



## **Job Aid – DCF Processing E&D Applications after January 1<sup>st</sup>, 2016**

### **Objective**

The goal of this job aid is to provide guidelines for DCF staff experienced in medical assistance to process applications for coverage under Elderly and Disabled programs.

### **Overview**

DCF will be processing E&D applications beginning March 21, 2016. Applications come from multiple channels and may have been originally submitted to DCF. Applications may also be late reviews.

This Job Aid provides processing instructions for DCF staff responsible for processing medical assistance prior to the ERO transition. The Job Aid is not intended for staff who have not previously processed medical cases. It focuses on changes that have occurred since the transition of the Elderly and Disabled caseload in January or that are specific to the Clearinghouse. The Job Aid covers independent living as well and institutional Long Term Care. It does not include Specialty applications or HCBS/MFP/PACE. Topics include task management, requesting information, communicating with third parties, verification and notices/forms.

### **Process**

Work is obtained through a report that will be distributed by DCF. Select the Eligibility tab then search on the case number. This will navigate to the Case Summary.

#### **1) Research and Screen**

Research the request for coverage to become familiar with the application and any information that was previously available for the household.

**NOTE:** The Registration team is starting a new process that changes how applications are registered when multiple applications are received. Registration staff no longer E-Link each application to the case. They will add a journal entry that identifies the E-app number of each application and will re-index images to the case.

a) Review the Application.

Review the request for coverage by perusing the request. These include:

- i) The image of a paper document
- ii) An E-Application (see Job Aid – Searching for an E-App using E-Tools - Attached)
- iii) The PDF of an E-application through Images or the SSP Document Drawer (see Job Aid – Locating Application in ImageNow – attachment)
- iv) The Journal for any verbal request for coverage

- v) The E-application for MIPPA or FFM applications
- vi) If there are multiple Applications/Requests for the case, review each document
- b) Read all journal entries made in recent history.

Review any past history on the application and/or family. Don't forget to review journal entries on Companion Cases too.

- i) Click Journal on the Utility task bar.



- ii) From the Journal List, click on **List Options**.



- iii) Update the Date Range to include all journals from the past 12 months. Click Search.

**Resource ID:**

**Journal Type:**

**Case Number:**

**Contact Type:**  


- Document
- Email
- Inbound Call

**Date Range:**  
 From  To

**Source:**

**Keyword Search:**

- c) Review any previous case history
  - i) Status of each program block
  - ii) Who is included in each program block
  - iii) Ghost Worker ID assigned to each program block
  - iv) Does someone on the case or program block have active coverage? If so, what type of coverage is it? What is each recipient's RMT?
  - v) If the program block was previously discontinued, determine if the new request was received within the Reactivation (RA) timeframe.
- d) Request for Specialty Coverage
  - i) If there is a request for coverage for one of the following programs, DO NOT WORK the application.



- Working Healthy
- MediKan Reintegration
- SOBRA
- Inmate
- Refugee
- Pre-Release
- Breast and Cervical Cancer
- SOAR
- TBI

## 2) View the images

a) Review the application

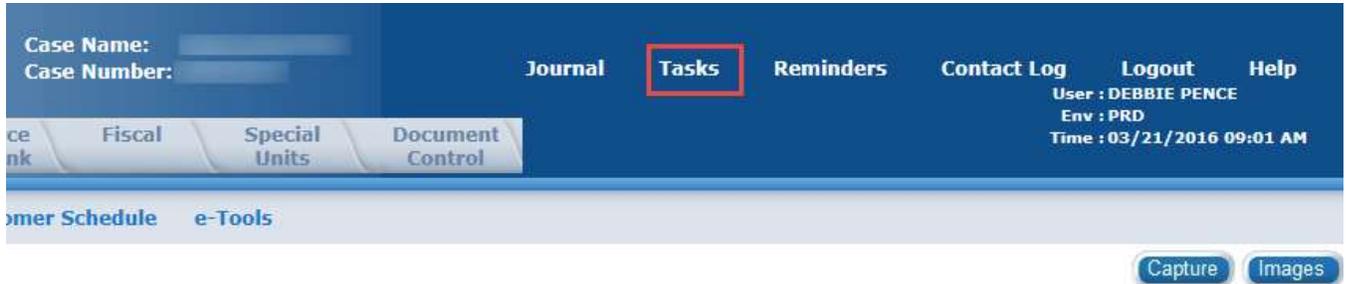
Quick Search		Search		
Case Number	starts with			
Created	Drawer	Received Date	Case Number	Document Type
1/4/2016	KEES Case	12/31/2015	2000000	CH Review

