eligible for AFDC-related Medicaid due to an increase in earned income.

1. When an AFDC-C, -F or -N family loses eligibility for AFDC-related Medicaid due to the following reasons, Medicaid eligibility continues for a period of 24 months

beginning with the month in which the family is no longer eligible for AFDC-related Medicaid:

- i. Earnings or increased earnings from employment, including earnings from new employment;
- ii. Increased hours of employment; or
- iii. Receipt of New Jersey State unemployment or temporary disability insurance benefits.

2. New members added to the eligible family during the 24 month extension period, as appropriate, are not included under the extended coverage, with the exception of a child born to the family during the 24 month extension period. For children born during this period, the child and the mother may be eligible for additional coverage if the 60-day post-partum period continues beyond the termination of the extension period applicable to the remainder of the household, or if the child's 12-month guaranteed period of Medicaid eligibility continues beyond that termination date. In either case, Medicaid eligibility terminates at the end of the guaranteed eligibility period, if that termination date is later than the termination date of the 24 month Medicaid extension.

3. Eligibility for the 24-month Medicaid extension is not available for any month to any individual who, except for income or hours of employment, is not otherwise eligible to receive AFDC-related Medicaid. The following individuals shall not be included in the eligible family for Medicaid extension:

- i. Any child who reaches the age of 18, or any child who is attending a secondary or vocational school full-time up to the month of graduation or age 19, except that such child shall be evaluated for Medicaid eligibility for other appropriate Medicaid programs; and
- ii. All other family members who are receiving Medicaid extension solely because of the presence in the home of a child who "ages out," as in (a)3i above.

4. When an AFDC-C related Medicaid family loses eligibility as a result (wholly or in part) of the collection of child or spousal support through the Child Support and Paternity process, AFDC-related Medicaid eligibility continues for a period of four calendar months beginning with the month in which such ineligibility begins.

- i. In order to qualify for this extension of Medicaid benefits, the family must have received and been eligible to receive AFDC-C-related Medicaid in at least three of the six months immediately preceding the month in which ineligibility for AFDC-related Medicaid begins;
- ii. Eligibility for this extension shall be terminated for any child who reaches the age of 18, or any child who is attending a secondary or vocational school full-time up to the month of graduation or age 19, except that such child shall be evaluated for Medicaid eligibility for other appropriate Medicaid programs; and

iii. All other family members who are receiving Medicaid extension solely because of the presence in the home of a child who "ages out," as described in (a)4ii above, shall be terminated.

(b) Those cases which are in Medicaid extension only shall also be transferred to the new county of residence when the family moves from the county of origin in the same manner as active AFDC-related Medicaid cases. The procedures established at N.J.A.C. 10:69-3.27(b) are to be followed when transferring a case in Medicaid extension.

(c) AFDC applicants may be eligible for retroactive Medicaid benefits; such determinations are made by DMAHS. The eligibility worker shall ask if the family has unpaid medical bills from the previous three months and shall provide the applicant with appropriate forms. The Division of Medical Assistance and Health Services shall make a determination of eligibility for each of the three previous months, based on the eligibility rules in this chapter.

(d) AFDC eligible families who would not have received any AFDC payments solely because the amount payable would be less than \$10.00, are eligible for AFDC-related Medicaid benefits. Likewise, AFDC families who would have been ineligible for AFDC solely because of rounding of the amount that would otherwise be payable, are eligible for AFDC-related Medicaid benefits.

(e) For newborns of eligible women who have applied (before or on the date of the birth) and are eligible for Medicaid on the date of birth (except for a presumptively eligible pregnant woman, as defined at N.J.A.C. 10:72-6.1, who is subsequently found ineligible for the month the child was born), eligibility continues for both mother and child through the last day of the month in which the 60-day post-partum period ends, without regard to other program requirements. So long as the mother remains eligible, or would remain eligible if pregnant, and the child resides with her, the child remains eligible for Medicaid for a period of one year, whether or not application has been made for the child.

(f) Individuals who were admitted to a hospital and were subsequently referred to the CBOSS through the use of Form PA-1C, Public Assistance Inquiry, may be eligible for Medicaid benefits from the date the PA-1C was completed, provided:

1. Such individual was an inpatient at the time the referral was made;
2. Except for good cause, including, but not limited to, hospitalizations lasting for three or more months, the homebound status of the applicant, the CBOSS was unable to schedule a timely application appointment, or the hospital failed to inform the applicant to apply at the CBOSS, the individual applies for AFDC-related Medicaid benefits within three months after the referral is made.

i. If the CBOSS determines that the individual had good cause for not applying within three months, an extension may be granted for an additional three months.

ii. Newborns of eligible women are deemed to have applied and shall be added to the Medicaid case, effective the date of birth, upon receipt of a valid Form PA-1C (see N.J.A.C. 10:69-8.10(e) for coverage limits).

(g) Those cases which are in Medicaid extension only shall also be transferred to the new county of residence when the family moves from the county of origin in the same manner as active AFDC-related Medicaid cases. The procedures established at N.J.A.C. 10:69-3.27(b) are to be followed when transferring a case in Medicaid extension.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).
See: 32 N.J.R. 3598(a).

In (a)1, deleted a former ii, and recodified a former iii and iv as ii and iii; and in (a)3 deleted a reference to resources.

10:69-5.14 Change in eligible unit

(a) A newborn child shall be added to the AFDC-related Medicaid case effective with the date of birth, provided that the CBOSS is notified within one year of that date.

(b) The date of change for adding other members added to an eligible unit shall be the first day of the month the eligible unit reports to the CBOSS the addition of the member.

SUBCHAPTER 6. COMPLAINTS, HEARINGS AND ADMINISTRATIVE REVIEWS

10:69-6.1 Definitions

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

“Adequate notice” means a written notice that meets the requirements of N.J.A.C. 10:69-6.3

“Administrative hearings” are hearings concerning either contested cases or non-contested cases, which have been determined by the Director of the Division of Medical Assistance and Health Services (DMAHS) in accordance with N.J.A.C. 1:1-1, to be appropriately heard in the Office of Administrative Law (see N.J.A.C. 10:6).

“Administrative law judge” (ALJ) means the person from the Office of Administrative Law (OAL) who conducts the hearing and who writes an initial decision which may be reviewed by the Director of the Division of Medical Assistance and Health Services.

“Administrative review” means a review of a disputed matter which has been determined by the Director of the Division of Medical Assistance and Health Services not to constitute a contested case and therefore remains in the Division for review. At the discretion of the Director, an administrative review may be conducted as a procedure at which parties appear and are heard or it may be a paper review. (See N.J.A.C. 10:69-1.2.)

“Administrative review official” is a representative of the State, Department of Human Services assigned to conduct an administrative review.

“Adverse action” means any action by a CBOSS resulting in denial of application for AFDC-related Medicaid. An adverse action is an action to deny an application for Medicaid, or to terminate Medicaid (including service, vendor payments or Medicaid entitlement) or to deny payment to a vendor for medical services required to be reimbursed by the county board of social services.

“CFR” is the acronym for Code of Federal Regulations.

“Contested case” means a dispute that is heard by an Administrative Law Judge.

“Fair hearing” means a formal or informal procedure through which a AFDC-related Medicaid client may protest an adverse action or decision of the county board of social services (CBOSS) regarding eligibility or manner of granting AFDC-related Medicaid. Fair hearing is a general term which includes administrative hearing and administrative review.

“Initial decision” means the decision of an administrative law judge that is sent to the Director of the Division of Medical Assistance and Health Services, who may accept, reject or modify it within 45 days.

“Timely notice” means that the notice is mailed at least 10 days before the effective date of agency action.

10:69-6.2 Right to fair hearing and administrative review

(a) It is the right of every applicant or beneficiary adversely affected by an action by a county board of social services (CBOSS) to be afforded a fair hearing in a manner established by the rules in this subchapter and by the Uniform Administrative Procedure Rules (N.J.A.C. 1:1). These rules have been established pursuant to Federal regulations (45 CFR 205.10) and the New Jersey Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.).

(b) The county board of social services shall promptly notify the beneficiary in writing of any agency decision affecting that client. The term “agency decision” refers to a decision made by the county board of social services and includes any decision made by the county board of social services. In the case of a client who cannot be located, notice shall be sent to his or her last known address.

(c) Agency action which adversely affects an applicant or beneficiary includes:

1. Any action, inaction, refusal of action, or unduly delayed action with respect to program eligibility, including, but not limited to, denial or termination of benefits; and

2. When the complete processing of an application is delayed beyond 30 days, the applicant is to be notified of this fact and the reason(s) for the delay on or before the expiration of such period (see N.J.A.C. 10:69-2.14 and 2.15).

