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SECTION L - FORMS AND INSTRUCTIONS

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MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-300B - SSI REDETERMINATION FORM

PURPOSE & USE

Form DOM-300B, SSI Redetermination Form, is used to determine continuing Medicaid eligibility for individuals terminated from SSI due to excess income and/or resources. The form is computer generated by the fiscal agent and issued along with the SSI Notice of Termination. Refer to Section C for policy governing the SSI Redetermination process.

INSTRUCTIONS

The completed DOM-300B will be filed in the case record upon receipt of the completed/signed form. The form must be signed by the client or designated representative before the redetermination process is completed.

DOM-TPL 406 DIVISION OF MEDICAID Initial___
Rev.01/01/92 MEDICAL INSURANCE FORM Updated___

Regional Office_____ Recipient_____

Specialist_____ Med ID # _____

1. MEDICARE INFORMATION

Claim # _____

2.A. HEALTH INSURANCE (OTHER THAN MEDICARE AND MEDICAID)

Relation of Policy Owner to Insured	Insurance Company Name and Address	Policy #	Begin Date	End Date

Policy is limited to: ___Cancer ___Indemnity ___Intensive Care ___Dread
___Medicare Supplement ___Accident ___Other (Explain_____)

FOR MEDICAID STATE OFFICE USE ONLY
Benefits: __Inp-Med __Inp-Surg __Inp-Psych __Inp-Hosp __Outpat-Ill
__Outpat-Surg __Outpat-Psych __Outpat-Acc __Phys-Med __Phys-Off
Phys-Psych __Phys-Acc __Pharm __Dental __Oral Surg __Psych-Res
__Transp __Eyeglass __Mental Hlth __Lab/Xray __Anesth
__Acc __Cancer __Hom Hlth __NF-SNF __NF-ICF __Medicare Supp

Policy Owner Name/Address	PolicyOwner Employer/Group Name&Address
SSN_____ Absent Parent Yes__ No__	Ph #_____ Group #_____ Mo'ly Prem $_____

2.B. ABSENT PARENT INFORMATION

Name_____	Employer Name_____
Address_____	Address_____
SSN_____	IV-D Status _____

3. REMARKS_____

Attach separate sheet if needed giving requested information for each additional item; i.e., multiple absent parents, health insurance policies, etc.

_____ _____ _____
Signature of Recipient or Representative Ph # Date

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-TPL-406 - THIRD PARTY LIABILITY INFORMATION

PURPOSE & USE

The purpose of this form is to collect third party liability (TPL) information which is used to ensure that Medicaid is the payer of last resort. The information obtained on the DOM-TPL-406 is used to update the Resource Information Module (RIM) in the MMIS. If the MMIS Recipient Subsystem indicates that there is other health insurance, claims either pay or reject based on the information contained in the RIM. In order to ensure that the claims pay correctly and not reject to the provider unnecessarily, the medical insurance information must be accurate.

This form must be completed at the time of application. The 406 is not required to go out for Redeterminations. The worker will document the telephone contact on the 300A. If the client obtained/dropped health insurance since the last contact, pull up the previous 406 and complete and then send to TPL.

INSTRUCTIONS

The worker will include this form with each DOM-300.

The worker will complete the top portion of the form identifying the Regional Office, the Specialist handling the case, the Medicaid recipient's name, his/her unique identifying number. In the space provided, the worker will indicate whether the form represents initial information or an update to previously reported medical insurance information. The Medicaid recipient or his/her representative is to complete the medical insurance information, sign/date the form, and list his/her telephone number. Since the assignment of rights to any third party source and cooperation is a factor of eligibility, all requested information must be completed in detail, if applicable.

If the application or redetermination results in approval and the DOM-TPL-406 indicates a third party source other then Medicare, mail the original to the DOM TPL Unit. File the copy in the case record. If the form indicates no third party source, file both original and copy in the case record.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

This form is not considered complete if all applicable medical insurance information is not indicated. The DOM TPL Unit will return any incomplete form to the client or designated representative for completion.

DOM-TPL-410

Issued 10-01-90

Medicaid RO _____

Address _____

_____

Absent Parent Referral

Responsible Relative Information

(1) _____
(2) _____
(3) _____
Child(ren)'s Case Number

_____ Name

_____ Relationship to Child

_____ Address

_____ City _____ State _____ Zip Code

_____ Telephone Number

_____ Social Security Number

Absent Parent Information

_____ AP Name

_____ Social Security Number _____ Date of Birth

_____ Address [ ] Current [ ] Last Known _____ City _____ State _____ Zip Code

_____ Telephone Number

_____ Employer Name [ ] Current [ ] Last Known

_____ Emp. Addr. [ ] Current [ ] Last Known _____ City _____ State _____ Zip Code

Absent Parent's Children Information

1. _____ Name _____ SSN ____/____/____ Date of Birth ____/____/____ Med. Elig. Date

2. _____ Name _____ SSN ____/____/____ Date of Birth ____/____/____ Med. Elig. Date

3. _____ Name _____ SSN ____/____/____ Date of Birth ____/____/____ Med. Elig. Date

Support Information

Is there a current court order involving paternity, divorce, child support payments, or medical support? Yes ____ No ____ Copy Attached: Yes ____ No ____

_____ Medicaid Specialist

_____ Date

_____ Date Received by IV-D

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-TPL-410 - ABSENT PARENT REFERRAL

PURPOSE & USE

The purpose of this form is to refer to the Child Support Enforcement Agency all living absent parents whose child(ren) receive medical assistance through the Division of Medicaid. Federal law requires the Child Support Enforcement Agency to provide all appropriate IV-D services, including the petition for medical support, to families with an absent parent when these families include a child who receives Medicaid and has assigned rights to medical support to the State Medicaid Agency.

The form must be completed at application or redetermination when the worker discovers there is a living absent parent. A onetime referral should be all that is necessary.

INSTRUCTIONS

The worker will determine at application or redetermination if there is a living absent parent. If so, the worker must complete information requested on the form sign and date. Prepare an original and one copy. Mail the original to the Department of Human Services (DHS) in the county of the child's residence, attention to Child Support Enforcement. Retain a copy in the case record. If available, include a copy of the current court order with the original form to DHS.

NOTE: There may be a rare instance where a worker will handle cases involving multiple children with the same absent parent. In this instance, if there is one responsible relative for all children, use only one form to identify the absent parent as well as the children of that absent parent.

There also may be an instance of a child with two absent parents. In this instance, complete two referral forms, one for each absent parent.

Responsible Relative Information - include information on the parent or other relative who has custody of the child or children receiving Medicaid.

Absent Parent Information - include information on the absent parent.

Absent Parent's Children Information - include information on the child or children of the absent parent receiving Medicaid.

DOM-TPL 411
Revised 12-01-01

DIVISION OF MEDICAID

Estate Recovery Form

TO: **Third Party Liability (TPL) Unit**

FROM: _____, **Medicaid Specialist**

_____ **Regional Office**

RECIPIENT'S NAME _____

MEDICAID ID NUMBER _____

DATE OF DEATH _____ **DATE OF BIRTH** _____

NURSING FACILITY _____

HCBS WAIVER _____

The above named client is now deceased and there is ownership of real and/or personal property which may be considered an estate. The client was age 55 or over when he/she received Medicaid in a nursing facility and there is no legal surviving spouse or dependent child(ren) under age 21 or dependent blind or disabled child(ren) known to the Regional Office.

The case record is attached.

List the assets that were used in calculating the value of the estate. Do not include burial or life insurance, joint bank accounts, life estate property, annuities or promissory notes.

_____

_____

_____

_____

_____

_____

Area Supervisor's Initials

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-TPL-411 - ESTATE RECOVERY FORM

PURPOSE & USE

This form is used to notify the TPL Unit of the death of a Medicaid eligible who was 55 years of age or older when nursing facility services were received and is affected by the estate recovery provision. A form is required whenever the recipient owned or shared ownership in real property or owned personal property totaling $5,000 or more in value.

Do not complete this form if the recipient is exempt from the estate recovery provision, or if there is no real property owned in full or in part and no personal property valued at $5,000 or more at the time of death.

INSTRUCTIONS

Mail the prepared form along with the case record to the TPL Unit.

DOM-TPL 412
Issued 02-01-96

DIVISION OF MEDICAID
NON-REFERRAL ESTATE RECOVERY FORM

TO: Third Party Liability (TPL) Unit

FROM: _____, Medicaid Specialist

_____ Regional Office

RECIPIENT'S NAME _____

MEDICAID ID NUMBER _____

TOTAL ASSETS (including burial contract) $_____

DECEASED SPOUSE'S NAME _____

COUNTY OF RESIDENCE PRIOR TO NF _____

The above named client is now deceased. There is no ownership of real property. There is ownership of personal property; however, the value is less than $5,000. The client was 55 or older when he/she received Medicaid in a nursing facility and there is no legal surviving spouse or dependent child(ren) under age 21 or dependent blind or disabled child(ren) known to Regional Office.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-TPL-412 - NON-REFERRAL ESTATE RECOVERY FORM

PURPOSE & USE

This form is used to notify the TPL Unit of the death of a Medicaid eligible who was 55 years of age or older when nursing facility services were received, but is not affected by the estate recovery provision. A form is required when there is no ownership of real property, personal property is valued at less than $5,000, there is no surviving legal spouse, no dependent child(ren) under age 21, and no dependent blind or disabled child(ren).

INSTRUCTIONS

Complete an original and one copy. Mail the original to the TPL Unit. Retain the copy in the case record. Do not mail the case record.

DOM - 301
Revised 10-01-96

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the agency/organization listed below to release benefit or other information needed to establish and/or continue eligibility for Medicaid. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for Medicaid benefits with the Mississippi Medicaid Agency. This authorization form will be in effect for one (1) year from the date of my signature.

✓_____ _____

SIGNATURE OF CLIENT OR DESIGNATED REPRESENTATIVE (attach copy of DOM-302 if Representative signs)

DATE

IDENTIFYING INFORMATION OF MEDICAID APPLICATION/RECIPIENT

Name _____ **Medicaid ID#** _____

Social Security No. _____ **Date of Birth** _____

Benefit Claim No. _____

NAME OF AGENCY/ORGANIZATION _____

ADDRESS _____

_____

Please release the following information on the above named Medicaid applicant/recipient.

Entitlement Amount of Benefit _____

Effective Date of Current Entitlement Amount _____

List Any Deductions Currently Withheld _____

List Any Bonus or Additional Payments Paid During Last 12 Months _____

_____

Other:

_____ _____

Signature of Agency Official Completing Form

Date

Please return the completed original to:

DOM-301A
Revised 10-01-00

For Medicaid Use Only
Applicant _____
Social Security Number _____
Medicaid ID Number _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO THE STATE AGENCY MAKING MEDICAID ELIGIBILITY DETERMINATIONS

Information for the medical sources (to be completed by DDS)

Name of Source _____ Address _____

Identifying patient information:

Name and address at time of admission or treatment _____

Birthdate _____

Check One:
☐ In-patient ☐ Out-patient

Admission date(s) _____ Discharge Date _____ Clinic/patient # _____ Other pertinent information (bldg, clinic, etc) _____

Claimant's Authorization (to be completed by Disabled Person or Person Authorized to Act in His/Her Behalf)
GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the state agency making Medicaid eligibility determinations the following information for the period(s) identified above:

1. All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for or infection with human immunodeficiency virus (HIV);
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3. Information about how my impairment(s) affected my ability to work.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

✍ _____ _____ _____
Signature of applicant (or representative*) * Representative's relationship to applicant Date

_____ _____
Street address (include apartment number if applicable) Telephone number

_____ _____ _____
City State Zip

Witnesses are required ONLY if this statement has been signed by mark "X" above.

_____ _____
1. Signature of Witness 2. Signature of Witness

_____ _____
Address Address

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-301 - AUTHORIZATION TO RELEASE INFORMATION

PURPOSE & USE

This form is used to authorize the release of benefit and other related information from an agency or organization that requires the client's signature prior to providing such information. It is designed to be a two-way form whereby the agency releasing benefit information can respond on the same form originated by the Medicaid agency. In the event the applicant or recipient is unable to sign his/her name, a completed Form DOM-302, Designated Representative Statement must be attached to Form DOM-301 to document that the individual signing the form is duly authorized to sign in the client's behalf. A signed DOM-301 is valid for one (1) year following the date of the authorizing signature.

INSTRUCTIONS

Prepare an original and 2 copies. Mail the original and 1 copy to the agency releasing the benefit information and retain the second copy only until the completed original is returned. The agency completing the form should retain the copy of the completed form.

Signature of Client: The client or designated representative will sign in this space. If the designated representative signs in the client's behalf, a completed DOM-302 must accompany the authorization form.

Date: Enter the date the client or representative signs the form.

The identifying information of the client should be completed by the Medicaid Regional Office along with the name/address of the agency where the form will be sent for benefit information.

The remainder of the form should be completed by the agency/organization releasing the benefit information; however, if the worker is requesting information not specified on the form, the worker must list the needed information in the "Other" section.

The Regional Office name and address must be stamped in the space at the bottom of the form. The worker should also sign his/her name below the Regional Office stamp so that the form can be returned to the appropriate worker when completed and returned.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-301A - AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PURPOSE & USE

The purpose of this form is to release medical information to the Disability Determination Service (DDS) for the purpose of making a disability or blindness decision. A separate form must be completed for each source (hospital, doctor, etc.) listed on the DOM-323, Disability or Blindness Report.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original along with the DOM-323 and DOM-325 to DDS. The Regional Office will complete the portion at the top of the form "For Medicaid Use" and the "Claimant's Authorization" portion of the form. The Medicaid Specialist/Supervisor completing the form will fill in the client's identifying information and have the client or representative sign the form in the designated space. Two witness signatures are required if the client signs with a mark.

NOTE: If the applicant is unable to sign Form DOM-301A and the authorized representative signs in the applicant's place, the representative must state on the form the reason the applicant is unable to sign his/her name, e.g., "patient unconscious," "patient senile," etc. A DOM-302, Designated Representative Statement, must accompany all DOM-301A Forms signed by the representative.

Leave the top portion of the form "Information for the Medical Sources" blank for DDS to complete. The Regional Office need only ensure that the client signs the appropriate number of forms for each doctor, hospital, or other medical source listed on the DOM-323, and explain to the client that the form(s) will be submitted to the sources the client listed on DOM-323.

DOM-302
Revised 07-01-84

DESIGNATED REPRESENTATIVE STATEMENT

CLIENT'S DESIGNATION

I hereby designate _____ as my representative in the application/redetermination process of eligibility for Medicaid from the State of Mississippi.

✓ _____ Date _____

Client's Signature

I understand that by accepting this designation as representative, I will provide or assist in providing the necessary information to establish the individual's eligibility for Medicaid. I also understand that if I knowingly withhold information or knowingly misrepresent facts about the situation of the individual, I may be prosecuted for perjury and/or fraud.