- b) Ensure the application form has been signed.
- c) Refer to *KC1500 – Elderly and Disabled Application Job Aid* to determine an acceptable answer for each question. Document is attached
- d) If the request is for institutional coverage, request an MS-2126 from the facility. The facility must fax the form to the Clearinghouse: 1-844-264-6285. Also, request a CARE score from KDADS.
- e) Screen for HCBS/PACE/MFP - If the consumer is requesting to add or change HCBS, PACE, or MFP, **DCF does not process.**
- f) Screen for PMDT

For applications that require a PMDT referral, follow the new process for sending a referral to PMDT. See PMDT Communications Job Aid - attachment.

3) Are you able to work the Application

a) **If yes** - Click on Tasks hyperlink at the top of the page.



b) The Task Management page displays. Claim all task on the case related to the E & D Application. DCF is responsible for completing other tasks associated with the case as part of processing the application.

Task Management				
Case 12693723 Tasks: <span style="float: right;">Add Task</span>				
Task	Queue	Received Date	Status	Actions
<a href="#">ProcessApplication</a>	E and D Eligibility	01/03/2016	New	<span style="border: 1px solid red; padding: 2px;">Claim</span> <span>Void</span>
<a href="#">ProcessApplication</a>	E and D Eligibility	01/03/2016	New	<span style="border: 1px solid red; padding: 2px;">Claim</span> <span>Void</span>

**NOTE:** If a task is claimed that cannot be processed by DCF, Release the task. **Do not Void any tasks.**)

c) **If No** - Contact your DCF point of contact.

4) **Update RMT** – If the RMT needs updated, update the RMT. Example: If an E&D recipient requests LTC , an RMT of LTC will need added if not already added by registration. The begin date for the new RMT would be the date the RMT should be used in determining eligibility.

5) **Update Prior Medical Months for New Applicants** - If there is a new request for medical assistance and prior medical coverage, continue using the steps below.

a) If Prior Medical coverage is requested, and the person requesting it did not receive coverage in that month, the prior medical months will need to be added to the program block.

b) Click on View Details in the program block you want to update. The Medical Program Detail page will display. Click Edit.

**Medical Programs**

**Worker:** Clearinghouse Worker  
**Worker ID:** [KH0206Q1A3](#)  
**Program Status:** Active

**Primary Applicant/Recipient:** Jennifer One  
**Language:** English  
**Phone Number:** (785)785-7857  
**Application Date:** 07/01/2013

**Review Due Month:** 06/2014 [Review](#)

Name	Requested Medical Type	Review Month	Relationship To Primary Applicant	Role	Role Reason	Status	Status Reason
▶ <a href="#">Jennifer One</a>	Medical	06/2014	Primary Applicant	MEM		Active	

[View Details](#)

- c) Click the Edit button to the right of the name of the person who is requesting the prior medical coverage in the Program Persons block.

**Program Persons**

Name	CE	Requested Medicaid Type	Relationship To Primary Applicant	Role	Role Reason	Status	Status Reason
<a href="#">Jennifer One</a>		Medical	Primary Applicant	MEM		Active	

[Edit](#)

- d) Enter the first prior medical month into the Retro Months block. Using the Requested Medical Type drop down, select the correct medical type then click the **Add** button. Repeat until all retro months are added.