(d) The written notice of adverse action shall, at a minimum, include the following:

1. The action the agency intends to take;
2. The reasons for the intended agency action;
3. The specific regulations supporting such action;
4. An explanation of the individual's right to request a fair hearing;
5. An explanation of how to request a fair hearing;
6. The time limits on requesting a hearing;
7. An explanation of the right to examine evidence;
8. An explanation of the circumstances under which continued Medicaid coverage is continued if a hearing is requested;
9. An explanation of the requirement to repay Medicaid coverage received during the period pending the hearing, if the agency action is upheld;
10. A sentence in Spanish cautioning the client that the notice relates to a change in Medicaid coverage and if he or she does not understand the notice, he or she should contact the CBOSS; and
11. The name, address and phone number of the nearest legal services office where available.

(e) Where an agency decision results in an adverse action, there will be no termination of the AFDC-Medicaid related coverage until at least 10 days after the mailing date of the notice, except in situations described in (f) below.

(f) Timely notice may be dispensed with but adequate notice shall be sent not later than the effective date of action when:

1. The agency has factual information confirming the death of a beneficiary;
2. The agency receives a clear written statement signed by a beneficiary that he or she no longer wishes continued Medicaid coverage, or that gives information which requires termination, and the beneficiary has indicated, in writing, that he or she understands that this must be the consequence of supplying such information;

3. The beneficiary has been admitted or committed to an institution, that does not qualify for Federal financial participation under the State plan;

4. The beneficiary has been placed in a nursing facility, intermediate care facility or long-term hospital;

5. The claimant's whereabouts are unknown and agency mail has been returned by the post office indicating no known forwarding address. The Medicaid Card must, however, be made available to the beneficiary if his or her whereabouts become known during the medical coverage period, unless (f)5i below applies.

i. The claimant moves out-of-State, with apparent intent to remain permanently absent from New Jersey;

6. A beneficiary has been accepted for medical assistance in another state and that fact has been established by the CBOSS previously providing Medicaid coverage;

7. An AFDC child is removed from the home as a result of a judicial determination, or voluntarily placed in foster care by his or her legal guardian; or

8. The application for Medicaid coverage is being denied.

10:69-6.3 Responsibilities of the CBOSS in processing hearing requests

(a) Upon receipt of a timely request for a fair hearing, Medicaid coverage shall be continued until a written decision is rendered, unless:

1. A determination is made at the hearing by the ALJ that the sole issue is one of State or Federal law or policy, or change in State or Federal law, and not one of disputed facts; or

2. A change occurs which further affects beneficiary's eligibility while the first hearing decision is pending and the beneficiary fails to request an additional hearing after notice of this change within the time allowed.

(b) In the event of either (a)1 or 2 above, the beneficiary shall be promptly notified in writing that the proposed action will be implemented after the hearing while the decision is pending.

(c) Any incorrectly paid benefit resulting from continued Medicaid coverage is subject to recovery. In the event that agency action is sustained and a beneficiary has received incorrectly paid Medicaid benefit, solely due to continued eligibility, recovery shall be effected in accordance with procedures in N.J.A.C. 10:69-9.23.

(d) A beneficiary may waive his or her claim to Medicaid by submitting a written statement at the time the fair hearing is requested.

(e) To assure orderly and expeditious processing of complaints and hearing requests, each CBOSS shall designate a liaison between the county and State Division whose duties shall include, but not be limited to:

1. Informing the Bureau of Legal and Regulatory Liaison (BLRL) by telephone on the same day an oral or written request for a hearing is received, providing the following information:

- i. The case number and the applicant/beneficiary's name and address;
- ii. The date the request received;
- iii. The nature of contested action;
- iv. The date of action; and
- v. The reason for action;

2. Establishing a system to assure that every written request for a hearing received in the CBOSS office is stamped with the date of receipt and forwarded to BLRL within one work day of the date;

3. Reviewing incoming requests for possible corrective action prior to hearing;

4. Identifying and arranging for participation of staff individuals who are essential to a hearing, and assembling all records relevant to a hearing and arranging for an interpreter when the client is non-English speaking;

5. Contacting the applicant/beneficiary or his or her legal or authorized representative not less than two days prior to a hearing to confirm attendance and arranging for transportation by agency staff and vehicles or otherwise at agency expense when no other reasonable means of transportation is available;

6. Submitting special reports on hearing requests prior to the hearing date, when requested by OEP or BLRL;

7. Submitting reports on implementation of fair hearing decisions as soon as such action is taken when requested; and

8. Serving as the single individual in the CBOSS to be contacted regarding matters relating to hearings and the monitoring system.

(f) The CBOSS is responsible to inform the applicant/beneficiary who is requesting a hearing and elects to receive continued Medicaid that the ALJ may find him or her not entitled to all or a portion of the Medicaid coverage received during the pendency of the hearing and that, in such event, repayment may be required of the amount of benefits received from the effective date of the proposed adverse action to the date of the scheduled hearing.

1. The beneficiary shall also be advised that if he or she elects not to receive continued Medicaid coverage and the hearing decision is favorable to the client, Medicaid cov-

erage shall be reinstated retroactive to when it was terminated.

10:69-6.4 Responsibilities of the Division of Medical Assistance and Health Services

(a) Each request for a fair hearing shall be registered by BLRL on the date the request is received.

(b) Requests initially received in BLRL shall be transmitted by telephone to the CBOSS on the date received.

(c) BLRL shall transmit each contested case to OAL within five work days of the receipt of the request.

(d) Written determination on entitlement to receive continuing Medicaid coverage shall be included in the OAL transmittal and sent to the applicant/beneficiary and the CBOSS.

10:69-6.5 Responsibilities of the Office of Administrative Law upon transmittal of a contested case from the DMAHS (45 CFR 205.10 and N.J.A.C. 1:1-1 et seq.)

(a) The Office of Administrative Law shall schedule the hearing and shall send any necessary notices to the parties.

(b) The hearing shall be conducted by an administrative law judge who shall issue an initial decision.

10:69-6.6 Administrative hearings and administrative reviews

(a) Requests on matters which constitute a contested case (as defined by N.J.A.C. 1:1-1 and consistent with case law) shall be handled in accordance with the Department of Human Services (DHS) rules on "Administrative Hearings and Administrative Reviews" at N.J.A.C. 10:6.

(b) Requests on matters which do not constitute a contested case (as defined by N.J.A.C. 1:1-1 and consistent with case law) shall be handled in accordance with the DHS rules on "Administrative Hearings and Administrative Reviews" at N.J.A.C. 10:6.

10:69-6.7 Complaints and adjustment procedures

(a) Prompt and courteous attention shall be given to all complaints, whether or not such complaints constitute requests for fair hearing and whether or not they are directed to the CBOSS or the Division of Medical Assistance and Health Services. All complaints received shall be acknowledged promptly and, if it is not apparent from the complaint that a fair hearing request has been made, the acknowledgment shall inform the beneficiary of his or her right to a fair hearing.

(b) Informal efforts to effect a resolution may be made through field contacts, office interviews with supervisory personnel, or consultation with Division staff as needed. In

no event, however, are such informal efforts to be considered as prerequisite to a fair hearing, and in no event do they delay, interfere with or otherwise impede the processing of a fair hearing whenever a request for such is made. Agency emphasis shall be on helping the client to prepare and submit his or her request for a fair hearing.

(c) Any clear expression (oral or written) by a beneficiary (or person acting for him or her, such as his or her legal representative or relative) to the effect that the beneficiary wants the opportunity to present his or her case to a higher authority constitutes a request for a fair hearing.

(d) A request for a fair hearing may be either oral or in writing and addressed to the CBOSS or to the State Division. Oral requests for fair hearing shall be immediately reduced to a written record by the staff person to whom the request is made. No special form of statement or manner of expression is required so long as the request identifies the nature of the complaint and the relief sought. Requests made to the CBOSS shall be immediately transmitted to the BLRL, and in no event later than one work day after receipt of the request.

(e) Upon receipt of any request for a fair hearing, a determination shall be made by the Division on the appropriateness of an administrative hearing or administrative review (N.J.A.C. 10:6-1.2). If the matter is deemed contested, BLRL will send an acknowledgment of the request to the client. All contested cases shall be promptly forwarded to the OAL for a hearing before an ALJ.

10:69-6.8 Time limitations on entitlement to fair hearings

(a) An applicant or beneficiary has a right to request a fair hearing which relates to an agency action or lack of action within 20 days of such action or lack of action.

(b) If the request for a fair hearing relates to an agency action or lack of action that occurred more than 20 days prior to the date of the request, there shall be no entitlement to a hearing on such action or lack of action, unless extraordinary and extenuating circumstances exist as determined by the Division of Medical Assistance and Health Services. Extraordinary or extenuating circumstances are defined as conditions beyond the applicant or beneficiary's control. This could include, but is not limited to, the beneficiary's receipt of notice after due date or personal illness or incapacity.