✓ _____ Date _____

Representative's Signature

Address _____

Witness _____ Date _____

STATEMENT OF SELF-DESIGNATION BY REPRESENTATIVE

I hereby declare that I am acting for _____ in providing information to establish the individual's eligibility for Medicaid because he/she is too aged or ill to provide information about his/her situation and to act responsibly for himself/herself. I will provide information to the best of my knowledge concerning the individual's situation. I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury and/or fraud. I agree to notify the State Medicaid Agency immediately of any change in the individual's situation of which I become aware.

✓ _____ Date _____

Representative's Signature

Address _____

Witness _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-302 - DESIGNATED REPRESENTATIVE STATEMENT

PURPOSE & USE

The purpose of this form is to designate in writing someone who is qualified to act in a client's behalf for the purpose of completing and signing all eligibility forms and providing all pertinent information about the client. Refer to Section C for policy governing persons who can file an application or redetermination for a client.

INSTRUCTIONS

Prepare an original and 1 copy. The client can designate a representative by completing the "Client's Designation" portion of the form. If the client is unable to designate someone, the representative can complete the "Statement Self-Designation By Representative" and designate himself/herself without the client's signature if the representative is determined qualified to act in the client's behalf.

Notate on the Record of Contact the date mailed to the client or representative. When the original is returned, file it in the case record. The representative keeps the copy.

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-303 - NOTICE OF DELAY

PURPOSE & USE

This form is used only for applications pending beyond the applicable standard of promptness due to agency delay. The purpose of the form is to explain to the applicant or representative the reason for the agency delay. Agency delay includes all delays attributed to the worker or DDS resulting in an overdue application.

The exception to issuing DOM-303 for an application processing agency delay is in the instance of a transfer of resources. Although an application may become overdue because a transfer is discovered, the Notice of Transfer of Resources form issued to the applicant serves as notice that the transfer issue must be resolved before eligibility is determined.

Refer to Section C for policy governing Standards of Promptness for applications.

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the applicant or representative and file the copy in the case record. Enter the applicable due date for the application and an explanation for the delay.

The worker sill sign, date and return address stamp the form.

DOM-303
Revised 11-01-84

NOTICE OF DELAY

_____ Applicant's Name _____

_____ Medicaid ID # _____

_____

At the time the application for Medicaid was filed, we explained that Medicaid is allowed _____ days to complete the application and determine eligibility. This processing period ended on _____; however, your application has not been completed due to agency delay. The reason for the delay is explained below:

_____

_____

_____

_____

_____

_____

_____

_____

You will be notified when a decision has been reached on your application.

Medicaid Specialist _____ Date _____

Regional Office Address/Telephone:

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-305 - NOTICE OF ACTION

PURPOSE & USE

This form is used to notify applicants of the approval of an application and to notify recipients of approval of a redetermination. For institutionalized recipients, this form is used to approve a redetermination provided Medicaid Income remains the same or decreases for the current month. If Medicaid Income increases in the first month of approval of a redetermination, the recipient must be notified via DOM-306, Notice of Adverse Action, and provided 10 days advance notice. For a complete discussion of the use of this form refer to Section C.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original and 1copy. The original is mailed to the client or representative and the copy is filed in the case record.

This form is divided into two sections. The portion to be completed depends on the type action to be taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION: The top portion is to be completed when approving an application. Check the appropriate block to indicate the action taken.

You have been approved for Retroactive Medicaid...: Check this block if the application involves retroactive approval and specify the month(s) of retroactive eligibility in the space provided. If the applicant is being denied any month(s) of retroactive eligibility, specify in the "Remarks" section. If the retroactive approval involves month(s) of nursing home care, include the amount of Medicaid Income in the space provided.

Note: For 1002 Retro approvals, include the following statement in the Remarks section: "You will not receive a Medicaid card for the month(s) identified above. Please show this notice to all providers of medical services that rendered services in your behalf during the month(s) shown above."

You have been approved for Medicaid beginning: Check this block if the application is being approved and enter the beginning date of eligibility.

If the recipient is in a nursing home/hospital, enter the amount of Medicaid Income and when the client must begin to pay toward the cost of his care in the spaces provided. If income protection is applicable, enter "$0" in the first space for the first month of care and enter the amount of Medicaid Income to begin the next month in the second space provided.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE: The lower section is completed when approving a redetermination in which Medicaid Income remains the same or decreases in at least the first month. This section is also used to notify the client that his/her Medicaid case is being transferred to another Regional Office. Check the appropriate block to indicate the action taken.

The redetermination of your Medicaid case has been approved: Check this block when approving a redetermination where Medicaid Income remains the same. Enter the amount of Medicaid Income, also.

The amount you must pay. . . has been reduced: Check this block when Medicaid Income will be reduced. Enter the effective date of the reduced amount and the amount. Note, it is only necessary for the first month to reflect a decrease in Medicaid Income and not all 4 months that can be shown.

Your case has been transferred. . .: Check this block if the client's case is being transferred to another Regional Office name the new Regional Office. Include at the bottom of the form the address and telephone number of the new Regional Office which will handle the case.

DATE OF MAILING: The Supervisor or Specialist reviewing the case will enter the date of mailing. The date entered must be the date the form is mailed out.

ADDRESS/TELEPHONE NUMBER OF REGIONAL OFFICE: Stamp or write the Regional Office address in the space provided and include the telephone number.

Signature of Medicaid Worker: The worker will sign the form in this space.

DOM-305
Revised 10-01-96

Regional Office _____

NOTICE OF ACTION

_____

_____

_____

Client's Name _____

Medicaid ID # _____

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION:

( ) You have been approved for Retroactive Medicaid benefits for the months listed below. If you were in the nursing home/hospital during these months, the money amount listed is the amount you must pay toward the coast of your care.

Month/Year _____ $ _____

Month/Year _____ $ _____

Month/Year _____ $ _____

( ) You have been approved for Medicaid beginning _____. If you are in a nursing home/hospital the amount you must pay toward the cost of care is:

Month/Year _____ $ _____

Month/Year _____ $ _____

HE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE:

( ) The redetermination of your Medicaid case has been approved. You remain eligible for Medicaid benefits. Medicaid Income remains $ _____.

( ) The amount you must pay toward the cost of your nursing home/hospital care has been reduced.

Beginning _____, you will pay $ _____

Beginning _____, you will pay $ _____

( ) Your case has been transferred to the _____ Regional Office. The address of this office is given below.

REASON/REMARKS: _____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR CASE, you may request a fair hearing. Hearing requests must be made in writing within 30 days of the date the worker signed this form. Your written request should be mailed to the Regional Office address shown below. THIS DOES NOT APPLY TO ESTATE RECOVERY PER MISS. CODE ANN. SEC. 43-13-317.

DATE OF MAILING: _____ MEDICAID SPECIALIST: _____

EGIONAL OFFICE ADDRESS/TELEPHONE:

Enclosures:

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-306 - NOTICE OF ADVERSE ACTION

PURPOSE & USE

The purpose of this form is to notify the client of any adverse action taken on an application or active case. Adverse actions include all rejections of applications, case closures, and increases in Medicaid Income. The form explains the client's right to a hearing and the right to continuation of benefits if a hearing is timely requested to appeal an increase in Medicaid Income or termination of benefits.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original and 1 copy. The original is mailed to the client along with a hearing pamphlet. The copy is filed in the case record. Refer to Section C for policy governing adverse actions and continuation of benefits.

The DOM-306 is divided into two sections. The correct section to complete depends on the type of action taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION: Complete the top portion of DOM-306 for a rejection of an application. In the space provided, enter the reason for the rejection which includes an explanation of the policy supporting the action taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE: Complete the lower portion of DOM-306 for either a termination of benefits (closure) or and increase in Medicaid Income, whichever is applicable. The effective date of the termination or increase will be entered in the appropriate space. Refer to Section C for policy which governs the effective dates of either type of action.

The reason for the closure or increase will be clearly stated in the space provided. For closures, include an explanation of the policy which supports the action taken. For an increase in Medicaid Income, include the new amount to be paid and the reason for the increase.

For both terminations and increases in Medicaid Income, complete the continuation of benefits portion of the fair hearing statement. The date to be entered is 10 calendar days from the date of mailing. The Supervisor or Specialist who reviews the case and mails the form should enter the date of mailing and the date which represents the end of the 10-day advance notice period in the space provided.

DATE OF MAILING: Enter the date the form is mailed.

WORKER: The worker will sign here.

ADDRESS/TELEPHONE NUMBER OF REGIONAL OFFICE: The Regional Office address and telephone number must be stamped in the space provided.

DOM-306
Revised 10-01-96

Regional Office _____

NOTICE OF ADVERSE ACTION

_____ Client's Name _____

_____ Medicaid ID # _____

_____

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION:

( ) Your request for Medicaid benefits must be denied because _____

_____

_____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR APPLICATION, you have 30 days from the date the worker signs this notice to request a fair hearing. A hearing pamphlet is enclosed which explains hearing procedures.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE:

( ) Your case will close effective _____.

( ) You remain eligible for Medicaid, however there has been an increase in the amount you must pay toward the cost of your nursing home/hospital care.

Beginning _____, you will pay $ _____

Beginning _____, you will pay $ _____

Beginning _____, you will pay $ _____

REASON: _____

_____

_____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR MEDICAID CASE, you have 30 days from the date the worker signs this notice to request a fair hearing. A hearing pamphlet is enclosed which explains hearing procedure.

If you request a hearing by _____, you can continue to receive Medicaid, or receive it at your current level, during the hearing process. THIS DOES NOT APPLY TO ESTATE RECOVERY PER MISS. CODE ANN. SEC. 43-13-317.

DATE OF MAILING _____ MEDICAID SPECIALIST _____

EGIONAL OFFICE ADDRESS/TELEPHONE

Enclosures: Hearing Pamphlet

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-307 - REQUEST FOR INFORMATION

PURPOSE & USE

The purpose of this form is to inform an applicant or recipient in writing of the information needed in order to complete the application or redetermination process. All requests for information must be put into writing to the client or representative with a copy for the case record.

THIS FORM IS AVAILABLE IN MEDS

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the client or representative and retain the copy in a tickler file. If the original is returned with the information, discard the copy and file the original and the information in the case record. If the original is not returned, but the information requested is submitted, file the copy in the case record. If the requested information is not submitted within ten (10) days, file the tickler copy in the case record and prepare DOM-309, Second Request for Information. The DOM-307 original or copy must be retained in the case record to confirm the request for information.

Note: This form is designed to be issued along with DOM-300A, Redetermination Form, to allow the recipient ten (10) days in which to complete the redetermination form and return the needed information. However, if new or additional information is required upon return of the completed DOM-300A, and this information was not included on the DOM-307 issued along with the DOM-300A, it is necessary to send another DOM-307 requesting the information for the first time.

Enter the appropriate identifying information and check the appropriate block to indicate whether the request is for an application or redetermination. Enter the date which is 10 days after the date the form is prepared and mailed in the space provided.

List in the space provided each item needed to determine eligibility.

The worker will sign, date and return address stamp the form.

DOM-307
Revised 10-01-96

REQUEST FOR INFORMATION

_____ Client's Name _____

_____ Medicaid ID # _____

_____

☐ This is to give you in writing the information we must have in order to determine Medicaid eligibility. If you have been in and talked with a worker, this letter will repeat for you the information needed.

☐ Enclosed is a Redetermination Form which must be completed in order to continue Medicaid eligibility for the client named above. Completion of the form is required at least once every year for each client. Listed below is the information needed to complete the redetermination.

Either bring or mail in the information listed below before _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Regional Office Address/Telephone:

_____
Medicaid Specialist

_____
Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-309 - SECOND REQUEST FOR INFORMATION

PURPOSE & USE

This form is used as a second request when the information requested via DOM-307 was not provided by the end of the 10-day period specified. The second request informs the client or representative of the information still needed to complete the application or redetermination process.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the client or representative and retain the copy in the tickler file. If the original is returned with the information, discard the copy and file the original and the information in the case record. If the original is not returned but the information requested is submitted, file the copy in the case record. If the requested information is not submitted within ten (10) days, file the tickler copy in the case record. The DOM-309 original or copy must be retained in the case record to confirm the second request for information.

In the space provided, enter the information requested via DOM-307, Request for Information, that has not been received.

Check the appropriate block to indicate whether the request involves an application or redetermination in process.

Applications - Enter the applicable standard of promptness of either 45 or 60 days in the space provided. Also enter the date the 45 or 60-day period will end as determined by the date application was filed. In the last space, enter the date which is ten (10) days following the date DOM-309 is mailed.

Redetermination - In the space provided, enter the date which is ten (10) days following the date DOM-309 is mailed.

The worker will sign, date and return address stamp the form.

DOM-309
Revised 11-01-84

SECOND REQUEST FOR INFORMATION

_____ Client's Name _____

_____ Medicaid ID # _____

_____

On _____, you were mailed a request for the following information:

_____

_____

_____

_____

_____

_____

_____

☐ We must have this information to complete the Medicaid application for the above named applicant. The processing time of _____ days that Medicaid is allowed to complete the application and determine eligibility ends on _____. If we do not receive the needed information by _____, appropriate action will be taken to deny the application.

☐ We must have this information to continue Medicaid eligibility for the above named client. As of this date, we have not received this information. If we do not receive the needed information by _____ _____, appropriate action will be taken to close the client's Medicaid Case.

Regional Office Address/Telephone:

Medicaid Specialist _____

Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-310 - STATEMENT OF HOUSEHOLD EXPENSES

PURPOSE & USE

This form is used only for individuals in Former SSI Recipients coverage groups who must have SSI policy applied to their case. When such a client has Income-In-Kind and alleges that the cash value of In-Kind Support & Maintenance (ISM) is less than the Presumed Maximum Value (PMV) or alleges that household expenses are shared, the client must complete this form to determine the income to count or the living arrangement in which the client will be placed.

INSTRUCTIONS

Prepare an original to mail or give the client for completion.

DOM-310
Issued 07-01-81

STATEMENT OF HOUSEHOLD EXPENSES

Client's Name _____

Medicaid ID # _____

RETURN BY: _____

PLEASE COMPLETE ITEMS BELOW FOR THE PERSON NAMED ABOVE WHO LIVES IN YOUR HOUSEHOLD.

1. Total number of persons living in this household: _____

2. Rent or mortgage payment for this household: _____

   City and county taxes, if not included above: _____

   House insurance, if not included above: _____

   TOTAL MONTHLY SHELTER EXPENSES: $_____

3. Average monthly expenses for utilities for this household:

   Lights $_____

   Water $_____

   Heating Fuel $_____

   Sewer $_____

   Garbage Collection $_____

   TOTAL $_____

4. Average monthly expenses for food for this household: $_____

5. TOTAL amount person named above pays each month: $_____

WHEN COMPLETE, MAIL TO:

✓_____

Signature of Person Completing the Form

Date _____

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-311 - REQUEST FOR MEDICAID APPLICATION

PURPOSE & USE

Form DOM-311 is designed to accompany Form DOM-300, Application Form, when a request for an application is made known to the Regional Office or when the Regional Office is made aware that an individual has entered a nursing facility and needs to apply for Medicaid. The form explains that all questions must be answered on DOM-300 and also informs the applicant of the processing time allowed to determine eligibility.