**Retro Months**

Month	Requested Medical Type
06/2013	MAGI
<input type="text" value="05/2013"/>	<input type="text" value="MAGI"/>

[Remove](#) [Add](#)

\* - Indicates required fields

[Save and Return](#) [Cancel](#)

- e) Once all necessary prior medical months have been added, click **Save and Return**. Repeat Steps above for all individuals who need prior medical.

Click **Save and Return** on the Medical Program Detail page. The Case Summary will display.

## 6) Check for Verifications

- a) Check KES for Verifications available through No-Touch process. If not sufficient, request verifications using the Request Verifications button (if applicable).



**NOTE:** Refer to new Job Aids for additional information regarding using KEES for Verification – Verification Page Training Materials and Request Verifications documents - attachments

b) Access verifications through other systems:

- i) Log into KAECSES.
- ii) Check BASI if the consumer is reporting earnings.
- iii) Check BARI if the consumer is reporting UI.
- iv) Check EATSS to verify if the consumer is receiving SSA Disability or SSI.

(1) If the applicant does not have a current TPQY, BENDEX, or SDX record on EATSS, skip to step 7 (e) – Send a TPQY.

(2) If the applicant does have a current record:

- (a) Check Payment Status for SSA and SSI. If receiving benefits, note the amount(s) being received.
- (b) Verify if the consumer is receiving Medicare Part A, Part B or both. If so, determine if they have been bought in.
- (c) Skip to step 7 - Check the Medicare Information page.

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CAN: 999999999 A      WIRE THIRD PARTY QUERY PAGE #1
SSN: 999999999      NAME: JONES                JOE                DOB: 01011900  SEX: F
-----TPQY/SSA INFORMATION-----
SSN: 000000000      NAME: JONES                JOE                S  DOB: 01011900  SEX: F
CAN: 999999999      PYMT STATUS: CURRENT PAYMENT.....  EFF DATE: $GROSS$
DOD: 000000          DUAL ENTITLEMENT NO: 000000000 ...  1215    ..755.00
INIT ENT: 0203      LUMP SUM AMT:$ ....0.00                1214    ..755.00
SSN VERIFIED: Y     LUMP SUM DATE: 0000                    1213    ..743.00
NET MO BEN:$ ..755.00  DISABILITY BEGAN: 090102              1212    ..732.00
-----MEDICARE INFORMATION-----
MEDICARE  ENTITLED  PREMIUM  STOP  STATUS  BUY-IN  START  STOP
PART A HOSP 0205    $ ..0.00  0000  YES-AUTO.ENTITLEMENT  ....  0000  0000
PART B SUPP 0205    $ 104.90  0000  YES-ENROLLED.....    KS..  0205  0000
-----TPQY/SSI INFORMATION-----
SSN: 999999999      NAME: JONES                JOE                S  DOB: 01011900  SEX: F
PYMT STATUS: TERMINATED.....          1619B: .          INIT ELIG: 1203
NET BENEFITS DATE  TYPE PAYMENT  FED AMT  STATE AMT
CURRENT--> 010116          $ ....0.00  $ ....0.00
HISTORY 010110  NO. PAYMENT.MADE.....  $ ....0.00  $ ....0.00
        060109  NO. PAYMENT.MADE.....  $ ....0.00  $ ....0.00
QOFC: .....  BENDEX: .....  SDX: .....  F7=TPQY: 20160121

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v) **Send a TPQY** (in order to verify SSA/SSI income)

(1) Press F4 to request an update in KAECSES.

**NOTE:** Updates sent prior to 3:30pm should be available the following day.

7) Check the **Medicare Information** page to see if page has been updated by the TBQ interface.

i) Click Medicare Information on the bottom right of the Medicare Expense Detail screen.





- ii) The Medicare Information page displays. The information displayed on the page should match the information shown in EATSS. If the Medicare Information page is out of date or is blank, update the Medicare Expense page. Any change to the Medicare Expense page will request a new TBQ even if a change is made and then immediately changed back to what it was initially.

