workers assigned to outstation locations to evaluate the information contained on the application and the supporting documentation and make a determination of eligibility if the workers are authorized to determine eligibility for the agency which determines Medicaid eligibility under §431.10 of this subchapter.

(e) Staffing. (1) Except for outstation locations that are infrequently used by the low-income eligibility groups, the State agency must have staff available at each outstation location during the regular office operating hours of the State Medicaid agency to accept applications and to assist applicants with the application process.

(2) The agency may station staff at one outstation location or rotate staff among several locations as workload and staffing availability dictate.

(3) The agency may use State employees, provider or contractor employees, or volunteers who have been properly trained to staff outstation locations under the following conditions:

(i) State outstation intake staff may perform all eligibility processing functions, including the eligibility determination, if the staff is authorized to do so at the regular Medicaid intake office.

(ii) Provider or contractor employees and volunteers may perform only initial processing functions as defined in paragraph (d)(2) of this section.

(4) Provider and contractor employees and volunteers are subject to the confidentiality of information rules specified in part 431, subpart P, of this subchapter, to the prohibition against reassignment of provider claims specified in §447.10 of this subchapter, and to all other State or Federal laws concerning conflicts of interest.

(5) At locations that are infrequently used by the designated low-income eligibility groups, the State agency may use volunteers, provider or contractor employees, or its own eligibility staff, or telephone assistance.

(i) The agency must display a notice in a prominent place at the outstation location advising potential applicants of when outstation intake workers will be available.

(ii) The notice must include a telephone number that applicants may call for assistance.

(iii) The agency must comply with Federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

[59 FR 48809, Sept. 23, 1994]

APPLICATIONS

§435.905 Availability of program information.

(a) The agency must furnish the following information in written form, and orally as appropriate, to all applicants and to all other individuals who request it:

(1) The eligibility requirements.

(2) Available Medicaid services.

(3) The rights and responsibilities of applicants and beneficiaries.

(b) The agency must publish in quantity and make available bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms.

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980]

EFFECTIVE DATE NOTE: At 77 FR 17208, Mar. 23, 2012, §435.905 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§435.905 Availability of program information.

(a) The agency must furnish the following information in electronic and paper formats (including through the Internet Web site described in §435.1200(f) of this part), and orally as appropriate, to all applicants and other individuals who request it:

(1) The eligibility requirements;

(2) Available Medicaid services; and

(3) The rights and responsibilities of applicants and beneficiaries.

(b) Such information must be provided to applicants and beneficiaries in plain language and in a manner that is accessible and timely to—

(1) Individuals who are limited English proficient through the provision of language services at no cost to the individual; and

(2) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.
§ 435.907 Written application.

(a) The agency must require a written application from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

(b) Subject to the conditions specified in paragraph (c) of this section, the application must be on a form prescribed by the agency and signed under a penalty of perjury.

(c) The application form used at outstation locations for low-income pregnant women, infants, and children specified in § 435.904 must not be the application form used to apply for AFDC. The application form (including any computerized application form) for these designated eligibility groups may be—

(1) A Medicaid-only form prescribed by the agency specifically for the designated eligibility groups;

(2) An existing Medicaid-only application; or

(3) A multiple-program application that contains clearly identifiable Medicaid-only sections or parts.

[59 FR 48810, Sept. 23, 1994]

EFFECTIVE DATE NOTE: At 77 FR 17208, Mar. 23, 2012, § 435.907 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 435.907 Application.

(a) Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant’s household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility—

(1) Via the Internet Web site described in § 435.1200(f) of this part;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

(b) The application must be—

(1) The single, streamlined application for all insurance affordability programs developed by the Secretary; or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in paragraph (b)(1) of this section, approved by the Secretary.

(c) For individuals applying, or who may be eligible, for assistance on a basis other than the applicable MAGI standard in accordance with § 435.911(c)(2) of this part, the agency may use either—

(1) An application described in paragraph (b) of this section and supplemental forms to collect additional information needed to determine eligibility on such other basis; or

(2) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard. Such application must minimize burden on applicants.

(3) Any MAGI-exempt applications and supplemental forms in use by the agency must be submitted to the Secretary.

(d) The agency may not require an in-person interview as part of the application process for a determination of eligibility using MAGI-based income.

(e) Limits on information. (1) The agency may only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the State plan.

(2) The agency may request information necessary to determine eligibility for other insurance affordability or benefit programs.