INSTRUCTIONS

Complete an original and 1 copy. Issue the original to the applicant or representative and file the copy in the correspondence file until the application is formally filed. When the application is filed and a case record set up, file the copy in the case record.

Check the appropriate block that applies to whether the application was requested or that the Regional Office is aware that the applicant has entered a nursing facility and needs to apply. If the latter is true, enter the name of the applicant and the name of the nursing facility.

The worker will sign, date and return address stamp the form.

DOM-311
Revised 02-01-99

REQUEST FOR MEDICAID APPLICATION

_____
Date

_____ RE: _____

_____

_____

☐ We have received your request for a Medicaid application. Enclosed is an application form for you to complete. Please answer all questions completely. We may require that you show proof of all income and resources available to the applicant. (Copies are allowed.)

☐ We have received notification that _____ has entered _____ nursing facility. If you are interested in applying for Medicaid to assist in the payment of the nursing home expenses, complete the enclosed application form. Please answer all questions completely. We will require that you show proof of all income and resources available to the applicant.

The application form may be mailed to the Regional Office listed below. If you need assistance with your application, you may call the phone number below. The date the Division of Medicaid receives the application is considered the date that you apply.

The Division of Medicaid is allowed an application processing time of 45 days for all aged (age 65 or over) and blind individuals and 90 days for all applications for disabled individuals. This processing time begins when the Medicaid office receives the signed application.

_____
Medicaid Specialist

Attachments: DOM-300
Application Checklist
Pamphlet

Regional Office Address/Telephone:

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-312 - NOTICE OF POTENTIAL ELIGIBILITY FOR VA BENEFITS

PURPOSE & USE

Form DOM-312 is used to advise Medicaid applicants or recipients of the requirement to apply for initial or increased VA benefits in accordance with the Utilization of Other Benefits provision. Refer to Section D for a policy discussion of this provision.

INSTRUCTIONS

Complete an original and 2 copies. Issue the original to the client or representative, file one copy in the case record and use the remaining copy as the tickler copy set for follow up in 30 days of issuance of the notice.

Check the appropriate block(s) to indicate that the client must apply for VA Improved Pension or VA Aid & Attendance or both. If another benefit is appropriate, enter the type of benefit under "Other."

The worker will sign and date the form.

DOM-312
ISSUED 07-01-93

DATE: _____

NOTICE OF POTENTIAL ELIGIBILITY FOR VA BENEFITS

_____ NAME: _____

_____ ID#: _____

_____ SSN: _____

VA CLAIM # _____

Our records indicate that you may be eligible for VA benefits or for an increase in your current benefit. To be eligible for Medicaid, you must apply for any and all VA benefits you may be entitled to receive even if your Medicaid eligibility is affected by your entitlement for VA benefits.

The benefit that you need to apply for is:

__ VA Improved Pension benefits <u>including</u> Unreimbursed Medical expenses which may increase your pension benefits.

__ VA Aid & Attendance benefits.

__ Other _____

_____

You must file an application with the Veterans Administration within 30 days of the date on this notice <u>and</u> provide this office with proof that you have filed with the VA. You must provide the VA with all information they need to process your application for benefits. This requirement is in accordance with 42 CFR 435.603.

<u>Notify this office when the VA has made a final decision regarding your benefits.</u>

If you have any question about these instructions, please contact the Regional Office listed below.

Medicaid Specialist _____

Regional Office Address/Telephone Number

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-317 - EXCHANGE OF INFORMATION BETWEEN NURSING HOME OR HOSPITAL AND MEDICAID REGIONAL OFFICE

PURPOSE & USE

This form is used by the Nursing Home or Hospital and Regional Medicaid Office as an exchange of information form regarding applicants for and recipients of Medicaid. The purpose of this form is:

1. It is initiated by the Nursing Home/Hospital at the time a Medicaid applicant/recipient enters, transfers in or out, is discharged, or expires in the facility.

2. It is completed by the Regional Medicaid Office at the time an applicant has been approved for Medicaid and will notify the facility of the effective date of Medicaid eligibility and the amount of the client's Medicaid Income. It will also be used to notify the Nursing Home/Hospital of any change in Medicaid Income which occurs or if Medicaid is terminated or denied.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

The Nursing Home/Hospital originating the form will prepare an original and 2 copies. The original and 1 copy will be mailed to the appropriate Regional Medicaid Office while the second copy is retained by the facility.

The Regional Office will respond on the same forms originated by the Nursing Home or Hospital. The original is returned to the Nursing Home or Hospital and the copy is retained in the client's case record.

If the Regional Office originates the DOM-317 Form, follow the same procedure outlined above for the distribution of the original and copies of the completed form.

The top portion of the form contains identifying information about the Medicaid applicant or recipient and is completed by the office originating the form. The initial DOM-317 is completed by the nursing home or hospital.

NOTICE OF ACTION TAKEN - This portion of the form is completed by the Nursing Home or Hospital at the time the following situations occur:

1. At the time a Medicaid applicant or recipient enters the facility, the Nursing Home/Hospital will check the appropriate block and enter the month, day, and year of entry.

   Check the appropriate block to indicate whether the client or his/her family has been given DOM-300, Application Form, to complete.

2. At the time a client is discharged to another medical facility, check the appropriate block and enter the month, day and year of discharge. Include the name and address of the new facility, if known, in the space provided.

3. If a client is transferred to another medical facility, check the appropriate block and enter the month, day and year of the transfer. Include the name and address of the new facility in the space provided.

4. When a client is discharged to a private living arrangement, check the appropriate block and enter the month, day and year of discharge. Include the client's new address, if known, in the space provided.

5. At the time of the client's death, check the appropriate block and enter the month, day and year of death in the space provided.

6. When a client is discharged from the facility but remains physically in the facility in the Hospice program, enter the date of Hospice enrollment.

The Nursing Home Administrator will sign the form and enter the date the form is completed in the space provided prior to sending the form to the appropriate Medicaid Regional Office.

Page 2 of DOM-317 - To be completed by the Medicaid Regional Office.

MEDICAID ELIGIBILITY STATUS - This portion of the form is completed by the Medicaid Regional Office as follows:

1. Approvals - Check the 1st block when an applicant is approved for long-term care. In the space provided, enter the beginning Medicaid eligibility date.

   In the spaces provided enter the effective date (month, year) and the amount of applicant's Medicaid Income as reflected on the Institutional Budget. The form is designed to show fluctuating income amounts or income protection for first month and the amount of income to be effective in second month, third month, and fourth month, if different.

2. Changes in Medicaid Income - Check the 2nd block to report a change in the client's Medicaid Income as a result of a special or regular review of the client's case. In the space provided enter the effective date (month, year) and the new amount of client's Medicaid Income.

3. Regular Review - No Change in Medicaid Income - Check the 3rd block if at the time of the regular review there is no change in the client's Medicaid Income. Also enter the amount previously reported.

4. Denials - Check the 4th block if an applicant has been denied eligibility.

5. Terminations - Check the 5th block if a client's case is closed. In the space provided enter the month, day and year the closure is effective.

REMARKS: Enter in the space provided any remarks regarding applicant's or recipient's case.

Signature of Medicaid Worker/Date: The Medicaid Specialist or Supervisor will sign and date the form in the space provided.

DOM-317
Revised 01-01-03

EXCHANGE OF INFORMATION BETWEEN NURSING FACILITY OR HOSPITAL AND REGIONAL MEDICAID OFFICE

Name of Nursing Facility/Hospital _____

Provider No. _____

Address _____

City _____ State _____ Zip _____

Client's Name _____

Medicaid ID _____ Social Security No. _____

Name of Responsible Relative _____

Address of Relative _____

Client's County of Residence Before Entering Facility _____

Does this client receive SSI? ( ) Yes ( ) No Amount _____

NOTICE OF ACTION TAKEN

( ) Client entered facility (Month, Day, Year) _____

Family or client has been given an application form? ( ) Yes ( ) No

( ) Client has been discharged to another medical facility as of _____ (date).

Name/address of new facility: _____

_____

( ) Client has been transferred to another facility as of _____ (date).

Name/address of new facility: _____

_____

( ) Client has been discharged to hospice care within same facility effective _____ (date).

( ) Client has been discharged to a private living arrangement: _____ (date).

( ) Client is deceased. Date of death: _____

_____ _____

SIGNATURE DATE

Client's Name _____

Medicaid ID # _____ Provider # _____

MEDICAID ELIGIBILITY STATUS

( ) Client is eligible for Medicaid effective _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

( ) Client has had a change in Medicaid Income.

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

( ) Yearly review has been completed, no change in Medicaid Income.

( ) Client has been denied Medicaid benefits.

( ) Client's Medicaid benefits terminate effective _____

The Medicaid Income figures shown represent a total monthly amount. When collecting medicaid Income from a patient for a partial month stay in your facility, the above figure must be prorated according to the number of days of the stay.

REMARKS: _____

_____

_____

_____

_____ _____

Signature Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-318 - EXCHANGE OF INFORMATION BETWEEN MEDICAID REGIONAL OFFICE AND VA/DHS/SSA

PURPOSE & USE

This form is used in conjunction with the Spousal Impoverishment income provision whereby an Institutionalized Spouse (IS) allocates monthly income to a Community Spouse (CS). If either spouse receives a VA Pension, SSI Benefits and/or AFDC or Food Stamps, this form is used to communicate with the Jackson VA Regional Office, the Social Security Administration and the Department of Human Services County Offices concerning cash assistance benefits that may be affected due to a CS allocation. The form is to be initiated by the Medicaid Regional Office after the CS allocation has been determined and agreed to by all concerned parties, i.e., the IS, the CS and/or their designated representatives.

If the IS makes money available to the CS, the appropriate agency must be informed. If cash assistance benefits (not Food Stamps) are affected for either spouse, the appropriate agency will complete the bottom portion of DOM-318 and return it to the Medicaid Regional Office with the adjusted benefits information specified.

Approval of a nursing home case is not to be delayed pending return of this form. When the completed form is returned by the VA/SSA or DHS, appropriate corrective action will be necessary to adjust Medicaid Income and/or the CS allocation amount.

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

INSTRUCTIONS

Prepare an original and 2 copies. The original and one copy will be mailed to the appropriate agency as follows:

For VA Purposes - VA requests that the Medicaid Regional Office send this form to the VARO in Jackson (100 W. Capitol, Jackson, MS 39269 ATTN: Adjudication Division). The form should be sent on a one-time basis only after the initial determination of a VA Pensioner's Medicaid Income and CS allocation. After Medicaid reports this income information once to VA, it is the veteran's responsibility to report any subsequent changes to VA.

For SSA Purposes - If a CS is SSI eligible and opts to retain SSI eligibility, the form should be sent to SSA to report the initial amount of the CS allocation and any subsequent changes. If the CS opts to receive an allocation amount that will cause SSI to terminate, the form will be sent only once.

For DHS Purposes - If a CS receives AFDC and opts to retain AFDC eligibility, send the form to report any allocation amount and subsequent changes. If the CS receives food stamps, advise the appropriate county DHS office of the allocation amount and any subsequent changes.

The top portion of the form is to be completed by the Medicaid Regional Office. Enter the IS/CS identifying information and the amount of the IS Medicaid Income (after the CS allocation has been deducted) and the amount of the CS monthly allocation.

The worker will sign and date the form in the space provided.

The appropriate agency (VA, SSA or DHS) will complete the bottom portion of the form after benefits have been adjusted.

DOM-318
ISSUED 03-01-90

EXCHANGE OF INFORMATION BETWEEN MEDICAID RO AND VA/SSA/DHS

TO: _____ FROM:

_____

_____

_____

The income information listed below involves a married couple whereby one spouse is in a nursing home and the other spouse is at home. This is being sent to you because one or both of the individuals named below have been identified as receiving benefits from your agency. If this information has any impact on the amount of cash assistance paid by your agency, please return this form to the Medicaid Regional Office named above after completing the bottom portion of this form.

Name of Spouse in Nursing Home _____

Name of Nursing Home _____

SSN: _____ Benefit Claim No. _____

Amount of Income Payable to Nursing Home $_____ Effective Date _____

Name of Community Spouse _____

SSN: _____ Benefit Claim No. _____

Income Allocated From Nursing Home
Spouse to Community Spouse $ _____ Effective Date _____

Signature of Worker _____ Date _____

TO BE COMPLETED BY VA/SSA/DHS - As a result of the income information shown above, cash assistance will be adjusted as follows:

Name of Spouse _____

Adjusted Benefit $ _____ Effective Date _____

Type of Benefit _____

Signature of Worker _____ Date _____

DOM-319 - REPORT OR REFERRAL TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

PURPOSE & USE

This form is used to provide notification to the branch or district Social Security offices in the following instances:

- Refer to the Social Security office a person who appears to be potentially eligible for Supplemental Security Income benefits.

- To notify the Social Security office of information which Medicaid has secured which will possibly affect the SSI benefit amount.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the appropriate Social Security Office and file the copy in the case record.

Enter the appropriate referral information and sign and date the form.

DOM-319
Revised 04-01-90

REPORT OR REFERRAL TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

TO: _____
Social Security Administration

RE: _____
(Name of Client)

FROM:

_____
(Social Security Number)

_____
(Medicaid ID Number)

We have secured the following information concerning the above named individual:

1. ( ) The above named person is being referred to you as a possible claimant for SSI benefits. Should this person be determined eligible for benefits, please report to us the beginning month of eligibility. His/her address is _____.

2. ( ) Beneficiary has entered a Title XIX institution as a patient.
   Name of Nursing Home _____
   Date of Entry _____
   Estimated length of stay _____

3. ( ) Beneficiary left a Title XIX institution patient status. His/her new address is _____
   Date of Departure _____

4. ( ) Change of address (moved from private living arrangement to another)
   Old Address _____
   New Address _____

5. ( ) Beneficiary deceased. Date of Death _____

6. ( ) Change in income or resources of beneficiary. Specify _____
   _____

7. ( ) Change in income or resources of spouse. Specify _____
   _____

8. ( ) Beneficiary entered a public institution.
   Name of Institution _____
   Address of Institution _____
   Date of Entry _____

9. ( ) Other, specify _____

REMARKS:

_____ _____
DATE Medicaid Specialist

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-320A - AGREEMENT TO SELL PROPERTY

PURPOSE & USE

This form is to be completed by the client or representative, with the assistance of the Medicaid worker if necessary, prior to application of the reasonable efforts to sell property exclusion. This exclusion and the use of this form is described in detail in Section F, Resources.

INSTRUCTIONS

Prepare an original and one (1) copy. The client or representative will keep the original and the copy will be filed in the case record.

The portion of the form describing the property in question is to be completed by the worker or the client or representative. The appropriate signature of the client or representative must appear on the form before the exclusion is applied. The form must also be dated.

IMPORTANT INFORMATION ABOUT THIS AGREEMENT

Within thirty (30) days of signing this agreement the Medicaid client or designated representative must take action to:

1. List the property in question with a realtor or begin any other appropriate method of sale (advertise via local media, place a "For Sale" sign on the property, conduct open houses or otherwise show the property).

