

KC1600 – E&D Pre-Populated Review Form Eligibility Processing Job Aid

This Job Aid is intended to provide instruction on the required elements of the KC1600 – Elderly and Disabled Medical Pre-Populated Review form. This job aid identifies when an answer left blank is acceptable and when additional follow-up is required.

The review form includes the following sections:

- Step 1:** Reporting changes
- Step 2:** Adding a new household member, if applicable
- Step 3:** Providing more information about changes

Assumptions and Requesting Information

In the sections outlined below, there will be various places where staff are allowed to make assumptions about the answer (or lack of an answer) provided. However, if contact is required with the consumer about any eligibility component, then clarification is required for all elements where an assumption was made.

If all information is not received from the consumer, re-evaluate the information requested to determine if an assumption could have been made in order to complete processing of the review.

Step 1 – Review the Household Information

Section A: Name and Address

Form asks to confirm the name, address and contact information.

| Application Question | Eligibility Action |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Are your name, address, and contact information correct in the box in the upper right-hand corner? | If left blank, assume the information is correct. |

Section B: Household Information

Form lists all household members, their relationship to the Primary Applicant, whether or not the individual is currently covered, and asks to confirm each person is in the home and, if the person wants medical assistance. This section also asks if there is anyone else living with them.

Note: The form only reports information for the Program Block that is being reviewed. So, if there is a household member that is open on another program block, such as a LTC recipient, they will be listed as NOT receiving medical coverage currently because they are not on the same program block. It should never be assumed that the consumer wants to end the other household member’s medical assistance based on a response or lack of a response in this section.

| Application Question | Eligibility Action |
|---------------------------------------|-----------------------------------|
| Still live with you? | If left blank, assume Yes. |
| Want medical assistance? | If left blank, assume No changes. |
| Is there anyone else living with you? | If left blank, assume No. |

Section C: Income

Form lists all income that is on file in KEES and asks to confirm if the income still exists and if the amount is still the same. Also asks if there are any changes in any of the income. If the form indicates 'Nothing on File', and they do not indicate that there are any changes, it is assumed that the consumer still has no forms of income.

| Application Question | Eligibility Action |
|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Still have this income? | If left blank, assume No changes. |
| Is the amount the same? | <p>If left blank, verification of income amount is required and shall be obtained using the methods described below.</p> <ul style="list-style-type: none"> • Payer sources such as SSA/SSI and Unemployment Income shall be verified. • VA, RRB, and other types of Unearned Income: If verification has been obtained since the last expected change, new verification shall not be requested and current information will be used. • Earned Income shall be verified following the tier structure using MAGI or old school budgeting as appropriate. |
| Is there any change in any of the income listed? | <p>If left blank, assume No changes.</p> <p>Note: Answering No to this question is also indicative that there are no other new income sources to report, unless additional information is provided in Step 3.</p> |

Section D: Resources

Form lists all resources that are on file in KEES and asks if they still have the resource and the current value of the resource. The applicant is also expected to provide answers regarding the existence of all resource types. If the form indicates 'Nothing on File', and they do not indicate that there are any changes, it is assumed that the consumer still has no resources unless a red flag or other discrepant information is identified.

Examples of red flags include but are not limited to the following:

- Some questions are marked 'No' but others are left blank
- Questions were answered but then marked out
- Bank statements are provided that show transfers to/from accounts that are not documented in KEES and have not previously been reported
- EATSS shows the consumer's Social Security income being direct deposited into a bank account that has not been reported