(3) The agency may request a non-applicant’s SSN provided that—

(i) Provision of such SSN is voluntary;

(ii) Such SSN is used only to determine an applicant’s or beneficiary’s eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the administration of the State plan; and

(iii) At the time such SSN is requested, the agency provides clear notice to the individual seeking assistance, or person acting on such individual’s behalf, that provision of the non-applicant’s SSN is voluntary and information regarding how the SSN will be used.

(f) The agency must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted.

(g) Any application or supplemental form must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with § 435.905(b) of this subpart.
Centers for Medicare & Medicaid Services, HHS

§ 435.908 Assistance with application.

The agency must allow an individual or individuals of the applicant’s choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

Effective Date Note: At 77 FR 17208, Mar. 23, 2012, § 435.908 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 435.908 Assistance with application and renewal.

(a) The agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with § 435.905(b) of this subpart.

(b) The agency must allow individual(s) of the applicant or beneficiary’s choice to assist in the application process or during a renewal of eligibility.

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency must not require a separate application for Medicaid from an individual, if—

(a) The individual receives AFDC; or

(b) The agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

(1) The individual receives SSI;

(2) The individual receives a mandatory State supplement under either a federally-administered or State-administered program; or

(3) The individual receives an optional State supplement and the agency provides Medicaid to beneficiaries of optional supplements under § 435.230.

§ 435.910 Use of social security number.

(a) The agency must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs).

(b) The agency must advise the applicant of—

(1) [Reserved]

(2) The statute or other authority under which the agency is requesting the applicant’s SSN; and

(3) The uses the agency will make of each SSN, including its use for verifying income, eligibility, and amount of medical assistance payments under §§ 435.940 through 435.960.

(c)-(d) [Reserved]

(e) If an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must—

(1) Assist the applicant in completing an application for an SSN;

(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and

(3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

(f) The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual’s SSN by SSA.

(g) The agency must verify each SSN of each applicant and beneficiary with SSA, as prescribed by the Commissioner, to insure that each SSN furnished was issued to that individual, and to determine whether any others were issued.

(h) Exception. (1) A State may give a Medicaid identification number to an applicant who, because of well established religious objections, refuses to obtain a Social Security Number (SSN). The identification number may be either an SSN obtained by the State on the applicant’s behalf or another unique identifier.

(2) The term well established religious objections means that the applicant—

(i) Is a member of a recognized religious sect or division of the sect; and

(ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(3) A State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

§ 435.910 Use of Social Security number.

(a) Except as provided in paragraph (h) of this section, the agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of his or her Social Security numbers (SSN).

* * * * *

(f) The agency must not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual’s SSN by SSA or if the individual meets one of the exceptions in paragraph (h) of this section.

(g) The agency must verify the SSN furnished by an applicant or beneficiary to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

(h) Exception. (1) The requirement of paragraph (a) of this section does not apply and a State may give a Medicaid identification number to an individual who—

(i) Is not eligible to receive an SSN;

(ii) Does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

(iii) Refuses to obtain an SSN because of well-established religious objections.

(2) The identification number may be either an SSN obtained by the State on the applicant’s behalf or another unique identifier.

* * * * *

DETERMINATION OF MEDICAID ELIGIBILITY

§ 435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—

(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and

(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency’s control.

(d) The agency must document the reasons for delay in the applicant’s case record.

(e) The agency must not use the time standards—

(1) As a waiting period before determining eligibility; or

(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

§ 435.911 Determination of eligibility.

(a) Statutory basis. This section implements sections 1902(a)(4), (a)(8), (a)(10)(A), (a)(19), and (e)(14) and section 1943 of the Act.

(b)(1) Applicable modified adjusted gross income standard means 133 percent of the Federal poverty level or, if higher—

(i) In the case of parents and other caretaker relatives described in § 435.110(b) of this part, the income standard established in accordance with § 435.110(c) of this part;

(ii) In the case of pregnant women, the income standard established in accordance with § 435.116(c) of this part;

(iii) In the case of individuals under age 19, the income standard established in accordance with § 435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State’s phase-in plan has been implemented for the individual whose eligibility is being determined.

(ii) In the case of pregnant women, the income standard established in accordance with § 435.110(c) of this part;

(iii) In the case of individuals under age 19, the income standard established in accordance with § 435.118(c) of this part;

(iv) The income standard established under § 435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State’s phase-in plan has been implemented for the individual whose eligibility is being determined.

(2) [Reserved]