2. Send appropriate proof to the Medicaid Regional Office of the method(s) of sale decided upon.

After initial proof of a sale attempt is submitted, the owner(s) of the property must actively maintain all efforts to sell the property and must not reject any reasonable offer to buy the property. The burden is on the client and other owners(s) to prove to Medicaid's satisfaction that an offer was rejected because it was not reasonable.

AT ANY TIME REASONABLE EFFORTS TO SELL ARE STOPPED OR A REASONABLE OFFER TO BUY IS REFUSED, THE PROPERTY BECOMES A COUNTABLE RESOURCE TO THE MEDICAID CLIENT BEGINNING WITH THE FIRST MONTH AFTER THE EFFORT TO SELL STOPPED OR THE REFUSAL TO SELL OCCURRED.

The Medicaid worker will check every ninety (90) days to determine if reasonable efforts to sell are being maintained. Appropriate proof will be requested as necessary.

DOM-320A
Issued 06-01-88

Client's Name: _____

Medicaid ID # _____

AGREEMENT TO SELL PROPERTY

I understand that the resources owned by the person shown as the Medicaid client exceeds the amount which an eligible individual may have and still qualify for Medicaid. By signing this agreement, I (We) agree to take all necessary steps to sell the real property described below and to actively continue my (our) efforts to do so until the property is sold. I (We) agree to sell the property for the best possible price and to notify Medicaid within five (5) working days after completion of the sale. Failure to comply with the terms of this agreement will result in the termination of Medicaid benefits and a demand for repayment of any Medicaid funds improperly spent.

Address/Location of Property: _____

_____

Name(s) of Owners: _____

_____

Current Market Value of Property: _____

Amount Owed on Property (if any): _____

Client's Ownership Interest: _____

Value of Client's Share: _____

NOTE: The Medicaid client must receive his/her portion of the net proceeds of the sale. Failure to make these funds available will result in a transfer of resources penalty.

✓_____ _____

Signature of Client or Designated Representative Date

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-321 - RESOURCE COMPUTATION WORKSHEET

PURPOSE & USE

The purpose of this form is to record the value of countable resources which will count toward the client's resource limit. This breakdown should agree with the amounts calculated by MEDS. If the client owns resources but any of the resources are excluded, indicate ownership by checking off the type of resource even though excluded.

INSTRUCTIONS

Prepare an original only and file in the case record.

The worker will make a check mark beside each applicable resource named on the form which the client owns. In the space provided in the right hand column the worker will record the value of each resource checked. The value of each resource will be totaled and the appropriate block checked to indicate if the applicable resource limit is that of an individual or couple. The worker will record in the Remarks section whether the client is eligible or ineligible based on resources and record any additional remarks relating to resources owned. Up to 4 months can be shown on one form.

The worker will sign and date the form.

DOM-321
Revised 10-01-96

Case Name: _____

Case Number: _____

RESOURCE COMPUTATION WORKSHEET

If Client owns any resource listed below, check space If countable, enter countable value	_____ (Month)	_____ (Month)	_____ (Month)	_____ (Month)
_____ Retirement Funds				
_____ Trust Funds				
_____ Safe Deposit Box (if countable, enter amt)				
_____ Cash on Hand				
_____ Checking Account				
_____ Savings Account				
_____ Certificates of Deposit				
_____ Patient Fund Account				
_____ Nursing Home Credit				
_____ Other Liquid Resources (Stocks, Bonds, Promissory Notes, Etc)				
_____ _____				
_____ Home Property (Enter EV if not excluded)				
_____ Life Estate or Heir Property (Enter EV if not excluded)				
_____ EV of Nonexcluded Property (includes mineral rights)				
_____ Household Goods & Personal Effects (Enter CMV if in excess of limit)				
_____ Automobiles: Excluded _____ Y _____ N If yes, reason: _____ If no, enter CMV or EV				
_____ Countable CSV of Life Insurance				
_____ Burial Spaces _____ (Enter CMV if not excluded)				
_____ Burial Funds _____ (Enter CMV if not excluded)				
_____ _____				
TOTAL COUNTABLE RESOURCES ( ) INDIVIDUAL ( ) COUPLE				

REMARKS: _____

_____

Worker: _____ Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

D0M-321A - BURIAL ASSETS EXCLUSION WORKSHEET

PURPOSE & USE

This form is used to document each case record which involves application of the burial asset exclusion with the amount to be excluded and the amount in excess of the exclusion limit which must be counted as a resource, if any. A separate worksheet is required for an eligible individual with an ineligible or eligible spouse since each member of a couple is entitled to a separate computation.

INSTRUCTIONS

Prepare an original only to be filed in each case record affected by the exclusion. Refer to Section F, Resources, for policy governing funds set aside for burial.

Complete this form only for those individuals who would be ineligible due to excess resources if the burial assets exclusion were not applied. Follow the instructions for the amount to enter in each step as outlined on the form. The end resuslt will designate the amount to be excluded as a resource.

The worker will sign and date the form.

DOM-321-A
Revised 11-01-96

CASE NAME:_____

MEDICAID ID #:_____

BURIAL ASSETS EXCLUSION WORKSHEET

Name _____ **Effective Month:** _____

Person Named Above Is: ___ Eligible Individual ___ Eligible Spouse ___ Ineligible Spouse

1. **Does client meet the resource limit without applying the burial assets exclusion?**

   ____ Yes ____ No If YES, STOP. If NO, CONTINUE:

2. **Determine net burial assets exclusion limit:**

   A. _____ Maximum Burial Assets Exclusion Limit (Use $3000 or $1500, whichever is applicable)

   B. - _____ Offset (Subtract total value of all irrevocable burial arrangments and/or the total face values of life insurance policies owned by the individual or spouse on his/her life PROVIDED cash surrender value was excluded in determining countable resources.)

   C. $_____ Net Burial Assets Exclusion Limit

3. **Determine excluded and countable burial assets:**

   A. $_____ Combined Value of Burial Assets (Revocable burial contracts, revocable trusts, or other designated assets ... e.g., bank accounts, etc.)

   B. $_____ Net Burial Exclusion Limit (2. C.)

   C. $_____ Excluded Burial Assets

   -- If 3.A. equals or exceeds 3.B., then 3.B. is the amount of excluded burial assets.

   -- If 3.A. is less than 3.B., then 3.A. is the amount of excluded burial assets.

   D. $_____ Countable Burial Assets

   -- If 3.A. exceeds 3.B. - - - 3.D. is the difference between 3.A. and 3.B. (Include this amount on DOM-321)

   -- If 3.B. exceeds 3.A. - - - 3.D. is -0-

Medicaid Specialist _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-321B - DESIGNATION OF BURIAL FUNDS

PURPOSE & USE

This form documents the client's designation of burial funds. It is to be completed by the worker and signed and dated by the client or representative in each instance when the burial fund exclusion is applied. If no portion of a client's burial fund is excluded, there is no need to complete this form.

Funds set aside for burial may be in the form of a bank account, life insurance, revocable burial contract, or some other form of funds, including cash. DOM-321B must be completed regardless of the form in which the funds are held if the burial exclusion is applicable.

INSTRUCTIONS

Prepare an original and 1 copy. The original is retained in the case record and the copy provided to the client or representative.

Enter the identifying information regarding the funds designated for burial. Show the total amount of funds set aside even though only a portion of the funds may actually be excluded.

TO BE COMPLETED BY THE MEDICAID REGIONAL OFFICE: In the spaces provided, enter the amount of the designated funds which can be excluded and the amount which is a countable resource as determined by completion of DOM-321A, Burial Assets Exclusion Worksheet.

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE: The client or representative must sign and date the form in order for the designation to be official.

The date must be entered in order to determine whether the exclusion can be applied as of the date the funds were first set aside for burial. Refer to the burial exclusion policy for a discussion of the 30-day time limit for designating funds.

DOM-321-B
Revised 04-01-86

Case Name _____

Medicaid ID # _____

DESIGNATION OF BURIAL FUNDS

Name of Person for Whom Funds Are Intended _____

First Month Funds Were Set Aside for Burial _____

Form in Which Funds Are Held _____

List below the specific identifying information concerning the burial funds:

Account No. or Policy No. _____

Name on Account or Name of Policy Owner: _____

_____

Name of Bank or Life Insurance Company or Funeral Home:

_____

Total Amount of Funds Set Aside for Burial (current balance in bank account or current cash surrender value of life insurance policy or current value of revocable burial contract)

$ _____

TO BE COMPLETED BY THE MEDICAID REGIONAL OFFICE:

Amount of Burial Funds Which Can BE EXCLUDED $ _____

Amount Which Must Be Counted As A RESOURCE $ _____

I understand that the funds or resource named above is designated for burial purposes only. A penalty for misuse will be applied if any excluded burial funds is used for a purpose other than burial. The penalty results in future Medicaid benefits due the client being offset by an amount equal to the amount of the funds misused.

✓_____ _____

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE DATE

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-322 - NOTICE OF TRANSFER OF ASSETS (OBRA-93)

PURPOSE & USE

The purpose of this form is to give notice to a nursing home client that a period of ineligibility exists as a result of a transfer of assets on or after August 11, 1993. DOM-322 informs the client/representative that a 10-day period is allowed in which rebuttal evidence may be presented. This form does not replace the advance notice which must be issued if the rebuttal is not successful. Refer to Section F, Resources, for transfer of assets policy from OBRA-93.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 2 copies. The original is given or mailed to the client or representative and 1 copy is retained in the case record. The third copy is used as a tickler copy to hold for 10 days.

Enter the appropriate information pertaining to the transfer(s) being charged.

The worker must sign and date the form.

DOM-322
Revised 10-01-93

Regional Office: _____

NOTICE OF TRANSFER OF ASSETS

_____ Case Name: _____

_____ Medicaid ID: _____

_____

A nursing home patient who applies for or receives Medicaid is prohibited from transferring assets at any time during the 36-month period before applying for or receiving medical assistance in a nursing facility. The look-back period for assets placed in a trust is 60 months prior to application for Medicaid. If assets are transferred, a period of ineligibility shall be charged which is equal to the number of months required to deplete the total uncompensated value based on the total value of all transferred asset(s) divided by the average cost of monthly nursing home care to a private pay patient. This period of ineligibility applies to assets transferred on or after August 11, 1993 as specified in the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66).

Listed below is specific information about assets transferred by the Medicaid applicant/recipient named above:

Resource(s) transferred: _____

_____

Uncompensated Value: _____

Period of Ineligibility for Nursing Home Services:

Beginning: _____

Ending: _____

If you wish to give us evidence that the individual intended to dispose of the resource(s) either at current market value or for other valuable consideration or that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid, you have ten days from the date given below to submit such evidence before final action is taken on the case.

Medicaid Specialist: _____ Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-322A - NOTICE OF TRANSFER OF RESOURCES (MCCA)

PURPOSE & USE

The purpose of this form is to give notice to a nursing home client that a period of ineligibility exists as a result of a transfer of resources on or after July 1, 1988 through August 10, 1993. DOM-322A informs the client/representative that a 10-day period is allowed in which rebuttal evidence may be presented. This form does not replace the advance notice which must be issued if the rebuttal is not successful. Refer to Section F, Resources, for transfer of resources policy from MCCA.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 2 copies. The original is given or mailed to the client or representative and 1 copy is retained in the case record. The third copy is used as a tickler copy to hold for 10 days. Prepare a separate form for transfers that occur in separate months, i.e., only transfers occurring in the same month are combined.

Enter the appropriate information pertaining to the transfer being charged.

The worker must sign and date the form.

DOM-322A
ISSUED 01-01-89

Regional Office: _____

NOTICE OF TRANSFER OF RESOURCES

_____ Case Name: _____

_____ Case No.: _____

_____

A nursing home patient who applies for or receives Medicaid is prohibited from transferring resources at any time during the 30-month period before applying for or receiving medical assistance in a nursing facility. If resources are transferred, a period of ineligibility shall be charged which is equal to the lesser of 1.) 30 months, or 2.) the number of months required to deplete the total uncompensated value based on the value of the transferred resource divided by the average cost of monthly nursing home care to a private pay patient. This period of ineligibility applies to resources transferred on or after July 1, 1988 as specified in the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

Listed below is specific information about resources transferred by the Medicaid applicant/recipient named above:

Resource(s) transferred: _____

Uncompensated Value: _____

Period of Ineligibility for Nursing Home Services:

Beginning: _____

Ending: _____

If you wish to give us evidence that the individual intended to dispose of the resource(s) either at current market value or for other valuable consideration or that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid, you have 10 days from the date given below to submit such evidence before final action is taken on the case.

Worker: _____ Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-323 - DISABILITY OR BLINDNESS REPORT

PURPOSE & USE

This form is used to record the applicant's condition and medical background when the applicant is under age 65 and is disabled and/or blind. If the applicant's disability is to be determined by DDS, this form must be completed by the applicant, representative or Specialist based on the applicant's response to the questions on the form. Refer to Section D, Nonfinancial Eligibility, for policy governing DDS decisions.

If the applicant is a child, complete DOM-323A, Disabled Child Questionnaire, in addition to DOM-323.

INSTRUCTIONS

Prepare an original. DOM-323 along with any prior medical information from the case record will be submitted to DDS in accordance with procedures outlined in the Blindness and Disability policy in Section D.

When the Medicaid Specialist or Supervisor completes the form for the applicant or representative, the CONFIDENTIALITY NOTICE portion of the form will be explained to the applicant. The remainder of the form will be completed based on the applicant or representatives responses to the questions. The information should be as detailed as possible for the benefit of the disability reviewer.

DOM-323
Issued 07-01-81

DISABILITY OR BLINDNESS REPORT

PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and Social Security Number in the space provided and answer all questions about them. **COMPLETE ANSWERS WILL AID IN PROCESSING YOUR APPLICATION PROMPTLY.**

CONFIDENTIALITY NOTICE: The information requested on this form is authorized by Title XIX of the Social Security Act. The information will be used to further document your request for Medicaid. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your eligibility. Information you furnish on the form may be disclosed by the Social Security Administration or the Medicaid Agency to another person or governmental agency only with respect to Social Security and Medicaid programs and only to comply with Federal laws requiring exchange of information between Medicaid and other agencies.