10:69-6.9 Eligibility for continued Medicaid coverage

(a) When a request is made for a fair hearing within 15 days from the date of mailing of a notice of termination, Medicaid coverage shall be continued until the scheduled date of the administrative hearing or the date of the administrative review unless the beneficiary waives such entitlement or requests postponement of the scheduled hearing or review date. In the event the beneficiary elects to receive continued benefits, they will be continued pending a final decision if the ALJ or the administrative review official determines that the issue is one of fact rather than law or policy. (45 CFR 205.10(a)(7))

(b) An adjournment of a hearing at the request of an beneficiary shall not prolong continuation of Medicaid coverage, unless the adjournment is due to delay caused by the State Division, OAL or the CBOSS; unavoidable causes, such as an illness on the part of the applicant/beneficiary; or the failure of the CBOSS to provide assistance for transportation when such assistance is required by regulations. Adjournment at the request of the CBOSS or by the ALJ shall not affect continued benefits.

(c) The CBOSS shall file with the Division of Medical Assistance and Health Services a detailed description of the administrative plan, and shall advise the division of any subsequent proposed change in the plan before it becomes effective.

10:69-9.18 Referral by the CBOSS in cases of suspected fraud

When the investigation of any case of suspected fraud is completed, the director of the CBOSS, in consultation with counsel, shall be responsible for determining whether the matter should be referred to the county prosecutor, other proper law enforcement official and/or the Division of Mental Health and Health Services (DMAHS).

10:69-9.19 Reports on cases involving fraudulent receipt of Medicaid coverage

(a) In cases where the CBOSS has completed an investigation based upon a belief that fraud has been committed, a report shall be routed through the CBOSS director to the Division of Medical Assistance and Health Services. The report shall be completed when the CBOSS determines that no fraud exists, when the case is disposed of through administrative action, or when the case is forwarded to the county prosecutor.

(b) Upon disposition of the case by law enforcement officials (county prosecutor or municipal court), a subsequent report shall be completed and routed through the CBOSS director to the Division of Medical Assistance and Health Assistance.

10:69-9.20 Recovery of incorrectly paid Medicaid benefits

(a) In every fraud case, in addition to any criminal prosecution, recovery of the amount of assistance provided for medical care or supplies shall be sought. If the beneficiary is involved in a Medicaid managed care plan, the higher of the payments made by the managed care plan or the amount expended by the Medicaid program for capitation costs shall be recovered. Recoveries of incorrect assistance by the CBOSSs shall be governed by N.J.A.C. 10:49-14.4(b). Recovery of civil penalties shall be pursued by DMAHS in accordance with N.J.S.A. 30:4D-17(c). The threat of prosecution should not be used as a means of effecting recovery; nor should the fact of a recovery affect the CBOSS decision concerning proper referral to the prosecutor. However, any recovery, or plan for recovery, should be reported to the prosecutor whenever such a referral has been made.

(b) The provision of (a) above is not intended to limit the responsibility and obligation of the CBOSS to seek recovery, through voluntary agreement or civil action, of funds improperly received by a client under circumstances other than fraud.

10:69-9.21 Reporting criminal offenses to law enforcement authorities

(a) Investigation of new applications or investigations for redetermination of eligibility may indicate to the CBOSS that a crime may have been committed. Allegations of the suspected commission of a crime may also be made known to the CBOSS through various other sources, including, but not limited to, phone calls, written communications, or verbal communications from individuals. In matters of reporting of criminal offenses, the CBOSS shall, at all times, maintain full compliance with the provisions of N.J.A.C. 10:69-7.31, dealing with basic principles for safeguarding of information.

(b) The nature of offenses which must be reported to local authorities are:

1. Arson, manslaughter, murder or any crimes which constitute crimes of the third, second and first degrees, such as atrocious assault and battery, carnal abuse, incest or rape. (Refer to legal counsel for additional information identifying crimes of the third, second and first degrees.); and

2. In order to afford protection to children, certain other crimes and abuses as required by Federal, State or local statute or regulations must also be reported to the proper authorities.

(c) Knowledge of the actual commission of a Federal felony must be reported to Federal authorities unless law prohibits the disclosure of such information. (Refer to legal counsel for identification of Federal felonies.)

(d) When the CBOSS becomes aware of facts that would indicate that one of the crimes in (b) or (c) above has been or may have been committed or receives a direct allegation in any form, written, verbal or anonymous, that such a crime has been committed, it shall proceed as follows:

1. The CBOSS director shall personally, and in collaboration with counsel, review whatever facts and circumstances are immediately available in order to determine whether there is suspicion that a crime was committed.

2. If the CBOSS director is satisfied that there is evidence to support an investigation as to whether a crime has been committed, he or she shall, after consultation with counsel, report the matter to the county prosecutor, or to a local police department or to the State Police if so directed by the office of the prosecutor. If such matter involves suspected child abuse or neglect, it shall also be reported to the social service unit which shall contact the Division of Youth and Family Services. (See N.J.A.C. 10:69-3.11).

3. When a decision has been made to report the alleged or suspected commission of the crime, such report shall be made in written form to the appropriate law enforcement agency.

4. The CBOSS shall cooperate fully with any subsequent investigation initiated by the law enforcement agency within the limits of this chapter. A CBOSS staff member may sign a written complaint only upon a written request from the law enforcement agency, provided his or her information of the facts to be stated in such complaint is based upon his or her own personal knowledge and belief.

10:69-9.22 Rights of individual under investigation

(a) The CBOSS shall insure that an individual under investigation shall have the following rights:

1. The agency shall insure that information obtained from or concerning a person under investigation shall be restricted in accordance with N.J.A.C. 10:69-9.8. The agency shall take special precautions in obtaining information from a third party so that no accusations relevant to the alleged fraud are disclosed, including the reason for the investigation or the nature of the allegation, without the written consent of the individual under investigation.

2. The agency shall insure that investigative methods do not infringe on the civil liberties of the individual or interfere with due process of law. The agency shall be prohibited from obtaining forced entry, conducting residence searches without consent of the client, making home visits during normal sleeping hours (generally 10:00 P.M. to 7:00 A.M.) or requiring that an individual be subjected to a lie detector test.

3. The individual shall be advised of the opportunity, where available, to obtain legal counsel through Legal Services, Legal Aid Society, lawyer referral service of the Office of the Public Defender.

10:69-9.23 Basis for recovery of incorrectly paid benefits for purposes other than for fraud, or third party liability

(a) Incorrectly paid benefits means Medicaid coverage received by or for an eligible unit for which they were otherwise not entitled. The overpayment was caused by reasons other than fraud or third party liability.

(b) Incorrectly paid benefits may occur through administrative error; failure of a client to inform the county board of social services or designee pursuant to Federal regulation of a change in income or circumstances; or when the client has received continued Medicaid coverage but has been found ineligible to receive such Medicaid coverage or part of such coverage by the fair hearing decision.

(c) The CBOSS or designee pursuant to Federal regulation shall seek recovery of all overpayments regardless of fault including AFDC-related Medicaid payments caused by administrative action or inaction. The CBOSS or designee pursuant to Federal regulation shall recover such incorrectly paid benefits in accordance with procedures set forth in this chapter.

(d) Medicaid incorrectly paid benefits to an eligible unit, all members of which are no longer receiving AFDC-related Medicaid program, shall be recovered by the CBOSS through a court of appropriate jurisdiction if the family does not voluntarily repay the overpayment.

(e) In locating former beneficiaries who have outstanding incorrectly paid benefits, the CBOSS shall use appropriate data sources such as unemployment insurance files, the Division of Taxation, the Department of Motor Vehicles, Bendex, and other data sources relating to current or former beneficiaries.

(f) For incorrectly paid benefits occurring prior to October 1, 1981, the CBOSS shall recover only if the overpayment resulted from willful withholding of information by the beneficiary.

(g) The CBOSS may waive recovery of AFDC-related Medicaid incorrectly paid benefits if the eligible unit is no longer receiving AFDC-related Medicaid and the amount overpaid is less than \$35.00. When the amount of the incorrectly paid benefit to an eligible unit no longer receiving AFDC-related Medicaid is \$35.00 or more, the CBOSS may waive the recovery of the incorrectly paid benefit, if after a reasonable effort to recover the incorrectly paid benefits, the CBOSS determines it is no longer cost effective to continue recovery efforts. Recovery of overpayments due to fraud may not be waived regardless of the amount of incorrectly paid benefit.

1. Reasonable efforts to recover an incorrectly paid benefits include, at a minimum, written notification of the amount of and reason for the incorrectly paid benefit and that repayment is required.