**NOTE:** TBQ requests may take up to **TWO** days to get a response.

Medicare Information				
Medicare Name	SSN	DOB	Medicare Claim Number	
<b>Medicare Information Part A header</b>				
Part A Entitlement Data	Part A Entitlement End Date			
Part A Entitlement Status	Part A 3rd Party Premium Payer	Payer Start Date:	Payer End Date:	
<b>Medicare Information Part B header</b>				
Part B Entitlement Data	Part B Entitlement End Date			
Part B Entitlement Status	Part B 3rd Party Premium Payer	Payer Start Date:	Payer End Date:	
<b>Medicare Information Part D header</b>				
Part D Start Date:	Part D End Date:	Part D Opt-Out Indicator:	Retiree Drug Subsidy Start Date:	RDS Term, Date:
<b>Other Medicare Information Header</b>				
End Stage Renal Disease Start Date		End Stage Renal Disease End Date		
Verified				

- 8) **Update the Non-Financial & Financial data collection screens-** When new, differing, or updated information is received it is necessary to update data collection screens. Accept or Reject all information with **NEW** beside it as appropriate.

**NOTE:** When multiple applications have been e-linked to the case, it requires data acceptance of each. A change has been made to the Registration process that reduces the need to complete Data Acceptance on multiple applications, but also impacts the methods that Eligibility staff use to review the multiple applications that have been received on the case. The registration staff will add a journal entry that identifies the e-App number of each additional application and will re-index images to the case.

Because the E-app is not going to be linked, Eligibility staff will have to search for the E-app by number, in order to review the information provided by the consumer on that application. See Job Aid - Searching for an e-App using e-Tools for instructions on how to locate an e-App – attached.

Comparing the E-apps is not an easy task – because it is not simple to view e-apps side by side. Staff will have to be diligent when comparing the application to identify differences between the various requests for coverage, which could be coming from different sources like MIPPA, FFM, SSP, or Paper applications.

**NOTE:** DO NOT open multiple KEES sessions to review the applications. This causes other problems in KEES and is not a solution for comparing applications.

When comparing multiple applications that have a PDF, such as the paper or SSP applications open these images and review side-by-side. For applications that do not have a PDF – such as MIPPA or FFM – staff will need to open each of the E-Apps in KEES, expand the sections and take screen shots in order to compare the applications side-by-side.



a) **Navigate to the Non-Financial Data Collection Screens**

- i) Verify each member in the home has a valid address on file.

**NOTE:** To ensure information goes to the MMIS, the address must include the county code. To do this, verify the zip code is in the Zip+4 format.

- ii) Check the Administrative Roles on the case to ensure the Medical Rep and/or Facilitators are correct. Updating using existing RDB processes. Registration staff at the Clearinghouse will add these as part of their normal process.
- iii) Ensure all information on the Individual Demographics screen is current.
- iv) Ensure the Citizenship/Identity record is set up correctly and, if not exempt, citizenship and identity has been verified.

The screenshot shows two forms side-by-side. The top form is titled "U.S. Citizenship Verification" and has a dropdown menu for "Document Type on File:" with "Federal Data HUB" selected. Below it is a dropdown menu for "Medical Citizenship Verified:" with "Pending" selected. The bottom form is titled "Identity Verification" and has a dropdown menu for "Document Type:" with "Federal Data HUB" selected. Below it is a dropdown menu for "Medical Identity Verified:" with "Pending" selected.

- v) Ensure each member has a current Household Status.
- vi) Add/Update the following records if applicable: Relationship, Non-Citizenship, Pregnancy, Residency, Other Program Assistance (OPA), Non-Compliance, Customer Options, and Employment.
- vii) If Institutional Care is being requested, add a LTC Data record.
- viii) Validate information on the Medical Condition page. Update if necessary.

b) **Navigate to the Financial data collection screens-** Verify all records on file are current. Add/End records if needed. If the source of the income remains the same, add a new amount record to the existing income record. Set the begin date to when the new income should begin being budgeted. Adding a new amount record will automatically end date the existing amount record.

- i) **Earned/Unearned income** - Add/Update income using the correct budgeting method.

(1) For self-employment and unearned income, use the appropriate TIER verification process.