A. NAME OF CLIENT | B. SOCIAL SECURITY NUMBER | C. CASE NUMBER/MEDICAID NUMBER

D. TELEPHONE NUMBER | E. WHAT IS YOUR ILLNESS?

PART I - INFORMATION ABOUT YOUR CONDITION

1. A. When did your illness or injury first bother you? Give month, day and year.

B. When did your illness or injury finally disable you? Give month, day and year.

C. Explain how your condition affects you and keeps you from working?

2. Have you worked since the date shown in item 1A? ☐ Yes ☐ No
If no, go on to Part II.

3. If you did work since the date in item 1A did your condition cause you to change --

Your job or job duties?	☐ Yes	☐ No
Your hours of work?	☐ Yes	☐ No
Your attendance?	☐ Yes	☐ No
Anything else about your work?	☐ Yes	☐ No

(If you answered NO to all of these, go to Part III)

4. If you answered YES to Item 3, explain below what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you had any of the following tests in the last year:

Test	Check Appropriate Block or Blocks: Yes	No	If "Yes", Show: Where Done	When Done
Electrocardiogram	☐	☐		
Chest X-Ray	☐	☐		
Other X-Ray (Name the body part here _____	☐	☐		
Breathing Tests	☐	☐		
Blood Tests	☐	☐		
Other (Specify)	☐	☐		

6. List the name, address and telephone of the doctor who has your latest medical record. If you have no doctor, check here ☐

Name _____ Address _____

Area Code/Telephone No. _____ _____

How often do you see this doctor? _____ Date you last saw this doctor _____

Reason for visits _____

_____

Type of treatment received _____

7. A. Have you seen any other doctor since your illness or injury began? ☐ Yes ☐ No

Name _____ Address _____

Area Code/Telephone No. _____ _____

How often do you see this doctor? _____ Date you last saw this doctor _____

Reason for visits _____

_____

Type of treatment received _____

B. Identify below any other doctor you have seen since your illness or injury began. List the doctor(s) names, addresses, dates and reasons for visits. If additional space is needed, use Part VI or attach another sheet of paper.

8. Have you been hospitalized or treated at a clinic for your illness or injury? ☐ Yes ☐ No If "Yes", show the following:

Name of hospital or clinic _____ Address _____

Patient or clinic number _____ _____

Were you an inpatient? (stayed at least overnight) ☐ Yes ☐ No If "Yes" complete the following:

Date of admission _____ Date of discharge _____

Reason for hospitalization or clinic visits _____

_____

Type of treatment received _____

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI, Remarks.

9. Have you been seen by other agencies for your injury or illness? (VA, Worker's Compensation, Vocational Rehabilitation, Welfare, etc) ☐ Yes ☐ No If "Yes", show the following:

Name of Agency _____ Address _____

Your Claim Number _____ _____

Dates of visits _____

Type of treatment or examination received _____

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

PART III - INFORMATION ABOUT YOUR ACTIVITIES

10. Has any doctor told you to cut back or limit your activities in any way? ☐ Yes ☐ No If "Yes", give name of doctor and tell what he or she told you about cutting back or limiting your activities: _____

_____

11. Describe your daily activities in the following areas and state what and how often you do it.

Household maintenance (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

Recreational activities and hobbies (hunting, fishing, bowling, hiking, musical instruments, etc.):

Social contacts (visits with friends, relatives, neighbors):

Other (drive car, motorcycle, ride bus, etc.):

PART IV - INFORMATION ABOUT YOUR EDUCATION

12. What is the highest grade of school that you completed? _____

13. Have you gone to trade or vocational school or had any other type of special training? ☐ Yes ☐ No If "Yes", complete the following:

Type of trade or vocational school or training _____

Approximate dates you attended: _____

How this school or training was used in any work you did. _____

PART V - INFORMATION ABOUT THE WORK YOU DID

14. A. If you did work, what was your usual job in the 15 years before you became disabled. (Normally this will be the kind of work you did for the longest period of time.) Include the type of business, for example, farming, restaurant, etc. _____

_____

B. Describe your duties in this job. (Show how much bending, lifting, walking, writing, or other activities were required. How often did you lift things, and how heavy were they? What kind of special tools or skills were required? What kind of written reports did you complete? How many people did you supervise?) _____

_____

_____

15. A. Did your condition make you stop working? ☐ Yes ☐ No

B. If "Yes", what is the date you stopped working? Give month, day, year

C. If this date is different from the one shown in Item 1B (the date you say you became disabled), explain the reason for the difference: _____

PART VI - REMARKS

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (Signature of Client or person filing on the Client's behalf)

✓ _____ Date _____

PART VII - FOR MEDICAID USE ONLY - DO NOT WRITE BELOW THIS LINE

Name of Client _____ SSN _____

16. A. Does the client need assistance in prosecuting his/her claim? ☐ Yes ☐ No If "Yes" show name, address, relationship, and telephone number of an interested party willing to assist the client.

B. Can the client (or his representative) be readily reached by telephone with no communication problems due to language, speec. or hearing difficulties? ☐ Yes ☐ No If "No" worker should also complete Form DOM-324, Vocational Report.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-323A - DISABLED CHILD QUESTIONNAIRE

PURPOSE & USE

This form is completed along with DOM-323 for all applicants age 18 and under. This form records pertinent medical and educational information for the child. The form is completed by the parent or representative or the Specialist based on the parent/representative's responses.

INSTRUCTIONS

Prepare an original. Submit DOM-323, 323A and any prior medical information to DDS in accordance with procedures outlined in the Blindness and Disability policy in Section D.

The parent or representative of the child must sign and date the form upon completion.

DOM-323-A
Issued 05-01-92

DISABLED CHILD QUESTIONNAIRE

Child's Name _____ Child's Social Security # _____

Your Name/Relationship to Child _____ Daytime Telephone # _____

1. Does child now or in the past attended any type of preschool and/or daycare?

   Name(s) _____

   Addresses _____

   _____

   Telephone #s _____ Dates Attended _____

2. Does child now or in the past attended school (public or private)?

   Name(s) _____

   Addresses _____

   _____

   Telephone #s _____ Dates Attended _____

   Last Teacher's Name _____

   Is the child in a Special Education Program? __ Yes __ No

   If yes, indicate type of program and number of hours per week

   _____

   PLEASE PROVIDE A COPY OF THE CHILD'S INDIVIDUAL EDUCATION PLAN THAT OUTLINES THE CHILD'S PROBLEMS AND LISTS THE PLANS FOR CORRECTING THEM.

3. Does the child receive any special counseling or tutoring?

   a. In school? __ Yes __ No

   b. Outside school? __ Yes __ No

   Please state type of counseling or tutoring, frequency of visits, name & address & telephone # of counselor/tutor.

_____

_____

_____

4. Does the child or family have a social services or early intervention caseworker? If yes,

Name _____

Address _____

Telephone # _____ File # _____

5. Has the child ever been tested or evaluated by any of the following?

Public/ Community Health/ Social Services Dept. __ Yes __ No

Developmental Evaluation Center __ Yes __ No

Community Mental Health Center __ Yes __ No

Speech and Hearing Center __ Yes __ No

Women, Infants & Children (WIC) Program __ Yes __ No

If yes to any of the above, provide the agency name, address & telephone # below. Also state the type of test or evaluation performed.

_____

_____

_____

_____

_____

_____

6. Does or has the child received physical therapy, occupational therapy, or speech & language therapy outside the home?

__ Yes __ No If yes, state the type and frequency of the treatment and the name, address & telephone # of the therapist.

_____

_____

_____

_____

_____

_____

7. Does or has the child received any special therapy, exercises, or any other services for disability at home? __ Yes __ No If yes, state the type and frequency of the treatment and the

name, address & telephone number of the therapist. Indicate if any medication included.

_____
_____
_____
_____
_____
_____

8. Does or has the child received rehabilitation services? ___ Yes ___ No If yes, describe services received and the name, address & telephone # of the rehabilitation counselor.

_____
_____
_____
_____
_____
_____

9. If the child takes any medication on an ongoing, routine basis, please indicate the following:

Name(s) of medication: _____

Dosage and Amount: _____

Frequency: _____

Prescribed by: _____

Address/ Telephone _____

What are medications for: _____

Side effects _____

Does medication work? _____

10. Has the child ever been involved with the court system? __ Yes __ No THIS INFORMATION IS OPTIONAL.

If yes, please explain involvement: _____
_____
_____

Name of Youth Court or Probation/Parole Officer (include address & telephone #.)

_____
_____
_____

11. Does the child participate in any community or school activities such as choir, athletics, clubs, etc.?
___ Yes ___ No If yes, describe involvement, amount of time spent in activity, and level of participation. Provide name, address & telephone # of individual who supervises the activity.

REMARKS

I authorize any person, agency or organization to disclose to the State Agency that may review my claim any medical records or other information about the child's disability.

Signature of person filing on child's behalf

Date

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-324 - VOCATIONAL REPORT

PURPOSE & USE

This form is a supplement to the DOM-323, Disability and Blindness Report, and is to be completed by the Specialist only when the applicant has a communication problem due to language, speech or hearing difficulties which would make it difficult for the DDS reviewer to contact the applicant in order for DDS to obtain the information. The Specialist will complete the form with the applicant or representative, or the applicant may wish to complete the form on his/her own.

INSTRUCTIONS

Prepare an original and attach the form to DOM-323 to be forwarded to DDS. Refer to policy in Section D for disability and blindness policy.

When the Medicaid Specialist completes the form, the CONFIDENTIALITY NOTICE will be explained to the applicant.

DOM-324
Issued 07-01-81

VOCATIONAL REPORT

This report supplements the Disability or Blindness Report (Form DOM-323) by requesting additional information about your past work experience. **PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY.** If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. **COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.**

CONFIDENTIALITY NOTICE: The information requested on this form is authorized by Title XIX of the Social Security Act. The information will be used to further document your request for Medicaid. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your eligibility. Information you furnish on this form may be disclosed by the Social Security Administration or Medicaid Agency to another person or governmental agency only with respect to Social Security and Medicaid programs and only to comply with Federal laws requiring the exchange of information between Medicaid and other agencies.

Name of Client _____

Social Security Number _____ Telephone Number (Where you can be reached) _____

Part I - INFORMATION ABOUT YOUR WORK HISTORY -List the job or jobs you have had in the last 15 years before you stopped working. (If you have a 6th grade education or less, AND performed only heavy unskilled labor for 35 years or more, list the job or jobs you have had since you began to work. If you need more space, use Part III)

JOB TITLE (Begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (Month, Year) FROM	TO	DAYS PER WEEK	RATE OF PAY (Per hr., day, wk., mo., yr.)
1.					
2.					
4.					
5.					
6.					

Part II - INFORMATION ABOUT YOUR JOB DUTIES - Provide the following information for each of the jobs listed in Part I, starting with your usual job:

Job Title (from Part I) _____

A. In your job did you:
- Use machines, tools or equipment of any kind? ☐ Yes ☐ No
- Use technical knowledge or skills? ☐ Yes ☐ No
- Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No
- Have supervisory responsibilities? ☐ Yes ☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

Walking (circle the number or hours a day spent walking) 0 1 2 3 4 5 6 7

Standing (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7

Sitting (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8

Bending (circle how often a day you had to bend) . . . . . Never Occasionally Frequently Constantly

Reaching (circle how often a day you had to reach) . . . . . Never Occasionally Frequently Constantly

Lifting and Carrying: Describe below what kind of objects or material was lifted; how much it weighed, how many times a day you lifted this material, and how far you carried it.

IF YOU NEED ADDITIONAL SPACE TO PROVIDE INFORMATION ABOUT OTHER JOBS LISTED IN PART I OF THIS FORM, USE PART III OR ATTACHED ADDITIONAL COPIES OF THIS FORM.

Part III - **REMARKS** - Use this section for any other information you may want to give about your work history, or to provide any other remarks you may want to make to support your disability claim:

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (Name of Client)

✓ _____ Date _____

Signature of Client or Person Filing on the Client's Behalf)

DO NOT WRITE BELOW THIS LINE

Form DOM-324 taken by: ☐ Personal Interview ☐ Telephone ☐ Mail

Form Supplemented: ☐ Yes ☐ No If "Yes", by ☐ Personal Interview ☐ Telephone ☐ Mail

Signature of Interviewer or Reviewer _____ Date _____

Title _____ Office _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-325 - DISABILITY DETERMINATION AND TRANSMITTAL

PURPOSE & USE

This form is used to transmit all medical information and DOM Forms 323, 323A and 324 to the Disability Determination Service (DDS). DDS uses the form to record the disability or blindness decision.

INSTRUCTIONS

Prepare an original and 4 copies. Submit the original and 2 copies to DDS, file one copy in the case file, and the remaining copy will serve as the tickler copy. Set a tickler for 75 days from the day of mailing the file folder to DDS. If the decision has not returned from the DDS within 75 days, the Regional Office will contact the State Office as outlined in the policy in Section D.

The top portion of the form is completed by the Regional Office giving specific information about the applicant. Specify whether retroactive months of eligibility are being requested prior to the month of application.

The worker will sign and date the form and include the Regional Office address and applicant's address.

DOM - 325
ISSUED 02-01-92

Case Name _____

Case Number _____

DISABILITY DETERMINATION AND TRANSMITTAL

TO: DISABILITY DETERMINATION SERVICE

1. DECISION REQUEST:
❑ Initial ❑ Cont. Dis. Inv. ❑ Hearing
❑ RETROACTIVE FOR PERIOD:

2. SOCIAL SECURITY NUMBER

3. MEDICAID NO.

4. GRANDFATHER STATUS
❑ Yes ❑ No

5. DATE OF BIRTH

6. PRIOR ACTION BY DDS
❑ No ❑ Yes prior medical

7. APPLICATION DATE

8. CLAIMANT ADDRESS

9. MEDICAID OFFICE ADDRESS

10. REMARKS

11. MEDICAID SPECIALIST / SUPERVISOR

12. DATE

DETERMINATION PURSUANT TO SOCIAL SECURITY ACT, AS AMENDED

13. CLAIMANT DISABLED
❑ DISABILITY ❑ DISABILITY
BEGAN _____ CEASED _____
❑ DISABILITY CONTINUES

14. DIAGNOSIS

15. RE-EXAM
❑ NONE
❑ _____ (Date)

CLAIMANT NOT DISABLED ❑ SEE SSA-834 FOR EXPLANATION (OR BELOW)

16. RETROACTIVE ELIGIBILITY DECISION:
❑ Not eligible during retroactive period. See above for explanation.
❑ Eligible on disability or blindness during retroactive period beginning _____ (Date) and ending _____ (Date).

17. VOCATIONAL REHABILITATION ACTION
❑ SC. IN ❑ SC. OUT ❑ PREV. REF.

18. DISABILITY EXAMINER - DDS DATE

19. REVIEW PHYSICIAN - DDS DATE

20. REMARKS

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-330 - REQUEST FOR FINANCIAL INFORMATION

PURPOSE & USE

This form is to be used to secure verification from a bank, savings and loan association, or other savings agency, concerning the cash or cash assets of an applicant/recipient. Refer to Section F, Resources, for policy regarding the use of this form.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the bank or give the form to the client/representative to take to the bank for completion. Retain the copy in the tickler file. When the original is returned, discard the copy and file the original in the case record.

Enter the client's identifying information on the top part of the form.

Signature of Client: The client or designated representative will sign here. If the designated representative is signing for the client, submit a copy of DOM-302 along with this form.

Signature of Medicaid Worker: The worker will sign in this space.

Date: Enter the date the form is completed.

The bank will complete the lower portion of the form and page 2 and sign in the space provided.