2. All circumstances concerning a waiver of recovery must be fully documented in the case record.

(h) The CBOSS shall not initiate or continue recovery of any outstanding incorrectly paid benefits of Medicaid coverage that occurred in another state.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (b), deleted a reference to resources.

SUBCHAPTER 10. INCOME

10:69-10.1 Income; financial eligibility standards

(a) As a condition of eligibility for the AFDC-related Medicaid program, applicants must comply with the income standards set forth in this subchapter.

(b) It is the purpose of this subchapter to establish methods for evaluating income eligibility for families and children.

10:69-10.8 Eligible AFDC child or parent regularly attending school or in vocational training at a Residential Job Corps Center

(a) When an eligible child is a student regularly attending school, college or university, or regularly attending a course of vocational training designed to fit him or her for gainful employment, this child shall be included as a member of the eligible unit whether or not he or she is living in the home during the period in which he or she is pursuing his or her studies. (See N.J.A.C. 10:69-10.9 for definitions of school attendance.)

(b) Any grant, scholarship, student loan or other financial aid received by such child shall be fully disregarded in determining eligibility so long as the child continues to attend school as stated in (a) above and meets the conditions under which such moneys are granted.

1. Funds received through college work-study programs shall be disregarded.

(c) When a child receives vocational training at a Residential Job Corps Center which permits him or her to return home for weekends, the child shall be considered temporarily absent and regarded as an eligible member of the family unit. (A child receiving training at a National Job Corps Centers is to be considered permanently absent and shall not be considered a member of the eligible family for AFDC-related Medicaid program eligibility.)

10:69-10.9 School attendance defined

(a) A child eligible under the age requirements of N.J.A.C. 10:69-3.13 shall be considered a student regularly attending a school or training course when he or she is enrolled in and physically attending, as certified by the school or institute, a program of study or training leading to a certificate, diploma or degree:

1. Full time;

2. At least half-time and is regularly employed part-time or is available for and actively seeking part-time employment; or

3. At least half-time and is precluded from full-time attendance or part-time employment because of a verified physical disability.

(c) Full-time and half-time attendance are defined as:

1. In a trade or technical school, in a program involving shop practice, full-time is 30 clock hours per week and half-time is 15 clock hours; in a program without shop practice, full-time is 25 clock hours and half-time is 12 clock hours;

2. In a college or university, full-time is 12 semester or quarter hours and half-time is eight semester or quarter hours;

3. In a secondary school, full-time is 25 clock hours per week or four Carnegie units per year and half-time is 12 clock hours or two Carnegie units; and

4. In a secondary education program of cooperative training or in apprenticeship training, full-time attendance is as defined by the State Department of Education.

(d) When a parent of an eligible child is a student regularly attending school as defined in this section, the provisions of N.J.A.C. 10:69-10.8(b) and (c) shall apply.

(e) A child shall be considered in regular attendance in months in which he or she is not attending because of official school or training program, vacation, illness, convalescence or family emergency, and for the month in which he or she begins, completes or discontinues his or her school or training program.

10:69-10.10 General provisions—income

(a) Income may be earned, unearned or in the form of contributions.

(b) Earned income shall not include the amount of Earned Income Credit payment that an individual receives.

10:69-10.11 Definition of earned income

(a) Earned income refers to gross income earned by an individual through the receipt of wages, tips, salaries or commissions from activities in which he or she is engaged as an employee or from his or her self-employment. It includes earnings over a period of time for which settlement is made in one payment, as in the sale of farm crops.

(b) When an individual receives shelter in return for performing work duties, the monetary value shall be determined from Schedule VI in N.J.A.C. 10:69-10:42(c) and included in the total amount of gross earned income. The amount of mandatory payroll deductions to be recognized shall be determined in relation to such total amount.

(c) When an individual is employed in a position where tipping is customary, a daily log or other acceptable documentation of tips received shall be used for income calculation. Tips income calculation shall not be based on estimated information as reported on W-2 forms.

10:69-10.12 Earned income from self-employment including provisions of personal care services

(a) With respect to self-employment, the term "earned income" means the total profit from a business enterprise (such as farming) resulting from a comparison of the gross receipts with the business expenses. Business expenses are those costs directly related to producing the goods or services and, without which, the goods or services could not be produced. However, items such as depreciation, personal business and entertainment expenses, personal transportation, purchase of capital equipment, and payments on the

principal of loans for capital assets or durable goods are not business expenses.

1. Persons who are self-employed shall be required to submit evidence of business receipts and expenditures as the basis for a sound estimate of earned income. A reliable, accurate accounting system or the method utilized in reporting to the Internal Revenue Service shall be acceptable for determining net income.

(b) In the case of an individual who is self-employed, it may be clearly evident that the expense of producing the income exceeds the income produced. AFDC-related Medicaid program shall not be continued if such person persists in operating the business.

1. A period of up to 24 months from the start of a new business shall be considered adequate to demonstrate a new business's potential for self-support. In situations where, in the judgment of the county board of social services, additional time would enable the business to show a profit, the period may be extended up to 12 months.

2. A business which is already established (that is, in operation for at least 36 months) and which shows only marginal profit, either constant or intermittent, shall be considered for purposes of AFDC-related Medicaid program eligibility to be failing if the profit, averaged over the preceding 12 months, is less than \$375.00 per month.

(c) An individual who is providing extensive personal services along with room and board accommodation to a noneligible individual shall be considered self-employed. An amount of \$125.00 shall be recognized as the business expense and cost of providing room, board and extensive personal services. Any income from this arrangement in excess of \$125.00 shall be recognized as earned income.

10:69-10.13 Earned income disregards for AFDC-C and AFDC-F related Medicaid

(a) The CBOSS shall disregard from the earned income of each employed individual in the eligible family, the first \$90.00 of such earnings to cover work-related expenses including, but not limited to, transportation and mandatory payroll deductions.

(b) The CBOSS shall disregard from the total earned income not already disregarded, an amount equal to the difference between the Income Standard established for the size of the family unit, in accordance with the chart at N.J.A.C. 10:69-10.2(a), and the current official poverty level for that family size (see 42 C.F.R. § 9902(2)).

(c) The CBOSS shall disregard from the remaining earned income, the actual costs paid for child care or for care of an incapacitated individual in the same home as the AFDC-C, -F or -N eligible family when the circumstances described at (d) below exist. The amount of the disregard shall not exceed the limits as follows.

1. \$175.00 per month, per child age two or older, or incapacitated adult, for full-time employment;

2. \$200.00 per month, per child under age two, for full-time employment;

3. \$135.00 per month, per child age two or older, or incapacitated adult, for part-time employment; and

4. \$150.00 per month, per child under age two, for part-time employment.

(d) None of the disregards above shall apply to the earned income of the individual for any month which one of the following conditions apply to him or her:

1. His or her employment is terminated or his or her earned income is reduced without good cause within 30 days prior to that month.

i. Good cause includes the following circumstances:

(1) The termination or reduction is not voluntary;

(2) The wages of employment are below the applicable minimum wage;

(3) The individual is not physically able to engage in the employment;

(4) The employment constitutes a risk to health or safety; or

(5) The applicant voluntarily requested AFDC-related Medicaid be terminated for the primary purpose of avoiding the receipt of the \$30.00 and one-third disregard for four consecutive months.

(e) The earned income disregard of a full-time or part-time student is described in N.J.A.C. 10:69-10.15.

(f) None of the disregards above in this section shall apply to the earned income of the individual for any month in which one of the following conditions apply to him or her:

1. The individual terminated his or her employment or reduced his or her earned income without good cause within 30 days prior to that month.

i. Good cause includes the following circumstances:

(1) The termination or reduction is not voluntary;

(2) The wages of employment are below the applicable minimum wage;

(3) The individual is not physically able to engage in the employment; and

(4) The employment constitutes a risk to health or safety.

2. The individual refused without good cause, within 30 days prior to that month, to accept employment in which he or she is able to engage which is offered through the State Division of Employment Security or any other bona fide offer of employment. The good cause provisions of (f)1i above apply.

3. The individual voluntarily requested AFDC-related Medicaid program coverage to be terminated for the primary purpose of avoiding the receipt of the \$30.00 and one-third disregard for four consecutive months.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Rewrote the section.

10:69-10.14 Disregard of certain allowances and payments in AFDC-related Medicaid program (all segments) for participation in JTPA

(a) Unearned income (including moneys to offset training expenses) received by an AFDC dependent child through the Job Training Partnership Act (JTPA) is exempt in the determination of initial eligibility, maximum income eligibility, and prospective needs test.

