APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

G. REINSTATEMENTS

Certain situations require a reinstatement of services which means that either eligibility is restored or Medicaid Income is corrected for a prior period. Either type of reinstatement is accomplished without requiring that a new application be filed on behalf of the recipient. A reinstatement of services is in order in the following situations:

1. Hearing Decision

A hearing decision is rendered as a result of a State or local hearing which grants eligibility or increased benefits. Based on the findings of a State or local hearing, the Regional Office may be required to reinstate eligibility or correct Medicaid Income, whichever is appropriate, retroactive to the date decided by the hearing official.

Note: If benefits were continued pending the hearing decision on an active case, reinstatement may not be required unless the decision at the hearing is to increase the level of benefits in effect prior to the hearing.

2. Advance Notice Period

Proper advance notice policy is not followed as outlined in the "Notification Process" subsection for adverse actions. This includes situations where:

a. Appropriate advance notice is issued; however, the client timely request a hearing during the advance notice period.

b. Advance notice to reduce or terminate benefits is not issued as required; therefore, benefits must be reinstated at the time the error is discovered, regardless of whether the client is currently eligible. Benefits must be reinstated and the appropriate advance notice issued.

3. Client's Whereabouts Become Known

A client's whereabouts are unknown as indicated by the return of unforwardable agency mail directed to him/her. Any discontinued Medicaid must be reinstated if his whereabouts become known during the time he/she is eligible for Medicaid. To do this the worker must determine

eligibility for each month that the client's whereabouts were unknown and reinstate for any period of time he/she would have been eligible.

4. Temporary Case Closure

A case is closed temporarily for 2 months or less.

Note: Although no new application is required for temporary closures of 2 months or less, a break in the client's eligibility correctly exists. Therefore, it is necessary to adjust the client's beginning Medicaid date via MEDS to reflect the most recent beginning Medicaid date.

5. Reapplication

A second application is requested on an application that has been in rejected status for less than 2 months. The rejected application can be updated and signed by the applicant or representative thereby establishing a new application date that supersedes the initial application date. However, all factors of eligibility that are not subject to change need not be reverified, i.e., disability, physician certification. Income and resource factors may require further verification, depending on the types involved.

The beginning date of eligibility is controlled by the second or updated date of application.

6. Agency Error

The agency discovers that eligibility was denied or terminated in error or that benefits were reduced in error due to agency failure to act on information present in the case record or information that was presented within the advance notice period that established eligibility.

The discovery of erroneous action may come about through:

- a review of the case or application,
- a complaint made by or for the applicant or client,
- recognition of the error by the worker, or

- other sources having knowledge of the error.

When the agency fails to act on information provided during the application/redetermination process or during the advance notice period, action must be initiated to reinstate benefits retroactive to the month in which the erroneous action took place. No corrective action to reinstate benefits is required when the information establishing eligibility was not provided to the agency either prior to or during the advance notice period; instead a new application must be filed.