DOM-330
Revised 10-01-96

REQUEST FOR FINANCIAL INFORMATION

Client's Name: _____

Spouse: _____

Address: _____

_____

Client's SSN: _____

Account #: _____

I hereby authorize you to disclose any information concerning my financial accounts to the Mississippi Medicaid Agency for the purpose of determining my Medicaid eligibility.

✓ _____ _____

Signature of Client or Person Authorized to Act for Client — Date

PLEASE NOTE: The Mississippi Medicaid Agency will not be held liable for any charges incurred for researching financial records.

_____ _____

Medicaid Specialist — Date

THE FOLLOWING IS TO BE COMPLETED BY A BANK OFFICIAL

1. Does client's name appear or has it appeared on a checking account (individually or jointly) within the last 3 years? ☐YES ☐NO (If yes, complete Page 2.)

2. Does client's name appear or has it appeared on a savings account (individually or jointly) within the last 3 years? ☐YES ☐NO (If yes, complete Page 2.)

3. Does client own or has client owned (individually or jointly) any Certificates of Deposit or Savings Certificates within the past 3 years? ☐YES ☐NO (If yes, complete Page 2.)

4. Does client rent a safe deposit box? ☐YES ☐NO

_____ _____

Signature of Bank Official Completing This Form — Date

RETURN TO:

TO BE COMPLETED IF "YES" IS CHECKED ON THE REVERSE SIDE

I. **CHECKING ACCOUNT NUMBER** _____ Individual ( ) Joint ( )

How is account listed? _____

Is this an interest bearing account? ☐ YES ☐ NO

Please provide account balance and interest earned as of the 1st of month:

MONTH	INTEREST	BALANCE
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

NOTE: If account is closed, give date of closure: _____

Balance at time of closure: _____

Person who authorized closure: _____

II. **SAVINGS ACCOUNT NUMBER** _____ Individual ( ) Joint ( )

How is account listed? _____

Interest Rate _____% Paid: Semi-Annually ( ) Quarterly ( ) Monthly ( )

Please provide account balance and interest earned as of the 1st of the month:

MONTH	INTEREST	BALANCE
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

NOTE: If account is closed, give date of closure: _____

Balance at time of closure: _____

Person who authorized closure: _____

III. **CERTIFICATES OF DEPOSIT AND SAVINGS CERTIFICATES**

Name(s) on Account _____

Amount of Certificate _____ Maturity or Redemption Date_____

CD # _____ Amount/Frequency of Interest _____

NOTE: If Certificate has been redeemed, give name of person who authorized redemption:

_____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-331 - REQUEST FOR INFORMATION CONCERNING INSURANCE

PURPOSE AND USE

This form is used to obtain information concerning any insurance policies a client may have. This does not pertain to Medicare insurance. This form also is a release from the client authorizing the Division of Medicaid to obtain this information for the purpose of determining the client's Medicaid eligibility.

INSTRUCTIONS

Prepare the original and 1 copy and obtain the client or representative's signature. Once signed, retain the copy in the tickler file and mail the original to the appropriate insurance company. When the original is returned, discard the tickler copy and file the original in the case record.

Note in the Record of Contact the dates the forms were mailed and returned by the client and the appropriate insurance company.

Signature of Client or Representative: The client or representative will sign in this space.

The insurance company will complete the middle section of the form requesting insurance information.

The worker will sign, date and return address stamp the form.

DOM-331
REVISED 11-01-88

Case No.: _____

REQUEST FOR INFORMATION CONCERNING INSURANCE

_____ RE: _____

_____ DATE OF BIRTH: _____

_____ SOCIAL SECURITY NO.: _____

Dear Sir:

I hereby authorize you to disclose any information concerning my insurance policy(ies) with your company to the Division of Medicaid for the purpose of determining my Medicaid eligibility.

_____ _____

DATE SIGNATURE OF CLIENT OR REPRESENTATIVE

We have been advised that this person has a policy(ies) with your company. In order for us to determine his/her eligibility, please complete the following items. When completed, please return this form to the address shown below. Your cooperation with this request is greatly appreciated.

NAME OF INSURED _____

POLICY NUMBER(S) _____

OWNER OF POLICY(IES) _____

TYPE OF POLICY(IES) _____

FACE VALUE OF EACH POLICY _____

CASH SURRENDER VALUE (CURRENT) OF EACH _____

AMOUNT OF LOANS AGAINST EACH _____

_____ _____

SIGNATURE OF INSURANCE OFFICIAL DATE

Regional Office Address/Telephone

Medicaid Worker _____

Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-333 - REQUEST FOR WORKERS' COMPENSATION COMMISSION DATA

PURPOSE & USE

This form is used to verify Workers' Compensation benefits as a result of an on the job injury. If a possibility of workers' compensation benefits exists, this form is completed by the Specialist and submitted to the State Office Eligibility Division along with a signed/dated DOM-301, Authorization to Release Information, signed by the client.

All inquiries must come through the State Office so that an Eligibility Division staff member can take it to the Workers' Compensation Commission for completion. The Workers' Compensation Commission will not fill individual written requests from Regional Offices.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the State Office Eligibility Division and retain the copy in the record until the original is returned. Include all identifying information on the client, including a workers' compensation claim number, if known.

Part II will be completed and returned by the State Office after verifying the information at the Workers' Compensation Commission.

DOM-333
Revised 01-01-91

REQUEST FOR WORKERS' COMPENSATION COMMISSION DATA

TO: Medicaid State Office, Eligibility Division

FROM: _____ Regional Office

We have received an application/redetermination form for Medicaid from the following person. On this form, he/she stated that a claim was filed with Workers' Compensation. Please check with the Mississippi Workers' Compensation Commission to acquire the information in Part II. We have enclosed a release signed by the applicant/recipient to authorize the Workers' Compensation Commission to release this information to an authorize representative of Mississippi Medicaid.

_____ _____
Date Medicaid Specialist

PART I

Name of Applicant/Recipient: _____

Address: _____

Social Security Number: _____ Medicaid ID Number: _____

MWCC Claim Number: _____

Employer at Time of Accident: _____

Address of Employer: _____

Date of Injury: _____

PART II

Weekly Benefit Rate _____ Maximum Number of Weeks Payable _____

Date of Initial Payment _____ Medicaid Payments _____

Date and Amount of Lump Sum Payment, if applicable _____

Amount of lump sum payment that goes towards: Doctor's bills, $ _____;

Lawyers fees, $ _____; Hospital bills, $ _____; Other, $ _____; $ _____.

No Claim _____

Claim in Process _____

Claim Disallowed _____

_____
Area Supervisor

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-334 - REQUEST FOR INFORMATION REGARDING UNEMPLOYMENT COMPENSATION

PURPOSE & USE

Medicaid routinely matches client's Social Security Numbers with the Employment Security Commission to determine if wages and/or Unemployment benefits are payable. However, if needed, DOM-334 can be used to secure this information from Employment Security.

INSTRUCTIONS

Prepare an original and 1 copy of the form and forward the original to the appropriate Unemployment Claims Center of the Mississippi State Employment Security Commission serving the region. File the copy in a tickler file until the original is returned, then discard the copy and place the original in the case folder.

Enter the client's identifying information on the top part of the form. The worker will sign and date the form and return address stamp the form.

The Employment Security Commission will complete the remainder of the form.

DOM-334
Revised 01-01-91

REQUEST FOR INFORMATION REGARDING UNEMPLOYMENT COMPENSATION

TO: RE: Name _____

S.S. No. _____

I authorize your agency to release to the Mississippi Medicaid Regional Office named above any information concerning my eligibility for and/or receipt of unemployment benefits.

_____ _____
(Signature of Claimant) (Date)

The following information is required for our use in determining the above-named individual's eligibility for medical assistance. This information will not be disclosed to any organization or person outside this agency, except in accordance with regulations or instructions of the Mississippi Employment Security Commission.

_____ _____
(Signature of Medicaid Specialist) (Date)

Please answer the appropriate item(s) including all unemployment insurance programs:

A. _____ If otherwise eligible, the above-named individual may receive benefits during his benefit year beginning _____ and ending _____.

1. $ _____ Weekly benefit amount
2. $ _____ Maximum unemployment benefits payable during the benefit year.
3. $ _____ Unemployment benefits have been paid to date during the benefit year, according to our records.
4. _____ Date most recent unemployment claim was filed.

B. _____ Benefits not being received.

1. _____ No record of claim.
2. _____ Disqualified for a period beginning _____ and ending _____.

BY: _____
Mississippi Employment Security Commission

REMARKS: _____

_____

When complete, please mail to the above stamped Regional Office.

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-335 - REQUEST FOR VERIFICATION FOR WAGES

PURPOSE & USE

This form is used to verify the earnings of an applicant/recipient or spouse whose income must be deemed. It can be adapted for use by parents whose income must be deemed to an eligible child. The signature of the "employee" whose earnings must be verified is required on the form prior to sending it to the employer.

INSTRUCTIONS

Prepare the original and 1 copy and obtain the appropriate signature authorizing release of the information. Mail the original to the employer and file the copy in a tickler file. When the original is returned, discard the copy and file the original in the case record.

Complete the top portion of the form giving identifying client information. The worker will sign, date and return date stamp the form.

The employer should complete the remainder of the form.

DOM-335
REVISED 11-01-88

Case No.: _____

REQUEST FOR VERIFICATION OF WAGES

_____ RE: _____

_____ DATE OF BIRTH: _____

_____ SOCIAL SECURITY NO.: _____

I hereby authorize you to disclose any information concerning my wages to the Division of Medicaid for the purpose of determining my Medicaid eligibility.

_____ _____
DATE SIGNATURE OF CLIENT, SPOUSE OR REPRESENTATIVE

The individual named above is requesting Medicaid benefits. In order for us to determine eligibility, **please provide wage information for the following time period:**

When completed, please return this form to the address shown below. Your cooperation with this request is greatly appreciated.

HOW OFTEN PAID?

_____ weekly _____ every 15 days _____ other (specify)

_____ bi-weekly _____ monthly _____

RATE OF PAY AS OF _____ $_____
DATE AMOUNT

NUMBER OF HOURS WORKED EACH WEEK? _____

DATE EMPLOYMENT BEGAN? _____ ENDED: _____

DATE OF NEXT SCHEDULED RAISE: _____ DATE OF LAST RAISE: _____

REMARKS: _____

_____

EMPLOYER SIGNATURE: _____ DATE: _____

Return to:

Medicaid Worker: _____

Date: _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-336 - INSTITUTIONAL BUDGET

PURPOSE & USE

This form is used to determine eligibility and continuing eligibility for all institutional clients. If the individual applying for long term care Medicaid is eligible based on income, this form is used to determine the SSI coverage group and the fulfillment of the 30-consecutive day requirement for those ineligible for Medicaid at home; and to determine the monthly maintenance needs allowance for a community spouse and other dependent family members; and to document the allowance of any non-covered medical expenses; and finally to determine the Medicaid Income due from the client to pay towards the cost of his/her care.

Refer to Section I, Institutionalization, for policy regarding institutional budgeting.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original only for the case record.

STEP 1. ELIGIBILITY BASED ON INCOME

Specify the month or months of the eligibility computation.

1.a. Enter the appropriate Federal maximum of an individual applying for Medicaid.

1.b. Enter the total income of the individual as defined in policy on institutional budgeting.

1.c. If the amount entered in 1.b. in any column is equal to or more than the Federal maximum, the individual or couple is ineligible for Medicaid for that month. Do not complete the remainder of the form if ineligible in all columns. If a deficit results, complete the remaining applicable steps.

STEP 2. COVERAGE GROUP DETERMINATION & 30-CONSECUTIVE DAY REQUIREMENT

Use this section to determine the individual coverage group in the institution based on countable income of the individual against the appropriate SSI FBR. Countable income is determined from preparation of an at-home budget or by showing income less all appropriate SSI exclusions.

If an applicant is ineligible for Medicaid (not just SSI) at home, complete the 30-consecutive day requirement portion (Step 2.b.) which documents date of admission and the 31st day.

Note: The exception to fulfillment of the 30-consecutive day requirement is death in the institution or placing the individual in an at-home MAO coverage group if the institutional stay is less than 31 days.

STEP 3. MONTHLY MAINTENANCE NEEDS ALLOWANCE FOR SPOUSE AND DEPENDENTS

This step is completed if there is a community spouse only or a spouse and other dependent family members who live with the spouse.

3.a. Determine the CS allowance by comparing CS income to the Maximum allowance (specified in Institutional Budgeting policy) for a CS. The CS allowance as determined by this computation may be reduced in Step 4, Medicaid Income Computation, if the IS has income less than the CS allowance.

3.b. Compute up to 3 other dependent family member's allowance amounts in Step 3. Enter the name of the dependent for each computation. Determine each dependent's allowance by using the Family maximum (specified in Institutional Budgeting policy) less each dependent's own income. The difference is then divided by 1/3 to arrive at each dependent's allocation amount. Add together each dependent's allowance as shown in the "1/3 Remainder" space and show the total in Step 4.e.

STEP 4. MEDICAID INCOME COMPUTATION

This portion is used to determine the amount the client must pay toward the cost of his/her care. The form is designed to show the computation of four (4) separate months, if needed, to reflect fluctuations in Medicaid Income.

4.a. Specify the month(s) of the Medicaid Income Computation.

4.b. Show the eligible individual's total income.

4.c. Subtract the appropriate PNA of the individual.

4.d. Subtract the CS monthly allowance which may be equal to the 4.c. Subtotal if the CS allowance computed in Step 3.a. is greater than the remaining income shown in 4.c.

4.e. Subtract the total other Family Members' Allowance if income remains after deducting the CS allowance.

4.f. Subtract the recipient's health insurance premium amount if applicable.

4.g. Subtract any other non-covered medical expenses allowed as per Institutional Budgeting policy.

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

Enter the total amount of Medicaid Income to be paid by the recipient for each month computed.

COMPUTATIONS: Use this space to document the computation of gross income from Step 1 and the income computations for Step 4, such as the computations for averaged income and the amount of health insurance premium(s) claimed by the client as a deduction. Specify the type of computations shown on the form. For health insurance premiums, specify the method of payment (monthly, quarterly, etc.).

The worker will sign and date the form.

DOM-336
Revised 10-01-96

Case Name: _____

Medicaid ID Number: _____

INSTITUTIONAL BUDGET

STEP 1. ELIGIBILITY BASED ON INCOME

	(Month)	(Month)	(Month)
a. Institutional Income Limit			
b. Income of Individual			
c. If Difference Results, Continue			

STEP 2. COVERAGE GROUP DETERMINATION & 30-CONSECUTIVE DAY REQUIREMENT

a. Determine applicant's SSI Coverage Group

SSI FBR _____

Countable Income _____

Difference _____

If eligible, Coverage Group is 30
If ineligible, Coverage Group is 20

b. Complete only for applicants who are ineligible for Medicaid at-home.