(b) Earned income received through the JTPA by an AFDC-related Medicaid program dependent child is exempt in the determination of initial eligibility, maximum income eligibility, and prospective needs test. However, the disregard of such income shall not exceed six months in any calendar year.

1. This disregard of income is independent of the earned income disregard found at N.J.A.C. 10:69-10.8 and 10.15. If a full-time student secures employment unrelated to JTPA participation, another six-calendar-month period shall be established in accordance with the provisions of N.J.A.C. 10:69-10.15(g).

(c) Income received by an AFDC-related Medicaid program parent or parent-person through the JTPA is treated as any other income received by such an individual with the exception of those payments classified as "needs based payments." Needs based payments (that is, moneys paid to offset expenses related to training) shall be disregarded in the determination of initial eligibility, maximum income determination, and prospective needs test.

10:69-10.15 Earned income disregards of a child who is a full or part-time student

(a) The earned income of any child in the eligible unit who is a full-time student, or is a part-time student who is not a full-time employee, shall be exempt in determining need of the eligible unit and in evaluating his or her capacity as a legally responsible relative. (See N.J.A.C. 10:69-10.9 for definitions of full and part-time students.)

(b) For the purposes of this section, a full-time employee shall be any student whose average employment on a monthly basis equals 35 hours a week or more.

(c) A student who is a full or part-time student during the regular school term shall be considered to be a full or part-time student during all vacation periods.

(d) When a child claiming the exemption of earned income described in this section is over 16 years of age, this student shall be informed in writing that he or she has a responsibility for participating in determining his or her eligibility for such exemption. The student and the county board of social services have joint responsibility for securing the factual data from the school necessary to make the determination as to whether he or she is a full or part-time student, and for securing from his or her employer the factual data of monthly hours employed.

(e) Part-time students who are fully employed and are thus not eligible for the exemption of earned income as described in this section are eligible for the appropriate disregards depending on program related Medicaid program.

(f) The exemption of earned income of part-time students under this section does not apply in determining maximum income eligibility in N.J.A.C. 10:69-10.3.

(g) The earned income of a full-time student shall be disregarded in the determination of maximum income eligibility (N.J.A.C. 10:69-10.3) for a total of six months in any one calendar year.

10:69-10.16 Income from family day care

(a) Payments by individuals or agencies for children placed in an eligible family's home for family day care shall be considered as gross earned income from self-employment. Earned income procedures for self-employment are discussed at N.J.A.C. 10:69-10.12.

1. The net income (adjusted gross earnings) to the eligible family is the difference between the cost of providing family day care and the total monthly amount paid for such care. Appropriate disregards apply in determining the calculated earned income (see N.J.A.C. 10:69-10.13).

10:69-10.17 Division of Youth and Family Services payments for foster care

(a) Division of Youth and Family Services' basic monthly payments for the placement of children in foster care and the clothing allowance shall be considered as equal to the cost of providing such care and maintenance. However, when extra payment is received for special services, such additional amount shall be considered as earned income from self-employment (see N.J.A.C. 10:69-10.13).

(b) For purposes of determining AFDC-related Medicaid program eligibility, such foster care children are not considered members of the eligible unit.

10:69-10.18 Income which is not earned

Net income from noneligible household members (except as stated in N.J.A.C. 10:69-10.12(c)), returns from capital investment such as dividends and interest, benefits and pensions, annuities, contributions from relatives, compensation payments, and any other payments not considered as earned income, shall be considered as unearned income. All such income shall be recognized in establishing eligibility.

10:69-10.19 Income from roomer-boarders and table boarders

Roomer-boarders or table boarders are noneligible household members.

10:69-10.20 Income from apartments, rooms or housekeeping units in the eligible unit's home

(a) When the eligible unit is receiving payment from rental of apartments, rooms or housekeeping units, the net income shall be determined by deducting the costs of operation and maintenance from the gross rental income received.

1. The costs of operation and maintenance are the greater of:

i. The actual costs of operation and maintenance, if known or subject to determination, or such reasonable allocation of actual or determined costs as may be indicated according to the space being rented out; or

ii. The number of rooms, excluding bathrooms, being rented out multiplied by the applicable monthly cost figure as follows:

(1) With no utilities: \$23.00;

(2) Including heat only: \$29.00;

(3) Including all utilities: \$34.00.

2. To determine the total cost, multiply the monthly cost figure by the number of rooms in each apartment or housekeeping unit, excluding any room used solely as a bathroom.

3. Deduct the total cost from the amount of rental income received by the eligible unit. The difference is the net income.

i. Rental income shall be treated as earned income except in those situations where rental properties are in the hands of rental agencies; in such case, the income shall be considered as unearned.

(b) When the functions of property management including the collection of rents are performed by a member(s) of the eligible unit, the net is earned income; otherwise it is unearned income.

10:69-10.21 Contributions of support

(a) Obligatory contributions to the support of one or more members of the eligible unit shall be recognized as unearned income, regardless of whether such contributions are in cash or in kind. (See N.J.A.C. 10:69-10.42, Acceptable forms of support.)

(b) When shelter is being provided by a legally responsible relative (LRR) who has been determined by the CBOSS IV-A unit to have a capacity to provide support, the actual cash value shall, whenever possible, be determined and recognized as unearned income to the eligible unit. Where the actual value cannot be established, and is not stipulated by a court order to be made in an identifiable cash amount to a third party, the monthly monetary values shall be recognized according to Schedule VI in N.J.A.C. 10:69-10.42(c) and shall not exceed the LRR's evaluated capacity.

(c) Non-obligatory contributions, other than occasional gifts identified in N.J.A.C. 10:69-3.2, shall be recognized as unearned income only when made in cash to one or more members of the eligible unit (see also N.J.A.C. 10:69-2.2). This does not apply to LRRs who have an evaluated capacity to support.

10:69-10.22 Exempt income

(a) Exempt income is not considered in determining eligibility for AFDC-related Medicaid program.

(b) Income shall be exempted as follows:

1. Income tax refunds, including Homestead Property Tax Rebates;

2. Earned income credit (EIC) payments shall be excluded.

3. Payments for child care (see N.J.A.C. 10:69-5).

4. Child care payments for "special circumstance" children and transportation or the cost of transportation, which is not available from any other source, to transport the "special circumstance" child to and from the child care site when it is essential for the child's physical health and safety.

5. Supplemental aid by other agencies or organizations, whether public or private, provided that:

i. There is no duplication between such aid and the TANF grant;

ii. Such aid is for a special purpose not within the function of the public assistance agency (for example, vocational rehabilitation); or

iii. Such aid is to any undergraduate student for educational purposes.

6. Any income received through the Subsidized Adoption Program of the Division of Youth and Family Services pursuant to N.J.S.A. 30:4C-45 through 49 (P.L. 1973, c.81).

7. Funds received by applicants and beneficiaries through certain Federal programs shall be regarded as exempt income.

i. Benefits or assistance received through the WIC program (Special Supplemental Food program for Women, Infants and Children) and the special food services program for children under the National School Lunch Act as amended by Public Laws 92-433 and 93-150;

ii. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965;

iii. Payments made through Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE), and payments made under Title I of P.L. 93-113 (for example, Volunteers in Service to America (VISTA));

iv. Payments received under the Experimental Housing Assistance Program (EHAP) made under annual contribution's contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937;

v. Payments made through the United States Department of Housing and Urban Development (HUD) Section 8, Rental Assistance Program (RAP), which provides funds to certain disabled individuals and low income families to assist them in meeting shelter costs;

vi. HUD community development block grant funds under Title I of the Housing and Community Development Act of 1974;

vii. Benefits received by eligible households under the Low Income Home Energy Assistance Act of 1981 pursuant to section 2605(f) of Public Law 97-35.

8. The value farm and garden products raised by the eligible unit for its own use is not considered income.

(c) Occasional nonrecurring gifts and contributions of nominal amount or value, such as those for birthdays, graduations, Christmas or other holidays, to the extent the value does not exceed an average of \$30.00 per beneficiary in any calendar quarter, are considered exempt income.

1. In cases where such gifts and contributions exceed an average of \$30.00 per beneficiary in any calendar quarter, that excess shall be counted as unearned income.

2. In determining value, a gift received by one member of the eligible unit but intended for the entire eligible unit

may be allocated among the eligible unit members in the way most advantageous to the entire unit.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (b), rewrote the introductory paragraph, 1 and 2.