- (2) For LTC and Working Healthy, verify income based on old school budgeting.
  - (3) Wages are subject to MAGI budgeting for E&D Medical programs that are not related to LTC or Working Healthy. Workers will need to use the Reasonable Compatibility Tool on the KEES Repository to compare the consumer's self-attestation of wages with what was reported on BASI. If wages are Reasonably Compatible (RC), the amount of wages which should be budgeted is shown on the Reasonable Compatibility Tool. If not RC, verify income using the appropriate TIER Verification processes. The RC Tool must be imaged to the case.
- ii) **Resources** - Update based on resources reported by the consumer. Follow existing verification policies for individuals without application history.
- (1) For individuals with case history, exempt resources (including those determined exempt at the time of initial approval such as irrevocable burial plans) may NOT need re-verified at review unless a change is reported which would affect the exempt status of the resource.
  - (2) For individuals with case history, existing non-exempt resources must be re-verified unless previously verified within the timeframes listed below:
    - Liquid Resources: Verified within the last 3 months
    - Personal Property: Verified within the last 12 months
    - Real Property: Verified within the last 12 months
  - (3) If a new resource is reported, it must be verified if either non-exempt or if verification is needed to determine its exempt status.
  - (4) If the countable value of an existing non-exempt resource has changed or an exempt resource has become non-exempt, a new record must be added and the existing record end dated. The begin date on the new record is the month in which the new value/non-exempt status should be used in determining eligibility. The end date on the old record would be the last day of the previous month.
  - (5) If applicant reports an annuity, obtain new KC3167/KC 3167. If application reports a trust obtain information necessary to complete a trust clearance. Send information to Jeanine Schieferecke ([jschieferecke@kdheks.gov](mailto:jschieferecke@kdheks.gov))
- iii) **Expense page** – Review the Expenses reported. An expense must be verified before it can be allowed. However, coverage is not denied for failure to provide proof of an expense. Update the Expense page if applicable.
- iv) **Medicare Expense** – Pay close attention to the following:
- (1) If the consumer has a spenddown and is not anticipated to meet another spenddown, ensure the Medicare Information page is correct. MSP will not determine correctly if this page does not



reflect the correct Medicare information. If needed, make a change to the Medicare Expense page to request a new TBQ.

- (2) If the consumer has Medicare premiums which can be allowed against a spenddown or LTC liability, ensure the page is updated appropriately based on findings from Medicare research conducted earlier. If the consumer does not have a spenddown or LTC Liability, a Medicare Expense record is not needed; however, if one exists, it can be updated.

v) **Other Health Insurance** – Add/Update records if applicable.

### 9) Verify Missing Information

- a) Navigate to the Verifications List page.
- b) The Verifications List page will display showing **Pending** as the Status and **Medical** as the Program.

Status:*	Program Type:*	From:	To:	View
Pending	Medical			

- c) Review the remaining verifications. If any of the verifications listed are in Pending status in error, navigate to the appropriate page and update the status of the verification.
- d) If the information is not verified, check the box next to the record and then click the **Request Verifications** button to check the interfaces.

Type	Program Type
<input type="checkbox"/> Liquid Resource	Medical
Verify	Request Verification

- e) If the information cannot be verified using an interface, send a V008 to request the missing information. Use the Verification Fragments from the Standard Text for Copy and Paste in the KEES Repository when requesting information.
  - i) ALL information requested from the consumer should be sent to the Clearinghouse, not to DCF. This information will be conveyed in the V008 as part of the Verification Fragments.
  - ii) When requesting information it is important that we give the consumer enough time to return requested information. With DCF assisting in processing E&D applications and information being sent to the Clearinghouse it is imperative that more time is allowed before case action is taken. Therefore when placing a task on hold, the due date should be set *3 days after the 10 day due date*. *This allows for additional time for the documentation to be received, imaged, and linked to the case.*



(1) For example: NOA was sent requesting bank statements on 3/1/2016. Due date on NOA will read 10 days from 3/1/2016 which is 3/11/2016. This is the correct date. However, the due date on the task will need to be set to 3/14/2016.

iii) It is acceptable to call the consumer in an attempt to resolve any issues at hand. If unable to reach the consumer on the first attempt, DCF staff need to follow their current process and leave a voicemail stating they will call back in five minutes. If unable to reach the consumer on the second attempt, leave a voicemail informing the consumer that information is needed and to call the Clearinghouse. If the consumer is reached, they need to be made aware that they are to call the Clearinghouse for all future case activity.