Date of Admission _____

Enter 31st Day _____

Did Applicant Meet 30-Consecutive Day Requirement? Yes _____ No _____

STEP 3. MONTHLY MAINTENANCE NEEDS ALLOWANCE FOR SPOUSE AND DEPENDENTS

a. Community Spouse (CS)

Maximum Allowance _____

Less CS Income - _____

CS Allowance _____

b. Other Dependent Family Members

(1) Name _____

Family Maximum _____

Less Income - _____

Difference _____

1/3 Remainder _____

2. Name _____

Family Maximum _____

Less Income - _____

Difference _____

1/3 Remainder _____

3. Name _____

Family Maximum _____

Less Income - _____

Difference _____

1/3 Remainder _____

If more than 3 Other Dependent Family Members - show computation on Page 2

STEP 4. MEDICAID INCOME COMPUTATION

	(Month)	(Month)	(Month)	(Month)
a. Specify Month(s) of Computation:	_____	_____	_____	_____
b. Eligible's Total Income	$_____	$_____	$_____	$_____
c. Less Personal Needs Allowance	-_____	-_____	-_____	-_____
Subtotal	$_____	$_____	$_____	$_____
d. Less CS Monthly Allowance	-_____	-_____	-_____	-_____
Subtotal	$_____	$_____	$_____	$_____
e. Less Other Family Members' Allowances (Show total amount)	-_____	-_____	-_____	-_____
Subtotal	$_____	$_____	$_____	$_____
f. Less Health Insurance Premium(s)	-_____	-_____	-_____	-_____
Subtotal	$_____	$_____	$_____	$_____
g. Less Non-Covered Medical Expenses	-_____	-_____	-_____	-_____
Subtotal	$_____	$_____	$_____	$_____
TOTAL MEDICAID INCOME	$_____	$_____	$_____	$_____

COMPUTATIONS:

Medicaid Specialist _____ Date _____

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-337 - ELIGIBLE INDIVIDUAL/ELIGIBLE COUPLE & SPOUSE TO SPOUSE DEEMING WORKSHEET

PURPOSE & USE

This form is used to determine income eligibility for individuals or couples who live at-home. Refer to Section H, Budgeting for At-Home Eligibility, for policy regarding at-home eligibility.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original only for the case record.

STEP 1. INDIVIDUAL OR ELIGIBLE COUPLE CALCULATION

This portion is used to determine the eligible individual/couple eligibility using the income of the eligible only or the combined income of an eligible couple.

1.a. If the eligible receives VA Aid & Attendance, use this space to subtract the portion designated as Aid & Attendance from the VA payment. Specify in the space provided the type of VA payment received by the eligible, such as pension, compensation, etc.

1.b. If the eligible receives a VA benefit which includes a dependent(s) allocation, use this space to deduct the allocation from the eligible's benefit, if appropriate. If 1.a. is completed, deduct the dependent's allocation from the 1.a. total. Specify the type benefit received by the eligible in the space provided.

1.c. List the type(s) and amount(s) of all unearned income received by the eligible. DO NOT LIST ANY INCOME BASED ON NEED RECEIVED BY THE ELIGIBLE, as this type of income is added in 1.f. Bring down the amount of the VA payment to be used in budgeting (1.a. or 1.b. total) provided the VA payment is not based on need. If the VA payment is based on need, the 1.a. or 1.b. total is added in 1.f.

1.d. Subtract any appropriate SSI/SSA disregard totals, if applicable. Show the computation of the disregarded amount(s) in the space provided in the lower right corner of page 1.

Note: Do not mix budgeting procedures, i.e., only COL applicants are eligible for COL disregards. Do not allow SSI disregards when budgeting for Poverty Level or QMB applicants.

1.e. Subtract the general exclusion from the 1.c. or 1.d. total.

1.f. Add any income based on need received by the eligible to the 1.e., subtotal and specify the type of payment (such as VA pension) that the income represents.

1.g. Enter the total countable unearned income.

1.h. List all type(s) and gross amount(s) of earned income, if applicable.

1.i. Enter the total gross earned income.

1.j. Enter the total countable earned income after all deductions have been applied.

1.k. Enter the totals from 1.g. and 1.j. and add together to arrive at the total countable income.

1.l. Enter the appropriate SSI FBR or Federal Poverty Level (FPL) for an individual or couple and subtract the total countable income taken from the 1.k., total.

If the total is equal to or exceeds the applicable FBR or if the total exceeds the appropriate FPL, the individual or couple is not Medicaid eligible. Do not continue. If a deficit results, the client is eligible based on his/her income and Steps 2 and 3 must be completed if an individual has an ineligible spouse.

STEP 2 - INELIGIBLE SPOUSE CALCULATION

This portion is completed if the eligible has an ineligible spouse at home.

2.a. Enter the ineligible spouse's total unearned income. Do not consider any income based on need received by the ineligible spouse or any income used to budget the income based on need. It may be necessary to contact the agency (such as Human Services, VA) to determine what income is used to budget the ineligible spouse's payment.

Subtract Allocation for Ineligible Child(ren) - If there is a dependent child (under age 18 or under 21 and a student) in the household, complete the allocation portion by entering each child's name in the space provided, an allocation for each child from the SSI Payment Table, and subtracting each child's own income to arrive at the total allocation for each child. Add all total allocations and subtract the total allocation from the ineligible spouse's unearned income. This equals the remaining unearned income.

2.b. Enter the ineligible spouse's earned income. If any unused child's allocation remains from 2.a., subtract the remainder from the earned income to arrive at the remaining earned income.

2.c. Add remaining unearned income total from 2.a. to the amount in 2.b.

2.d. Total Income After Allocations - The sum of 2.a. and 2.b. equal the income after allocating. If this total is less than the difference between the couple and individual SSI FBR or less than the difference between the couple and individual Poverty Levels (whichever is appropriate for the type of budgeting involved) then no deeming applies. Do not complete Step 3 as the eligible individual is eligible.

STEP 3 - COMBINED INCOMES AFTER ALLOCATING

This portion is completed if the eligible has an ineligible spouse at home.

3.a. Enter the eligible's unearned income taken from the Step 1.d. Subtotal in the first space.

Enter the ineligible spouse's remaining unearned income from Step 2.a. in the 2nd space and add this amount to the eligible's unearned income.

Subtract the $20 General Exclusion

Add any income based on need received by the eligible (not any received by the ineligible). This figure is taken from Step 1.f.

This procedure equals the couple's countable unearned income.

3.b. Enter the eligible's gross earned income and add this amount to any remaining earned income from Step 2.b. belonging to the ineligible spouse. Apply the applicable deductions to earned income to arrive at the couple's countable earned income.

3.c. Add together the totals from Step 3.a. and 3.b. to arrive at the total countable income,

3.d. Enter the couple FBR or FPL and subtract the total countable income from the FBR or FPL. If the couple's income is equal to or exceeds the SSI FBR or if income exceeds the FPL, the client is not Medicaid eligible. If a deficit results, the client is eligible based on income.

Instructions for Deeming from Ineligible Spouse to Eligible Individual and Eligible Child

1. Apply the rules of spouse to spouse deeming.

2. If spouse is eligible for Medicaid, there is no income to be deemed to eligible child.

3. If spouse is ineligible (determined in Step 3.d. on this worksheet), deem remaining income to eligible child(ren). Remaining income is that income over the amount needed to reduce the eligible spouse to zero payment. Transfer the countable income from Step 3.d. and the Monthly FBR for a couple, Step 3.d., to the Parent to Child Deeming Worksheet, Form 338, under "Additional Computation Space." Subtract these amounts to obtain the amount of income deemed to the child(ren). Enter this amount in Step 2 of Parent to Child Deeming Worksheet as unearned income and proceed with the remaining steps in Step 2 to determine child(ren)'s eligibility.

DOM-337
Revised 10-01-89

Regional Office _____

ELIGIBLE INDIVIDUAL/ELIGIBLE COUPLE & SPOUSE TO SPOUSE DEEMING WORKSHEET

Case Name _____ Case No. _____

INDIVIDUAL OR ELIGIBLE COUPLE CALCULATION

STEP

1. UNEARNED INCOME COMPUTATION

a. If applicable, subtract portion of VA that is Aid & Attendance

VA _____ _____
(specify type of VA)
less Aid & Attendance -_____

TOTAL . . . . . _____

b. If applicable, subtract portion of VA that is dependent's allocation (Use 1a total, if applicable)

VA _____ _____
(specify type of VA)
less dependent's allo. -_____

TOTAL . . . . . _____

c. List below the type(s) and amount(s) of all unearned income. Include VA total from 1a or 1b, whichever applies (Total VA is included in either 1c or 1f, depending on the type of VA.)

_____ _____

_____ + _____

_____ + _____

Sub Total _____

d. Subtract HR-1 and/or COL Disregard(s) - _____

Sub Total _____

e. Subtract General Exclusion - 20.00

Sub Total _____

f. Add Income Based on Need rec'd by the Eligible
Specify _____ + _____

g. COUNTABLE UNEARNED INCOME _____

h. EARNED INCOME COMPUTATION
(List type(s) and gross amount(s)

_____ _____

_____ + _____

_____ + _____

i. GROSS EARNED . . . . . _____
Subtract Portion of $20 Not Used in Step 1e. - _____

Sub Total _____

Subtract Work Exclusion - 65.00

_____
2) Sub Total _____

Subtract ½ Remainder - _____

Sub Total _____

Other Deductions
Specify _____ - _____

j. COUNTABLE EARNED INCOME _____

k. COUNTABLE UNEARNED (1g) _____

COUNTABLE EARNED (1j) + _____

TOTAL COUNTABLE INCOME _____

l. Appropriate FBR or FPL (Individual or Couple) _____

less TOTAL COUNTABLE INCOME (1k) - _____

_____

IF "0" OR SURPLUS, NOT ELIGIBLE--DO NOT CONTINUE

Worker Signature _____ Date _____

INELIGIBLE SPOUSE CALCULATION

STEP 2

a. Ineligible Spouse's Unearned Income (Do not include income based on need rec'd by spouse or any income used to budget this income) $_____

Subtract Allocation for Ineligible Child(ren)

Child's Name _____

Allocation _____

Subtract Child's Own Income - _____ - _____ - _____ - _____

Total Allocation + _____ + _____ + _____ = - _____

REMAINING UNEARNED INCOME _____

b. Ineligible Spouse's Earned Income . . . . . _____

Subtract Remaining Child's Allocation Not Offset in 2a. - _____

REMAINING EARNED INCOME _____

c. Add Remaining Unearned Income Total from 2a. . . . . + _____

d. TOTAL INCOME AFTER ALLOCATIONS . . . . . _____

- IF LESS THAN THE DIFFERENCE BETWEEN THE COUPLE AND INDIVIDUAL FPL OR THE COUPLE AND INDIVIDUAL SSI FBR (WHICHEVER IS APPROPRIATE) - NO DEEMING APPLIES, DO NOT CONTINUE.

COMBINED INCOMES AFTER ALLOCATING

STEP 3

a. Eligible's Unearned From Step 1d. Sub Total _____

Ineligible's REMAINING UNEARNED INCOME (2a.) + _____

Sub Total _____

Subtract General Exclusion - 20.00

Sub Total _____

Add Eligible's Income Based on Need (Step 1f) + _____

COUNTABLE UNEARNED INCOME _____

b. GROSS EARNED (Step 1i) _____

Ineligible's REMAINING EARNED INCOME (Step 2b) + _____

Sub Total _____

Subtract Portion of $20 Not Used in 3a. - _____

Sub Total _____

Subtract Work Expense - 65.00

2) _____ Sub Total _____

Subtract ½ Remainder - _____

COUNTABLE EARNED INCOME _____

c. Countable Unearned (3a.) _____

Countable Earned (3b.) + _____

Total Countable Income _____

d. FBR or FPL for Couple _____

Subtract Total Countable Income (3c.) - _____

IF "0" OR SURPLUS, NOT ELIGIBLE _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-338 - PARENT TO CHILD DEEMING WORKSHEET

PURPOSE & USE

This form is used to determine income eligibility for a disabled child when parent to child deeming is involved. Refer to Section H, Budgeting for At-Home Eligibility, for policy regarding parent to child deeming.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original only for the case record when needed.

STEP 1

1.a. Enter parent's combined gross unearned income. Do not include any income based on need received by the parent(s).

1.b. Subtract the living allowances for each ineligible child by entering the allocation amount from the chart of Need Standards in the Appendix for each ineligible child. Subtract each child's own income from the allocation. The remaining amount equals each child's total allocation. The total allocations are added together and subtracted from the parent(s) unearned income to arrive at the remaining earned income of the parent(s).

1.c. Enter the parent's combined gross earned income. Subtract any unused allocation for the ineligible children from Step 1.b. If there is no unearned income from 1.a., subtract the total allocation computed in 1.b. from any earned income in 1.c. The result is the remaining earned income.

STEP 2

2.a. Enter remaining unearned income from Step 1.b. Subtract the $20 general exclusion to arrive at countable unearned income.

2.b. Enter remaining earned income from Step 1.c. Subtract any portion of the $20 general exclusion not used in 2.a. Subtract the $65 work exclusion then subtract 1/2 the remainder to arrive at countable earned income.

2.c. Add countable earned income and countable unearned income together then subtract the living allowance for the parent(s). One parent's living allowance is equal to the full FBR for an individual. Two parents get the full FBR for a couple. Do not use the FPL (Federal Poverty Level) as a living allowance regardless of the coverage group of the child applying.

2.d. The result is the amount of income to deem in Step 3.

STEP 3

If there is more than one eligible child the amount of the parent(s) income deemed from Step 2 will be divided equally among the number of eligible children.

3.a. Enter the amount of deemed income from Step 2.

3.b. Enter the child's own unearned income. Add deemed income from 3.a. then subtract the general exclusion to arrive at the countable unearned income.

3.c. Enter the gross earned income belonging to the child and subtract applicable deductions to arrive at the countable earned income.

3.d. Add the countable earned to the countable unearned income.

3.e. Enter the appropriate FBR if the child is applying for SSI Retroactive benefits or as a Former SSI Recipient. If the child is applying as a PLAD or QMB, use the FPL for an individual. Subtract the total from 3.d. If the income equals or exceeds the SSI FBR or if the income exceeds the FPL, the child is not Medicaid eligible. If a deficit results, the child is eligible.

REMARKS/COMPUTATION SPACE: Use this for any necessary remarks or computation of income.

The worker will sign and date the form.