10:69-10.23 Nonrecurring earned or unearned lump sum income

(a) When a beneficiary receives nonrecurring earned or unearned lump sum income, including retroactive RSDI payments and other monthly benefits, and payments in the nature of a windfall, such as inheritances and lottery winnings, personal injury and worker compensation awards, to the extent it is not earmarked and used for the purpose for which it was paid (for example, moneys for back medical bills resulting from accidents or injury, funeral and burial costs, or replacement or repair of resources), that income will be added together with all other income received that month by the eligible family after application of the disregards in N.J.A.C. 10:69-10.32 and the exemption of income in N.J.A.C. 10:69-10.31. The TANF grant shall not be considered income. When this total exceeds the standard of need for the eligible family size as set forth at N.J.A.C. 10:69-10.2, the family shall be ineligible for AFDC-related Medicaid program for the number of full months derived by dividing this total income by the standard of need applicable to the eligible family. Any remaining income from this calculation is treated as if it is unearned income received in the first month following the period of ineligibility and is considered available for use at that time. SSI payments shall not be subject to lump sum treatment.

1. For purposes of determining the period of ineligibility, the family includes the AFDC-related Medicaid program eligible unit and any other individual (such as a stepparent) whose lump sum income caused the unit's income to exceed the allowance standard.

2. The period of ineligibility shall begin in the first month subsequent to the month the nonrecurring income is received or, if there is insufficient time for a timely adverse action notice, the following month.

3. In the event the nonrecurring income is not reported timely, the period of ineligibility shall begin at the point the ineligibility would have occurred had the CBOSS had knowledge of its receipt. The amount of Medicaid overpayment for the period of ineligibility must be established and recovery made.

4. The period of ineligibility applies to each individual in the eligible family at the time of receipt of the lump sum nonrecurring income. Other family members to whom the penalty does not apply, may be eligible as a separate Medicaid eligibility unit.

5. Once established, the period of ineligibility may be reduced only in the circumstances below. It is the responsibility of the former eligible family to provide all

necessary information and documentation required to make a determination to shorten the period of ineligibility. The basis for a determination to shorten the period of ineligibility shall be thoroughly documented in the case record.

i. The period of ineligibility may be recalculated when the AFDC standard of need is increased. Upon request of a former AFDC eligible family, the period of ineligibility shall be reduced as follows:

(1) The number of months of ineligibility already elapsed shall be multiplied by the standard of need used to compute the original period of ineligibility;

(2) The result shall be subtracted from the original lump sum amount; and

(3) The remaining amount shall be divided by the new AFDC standard of need for the eligible family size and the result will be the number of months of ineligibility remaining.

ii. The period of ineligibility may be recalculated if the income used to determine such period becomes unavailable to the eligible family for reasons beyond the control of the family members. Acceptable reasons are limited to those below:

(1) The former eligible family shall thoroughly substantiate an allegation of loss or theft of part or all of the lump sum income and shall provide the CBOSS with evidence that a police report of an incident of theft has been filed. Upon receipt of credible evidence of loss or theft of the income, the CBOSS shall reduce the amount of the original lump sum by the amount of the loss or theft. Loss of the income, for the purposes of this section, shall include circumstances where a member of the former eligible family has absconded with the funds.

(2) When the former eligible family incurs and pays verifiable expenses due to an emergent situation, including fire, flood, natural disaster or other emergent situation, for which, had the family been eligible, emergency assistance would have been authorized under N.J.A.C. 10:90, those expenses shall reduce the amount of the original lump sum.

iii. The period of ineligibility may be reduced if the family incurs, becomes responsible for, and pays medical expenses during the period of ineligibility. In such cases, the original income used to compute the period of ineligibility shall be offset by verified medical expenditures. For this purpose, allowable medical expenses are as follows:

(1) Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional;

(2) Hospitalization or outpatient treatment, nursing care, and nursing home care, including payments by the household for an individual who was an eligible family member immediately prior to entering a hospital or nursing home, provided by a facility recognized by the State;

(3) Prescription drugs when prescribed by a licensed practitioner authorized under State law and other over-the-counter medication (including insulin) when approved by a licensed practitioner or other qualified health professional; in addition, costs of medical supplies, sick-room equipment (including rental) or other prescribed equipment;

(4) Health and hospitalization insurance policy premiums;

(5) Medicare premiums related to coverage under Title XVIII of the Social Security Act;

(6) Dentures, hearing aids, and prosthetics;

(7) Securing and maintaining a seeing eye or hearing dog including the cost of dog food and veterinarian bills;

(8) Eye glasses prescribed by a physician skilled in eye diseases or by an optometrist;

(9) The reasonable cost of transportation and lodging to obtain medical treatment or services; and

(10) Maintaining an attendant, homemaker, home health aid, housekeeper, or child care services, necessary because of age, infirmity, or illness.

6. In all instances, where the previously eligible family has been terminated due to receipt of lump sum income, the notice of adverse action shall include:

i. The reason for the family's termination from AFDC-related Medicaid program;

ii. The duration of the period of ineligibility;

iii. The earliest date the ineligible family may apply to reopen their AFDC-related Medicaid program case; and

iv. A statement concerning possible reduction of the ineligibility period (see (a)5ii or iii above).

(b) For the AFDC-related program, lump sum income and the resulting period of ineligibility shall be treated in accordance with the following provisions:

1. Only those individuals actually receiving AFDC-related Medicaid or Medicaid Special are considered to be AFDC-related Medicaid program beneficiaries. Any individual receiving Medicaid Only, New Jersey Care ... Special Medicaid programs, Medicaid Special, NJ Kid-Care or any other medical coverage is not considered an AFDC-related Medicaid program beneficiary. Therefore, a period of ineligibility imposed on a beneficiary of Medicaid Only or Medicaid Special benefits due to the receipt of lump sum income cannot be carried over into the AFDC-related Medicaid program, and cannot cause ineligibility for AFDC-related Medicaid program benefits.

(c) This section is not to be construed to limit any policy pertaining to reimbursement in any program but must be applied in conjunction with any repayment agreement.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

In (a), deleted a former third sentence in the introductory paragraph.

10:69-10.24 Child support received by the eligible unit

The first \$50.00 of any child support payments received on behalf of a dependent child or children by any family applying for or eligible for AFDC-related Medicaid program shall be disregarded. Such child support payments shall include disregarded child support (DCS) payments paid the family through the child support and paternity process and direct support payments received by the eligible unit which represent a current monthly support obligation. These moneys are disregarded in determination of initial eligibility, maximum income eligibility, and the prospective needs test. The total amount of child support disregarded shall not exceed \$50.00 per month per eligible unit.

10:69-10.25 Prospective budgeting

(a) Prospective budgeting policy shall be applied to applicants and beneficiaries of AFDC-related Medicaid program benefits, including Medicaid Special.

(b) AFDC-related Medicaid program eligibility shall be based on a best estimate of the family's income and other circumstances that will exist until the next reported significant change in circumstance or redetermination, whichever is first. The best estimate of income is based on the family's and the agency's reasonable expectations and knowledge of current, past, and future circumstances. In determining the best estimate of income, the CBOSS shall use income averaging and the concept of "significant and non-significant" income and circumstance changes. Verification of the income used shall be clearly documented in the case record.

1. For purposes of determining the family's eligibility, the CBOSS shall determine earnings by obtaining wage information for the four consecutive week period immediately preceding the date of application, redetermination, or change in circumstance. Likewise, all unearned income received within this four-week period is also determined. All earned and unearned income received within this four week period shall be verified and documented in the case record, even if all four weeks of income are not ultimately used to calculate the best estimate.

2. The receipt of income generally occurs weekly, bi-weekly, or on a semi-monthly basis. The CBOSS shall convert the averaged income amount to a gross monthly amount by multiplying the averaged income amount by

the appropriate conversion factor as follows: weekly amounts by 4.333; biweekly amounts by 2.167; and semi-monthly amounts by two.

(c) Significant income and circumstance changes are defined as changes in sources or amounts of earned or unearned income or changes to the eligible unit size which are expected to continue into the future. Examples of significant changes include, but are not limited to: starting a new job or gaining a new source of unearned income; losing a job or a source of unearned income; permanent or long term changes in hours worked and/or rate of pay; permanent or long term changes in unearned income; changing from part-time to full-time employment (or vice versa); promotion or demotion; beginning to work piece work or regular overtime (or vice versa); changing employers; short term plant closings (such as one or more weeks) or periods of sick leave without compensation (more than one day); or addition of or loss of an eligible family member.

1. The CBOSS shall use information about past significant changes of a continuous nature in estimating future income. The date of an anticipated significant income/circumstance change may be used to schedule a desk review to coincide with the expected date of the change, in order to recalculate the best estimate of income.

2. Families shall be required to report all significant changes in income and circumstances that could affect eligibility as soon as possible, but in no event later than 10 calendar days of the date the change happened. The CBOSS shall initiate appropriate action on the reported change within 10 calendar days of receiving the report of the change, subject to timely and/or adequate notice requirements.