**NOTE:** The KEES Journal must accurately reflect all of the information that is required of the consumer so the Call Center at the Clearinghouse can relay this information when they call.

(1) A sample script may say: *I am assisting the KanCare Clearinghouse with processing your application. We need to speak with you before we can continue processing your application. Please contact the Clearinghouse at 1-800-792-4884 during the hours of 8am to 7pm.*

iv) Clearinghouse information is as follows:

**KanCare Clearinghouse**  
**P.O. Box 3599**  
**Topeka, KS 66601-9738**  
**Phone: 1-800-792-4884**  
**TTY: 1-800-792-4292**  
**Fax: 1-844-264-6285**

f) Once all information on file has been verified, proceed to **Step 10**. If information is not received, determine if the applicant/recipient(s) will be denied due to failure to provide the information. Remember expenses which are not verified do not result in denial. Instead, the expense is not allowed. If a denial due to failure to provide is appropriate, set any pending verifications to Refused and create a non-compliance record. Set the begin date to the 1<sup>st</sup> of the first month which should be denied due to failure to provide.

**NOTE:** Consider the self-attestation (SA) of the income and resources for E&D Programs that use MAGI budgeting methods – if the applicant is over the income or resource limit based on SA, do not request hard copy verification.

## 10) Run EDBC

a) Navigate to **Run EDBC**.

b) Run EDBC months sequentially.

i) **NOTE:** If processing Medicare Savings Programs follow the process in the KEES User Manual in KEES User Manual>Processing Medicare Savings Programs.



- c) If LTC, ensure all long term care information is available.
- d) Important Info About EDBC:
  - i) If working a case with previous history (especially with existing base periods, check MMIS before running EDBC.
  - ii) If the application is for spenddown, run all the months of eligibility and check the “budget” hyperlink for each EDBC. The Base Period and spenddown amount needs to be correct for each EDBC.
    - (1) Do NOT Accept and Save an EDBC if the Base Period isn’t correct or overlaps one that has already been created. KEES will not know which base period to send. That’s why it’s good to check what the MMIS has so you can match the base periods up with KEES.
    - (2) Be sure to NOT skip any months when you run the EDBC or KEES begins a new base period. If you’re checking the budget for each EDBC it should be obvious to see the different base period for that EDBC.
    - (3) Be sure that the last base period that is created covers the current month. Since these applications may be many months old, be sure you have a base period that covers the current and future month (if you’re working the application late in the month). Otherwise eligibility will be sent to the MMIS but no base period will be sent because there isn’t one created to send.
  - iii) For LTC Cases – Be sure to check each EDBC that is run for Long Term Care cases.
    - (1) With the fix that went in so KEES now creates the “TC” code, if a case hasn’t been touched since conversion there could be problems if you just accept the EDBC – as it may have TC codes. That’s because the LTC Data Details page may have the “Length of Stay” as “30 days or less” which creates the TC.
    - (2) Change the Length of Stay to “More than 30 days” and the correct LTC code should then display on the EDBC. If the TC code is present, the Patient Liability may be wrong also as it will be using the Independent Living PIL in the budget.
    - (3) Check the “budget” hyperlink to ensure ALL the details are correct before Accepting and Saving the EDBC.
  - iv) If the EDBC has LTC Details the Aid Code MUST be 300% or else Medically Needy eligibility will be sent to the MMIS. In these situations, you must override the EDBC results to set the 300 Aid Code.
  - v) Users should pay attention if they receive a ‘Read Only’ EDBC they should not Save and Accept it. This will not send any benefits over to MMIS.