| Application Question | Eligibility Action |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you still have this resource? | Must obtain an answer. |
| Current Amount or Value | <p>Must obtain an answer. Proof of new value required for existing non-exempt resources in the following circumstances:</p> <ul style="list-style-type: none"> • Real Property: Last verified 12 months ago. • Personal Property: Last verified 12 months ago. • Liquid Resources: Last verified 3 months ago. <p>Proof of existing exempt resources are not required at review unless a change is reported which affects the exempt status of the resource.</p> |
| For all items below, a Yes or No answer is required. If the answer is Yes – Verification of the Resource is required. If ALL of the questions in this section are left blank, it can be assumed there are no additional resources to report unless a red flag or discrepant information is identified. | |
| Cash | |
| Checking Account | |
| Savings Account | |
| Certificate of Deposit (CD) | |
| Retirement Plan | |
| Annuity | |
| Other Real Estate | |
| Promissory note or loan | |
| Funeral or Burial Plans | |
| Burial Plots | |
| Vehicle | |
| Home | |
| Trust | |
| Stocks or Bonds | |
| Life estate or Life interest in property | |
| Other Assets | |
| For all items below, a Yes or No answer is required. If the answer is Yes – Verification of the Resource is required if the individual is requesting LTC. For all other requests, the Journal must include potential Transfer of Property information that will affect future requests for LTC. | |
| Have you or your spouse ever waived rights to an inheritance or will? | Yes or No answer is required. |
| Have you or your spouse taken a loan against any property in the last five years, including a second mortgage or reverse mortgage? | Yes or No answer is required. |
| Have you or your spouse ever worked with an attorney for Estate Planning purposes? | Yes or No answer is required. |

| Application Question | Eligibility Action |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Have you or your spouse sold, traded, given away or changed ownership of any property such as a house or money or any other property in the last 5 years? | Yes or No answer is required. |

Section E: Expenses

Form lists all expenses that are on file in KEES and asks if there have been any changes to the expense information.

| Application Question | Eligibility Action |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Is there any change in any of the expenses listed above? | If left blank, assume No changes for recurring monthly expenses such as health insurance premiums. For non-recurring expenses such as past due and owing expenses, research is necessary to determine if/when the expense should be end dated. |

Section F: Health Insurance

Form lists information about health insurance and asks if the insurance information has changed. If the form indicates 'Nothing on File', and they do not indicate that there are any changes, it is assumed that the consumer still has no other health insurance.

| Application Question | Eligibility Action |
|----------------------------------------------------------|-----------------------------------|
| Any change? | If left blank, assume No changes. |
| Is there any change in any of the expenses listed above? | If left blank, assume No changes. |

Step 2 – Reporting Changes in the Household

Address or Phone Number

This section is used to provide an update to the address or phone number for the household. Assume no changes if nothing included in this section.

Adding a New Person

This section is used to add a person who is living in the home that was not already included on the Review Form. The questions presented on the review form do NOT capture everything that may be required to make an eligibility decision. Specific assumptions are allowed and documented below:

- Assume the individual is NOT pregnant.
- Assume the individual is NOT disabled.
- Assume the individual was NOT in Kansas foster care on their 18th birthday.

If the individual is requesting medical assistance and enough information is not provided in the questions outlined below, then send an Application Supplement to the consumer to complete.

| Application Question | Eligibility Action |
|----------------------------|--------------------|
| Name (First, middle, last) | Must obtain answer |

| Application Question | Eligibility Action |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maiden Name | Not required |
| Relationship to Person 1 | Must obtain answer; use other known family relations to try to determine relationship before contacting applicant. |
| Relationship to Person 2 | Must obtain answer; use other known family relations to try to determine relationship before contacting applicant. |
| Gender | Must obtain answer |
| Date of Birth | Must obtain answer |
| Marital Status | Not required |
| Person live at the same address as applicant | Assume Yes, if left blank |
| Lived in a state other than Kansas in the last 3 months | Required if requesting assistance with prior medical |
| Applying for medical assistance | Assume No, if left blank |
| Special types of Medical | <p>The special medical types determine what is entered into ABMS for the Requested Medical Type.</p> <ul style="list-style-type: none"> • Working Healthy RMT <ul style="list-style-type: none"> ○ Working Healthy • Long Term Care RMT <ul style="list-style-type: none"> ○ HCBS ○ Nursing Home ○ PACE • Medical RMT <ul style="list-style-type: none"> ○ Medically Needy ○ Medicare Costs • MSP RMT <ul style="list-style-type: none"> ○ Medicare Costs ONLY (no other assistance) |
| Guardian or conservator? | Assume No, if left blank |
| Social Security # | Required, if requesting assistance. |
| U.S. citizen | Required, if requesting assistance. The Federal Hub may provide the answer. |
| Race | Required for ABMS. If left blank, choose Other |
| Ethnicity | Required for ABMS. If left blank, choose Other |
| Delivered a baby in the last 3 months | Assume No, if left blank. Identifies a potential SOBRA application. Used when the applicant is a non-citizen. |
| Emergency care in the last 3 months | Assume No, if left blank. Identifies a potential SOBRA application. Used when the applicant is a non-citizen. |
| Prior Medical | Assume No, if left blank, unless a baby was born in the prior 3 months, other indication of recent major medical expense, or approving LMB. |
| Changes in the household during the last 3 months | Must obtain answer if prior medical assistance has been requested. |
| Description of household changes | Required if above answered Yes. |
| Changes in the income during the last 3 months | Must obtain answer if prior medical assistance has been requested. |
| Description of income changes | Required if above answered Yes. |