DOM-338
Revised 01-01-93

Regional Office _____

PARENT TO CHILD DEEMING WORKSHEET

CASE NAME _____ MEDICAID ID# _____

Step 1

a. Parents Unearned Income (Do not include income based on need received by either parent or any income used to budget this income.) _____

b. Subtract Allocation for Ineligible Child(ren):

Child's Name _____

Allocation _____

Subtract Child's Own Income _____ - - - -

Total Allocation _____ + + + + = - _____

REMAINING UNEARNED INCOME _____

c. Parents Earned Income (Total Gross) _____

Subtract Unused Portion of Allocation for Ineligible Children From Step 1b. - _____

REMAINING EARNED INCOME _____

Step 2

a. Remaining Unearned Income (1b) _____

Subtract General Exclusion - 20.00

COUNTABLE UNEARNED . . . . . _____

b. Remaining Earned Income (1c) _____

Subtract Portion of $20 not used above - _____

Sub-Total _____

Subtract Work Exclusion - 65.00

2) Sub-Total - _____

Subtract 1/2 Remainder - _____

COUNTABLE EARNED . . . . . _____

c. Add Countable Unearned + _____

TOTAL COUNTABLE INCOME _____

Subtract Living Allowance for Parent(s):
1 Parent = Full FBR Individual
2 Parents = FBR for Couple - _____

d. Amount of Deemed Income _____

	÷		=	
AMOUNT OF DEEMED INCOME	÷	NUMBER OF ELIGIBLE CHILDREN	=	DEEMED INCOME PER CHILI

STEP 3

a.	Amount of Deemed Income to be Deemed to Child	
b.	Add Child's Own unearned Income	+
	Sub-Total	
	Subtract General Exclusion	- 20.00
	COUNTABLE UNEARNED INCOME	
c.	Add Child's Own Earned Income	+
	Sub-Total	
	Subtract Portion of $20 General Exclusion Not Used in 3b.	-
	Sub-Total	
	Subtract Work Exclusion	- 65.00
	Sub-Total	
	Subtract 1/2 Remainder	-
	COUNTABLE EARNED INCOME	
d.	COUNTABLE UNEARNED (Total from 3b)	
	ADD COUNTABLE EARNED (Total from 3c)	+
	TOTAL COUNTABLE INCOME	
e.	Appropriate FBR or FPL	
	Subtract Total Countable Income	-
	RESULT	

REMARKS/COMPUTATION SPACE

Medicaid Specialist _____ Date _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-339 - STATEMENT REGARDING PAYMENT OF HEALTH INSURANCE PREMIUMS & NON-COVERED MEDICAL EXPENSES

PURPOSE & USE

This form is used to verify payment of an allowable health insurance premium and non-covered medical expenses billed to a nursing home client in a given quarter. The form must be completed by the client or designated representative for both health insurance and non-covered medical expenses deductions. In addition, if non-covered medical expenses are claimed, the provider of the service must complete the appropriate section of the form. Refer to Section I, Institutionalization, for policy regarding these deductions.

INSTRUCTIONS

All new nursing home approvals must be provided with a Form DOM-339 to be returned at the end of the assigned quarter. Recipients who participate in claiming non-covered medical expenses will be provided with a new Form DOM-339 whenever a completed form is submitted to the Regional Office. DOM-339 Forms that are not completed by the proper authority (Designated Representative, Physician or Hospital) will not be accepted as sufficient verification and the expense(s) will not be allowed as a deduction.

The worker will complete the top portion of the form to specify the months of the quarter to be reported on the form by placing the name of each of the 3 months in the assigned quarter at the top of each column on page 2.

The worker will complete the bottom portion of the form to specify the date the form is due. The Regional Office name and address must also be stamped in the space provided.

DOM-339
Revised 10-01-96

Case Name _____

Medicaid ID #_____

STATEMENT REGARDING PAYMENT OF HEALTH INSURANCE PREMIUMS AND NON-COVERED MEDICAL EXPENSES

Medicaid will allow certain non-covered medical expenses and one health insurance premium to be deducted from the income a nursing home client must pay toward the cost of care (Medicaid Income). Expenses are computed on a quarterly basis. An allowable expense billed in one quarter will not be allowed as a deduction until the next quarter. For example, expenses billed in October will be deducted from Medicaid Income due for January.

Health Insurance Premium Verification

Medicaid can allow an income deduction for one health insurance premium paid by a nursing home client. If the client named above pays for health insurance (other than Medicare), name the policy to be allowed as a deduction.

_____

How often is the premium paid? _____

Is the client's money used to pay for this health insurance premium? ☐ YES ☐ NO

YOU MUST SEND IN PROOF OF PAYMENT BY THE CLIENT AND THE PREMIUM NOTICE FOR A PREMIUM BILLED IN ORDER FOR THE PREMIUM TO BE ALLOWED. If paid monthly or bi-monthly, submit proof of only one payment.

✓_____ _____

SIGNATURE OF CLIENT OR DESIGNATED REPRESENTATIVE DATE

COMPLETED FORM DUE BY _____

Mail to the Regional Office address stamped below:

Non-Covered Medical Expenses

Medicaid can allow income deductions for medical services in excess of the Medicaid service limit for physician visits and/or hospital admissions. Before the expense can be allowed, it must be verified by the provider and all other third party payments must have been paid (such as Medicare and other insurance) so that the client's liability can be clearly identified.

If the client has been billed for physician and/or hospital expenses, is the client's money used to pay for these expenses? ☐ Yes ☐ No

✓ _____ _____

SIGNATURE OF CLIENT OR DESIGNATED REPRESENTATIVE DATE

	MONTH	MONTH	MONTH
PHYSICIAN EXPENSES -- THIS PORTION MUST BE COMPLETED BY THE PHYSICIAN'S OFFICE BILLING THE EXPENSE -- There should be no physician charges for a recipient who has Medicare as there are no physician limits on Medicaid/Medicare recipients. Include only charges in excess of the annual service limit. Name of Physician _____ Physician Charges Billed to Recipient	$_____	$_____	$_____
Physician's Signature _____ Date _____			
HOSPITAL EXPENSES -- THIS PORTION MUST BE COMPLETED BY THE HOSPITAL BUSINESS OFFICE. Include only those charges in excess of the annual service limit that are not covered by Medicare or other insurance. Name of Hospital _____ Hospital Charges Billed to Recipient	$_____	$_____	$_____
Business Official's Signature _____ _____ Date _____			

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-350 - REQUEST FOR LOCAL HEARING

PURPOSE & USE

The purpose of this form is to allow a client or representative to make a written request for a local hearing. Refer to Section J, Hearings, for policy regarding local hearings.

INSTRUCTIONS

This form will be completed when the client requests a local hearing via a form rather than a letter. The completion of this form is not mandatory; however, the hearing request must be made in writing. Prepare an original and 1 copy. File the original in the case record for use in scheduling the hearing. The copy belongs to the client.

The client or representative will complete and sign the form except for the Regional Office section.

The worker will enter in the space provided the following: The date the hearing request was received in writing; the date the notice to the client, either DOM-305 or 306, was mailed to the client; and, check whether or not continuation of benefits applies. Refer to Section J, Hearings.

DOM-350
Revised 04-01-82

Regional Office _____

Case Name _____

Medicaid ID # _____

REQUEST FOR LOCAL HEARING

I wish to request a local hearing for the following reason (s):

_____
Date

✓ _____
Signature of Client or Representative

_____
Mailing Address

_____

FOR REGIONAL OFFICE USE ONLY

Date Local Hearing Request Received in Writing _____

Date Notice to Client Mailed _____

Continuation of Benefits ☐ Yes ☐ No

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-351 - NOTICE OF DECISION ON LOCAL HEARING

PURPOSE & USE

This form is used to notify the client of the decision rendered as a result of the local hearing. This form may also be used by the client to request a State-level hearing if he/she disagrees with an adverse local-level hearing.

Prepare an original and 1 copy. The original is mailed to the client or representative and the copy is filed in the case record. Refer to Section J, Hearings.

INSTRUCTIONS

In the space provided, enter the date the local hearing was held and the decision reached by the Regional Office staff member who conducted the hearing. The decision must include a policy statement which supports the decision, i.e., the policy pertaining to the hearing issue must be explained.

In addition, the effective date of any further action to be taken as a result of the hearing will be specified. For example, if benefits are to be reinstated, the effective date of reinstatement must be shown. If benefits have been continued pending the hearing and the hearing decision is adverse, the effective date of any reduction or termination of benefits will be shown.

Date of Mailing: Enter the date the form is mailed to the client.

Signature of Local Hearing Officer: The person who conducted the local hearing will sign here.

Mailing Address of Regional Office: Stamp the Regional Office address in this space.

A hearing pamphlet will be enclosed on all adverse hearing decisions.

DOM-351
Revised 04-01-82

Regional Office _____

NOTICE OF DECISION ON LOCAL HEARING

TO _____

_____

_____

Case Name _____

Medicaid ID # _____

This is to notify you of the decision reached as a result of the local hearing held _____

_____. The decision is as follows:

If you disagree with this decision and wish to request a State hearing, we must receive your written request within 15 days from the date of mailing shown below. In order to request a State hearing you may complete the bottom portion of this form and mail it into the Regional Office at the address shown below. If we do not hear from you within 15 days from the date of mailing this form, we will know that you understand the reason for this decision on your local hearing.

_____ _____

Date of Mailing Signature of Local Hearing Officer

Mailing Address of Regional Office:

COMPLETE THIS SECTION IF YOU WISH TO REQUEST A STATE HEARING

I wish to request a State Hearing because I disagree with the decision reached on my local hearing.

_____ _____

Date Signature of Client or Representative

Enclosure: Hearing Pamphlet

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-352 - REQUEST FOR STATE HEARING

PURPOSE & USE

This form is used to allow the client/representative to make a written request for a State hearing. If a local-level hearing has already been held on the same issue, the client may request a State hearing by completing the bottom portion of DOM-351 or by completing DOM-352. Either method is acceptable.

The completion of this form is not mandatory; however, all hearing requests must be made in writing. If the client prefers, the request may be put in a letter to the Regional of State Office. Refer to Section J, Hearings.

INSTRUCTIONS

Complete an original and 2 copies. The original will be forwarded to the Eligibility Division in the State Office. One copy is part of the case record kept in the Regional Office, and the other copy is the client's.

The client or representative will complete and sign the form except for the Regional or State Office section.

FOR REGIONAL OR STATE OFFICE USE ONLY

The Regional Office will complete this section if the hearing request is filed with the Regional Office. If the request is mailed directly to the State Office, the hearing official will complete this portion by contacting the Regional Office.

1. Check whether or not a local hearing has been held.

2. Enter the date DOM-306 was mailed to the client; or, if a local hearing has been held, enter the date DOM-351 was mailed to client.

3. Check whether or not continuation of benefits is applicable.

DOM-352
Revised 10-01-96

Regional Office _____

Case Name _____

Medicaid ID # _____

REQUEST FOR STATE HEARING

TO: **Division of Medicaid, Office of the Governor**
Eligibility Division
239 North Lamar Street, Suite 801
Jackson, Mississippi 39201-1399

I wish to request a State hearing before a State hearing officer for the following reason(s):

_____

_____

_____

_____

_____

_____

_____

Date: _____ ✓ _____

SIGNATURE OF CLIENT OR REPRESENTATIVE

_____

MAILING ADDRESS

_____

FOR REGIONAL OR STATE OFFICE USE ONLY

Has Local Hearing been held? ☐ Yes ☐ No

Date DOM-306 or DOM-351, if Local Hearing held, was mailed: _____

Continuation of Benefits apply: ☐ Yes ☐ No

MEDICAID ELIGIBILITY FORMS AND INSTRUCTIONS

DOM-354 - IMPROPER PAYMENT REPORT

PURPOSE & USE

This form is used by the Regional Office to report cases involving improper Medicaid payments due to Agency or client error. The form is submitted to the Medicaid Eligibility Division in the State Office. Refer to Section I, Improper Medicaid Benefits.

INSTRUCTIONS

Prepare an original and 1 copy. Exception: Prepare an original and 2 copies when the report is for a Medicaid eligible couple or two separate cases in the same family. The copy remains in the case record and the original is routed to the Medicaid Eligibility Division. The form should be typewritten when possible. If typing is not possible, please be sure the handwriting is legible. Each section of the form should be completed or notated as not applicable (NA). Extra sheets of paper may be used when there is not enough room on the form to fully explain.

Regional Office: Enter the Regional Office name.

1. Aged & Disabled Medicaid: Enter the name of the recipient, Medicaid ID number, and address. For an eligible couple, enter the name of the spouse also. Enter the name and address of the designated representative, if applicable.

2. Improper Payment Information: Enter the reason for the Improper Payment (check the applicable block) and the source of the information, such as IEVS hit, SVES, BENDEX, SDX, bank clearance, etc. Explain how this information was verified by independent verification. Enter the date of the last redetermination (or application or last contact with the client or representative as appropriate). In the space provided, summarize the events/cause of the improper payment. Include pertinent dates, such as the date(s) the changes occurred that caused the improper payment.

3. Period of Time Covered by Improper Payment: Enter the beginning date (month/day/year) that the improper payment began. This is the date the change could have been effected had the change been reported timely or acted upon promptly. Also enter the ending date (month/day/year) of the improper payment.

   Enter the client's coverage group for each improper payment period of time. In the space provided, enter the amount of Medicaid Income used and the amount Medicaid Income should have been (correct amount). Enter the coverage group in which eligibility remains for each improper payment period (if appropriate).

4. Action by Regional Office: Enter the effective date of closure via MEDS or the effective date of the corrective action via MEDS, whichever is applicable.

5. Resources Available for Recovery: Enter the client's income source(s) and amount(s) and list any and all resources available to the client.

   Worker Signature/Date: The worker completing the form will sign and date here.

   Supervisor Signature: The Medicaid Specialist Supervisor will sign here after reviewing the form.

   Date: Enter the date the form is signed by the Supervisor.

DOM-354
Revised 09-01-95

Regional Office_____

IMPROPER PAYMENT REPORT

1. AGED & DISABLED MEDICAID

Recipient's Name_____ ID#_____

Address_____

Designated Representative's Name & Address_____

_____

2. IMPROPER PAYMENT INFORMATION

Reason for Improper Payment:
( ) Suspected Fraud
( ) Agency Error
( ) Client Error

Source of Information:

_____

Verification of Information:

_____

Date of Last Redetermination (or Application) or Date Information Was Last Reported

_____

Summarize the Events/Cause of Improper Payment (include date(s) changes occurred)

_____

_____

_____

_____

_____

_____

3. PERIOD OF TIME COVERED BY IMPROPER PAYMENT:

The begin date of the improper payment is the date action could have been taken if the information had been promptly reported or acted upon:

Begin Date MM/DD/YY	End Date MM/DD/YY	Cov. Group in which ineligibility occurs	Medicaid Income Used	Correct Medicaid Income	Cov. Group in which eligibility remains
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

4. ACTION BY REGIONAL OFFICE

Effective date of case closure or correction: _____

_____

5. RESOURCES AVAILABLE FOR RECOVERY

_____

_____

_____

_____

WORKER'S SIGNATURE _____ DATE _____

SUPERVISOR'S SIGNATURE _____ DATE _____

MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-367 - RECORD OF CONTACT

PURPOSE & USE

The Record of Contact is used to record the events that occur during the application process and during the remainder of the time the case remains active. All telephone contacts concerning the client and correspondence or forms issued to the client are recorded on DOM-367. Any action taken by the worker on the case is also recorded on the form.

INSTRUCTIONS

The Record of Contact is completed by the worker or supervisor handling the case and is filed in the case record. Only the original is required and when both sides are full, begin entries on a new form. Disposal of an application should be notated in red ink for easy reference.

Revised 11-01-84

Medicaid ID #______________________

RECORD OF CONTACT

...e	Person/Source Contacted	Purpose/Results of Contact	Init.