- e) The process for completing a Temporary Stay in KEES has changed. Staff will need to follow the instructions in the KEES User Manual when processing all requests for coverage when a temporary stay is involved.

**11) Send the NOA**

- a) If the EDBC results were accepted and saved, a Notice of Action (NOA) will automatically be generated. Click on the name of the NOA to review the contents.

Select	Date	Worker	Document	Recipient	Type	Program	Benefit Month	Status	Receive Date	Posted Date
<input type="checkbox"/>	05/12/2014	user user	<a href="#">NOA - MC Approval</a>	Jennifer One		Medical	07/01/2013	Accept - Pending Print Central		

- b) Review the notice, making sure that the determination that was authorized is reflected.

KanCare Clearinghouse  
PO Box 3599  
Topeka, KS 66601-9738



Jennifer One  
1234 SW TOPEKA BLVD  
  
TOPEKA, KS 66604

**Notice Date:** 05/12/2014  
**Case Name:** Jennifer One  
**Case Number:** 20001081  
**Program:** Medical

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We have approved your application for Medical Assistance beginning 07/01/2013 for the following individuals:  
One, Jennifer

People eligible for coverage will get a medical ID card. We will send a medical card to new members. If

- c) Make sure the eligibility dates are correct, as well as the names of who was approved and who was denied, and the amount of the patient liability, spenddown or other cost sharing information. Verify the notice meets all applicable criteria for an acceptable NOA. If all the information on the notice is correct, click **Save and Print Centrally**. If the NOA is not correct, append the NOA or send a manual form as appropriate.

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Print
Save and Print Locally
Save and Print Centrally



If processing an application for Institutional Care, a Form will need to be sent to the nursing facility to inform them of the changes. This will need to be completed if the application was approved or denied.

### 12) Future Dated Tasks

Set any future dated tasks need to be set (e.g. removing Medicare Premium due to Buy-In). See the Job Aid for Future Dated tasks – attachment.

### 13) Journal

Complete a journal entry according the Application Journal Templates – Attachment A

a) Click the **Journal** link in the Utility Navigation bar.



b) Ensure Free Form is selected under the Add Entry: designation at the bottom right of the Journal List window and click Go.



c) Complete a journal entry documenting the reasoning and decisions made on the case. See attached Journal Template for guidelines of what an appropriate journal entry contains.

### 14) Complete the Task

a) Once all case actions have been completed, the Process Application task will need to be completed. Click the **Tasks** link in utility navigation.



b) When the Task Management window opens, click the name of the Process Application task. The Task Details window will open.

c) If the final determination on the case has been completed and coverage was authorized, click the **Complete** button on the Task Details window without updating the status. Do not click the Void button.

<b>Status:</b> Assigned	<b>Status Reason:*</b> KDHE-Being Worked		<b>Priority:</b> None
<b>Created Date:</b> 05/13/2014	<b>Created Time:</b> 8:01 PM	<b>Due Date:*</b> 05/18/2014	<b>Review Due:</b> [ ]
<b>Received Date:</b> 05/02/2014	<b>Region:</b>	<b>Location:</b>	<b>Worker Assigned:</b> user user



- d) If the task was pending for requested information, update the Status Reason to reflect **KDHE – On Hold** and list the appropriate Due Date. See Step 11(e)(ii) for more details about the Due Date when placing tasks on hold for requested information. Click **Save and Continue** and close the Task Management window.

<b>Claim</b>		<b>Save and Continue</b>		<b>Cancel</b>
<b>Status:</b> New	<b>Status Reason:*</b> KDHE-On Hold	<b>Priority:</b> None		
<b>Created Date:</b> 06/13/2015	<b>Created Time:</b> 11:18 AM	<b>Due Date:*</b> 06/17/2015	<b>Review Due:</b>	
<b>Received Date:</b>	<b>Region:</b>	<b>Location:</b>	<b>Worker Assigned:</b>	

**15) Check MMIS**

- a) It is required that workers check MMIS the day after approving new coverage to determine if accurate coverage is reflected. If expected eligibility is not in place, follow instructions in the KEES user manual to determine the next steps.