(d) Non-significant income/circumstance changes are defined as temporary, very short term variations in the earned or unearned income amount or eligible unit size caused by a situation which is not of an ongoing nature, or which is of a variable nature. Examples include, but are not limited to: fluctuations in wages due to ongoing (reported) earnings from piece work; occasional changes in wages due to very irregular overtime; or an occasional unpaid day off.

(e) The following procedures are to be followed in determining the best estimate of income:

1. Verification through wage stubs or documentation from the employer, of income received within the specified time frame in (b) above. All earned and unearned income received within this four week period shall be verified and documented in the case record even if all four weeks of income are not ultimately used to calculate the best estimate.

2. Determination, through a review of the income documentation and discussion with the family, if there have been any significant changes during that period. If a significant change has occurred and the change is of a continuous nature, the change shall be documented and taken into consideration when determining the best estimate. For example, if a family has received an increase in hourly rate, the new hourly rate shall be multiplied by the appropriate number of hours (either stable or averaged) to determine anticipated income.

3. Determination of any significant changes that are expected in the future. If a significant change is expected and the exact nature of the change is known, the CBOSS shall use the information in determining the best estimate of income and shall require that the family provide the required verification subsequent to the change to determine if the best estimate was correct or needs to be recalculated. If the exact nature of the anticipated change is not known, then a desk review can be scheduled to coincide with the expected date of change and/or the client advised to report the change within 10 days of the date of change.

4. Determination, through review of the documentation, of the case record and discussion with the client, if any of the income received is not expected to be representative of the future. For instance, the first pay check of new employment may not represent a full-pay period; a missing week's income may represent a summer plant closing; or a larger check may represent nonrecurring overtime, all of which may not be anticipated to occur in the future. Non-representative income (or lack of income) shall not be used in calculating the best estimate. The case record shall be clearly documented to explain why any income was not used, and to show how the best estimate was calculated. For example, the family receives regular weekly income but is missing one week's pay due to a plant closing for that week only. The three available amounts would be averaged to determine average weekly income and that average converted to monthly gross income as described in (b)2 above.

5. If income fluctuates (that is, is not exactly the same each time received and/or is not received on a regular schedule) to the extent that a four-week period is not expected to provide the best estimate of income until the next redetermination, the CBOSS shall require the family to submit verified wage information for those months subsequent to the month of review, in order that the CBOSS may recalculate the best estimate. When income fluctuates dramatically, CBOSSs shall recalculate eligibility as often as deemed necessary to ensure the most accurate best for determination of continued AFDC-related Medicaid eligibility.

i. When four consecutive weeks of income fluctuate but are representative of the family's anticipated fluctuation in income for future months, the CBOSS shall average the income from the four-week period and project that gross income estimate for future months, taking into account any anticipated significant changes.

6. The final step shall be to average the income that has been determined to be representative of the eligible family's circumstances and to convert that average to a gross monthly income "best estimate" amount by using the conversion factors set forth in (b)2 above. The best estimate amount shall then be used to determine eligibility until the next redetermination or report of a significant change.

(f) If there are no significant changes in circumstances, a new best estimate of income shall, at a minimum, be completed at the time of the next redetermination of eligibility.

1. When non-significant changes are reported, it shall not be necessary to redetermine eligibility immediately. Non-significant changes shall, however, be taken into consideration when determining the best estimate of income at the next regularly scheduled redetermination. When such changes are reported, the case record shall be clearly documented to show that the change was non-significant.

2. A significant change in circumstances of the eligible family may result in loss of eligibility. The termination of eligibility shall be effective no later than the first day of the month following the month in which the significant change in circumstance occurred, or 10 business days after the change is reported to the CBOSS, whichever is later. Termination of eligibility shall be subject to timely and adequate notice and meet the requirements of N.J.A.C. 10:69-6.

10:69-10.26 Eligibility

(a) In determining initial eligibility, the appropriate disregards shall be applied to earned income.

(b) The effective date of initial eligibility shall be the first day of the month of the date of the application if the client was eligible on the date of application. If the client was found eligible on any other date, initial AFDC-related Medicaid eligibility shall be retroactive to the first day of the month the date eligibility commenced.

Special amendment, R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).

See: 32 N.J.R. 3598(a).

Deleted former (a) and recodified former (b) and (c) as (a) and (b).

10:69-10.27 Income from eligible and noneligible individuals in the household

(a) For purposes of AFDC-related Medicaid program, in family groups living together, income of the spouse is considered available for the other spouse and income of a parent (natural or adoptive) is considered available for children under 18. If the spouse or parent is living with his or her spouse or children, respectively, income is considered available regardless of whether the spouse or natural or adoptive parent is noneligible. However, if a spouse or parent is receiving SSI benefits, including mandatory or optional State supplementary payments, then for the period for which such benefits are received, his or her income shall not be counted as income available to the eligible family.

(b) A noneligible individual is neither sanctioned nor required by law or regulation to be included in the eligible unit. When a noneligible individual is living in the household of an eligible unit, the income from that living arrangement to the eligible unit shall be treated in accordance with N.J.A.C. 10:69-10.3, if extensive personal services are provided, or N.J.A.C. 10:69-10.20. If the non-eligible individual is a non-qualified alien parent (see N.J.A.C. 10:69-3.9), his or her income shall be considered available to the eligible unit and shall be calculated in accordance with the step-parent deeming formula in N.J.A.C. 10:69-10.33 and 10.34.

10:69-10.28 Penalty of ineligibility for CSP sanction

(a) An adult sanctioned for failure to cooperate with the child support and paternity requirements is not included in the eligible unit. When the adult is not included in the eligible unit because of this sanction and has earned or unearned income of his or her own, such income shall be considered available to the remaining members of the eligible unit.

1. For earned income, the net amount to be considered available to the eligible unit shall be determined without application of earned income disregards set forth in N.J.A.C. 10:69-10.10 through 10.23.

10:69-10.29 Needs of certain children temporarily in the home

When an institutionalized child is on temporary visit home (and an AFDC-related Medicaid program eligible case is not in existence), he or she may be eligible for General Assistance if the visit does not exceed 21 consecutive days. If the length of such child's visit is expected to exceed 21 days, the CBOSS shall process an AFDC-related Medicaid program application and evaluate the family's eligibility for AFDC-related Medicaid program for the duration of the visit.

10:69-10.30 Initial eligibility and application of disregards

(a) On all new applications, reapplications, or reopened applications, initial financial eligibility must be established before a AFDC-N-related Medicaid card can be issued.

1. For AFDC-C, -F and -N related Medicaid cases, when the eligible family received AFDC-related Medicaid program assistance in one of the four months prior to the month of application, all earned income disregards at N.J.A.C. 10:69-10.13 shall apply to the determination of initial eligibility. For AFDC-C, -F and -N-related Medicaid cases which have not received AFDC-related Medicaid benefits in one of the four months prior to the month of application, the earned income disregards apply, except that the disregard of the first \$30.00 of the remaining income plus one-third of the remainder does not apply. If total income equals or exceeds the income standard in N.J.A.C. 10:69-10.21 for the eligible family size, the family is ineligible for Medicaid. In the computation of initial

Medicaid eligibility, application of the \$30.00 and one-third earned income disregards is subject to the limitations at N.J.A.C. 10:69-10.16.

2. The earned income of a full-time student shall be disregarded in determining initial Medicaid eligibility to the same extent as provided in N.J.A.C. 10:69-10.15. The income of a part-time student is not disregarded in determining initial eligibility.

10:69-10.31 Procedures for determining initial eligibility for AFDC-C, -F and -N related Medicaid

(a) The procedures regarding initial income eligibility are:

1. Identify the number of persons in the eligible unit; and
2. Determine the total monthly income (including gross earned income) available to the eligible unit and compare it to the maximum income level in N.J.A.C. 10:69-10.3 (Exception: For a non-needy stepparent who marries an AFDC-C related Medicaid beneficiary parent on or after October 1, 1992, eligibility for the children shall be determined in accordance with the regulations at N.J.A.C. 10:69-10.33 or 10.34 as applicable.) If total income equals or is less than the maximum for the appropriate eligible unit size, maximum income eligibility has been established. If total income exceeds the appropriate maximum for any month, the family is not eligible for AFDC-related Medicaid program.

10:69-10.32 (Reserved)

10:69-10.33 AFDC-C procedures for stepparents

(a) When a stepparent of eligible AFDC-C-related Medicaid program children is in fact a member of the household and has married the natural or adoptive beneficiary parent, the natural or adoptive parent who is applying for or receiving AFDC-related Medicaid program shall be afforded the following elective options:

1. The stepparent may be included as a member of the eligible unit, with all needs recognized and his or her income considered in determining AFDC-related Medicaid eligibility.
2. The stepparent may not be included in the eligible unit, in which case the income of the stepparent shall be treated in accordance with (d) below.