| Application Question | Eligibility Action |
|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Changes in the assets during the last 3 months | Must obtain answer if prior medical assistance has been requested. |
| Description of asset changes | Required if above answered Yes. |
| Which of the following best describes this person's current living situation? | Assume 'Own Home' if left blank, unless the applicant has requested Long Term Care. If requesting Long Term Care, need to make contact with applicant to determine if HCBS or Nursing Facility is the living situation. |
| Living outside of the home | Assume No, if left blank |
| If yes, why is this person living outside of the home? | Must obtain answer |
| Date expected to return | Must obtain answer |
| If in a hospital, nursing facility or other institution, what is the name of the facility? | Must obtain answer |
| Date Admitted | Must obtain answer |
| Date Discharged | Must obtain answer |
| Has this person ever been in a hospital or nursing facility for more than 30 days in a row? | Required for a spousal impoverishment assessment. Otherwise, assume no. |
| If yes, when | Required for a spousal impoverishment assessment. |
| Has this person served in the military? | Assume No, if left blank. |
| Is this person the spouse or widow of someone who served in the military? | Assume No, if left blank. |
| What is this person's VA file number? | Not Required |
| Does this person pay for medical expenses? | Assume No, if left blank. |
| How much is the expense? | Required in order to determine if the expense is allowable. |
| How often? | Required in order to determine if the expense is allowable. |
| Describe the expense | Required in order to determine if the expense is allowable. |
| Does this person have a disability that will last at least 12 months or result in death? | Assume No, if left blank. |
| Has this person ever applied for Social Security benefits? | Assume No, if left blank. |
| Was the application denied? | All answers required if the above is Yes. |
| If yes, when? | |
| Is the denial under appeal? | |
| If yes, what is the status? | |

| Application Question | Eligibility Action |
|------------------------------------------------------------------------------------------------------------------|--------------------|
| Has the existing condition become worse since the Social Security denial? | |
| If yes, explain | |
| Does this person have a new disability or condition that Social Security did not look at? | |
| If yes, briefly describe the disability | |
| Is an attorney or someone else helping this person with the Social Security application for disability benefits? | |
| If yes, list the name of the person and organization | |
| Phone number of the Person or Organization | |

Step 3 – Other Important Household Information

In Step 3, the applicant is required to provide additional information about any changes that were reported in Step 1. This is also the place to provide income, health insurance and expense information for a person added in Step 2.

| Application Question | Eligibility Action |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| INCOME | |
| Are there other people from Step 2 who have income? | Must obtain answer if relevant to the eligibility determination (e.g. reporting a spouse at review). |
| Name | If answer to above is Yes, or consumer indicated a change in income in Step 1, an answer to all of these questions is required. |
| Source of Income | |
| How much? | |
| How often? | |
| HEALTH INSURANCE | |
| Multiple Health Insurance Questions | A TPL referral is completed with all information known. All answers are not required in order to approve Medicaid coverage. If additional information is needed about the health insurance policy, it will be requested after Medicaid approval, and only after the MMIS fiscal agent has a chance to verify the information. |
| EXPENSES | |
| Type of Expense | If consumer indicated a change in expenses in Step 1, an answer to all of these questions is required. |
| Amount | |
| How often? | |

Medical Representative

Form allows the applicant to appoint a medical representative.

If nothing new reported, assume the existing medical representative continues.

If a new medical representative is reported and one already exists, make contact with the consumer to determine if they are revoking the initial medical representative or adding a second one.