APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

A. NOTICE TO CLIENT

The client must be notified in writing, via the appropriate DOM Form, of any action taken on the client's application or active case which affects eligibility or level of benefits. The appropriate notice to use depends on the type of action taken on the case as outlined below:

1. DOM-305, Notice of Action

This notice to the client is used when the action taken on an application or active case involves any of the following:

- Approval of application. This form is used to approve retroactive benefits, ongoing eligibility, or a combination of the two. The effective date of approval and the amount of Medicaid Income, if any, will be shown on the form. DOM-305 is used when approving only a portion of the benefits applied for, e.g., when the applicant applied for 3 months retroactive benefits but can only be approved for 1 month. If a portion of the benefits applied for are to be denied or if eligibility will expire at a predetermined time, an explanation must be provided in the remarks section of the form.

- Approval of redetermination. For nursing home clients this form is used to approve the redetermination or special review of a case, provided benefits remain the same or increase, meaning the client's Medicaid Income is reduced. If Medicaid Income increases, this is considered a reduction in benefits and, thus, results in an adverse action. Refer to the following subsection for policy outlining the effective date of action for changes.

- Transfer of case to another Regional Office. This form is used to notify the client when the case record is transferred to another Regional Office. The address of the Regional Office that will handle the case will be posted on the form.

The Notice of Action includes a statement concerning the client's right to a fair hearing. However, the fair hearing statement does not include the 10-day advance notice for continuation of benefits, as this provision is not applicable to approval of applications or an increase in benefits. The applicant or client has 30 days from the date of mailing posted on the form to request a hearing if dissatisfied with the action taken on the case.

2. DOM-306, Notice of Adverse Action

This notice is used when the action taken on an application or active case involves any of the following adverse actions:

- Denial of application. This form is used when all benefits applied for must be denied. The reason for the denial will be clearly stated in the space provided on the form. Although a denial is an adverse action, there is no need to hold the denial for 10 days, since the continuation of benefits provision does not apply.

- Closure of active case. This form is used to close a client's case. The effective date and reason for the closure will be clearly stated in the space provided and the continuation of benefits provision applies as outlined below. Refer to the following subsection for policy outlining the effective date of closure.

- Increase in Medicaid Income. This form is used to report an increase in Medicaid Income for nursing home/hospital clients. The effective date and reason for the increase will be clearly stated in the space provided and the continuation of benefits provision applies outlined below. Refer to the following subsection for policy outlining the effective date of increases in Medicaid Income.

- Termination of Nursing Facility vendor payment. This form must be used to terminate a client's vendor payment in instances where a transfer penalty is to be applied or a nursing facility level of care is denied or terminated. Advance notice to terminate the vendor payment is required for MAO and SSI-only clients

- Conversion to a reduced services coverage group. This form is used to notify the client that eligibility for full Medicaid services is being terminated and eligibility will continue for reduced services only, such as QMB or SLMB.

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B. ADVANCE NOTICE PERIOD

Federal regulations mandate that the agency mail a notice of of adverse action 10 days before the date of action to reduce or terminate Medicaid benefits, except for situations classified as "Exceptions to Advance Notice." The required advance notice period is 10 calendar days beginning with the day after the date of mailing which is posted on the DOM-306. However, for MEDS purposes the actual advance notice period is 12 calendar days from the end of a month to allow for notice processing and mailing. It is mandatory that the Notice is mailed out on the date posted as the date of mailing so that the client is allowed the maximum advance notice time in order to timely request a hearing whereby continuation of benefits applies.

During the 12-day advance notice period, the agency cannot authorize any action to reduce or terminate benefits. If action is erroneously taken to reduce or terminate benefits during the advance notice period and the client requests a hearing during the advance notice period, benefits must be reinstated as discussed in the following subsection.

1. Continuation of Benefits

This provision applies to any action taken to reduce or terminate Medicaid benefits. Form DOM-306, Notice of Adverse Action, contains space for the worker to enter the date which represents the last day of the advance notice period. This is the 12th calendar day from the day after the date of mailing which is posted on the notice. If a client requests a fair hearing during the 12-day advance notice period, the agency may not reduce or terminate benefits until the final hearing decision is rendered. For a detailed discussion on how to determine if a hearing is requested timely in order for continuation of benefits to apply, refer to the Hearings Section.

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2. Exceptions to Advance Notice

The following situations represent exceptions to advance notice whereby the action does not have to be held; however, the DOM-306 must be issued:

- The agency has factual information confirming the death of a client.

- The client submits a voluntary request for closure of his/her case. This request must be in writing, signed by the client or his/her designated representative.

- The client is admitted to a public institution, e.g., prison or a State hospital in a non-Title XIX facility.

- The recipient's whereabouts are unknown and the Post Office returns agency mail indicating no forwarding address. If the client's whereabouts become known during the time the client is eligible for services, the case must be reinstated.

- The agency establishes the fact that the client has been accepted for Medicaid services by another State.