(b) The options and all consequences thereof shall be fully discussed with the applicant before the decision is made. The decision as to whether the stepparent shall be included (assuming the stepparent is so willing) or excluded shall be made by the natural or adoptive parent.

(c) When the stepparent who has married the AFDC-C-related Medicaid program beneficiary parent and is not

included in the eligible unit, the eligible unit shall consist of the natural or adoptive parent and the eligible children.

1. The parent of the eligible children shall sign the application for AFDC-related Medicaid and fulfill all obligations contained therein.

2. The eligible unit's financial eligibility shall be computed in accordance with N.J.A.C. 10:69-10.3(c). The countable income of the stepparent to the eligible unit, as determined in (d) below, shall be deducted as a countable income source.

(d) When a stepparent of eligible AFDC-C-related Medicaid program children lives in the same home as the children, has married the AFDC-C-related Medicaid program beneficiary parent, and is not included as a member of the eligible family, his or her income shall be considered available to the eligible family in accordance with the following procedures:

1. Reduce the stepparent's gross earned income (and net income from self-employment) by \$90.00;

2. Add the result to the stepparent's unearned income;

3. Further reduce the remaining income by the appropriate amount in the standard of need (N.J.A.C. 10:69-10.2) for the stepparent and any other individuals residing in the household who are or could be claimed by the stepparent as dependents for Federal personal income tax liability and who are not beneficiaries of AFDC-C, -F or -N related Medicaid program;

4. The remaining income shall be further reduced by amounts paid by the stepparent to individuals not living in the household who are or could be claimed by him or her as dependents for purposes of determining his or her Federal personal income tax liability;

5. Any income remaining shall be reduced by any amounts paid by the stepparent as alimony or child support to individuals not living in the household; and

6. All income remaining shall be counted as unearned income available to the eligible unit and shall be counted toward total income (N.J.A.C. 10:69-10.3(a)).

10:69-10.34 (Reserved)

10:69-10.35 Procedures for AFDC-C and -F related Medicaid eligibility

(a) A child not meeting AFDC-related Medicaid age requirements but who is under age 21, may be eligible for Medicaid Special if he or she would be otherwise eligible for AFDC-C or -F except for age (see N.J.A.C. 10:69-4).

(b) Medicaid eligibility does not exist in cases where, after excluding the child(ren) whose income caused ineligibility for AFDC-related Medicaid, there is no child remaining in the eligible family.

(c) Any family whose eligibility is denied or terminated as a result of deeming of a sibling's or stepparent's income shall have its AFDC-related Medicaid eligibility evaluated without regard to that individual's needs or income.

1. When a sponsor is found to have good cause or to be without fault for not providing information to the CBOSS, the sponsor shall not be held liable for a recovery of incorrectly paid benefits.

i. Good cause is defined as including, but not limited to, a language barrier, mental impairment of the sponsor, the information was thought to be correct by the sponsor, or the sponsor did not realize foreign assets must be reported.

2. Incorrectly paid benefits for which the alien or the sponsor and the alien are liable as described in (f) above shall be recovered in accordance with the provisions of N.J.A.C. 10:49-14.

10:69-10.44 Deeming income of parents of adolescent parents

(a) Pursuant to the Tax Reform Act of 1986 (P.L. 99-514), which clarifies certain amendments of the Deficit Reduction Act of 1984 (P.L. 98-369), an adolescent parent is an individual under the age of 18 and who is himself or herself a parent of a dependent child.

(b) When an adolescent parent lives in the same home as his or her own parent(s), the income of such parent(s) shall be considered available to the eligible family in accordance with the following procedures. These rules do not apply if the parent(s) receive(s) SSI or AFDC-related Medicaid or if the adolescent parent is categorically eligible for the AFDC-N related Medicaid program only.

1. The gross earned income (and net income from self-employment) of each employed parent shall be reduced by \$90.00.

2. The result shall be added to the unearned income of the parent(s).

3. The remaining income shall be further reduced by the appropriate amount from the standard of need (N.J.A.C. 10:69-10.2) for the parent(s) and any other individuals residing in the household who are or could be claimed by the parent(s) as dependents for Federal personal income tax liability and who are not beneficiaries of TANF or AFDC-C, -F or -N-related Medicaid.

4. The remaining income shall be further reduced by amounts paid by the parent(s) to individuals not living in the household who are or could be claimed by him or her as dependents for purposes of determining his or her Federal personal income tax liability.

5. Any income remaining shall be reduced by any amounts paid by the parent(s) as alimony or child support to individuals not living in the household.

6. All income remaining shall be counted as unearned income available to the eligible unit and shall be counted toward total income (N.J.A.C. 10:69-10.3) and in the determination of eligibility.

i. In the event the eligible family unit is determined financially ineligible for AFDC-related Medicaid program due to the inclusion of such deemed income, Medicaid eligibility for the dependent child(ren) of the adolescent parent shall be determined in accordance with (c) below.

(c) When a family is determined financially ineligible for AFDC-related Medicaid due to deeming of the income of the parent(s) of an adolescent parent in accordance with this section, the dependent child(ren) of the adolescent parent shall be or continue to be eligible for AFDC categorically-related Medicaid coverage as long as the family's countable income, excluding the deemed income of the parent(s) of the adolescent parent, is less than the AFDC eligibility standard set forth at N.J.A.C. 10:69-2.6, Schedule II, as applicable for the family size. Eligibility, in such instances, would be limited to the dependent child(ren) of the adolescent parent; the adolescent parent, therefore, would remain ineligible for such Medicaid coverage.

(d) If the adolescent parent does not live in the same home as his or her parents, the legally responsible relative provisions of N.J.A.C. 10:69-3.31 apply, and Schedule IV-B of N.J.A.C. 10:69-10.41(a) shall apply.

SUBCHAPTER 11. RESOURCES

Authority

N.J.S.A. 30:4D-7a, b and c, and 30:4J-1 et seq.

Source and Effective Date

R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001).
See: 32 N.J.R. 3598(a).

Subchapter Historical Note

Subchapter 11, Resources, was specially repealed and Subchapter 11, Resources, was adopted as special new rules by R.2000 d.411, effective September 12, 2000 (to expire March 12, 2001). See: Source and Effective Date.

10:69-11.1 Resources and eligibility

(a) Individuals seeking benefits under the provisions of this chapter shall be determined eligible or ineligible without regard to the value of the household unit's resources. The eligibility determination agency shall inquire about the household unit's resources only in order to establish income that may result from the household unit's resources.

1. For the purposes of this section, resources shall include, but not be limited to, stocks, bonds, certificates of deposit, savings accounts and checking accounts.

**SUBCHAPTER 12. PRESUMPTIVE ELIGIBILITY
FOR AFDC-RELATED MEDICAID
CHILDREN**

Authority

Sections 1902(a)(47), 1903(u)(1)(D)(v) and 1920A of the Social Security Act (42 U.S.C. §§ 1396a(a)(47), 1396(a)(8), 1396(b)(u)(1)(D)(v) and 1396r-1a) and P.L. 1999 d.170.

Source and Effective Date

R.2000 d.266, effective July 3, 2000.
See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

10:69-12.1 Scope

This subchapter describes presumptive eligibility for children up to the age of 19 who otherwise meet the eligibility requirements for AFDC-related Medicaid or Medicaid Special. The presumptive eligibility determination makes it possible for a child or the children to be covered by AFDC-related Medicaid or Medicaid Special services from a Medicaid provider for a temporary period prior to application for AFDC-related Medicaid or Medicaid Special benefits and while an application for these benefits is being processed by the county board of social services.

10:69-12.2 Period of presumptive eligibility

(a) The period of presumptive eligibility shall begin on the date an approved presumptive eligibility entity determines that, based on information provided by the family or representative of the presumptive eligibility beneficiary, the child(ren) meet(s) the requirements and standards of this subchapter.

(b) The period of presumptive eligibility shall terminate:

1. On the date a determination of eligibility or ineligibility for AFDC-related Medicaid or Medicaid Special is made; or

2. If the child (if appropriate), the child's parent, guardian, caretaker relative, or sponsoring adult fails to file an application with the county board of social services, on the last day of the month subsequent to the month in which the child(ren) was determined presumptively eligible.

**10:69-12.3 Requirements for presumptive eligibility
determination entities**

(a) A qualified presumptive eligibility entity shall be a New Jersey Medicaid provider and:

1. An acute care hospital;
2. A local health department; or
3. A Federally Qualified Health Center (FQHC).

(b) An entity shall apply to the Division of Medical Assistance and Health Services and shall be approved as a presumptive eligibility determination agency upon training of the entity by the Division of Medical Assistance and Health Services.